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Support for Internationally Educated Nurses Transitioning into Practice:

An Integrative Literature Review

By

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BScN, University of Victoria, 2007.

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Abstract

An integrative literature review is a form of research that allows for the review and critique of empirical and theoretical literature on a particular phenomenon, or topic (Torraco, 2005; Whittemore & Knafl, 2005). The integrative literature review essentially combines findings from studies of different methodologies, (for example, quantitative and qualitative research,) and can therefore provide a broader scope regarding the enhancement of nursing practice and related theory and policy development (Whittemore & Knafl, 2005). As workforce diversity for registered nurses continues to evolve within Canadian practice settings, there will be a need to develop evidence based practice initiatives to align with this workforce (Canadian Nurses Association, 2005). The aims of this integrative review are to explore the phenomenon of support for internationally educated nurses (IENs) as they transition into practice, and to make recommendations regarding the development, implementation and evaluation of a framework of support for IENs, as they integrate into Canadian practice settings.

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Acknowledgement

"Other things may change us - but we start and end with family" Anthony Brandt.

This journey has not been a solo adventure. Instead, it has been shared and supported by those who are most dear to me – my family. To my husband who has shared in my triumphs and my tears along the way – all that I have accomplished, I could not have done without you. To my children who have encouraged me along the way – having faith that I would find a balance within my many roles in life. To my mother who sparked this educational journey so many years ago. To my siblings for their continued love and support. To my grandmother who crossed the Atlantic Ocean when she was sixteen years old, never to see her family again, so that her children and her grandchildren would have opportunities such as these. The phrase "thank you" in no way can encapsulate how deeply grateful and how blessed I am, to be a part of this amazing family. As such, I would like to dedicate this piece of the journey to their hard work and extra love and support as I have pursued this dream.

To my academic advisors, Jane Milliken and Carol McDonald - thank you for your guidance, for sharing your collective knowledge and wisdom and for pointing me in the right direction when I could not seem to find my way. Your many hours of additional time in supporting my journey have not gone unnoticed.

It only seems fitting to end this dedication with our family motto: "On to the next adventure!"

Support for Internationally Educated Nurses Transitioning into Practice: An Integrative Review

Operational Definition – Internationally Educated Nurse

Internationally educated nurses (IENs) are registered nurses who have obtained their basic nursing education in a country different from the one in which they are practicing (Lum, 2009; Xu & Kwak, 2005b). While they may come to Canada from a variety of source countries, such as the Philippines (Blythe & Baumann, 2008) and for a variety of reasons, including seeking out a better life for themselves and their families (Sochan & Singh, 2007), little is known about them and thus they have been referred to as the "forgotten nurses" in the health care system (McGuire & Murphy, 2005).

Statement of the Problem

Canada is considered a destination country for immigration, as it provides opportunities for economic and social development in an environment free of war and discrimination (Human Resources and Skills Development Canada [HRSDC], 2005). Current demographic trends suggest immigration will account for "all net labor force growth in Canada within the next 10 to 15 years and all net population growth in Canada within the next 30 years" (HRSDC, 2005, p. 1). Approximately 85% of the labor market accounts for non-regulated occupations, while 15% of the workforce, such as registered nurses, are regulated through legislation and regulatory bodies (HRSDC, 2005). In 2005, 7.6% of employed registered nurses in Canada identified that they were internationally educated (Canadian Institute for Health Information [CIHI], 2006).

Anticipating a growing trend in internationally educated nurse (IEN) immigration, the Canadian Nurses Association (CNA) projected a vision for nursing practice in the year 2020 (Villeneuve & MacDonald, 2006). Citing the growing gap between nursing human resource

availability and employment vacancies, Villeneuve and MacDonald (2006) predicted a shift of cultural diversity within the nursing profession, with an increase in Aboriginal and visible minority nursing professionals and the additional migration of IENs from around the globe.

Although some new Canadians will not experience any difficulties in securing employment, many highly skilled immigrants will. The process of verifying foreign credentials and previous career experience can be inhibited by time delays, financial burden and biased interpretation, resulting in the inability to secure discipline specific employment (Baldacchino & Hood, 2007; Blythe & Baumann, 2008). Although challenges such as these may impede the ability of Canadian employers to recruit skilled immigrants, they also highlight the importance of a Pan-Canadian approach to human resource strategy and policy development (Health Canada, 2008).

IENs are one such group that has experienced barriers in meeting entry to practice requirements and in obtaining full licensure to practice (Baldacchino & Hood, 2007; Blythe, Baumann, Rheaume & McIntosh, 2009). Some of the recognized barriers include non-recognition of international credentials (Baldacchino & Hood, 2007), inability to demonstrate nursing competencies (Meretoja, Leino-Kilpi & Kaira, 2004), English language fluency and cultural barriers (Curtis, Dreachslin & Sinioris, 2007; Kolawole, 2009).

In Ontario in 2005, 94.9% of IEN licensure applicants had not secured their license to practice within a year of their application date, leaving a success rate of only 5.1%. This compares to 82.5% of successful Ontario educated nurses during the same one year time frame (Kolawole, 2009). IENs wishing to practice in British Columbia have experienced similar challenges. In May 2007, the College of Registered Nurses of British Columbia (CRNBC) reported a total of 946 IEN applications for licensures were in review. From these applications,

the CRNBC granted 306 IENs full registration status. A majority of the 306 successful applicants had originally applied for licensure more than a year before approval, and some as far back as 2004 (CRNBC, 2007).

In collaboration with federal, provincial and territorial stakeholders, several pan-Canadian strategies to support IENs were initiated in 2005, including the Framework for Collaborative Pan-Canadian Health Human Resource Planning and the Internationally Educated Health Professionals Initiative (Health Canada, 2008). Underpinning these initiatives are the principles of consistency, public safety, fairness, equitable access, consideration for competencies and credentials, as well as a process of transparent disclosure (CNA, 2005).

Development in IEN competency assessment was supported by the creation of the Capacity Building for Internationally Educated Nurses Assessment Project (CBIA). Funded through Health Canada, this three-year project was a proposal for developing a Pan Canadian IEN assessment and bridging program (CBIA, 2009). As of 2009, a total of three IEN assessment centers have been established in the provinces of BC, Saskatchewan and Manitoba. For complex IEN applications, or where validating international experience and competency knowledge may be in question, regulatory bodies can have IEN applicants assessed by one of the endorsed assessment centers, with the aim of providing recommendations for supplementary education if required (CRNBC, 2010). These initiatives provide a structural framework for regulatory bodies during preliminary assessment and evaluation stages of the licensure process, but they do not provide the same direction or guidance for workplace integration (Kolawole, 2009; Lum, 2009).

Challenges with integrating IENs into Canadian practice settings have been well documented and include ineffective orientation programs (Blythe et al., 2009), occupational

barriers to employment (Baldacchino & Hood, 2007), and inadequate assimilation and acculturation into Canadian culture and practice environments (Lum, 2009; Raghuram 2007). Further, various authors posit that successful integration of IENs into new practice settings is best facilitated with effective acculturation programs (Ea, Griffin, L'Eplattenier & Fitzpatrick, 2008), structured work environments to foster education (Meretoja, et al., 2004), as well as strong organizational, supervisory and peer supportive environments (Drach-Zahavy, 2004). While various theorists may endorse one concept or methodology of IEN assessment and transition over another, for many health authorities understanding the concept of support for IENs as they transition into practice still remains unclear.

For the purposes of this integrative review I will explore the following question: "What does support look like for IENs as they transition into practice?" A review of literature related to the idea of support for IENs suggests there are many variables, both implicit and explicit, that contribute to the overall concept of support (Blythe et al., 2009; Curtis, et al., 2007; Puzan, 2003). Herein lies the inquiry – what are the embedded variables, or themes, within existing frameworks of support and what influence do they have on IENs? I wonder whether there are any differences in the bridging support for IENs versus Canadian nurses. Why would this issue be of concern to nursing practice? What impact does it have on providing safe client care? I would like to identify if there an existing framework or methodology that would facilitate the creation of a supportive environment for IENs.

Aims/Objectives of the Project

The intention of this integrative literature review is to explore what is known about the various interpretations and contributing concepts of support for IENs. What support processes

occur when integrating IENs into Canadian practice settings? Are there any barriers? What is the source of these barriers and are there any recommendations to address them?

Importance or Significance of Topic

Watt, Law, Ots and Waago (2002) suggest that the very label of IEN implies that these nurses may originate from any country and may migrate to any country. The global variation within nursing education and practice introduces varied interpretations of knowledge, competencies and skills. Varied interpretations of nursing heighten the importance of sensitivity around issues related to support for IENs. Villeneuve and MacDonald (2006) predict an increase of IENs practicing in Canadian contexts, primarily under a proposed Pan-Canadian license. The move toward consistency in licensing further suggests the urgency for the development of a consistent assessment and transition process for IENs. Failure to do so could result in financial implications, with substantial decrease in health services and increases in nursing vacancies (Kolawole, 2009).

Although many regulatory bodies do not advocate the active recruitment of IENs from other countries also experiencing professional nursing shortages (International Council of Nurses [ICN], 2008), many IENs are already living in Canada and are either unemployed, or underemployed, working in survival jobs (Blythe & Baumann, 2009; Lum, 2009). Baldacchino and Hood (2008) report that 61% of research respondents who were internationally educated health professionals had self declared they were either unemployed or underemployed and working in non health related areas, such as pizza restaurants. While the true number of internationally educated health professionals remains difficult to capture, there is a moral and ethical obligation to provide support in assisting registered nurses in securing profession-appropriate employment (Hamilton, 2008a).

Work related to a framework of support for IENs still remains in the infancy stage and has yet to demonstrate generalizability throughout Canada (Kolawole, 2009; Lum, 2009). As such, we should look beyond Canadian boundaries to explore the migration, implementation and integration of IENs in other geographical areas.

Theoretical Perspectives

Crotty (2009) posits that for purposes of structure and direction, any research process should include four distinct elements. These four elements have been identified as: (a) epistemological underpinnings, (b) theoretical perspective, (c) methodology, and (d) methods. Each of these four elements has been incorporated within this integrative review and explained in relation to their relevance to this project.

The epistemological perspective or element chosen for this review is aligned with constructionism. Within constructionism there is no objective truth. Instead, truth and meaning comes into existence through our engagement with the realities and experiences within our world. As such, different people will construct meaning and truth in various ways (Crotty, 2009). For IENs who may emigrate from a variety of countries and who will have various interpretations of their experiences, it becomes imperative to recognize that each person's experience and perception will be valid and truthful for that individual. As a research reviewer for this project, I will adopt a constructionist lens and in doing so, will approach this review recognizing that different people, as portrayed within the research, will experience and construct meaning on the phenomenon of support in different ways.

The theoretical perspective or philosophical stance that has been chosen to guide this project is phenomenology. The philosophical assumptions within phenomenology posit that reality consists of objects and events as they are perceived, or understood in human

consciousness (Polifroni & Welch, 1999). For IENs and those they encounter during the support and integration phase of practice, it becomes crucial to examine the lived experience of each of these individuals, regarding their perceived experiences of practice support and transition processes. As a research reviewer for this project, I will locate myself within the theoretical assumptions grounded in phenomenology, in order to examine the lived experiences identified within the literature.

Methodological Approach and Stages

The methodology chosen for this project is the framework of an integrative review process, guided by the work of Cooper (1989), and Whittemore and Knafl (2005). An integrative review provides an opportunity to comprehend a poorly understood phenomenon, using multiple means of data collection and triangulation of ideas to explore interpretations across various paradigms (Cooper, 1989). Further, an integrative review methodology provides an opportunity to summarize the accumulated knowledge on the phenomenon, in this case the phenomenon of support, and to highlight issues that research has left unresolved (Whittemore & Knafl, 2005). It is important to note that while a framework of constructionism and phenomenology was used for the purposes of this integrative review, various paradigms and theoretical perspectives, including post-colonialism, feminism and critical theory were also considered during the assessment of identified literature for this project. The connection between these paradigms and theoretical perspectives, as it applies to the phenomenon of support, was evident in identified themes within literature examined for this project, such as oppression and workplace violence. These themes and others were further explored in the data interpretation section of this project, as they contribute towards providing a more comprehensive understanding of the phenomenon of support and integrating IENs into practice.

Cooper's (1998) integrative review process has five distinct methods by which to explore previous literature and select literature in relation to demonstrated reliability and validity. These five methods include: (a) problem formulation – identifying and defining a concept of interest, (b) data collection from the target and accessible population, (c) evaluation of data points, (d) data analysis and interpretation and finally (e) presentation of the results. Each of these five methods are explored in further detail.

Problem formulation.

I conducted an integrative literature review to address the question: "What does support look like for internationally educated nurses as they transition into practice?" For the purposes of this review, the concept of support has been operationally defined as an explicit structure or framework that provides a foundation of educational, cultural, ethical and organizational membership support. Within this definition of support, six concepts specifically related to IENs, emanating from the preliminary research review, have been explored in greater depth. These six concepts include: (a) mentorship, (b) explicit learning/education plans, (c) educational theory/pedagogical approaches, (d) organizational support/sponsorship, (e) connection with community, and (f) work and learning environments.

There are also three stages within the transition process identified within the literature: (a) pre-licensure stage, (b) employment stage and, (c) post-licensure stage. It was important to identify at what stage of transition each of the six concepts of support can be successfully applied. By combining both of these frames of reference, I have been able to offer recommendations for a framework of support for IENs.

Cooper (1998) recommends that when conducting an integrative literature review, data needs to be gathered from a variety of sources and researchers should employ a variety of

methodologies in the analysis and synthesis of the data. The intent of this process is two-fold: (a) to reduce bias by conducting a broad review of available data, and (b) to ensure all relevant literature is gathered and analyzed with the intention of demonstrating generalizability, or homogeneity, related to the subject matter being explored.

Literature search – data collection.

For the purposes of this integrative review, the term "data" has been defined as the pieces of information obtained from the literature that was reviewed, critiqued, and included for this project as it relates to the phenomenon of support (Polit & Beck, 2008). I utilized Cooper's (1998) Five Stages of Integrative Research Review to collect and analyze the data within the following sequenced framework: (a) problem identification, (b) literature search – data collection, (c) data evaluation, (d) data analysis and interpretation, (e) public presentation. Studies have been identified utilizing a database search. Data were gathered from these online databases: (a) Cumulative Index of Nursing and Allied Health Literature (CINAHL), (b) Social Science Index, (c) J-STOR, (d) Cochrane, (e) Medline with full text, (f) PubMed Canada Central, (g) EBSCO, and (h) Springer Link. Key search terms included the following: (a) "internationally educated registered nurses", (b) "support", (c) "practice environments", (d) "transition", (e) "integration", (f) "cultural adaptation", (g) "educational support", or different combinations of these key search terms.

For further clarity and focus, literature was initially excluded if it did not clearly identify IENs as the primary population of interest. However, to reduce the potential invalidity in review conclusions, literature initially excluded from this process was further examined to identify whether it included one or more of the six concepts of support relevant to this integrative review, as outlined in the data interpretation section of this project. The inclusion of literature from

accessible studies provided an opportunity to understand a poorly understood phenomenon (support), by using multiple means of data collection, triangulating ideas, and interpretations across paradigms (Cooper, 1989). Cooper (1989) identifies that people sampled in accessible studies might be different from the target population, but that the findings of the research can be pragmatically connected with the population of interest (IENs).

Data were also gathered through a process of journal hand searching (Patton, 2001; Whittemore & Knafl, 2005). In a literature review of the following journals, I have identified content specific to IENs: (a) International Journal of Intercultural Relations, (b) Journal of Advanced Nursing, (c) Journal of Nursing Scholarship, (d) Journal of Transcultural Nursing, and (e) Journal of Clinical Nursing, and therefore they have undergone a process of hand searching.

I also examined grey literature pertaining to internationally educated nurses within Canadian practice environments for relevancy to this project. This was retrieved utilizing a process of journal hand-searching, an ancestry search from authors recommendations within the literature, and/or through the bibliographies of articles meeting inclusion criteria for this review.

Inclusion and exclusion criteria.

Literature obtained from the electronic databases was further categorized utilizing the following inclusion criteria: (a) published within the last ten years (January 1999- January 2010), (b) English articles, (c) full text literature available (to facilitate the ability to further analyze and critique the literature specific to IEN support), (d) researched based – publication type, and (e) peer reviewed articles/journals. The preliminary literature review highlighted the majority of relevant literature pertaining to IEN support and integration into Canadian practice settings was published within the last ten years. Sources appearing in more than one database were further cross referenced to eliminate duplication.

Exclusion criteria included: (a) unpublished manuscripts, (b) studies that do not demonstrate IENs as the primary population of interest, (c) studies identifying relevant concepts but not connected with IENs, (d) studies demonstrating methodological scoring of <5 (Appendix A).

A total of 123 articles were retrieved utilizing the aforementioned key search terms. Out of the 123 articles found, an initial subset of 76 articles met further inclusion criteria. The first is that IENs have been clearly identified as the population of interest and the authors identify one or more of the six previously identified concepts of support. The second is that the authors identify concepts related to support but have not utilized IENs as the primary population of interest. However, based on my understanding of IENs and the support they require in practice, the findings from these studies may also be important in developing explicit programs to support them in practice (Appendix A).

Within Cooper's (1998) framework for literature review, the focus is aligned with a systematic, or meta analytical review, and reveals limitations in incorporating diverse data. As such, Whittemore and Knafl's (2005) methods have also been utilized to provide a more comprehensive exploration on the concept of support for IENs, by incorporating data from both theoretical and empirically based literature.

To highlight the diversity of literature chosen, the following chart was created to assist with the identification of qualitative, quantitative and grey literature articles that have met the inclusion criteria for this project and that have undergone further evaluation and analysis.

Table One – Number of articles retrieved.

Total Number of Articles	Total Number of Articles	Total Number of Qualitative Studies	Total number of Quantitative studies	Total Number of Grey Literature	Total Number of Resource Texts &

	Meeting Inclusion Criteria			Articles & Subject Matter Expertise	Literature
123	76	7	26	36	7

This subset of 76 articles was then critiqued for methodological worthiness. Through the use of a coding sheet (Appendix A) assessed the studies, utilizing three out of the five dimensions of research critique: (a) substantive and theoretical dimensions, (b) methodological dimensions, and (c) interpretive dimensions. (Polit & Beck, 2004, p. 656). Articles were then given a score from zero to ten based on the research critique dimensions listed in Table 2 below:

Table Two – Scoring Sheet

Research critique dimensions	**Score assigned**	**Total scoring available**
Substantive/theoretical	1/10	1/10
Methodological	1/10 study design 2/10 sampling plan 2/10 data collection plan 3/10 data analysis	8/10
Interpretive	1/10	1/10
Total score		10/10

Literature Critique Criteria

All literature has been critiqued utilizing the guidelines for evaluating research reports provided by Polit & Beck (2004). All literature has been subjected to three levels of analysis:

First, I coded for relevance to IEN and the concept of support. IENs have been clearly identified as the population of interest and identify one or more concepts of support. Studies

meeting the criteria have been provided with a coding level of (A). These studies have been included and have greater significance in the data analysis.

Second, I coded for relevance for generalizability of research findings to IENs. Study identifies concepts related to support, but have not utilized IENs as the primary population of interest. Studies meeting these criteria have been provided with a coding level of (B). These studies have been included, but have contributed less in the data analysis stage.

Third, I coded for the study's worthiness utilizing three out of the five dimensions of research critique: (a) substantive and theoretical dimensions, (b) methodological dimensions, and (c) interpretive dimensions. (Polit & Beck, 2004, p. 656).

Each study was eligible to receive a total of ten points, if complete answers could be ascertained in relation to specific critique criteria, as listed below, in Table Two. A half point was assigned if the questions were only partially answered, or the answers were not readily identifiable within the research study. Studies which did not meet or mention standards of research ethics were deducted one point from the total methodological score.

Table Three - Specific Critique Criteria – Methodological Score:

	Criteria for Assessment – Data Points	Assessment Score (0-10)
Substantive - Theoretical Dimension	Research problem identified? Is it clear? Scope identified? Are key concepts/variables identified? Does the problem have significance for nursing? Nursing practice? Education? Is there congruence between research problem and paradigm research was conducted within? Do hypothesis flow from a theory or previous research?	/1
Methodological Dimension	Quantitative study *(Design, sample, data collection, data quality, data analysis)* Is the research design clearly articulated? Does the research design correspond to the research question? What types of	

	comparisons are specified in the design?	/1
	Is the sample population identified? Are eligibility criteria clearly identified? How many subjects were recruited? Does the method suggest potential biases? Is the sample population a representative sample? Were there any other factors identified affecting the representativeness of the sample?	/2
	How was data collected? Who collected the data? Could the data collector's relationship with the study participants undermine the collection of unbiased, high-quality data? Where and under what circumstances were data gathered? Did the collection of data place any burdens on the participants? Could this have affected the data quality?	/2
	Is there congruence between the research variables as conceptualized? Does the study offer evidence of the reliability of measures? Does the study offer evidence of the validity of the measures? Does the evidence come from the research itself or is it based on other studies? Was the research hypothesis supported?	
	Does the study include any descriptive statistics? Does the study include any inferential statistics? Does the study provide a rationale for the use of the selected statistical tests? Are the findings clear and logically organized? What were the results?	/3
	_____	_____
	<u>Qualitative study –</u> *(Design, setting & study participants, data sources, data analysis, quality enhancement)*	
	Does the research tradition match the research question?	/1
	Is the setting or study participants identified? Characteristics? Has the sampling strategy been identified? Is the sampling approach appropriate? Is the sample size adequate? Does the sample adequately represent the phenomenon under study?	/2
	How was the data collected? By whom? Was the setting and timing of the data collection appropriate? Were there any factors identified which contribute to any biases? Did the collection of data place any burdens on the participants? Could this have affected the data quality?	/2

	Was the data analysis techniques appropriate for the research design? What evidence does the study provide that the analysis is accurate and replicable? Was data displayed in a manner that verifies the researcher's conclusions? Was the context of the phenomenon adequately described? Does there appear to be a strong relationship between the phenomena of interest as conceptualized? Does the study identify efforts to enhance the trustworthiness of the data? What techniques were used to enhance and appraise data quality? Were the procedures used to enhance and document data quality adequate? How much faith can be placed in the results of this study based on credibility, transferability, dependability and conformability of the data?	/3
Interpretive Dimension	Are the interpretations of the findings identified? What types of evidence are offered in support of the interpretation? Are results interpreted in light of findings from other studies? Are alternative explanations for the findings offered? Are the implications of the research for nursing practice, theory or research identified? Are specific recommendations made how the study could be improved? Are there recommendations for future research?	/1
	TOTAL SCORE	/10
	RELEVANCY SCORE: Content specific to IENs = A Content demonstrating generalizability to IENs = B	

Low score: 1 – 3; Mid-range score: 3 - 7; High score: 8 – 10

(Polit & Beck, 2004, p. 655-672).

Articles receiving a methodological score of < 5 were eliminated from this integrative literature review, as concepts within these eliminated articles were thoroughly covered within remaining review literature, demonstrating a higher methodological ranking (>5).

In the end, this critique process resulted in a smaller subset of 33 articles (Appendix F) that have been included and form the foundation of this integrative literature review. As a further level of analysis and synthesis, extracted data were cross referenced against each other and categorized to demonstrate themes, patterns and relationships across paradigms and research methodologies (Appendix B, C, D, and E).

My interpretation of the data follows. At this point, it is important to note that I have been the sole reviewer of the literature selected for this integrative literature review, thus there is a level of subjectivity that may have produced bias in terms of the inclusion criteria.

Data Interpretation

Migration – Understanding the Basis for Immigration

According to the Canadian Institute for Health Information (2007), 7.9% of registered nurses currently employed in Canada graduated from a nursing school outside of Canada. Although this is a relatively small population of nurses, the CNA has predicted growth in the number of IENs over the next ten years (Villeneuve & MacDonald, 2006).

Reasons for migration to Canada include "perceived experiences of personal, financial and cultural injustices" (Sochan & Singh, 2007, p. 135). In Canada, Blythe et al., (2009) described five distinct motivations as to why IENs migrate: (a) expectations of increased financial benefits resulting in a higher standard of living, (b) increased financial ability to send remittances back to the country of their origin, (c) security and personal freedom from persecution, (d) family enterprise and immigration opportunities through career development by having the ability to sponsor other family members in the immigration process, and (e) personal career advancement.

A US based study conducted by Xu and Kwak (2005b, 2006) revealed IENs migrated to more populated, urban practice areas for both financial and cultural incentives, into what have traditionally been identified as underserviced types of practice, such as inner city hospitals and working night shifts. Understanding the migration patterns and motivations of IENs may be helpful in planning support for IENs practicing within BC health care environments.

Blythe and Baumann (2008) identify that IENs migrating to Ontario will likely assume staff nurse positions regardless of their education and previous experience, and 90% of these same nurses will be in direct client care roles. In addition, one third of the IENs migrating to Ontario from either China or Yugoslavia will find employment in long-term care settings.

Xu and Kwak (2005a) report a similar trend of IENs migrating to the US who find employment in long-term care practice settings. Unlike their American counterparts, statistics demonstrate an increase of IENs in these practice environments, aligning with the growing US demographic trend of an aging society. Although more research would be required in this area, Xu and Kwak (2005a) offer a preliminary recommendation in suggesting that long-term care practice settings could serve as a transitional workplace for IENs, due to the slower pace and low patient turnover.

Statistically it is difficult to secure an accurate number of internationally educated nurses in Canada, as many IENs may not initiate the process of licensure and may either be unemployed or underemployed in other areas (Blythe & Baumann, 2009; Lum, 2009; Sherman & Eggenberger, 2008). For IENs who commence the licensure process, the majority in Canada (Blythe & Baumann, 2009; Tregunno, Peters, Campbell & Gordon, 2009) and the United States (Xu, Zaikina-Montgomery & Shen, 2010) emigrate from the Philippines. Similar studies indicate these IENs are predominately women with significant nursing experience, who will

likely migrate with their spouse and children (Baldacchino & Hood, 2008; Tregunno, et al., 2009).

Some IENs are educated with the intention of migrating to other countries. With an increase in nursing schools in India and the Philippines more registered nurses are seeking employment in the UK and the US post graduation. As the UK only requires a three year degree to practice, it has been seen as a "conduit" for nurses wishing eventually to immigrate to either the US or Canada (Blythe & Baumann, 2008). While regulatory bodies (Gushuliak, 2004; Hamilton, 2008) and professional nursing associations (ICN, 2008; McIntosh, Torgerson & Klassen, 2007) do not support the active recruitment of IENs as a strategy to address the nursing shortage, these same associations articulate a moral and ethical responsibility to ensure IENs are afforded an equitable, fair and transparent process in their transition to Canadian practice environments.

Mentorship

Mentorship can be demonstrated either through a formal process of identifying one or more individuals who will act in the capacity of a mentor, or alternately individuals may also offer mentorship and guidance in an informal manner. Mentorship, whether formal or informal in nature, will influence IEN integration into clinical practice environments (Blythe, et al., 2009; Coffey, 2006b; Hamilton, 2008). Interventions and factors such as educator involvement (Henderson, Twentyman, Eaton, Creedy, Stapleton & Lloyd, 2009), relationships with colleagues and supervisors (Blythe, et al., 2009), and nurse-doctor relationships (Xu & Kwak, 2006) will foster the integration of IENs into practice.

While mentorship and coaching have been identified within the literature as an important concept in transitioning IENs into practice, Sherman and Eggenberger (2008) have identified that

certain mentors, such as nursing managers, may demonstrate difficulty in performing this role. To facilitate a level of understanding and knowledge about the culture and practices of IENs, Johns Hopkins University Hospital in Maryland provides educational training for educators, preceptors and nursing managers who will be acting in mentorship roles for IENs (Sherman & Eggenberger, 2008).

Nursing leaders and front line RNs require education and support in learning how to become effective mentors for IENs. In an Australian study, Henderson and colleagues (Henderson, Twentyman, Eaton, Creedy, Stapleton & Lloyd, 2009) looked at the impact of conducting capacity building intervention sessions within practice environments over a six-week period. During this period, an experienced educator visited the unit every second day for 3 – 4 hours and conducted in-service sessions on mentorship for unit staff. The focus of these sessions included encouraging RNs to be verbally explicit in revealing the knowledge underlying their assessment and decision-making processes within their practice. They demonstrated this intervention was effective in building the mentorship capacity of the RNs in practice environments, as well as creating an environment conducive to supporting new learners. However this research also revealed the challenges with sustaining this capacity building knowledge over a longer period of time. Sustainability of new knowledge and skills remains an ongoing challenge within any practice environment. Although this study did not identify IENs as the population of interest, it did highlight the need to create a positive learning environment for new learners. As such, this article demonstrates relevance to the process of support and transition into practice for IENs.

IENs may not always receive employment in clinical areas similar to their previous area of expertise from their home country (Sherman & Eggenberger, 2008). In these situations, the

role of the mentor becomes even more significant, as new skills and knowledge competencies may be required.

Mentorship also provides an opportunity for IENs to learn "soft skills", such as how to deal with clients' non verbal body language, the nomenclature of nursing practice and the interaction of interprofessional team members within nursing units (Baldacchino & Hood, 2008). As nurses do not practice in isolation, the collegial and professional aspects within shared practices contribute to the mentoring experience and integration of IENs into practice settings.

IENs should be afforded the opportunity to connect with another IEN in a mentoring relationship (Xu & Kwak, 2006). Aligning personal meaning and motivation to similar transitional experiences can provide additional richness to the mentorship network experience.

Coffey (2006) points out that creating mentorship networks can occur outside of the workplace settings. In Ontario, members of the Canadian Federation of University Women (CFUW) have partnered with York University, to offer informal mentoring experiences with IEN students who are enrolled in the Bachelor of Science in Nursing for IEN program. CFUW members who have experience in the healthcare field in Ontario provide informal mentorship, by raising awareness of the Canadian health care system from a different perspective.

Educational Frameworks

There is a need to review current bridging and educational programs designed for IENs to ensure alignment occurs with outcomes and efficacy. Lum (2009) highlights that assessment and bridging programs have been in operation over several years, yet statistics reveal internationally educated professionals remain unemployed or, underemployed and continue to face challenges in workplace integration.

Lum (2009) draws attention to several key considerations when designing educational content for internationally educated professionals, including the need to: (a) align educational theory with the learning styles of internationally educated professionals, (b) create and foster a learning environment, and (c) choose a delivery methodology that is flexible, individualistic and meets the needs of adult learners.

Lum (2009) suggests that IENs possess a distinct learning style and preference that requires specific educational content and alignment, such as that reflected within Kolb's Experiential Learning Theory (ELT) or learning styles framework. Kolb's ELT framework highlights two factors: (a) every individual will demonstrate a preferred method or learning style, and (b) learners may move through any one of four cycles of learning (Joy & Kolb, 2009).

Displayed as a quadrant matrix model, Kolb's ELT includes four distinct learning styles: (a) diverging, (b) assimilating, (c) converging, and (d) accommodating. In any new experience learners may move through one or more of four cycles of learning that includes (a) concrete experience, (b) reflective observations, (c) abstract conceptualization, and (d) active experimentation. For example, individuals who demonstrate a preference within the diverging learning style tend to learn best when presented with concrete experiences and reflective observational opportunities. These learners gather information from different perspectives or viewpoints, are sensitive and emotional, prefer to work in groups and require personal feedback (Joy & Kolb, 2009).

Utilizing Kolb's Learning Style Inventory as a guiding framework, Lum (2009) underscores that internationally educated professionals reveal a preference for the diverging learning style, which is consistent with a need for concrete experience and reflective observation. While this may appear essentializing and to be attaching a cultural label to IENs, it is a point of

interest and consideration for policy developers, educators and mentors who will be working with IENs. Learners who find themselves within the divergent quadrant analyze situations from varying perspectives and will diverge from conventional solutions, by coming up with alternative possibilities. Considering that internationally educated professionals would have vast alternative experiences to draw upon and reference from, it would be important to understand individual experiences in order to ascertain how alternative solutions could be created.

Sherman and Eggenberger (2008) in their qualitative study presented the example of a Filipino nurse who was competent in knowledge related to pain symptom management, but unprepared for the culture shift associated with how to manage pain in the context of end of life care, or the volume of work and time allotted to complete assigned role expectations during her shift. One of the most significant factors affecting the transitioning of IENs into clinical settings is the ability to translate new structured learning into Canadian practice settings, while referencing and drawing from previous competencies and practices from their country of origin. As a result, Sherman and Eggenberger (2008) emphasize practice experience must accompany formal structured learning.

Various authors posit the advantage of utilizing structured educational frameworks to facilitate the transition of IENs into clinical practice settings (Abriam-Yago, Yoder & Kataoka-Yahiro, 1999; Coffey, 2006; Joy & Kolb, 2009; Lum, 2009). Although there appear to be unique variations of frameworks and conceptualized theories within the literature, Kolb's Experiential Learning Theory (ELT) (Joy & Kolb, 2009) provides clear guidelines towards achieving an understanding of the learning process. Utilized in combination with Kolb's Learning Style Inventory (KLSI), these theoretical frameworks reveal how knowledge is created through the experiences we encounter (Joy & Kolb, 2009).

Within the ELT, Kolb (2005) describes two distinct methods in which individuals will gain experience: concrete experience (CE) and abstract conceptualization (AC). This is further expanded to identify two modes in which these experiences are further analyzed and interpreted, reflective observation (RO) and active experimentation (AE).

To supplement and challenge Kolb's theories, Joy and Kolb (2009) asked the question "Are there cultural differences in learning style?" (p. 69). Utilizing a two phased exploratory research approach, data were analyzed from several collection points including (a) existing databanks, (b) historical research conducted by Kolb, (c) previous research findings and frameworks from the Global Leadership and Organizational Effectiveness (GLOBE) study (House, Hanges, Javidan, Dorfman & Gupta, 2004, as cited by Joy & Kolb, 2009), and (d) a general linear model (GLM) to frame the variables of interest.

The inclusion of the GLOBE study (House, et al., 2004) offered the use of an empirically validated cultural classification system that could be used to inform how culture impacted various learning styles. Within this classification system, Joy and Kolb's research (2009) examined "how in-group collectivism, institutional collectivism, uncertainty avoidance, future orientation, performance orientation, assertiveness, power distance, gender egalitarianism and humane orientation might have influenced the shaping of learning styles in each culture" (p. 74). These variables are of importance in understanding the support needs of internationally educated nurses as they migrate from one culture to another. Joy and Kolb (2009) further reinforce this notion when stating, "in organizations, workers from different cultures appear to exhibit different styles of work and problem solving" (p. 69).

The result of Joy and Kolb's (2009) research aligns with Lum's (2009) study to reinforce the understanding of how cultural differences will impact learning styles. Though other models

and frameworks, such as Reid's (1984) Perceptual Learning Style Preference Questionnaire (Winergest, DeCapua & Itzen 2001), offer a similar context of exploration, Kolb's Learning Styles Inventory (2005) has demonstrated greater adaptability and generalizability across cultures, environments and learners (Barmeyer, 2005; Brazen & Roth, 1995; Naimie, Sirij, Piaw, Shagholi & Abuzaid, 2010; Rakoczy & Money, 1995; Smith, 2010; Yamazaki, 2005).

Creating and fostering a learning environment will maximize learning potential. For internationally educated professionals, one focal point for consideration when creating a learning environment is the recognition of the impact of culture on learning styles (Lum, 2009). Culture influences learning styles in how we organize and process information, as well as how we act on that information. As most bridging programs are based on a deficit learning model, internationally educated professionals are forced to unlearn or abandon their worldviews, in order to assimilate into ethnocentric Western environments (Lum, 2009). The challenge for educational programs is how to activate the prior knowledge and experience of the learners, while at the same time creating opportunities for learners to move through a variety of experiences to expand their learning.

Educational programs need to adopt flexible delivery modalities to accommodate the diverse learning needs of internationally educated professionals. Lum's (2009) research revealed that internationally educated professionals demonstrated a strong preference for self-direction in learning and would like to be actively involved in the choice of options. Options for delivery can include didactic classroom instruction, online learning, workplace experiences, small group work, training CDs and videos, or a combination thereof (Edwards & Davis, 2006). What is important within this structure is not only to offer diversity for the learners, but also for the instructors to be aware of their own comfort level in facilitating these modalities.

Other methods, such as various forms of simulation including high fidelity simulators with clinical scenarios, may augment learning (Lasater, 2007). Lasater (2007) created a clinical judgment rubric to assess a learner according to the four dimensions of Tanner's (2006) clinical judgment model: (a) exemplary, (b) accomplished, (c) developing and (d) beginning. Tanner provides detailed criteria related to demonstrating success in knowledge or a level of competency. Tanner's model also opens the possibility for assessing IENs' clinical judgment, through various degrees of knowledge acquisition.

Although some authors suggest IENs may only require a small number of upgrading courses to orient to Canadian practice (CBIA, 2009), other authors posit the need for a more robust and rigorous framework of assessment, education, integration and accountability within the process of recruiting and integrating IENs into Canadian practice, while also reinforcing the need for quality and patient safety (Coffey, 2006; Tregunno, et al., 2009). As IENs commence their transition, they should be considered cultural novices, despite their previous clinical expertise. Failure to recognize competency gaps and transitional challenges could result in compromised client care (Tregunno, et al., 2009, p.188).

Data gathered through an empirically grounded study conducted by Tregunno, et al. (2009) offers numerous recommendations for creating a framework of support for IENs. These include the following four distinct recommendations: (a) challenging the discourse occurring within the reality of practice settings, integration and assimilation, (b) aligning policy and management directives to recognize and support the needs of IENs, (c) recognizing that the challenges of integration go beyond the licensure process, and (d) acknowledging the impact of integration on IENs which may include cognitive fatigue, psychological stress and even racism.

In congruence with other studies, Tregunno et al., (2009) identified five themes reflecting challenges for IENs in their transition to Canadian practice environments: (a) expectations of practice, (b) nurse-client relationship, (c) resource utilization, (d) language, and (e) being the outsider (p. 186). These IENs continued to articulate overwhelming challenges in Canadian practice and role expectations, the socio-cultural context of clients and their families, and the nomenclature of professional nursing communication, despite having significant nursing experience (mean=15 years) in their country of origin. Although developers of educational frameworks must take each of these factors into consideration, there are other often overlooked areas for educational development that must occur.

Tregunno et al. (2009) also revealed the hidden challenge of integrating IENs into practice settings – horizontal violence within the workplace. Tregunno et al., identify study participants who experience racism, aggression and discrimination by co-workers, clients and family members (p. 187). These findings are consistent with existing evidence in other studies that point to the inherent racism found in either the integration into workplace settings or the assimilation into the ethnocentric practices (Baldacchino & Hood, 2008; Raghuram, 2007).

Tregunno, et al., (2009) recommend Benner's (1984) "From Novice to Expert" as a foundational model to support the transition of IENs into the workforce. Through a Canadian practice lens, IENs would move through five levels of competency development and skill acquisition, as they become increasingly competent and proficient practitioners. Within Benner's model is the understanding that success is achieved when expertise is demonstrated and successful integration has occurred.

Others advise a more structured approach. IENs in Ontario have the unique opportunity of participating in the Bachelor of Science in Nursing (BScN) for IENs (Coffey, 2006).

Designed with the intent of recognizing the knowledge and skills IENs already possess, IENs spend 20 months in full time study combining classroom, lab and clinical practice education through a Canadian practice lens. This combination of theoretical and clinical instruction provides the basis for the successful completion of the CRNE examination while acculturating to the workplace experience.

Research conducted by Blythe and Baumann (2009) can offer a different approach to understanding the education and practice needs of IENs through profiling migration patterns and workforce characteristics. Although IENs in Ontario emigrate from a variety of countries, over one third of them have come from the Philippines (p.193). These IENs can be further classified as being predominately over the age of thirty. They tend to work fulltime and to be employed in a hospital, or long-term care setting. Statistical information such as this can help to inform the design and choice of pedagogical approaches for facilitating the integration of IENs into practice settings.

Connection with community

A community can include a network of like minded individuals who gather and share common interests, practices or beliefs (Sochan & Singh, 2007). For those who migrate to different countries, the need for a connection to a community becomes central in the transition process. IENs have demonstrated migratory patterns indicative of cluster formations (CIHI, 2006; Kolawole, 2009). Predominantly choosing urban areas, IENs demonstrate a pattern of moving closer to established immigrant communities where they can easily connect with psychosocial and practice support while engaging in familiar ethnic foods and practices (Xu & Kwak, 2005b).

IENs may arrive in Canada as landed immigrants with their families (Blythe & Baumann, 2009) or independently, leaving their family and support in their country of origin (Sochan & Singh, 2007). While enduring language differences and significant cultural learning IENs may feel considerable pressure to succeed, yet at the same time experience a significant lack of self respect and self confidence, as they grieve for the familiarity of culture, family and familiar settings.

Connecting new immigrants with culturally similar people and community supports will assist IENs and their families in the transition to living and working in Canada (Government Services Canada, 2010, Sochan & Singh, 2007). Whether this is achieved through connection with a workplace mentor who shares the same cultural background, beliefs and practices (Government Services of Canada, 2010) or through community cultural groups (Sherman & Eggenberger, 2008), mentorship is seen as an essential component to the success of integrating IENs into practice settings.

Winklemann–Gleed and Seeley (2005), in a study carried out in Britain, found that cultural identity had a significant impact on being accepted into the hospital and larger community as a whole. Providing opportunities for cultural connection may provide an essential level of support for IENs transitioning into Canadian practice settings.

Work and Learning Environments

Puzan (2003) in a critical essay on the issue of whiteness in nursing suggests health care is fraught with issues of racism and white solipsism. She further suggests "whiteness, which includes 'acting white', is required for full assimilation into the nursing establishment on the part of students, faculty and clinical nurses (regardless of color)" (p. 195). The ability to adapt to patterns of communication, attitudes toward authority, or the treatment of culturally diverse

patients may challenge the moral and cultural compass of the new IEN, yet in many circumstances, there is no alternative.

A second issue pertaining to cultural competence and sensitivity is reflected in the work of Madeleine Leininger (1994), i.e. her culture care theory. Leininger's Sunrise Model helps nurses understand how culture influences individuals, families, groups, communities, and institutions by recognizing their religious, philosophical, kinship, beliefs, care expression patterns, and practices woven into their daily life context and across the life span (p. 76). Utilizing a format of key questioning, respectful inquiry/sharing, and critical thinking, nurses are able to reveal if and how culture will impact an individual's health and healing processes such as pain management or acceptance of mental health issues.

First Nations population health and wellness needs may be very foreign to an IEN. Applying the Sunrise Model can help us understand how issues of white solipsism, cultural competence and sensitivity affect support, during the assessment and integration of IENs in preparation for practice environments.

IENs experience unique challenges within their work environments, including communication difficulties and socio-cultural knowledge within client care (Lum, 2009; Xu, et al., 2010). Factors such as the nuances of communication in practice settings and socially accepted behaviors may be foreign to IENs.

Stability within the work environment can be affected by various environmental factors and, in turn, affects the new IEN staff member. External environmental influences include high turnover rates of staff, evolving skill mix, changing acuity of patients and increasing clinical workload demands, affecting the ability and willingness of clinical staff to support new learners

(Henderson, et al., 2009). Development of professional relationships and creating and fostering a learning environment can be hampered by such external influences.

Slater and McCormack (2007) suggest many health care environments are complex dynamic systems comprising an intricate network of smaller micro systems. Although some researchers hypothesize that a clear role model of culture within health care does not exist (Slater & McCormack, 2007), others suggest there are common attributes within the work environment that attract and retain health professionals. These include adequate staffing levels and support, supportive physician – nurse relationships, and a supportive level of nursing management (Chiang & Lin, 2008; Slater & McCormack, 2007).

To examine the issues of recruitment, retention and higher job satisfaction within the New Zealand health care environment, Budge, Carryer and Wood (2004) conducted a study utilizing a US measure, the Revised Nursing Work Index (NWI-R), in order to examine the influence of autonomy, control and physician – RN professional relationships, on the health and wellbeing of registered nurses. Similar US studies utilizing the NWI-R have demonstrated that these three core elements of a professional nursing practice model (autonomy, control and nurse-physician relations) will impact staff retention, patient outcomes, staff burnout, and injuries related to needle sticks.

Utilizing a sample of 255 registered nurses in a general hospital in New Zealand, Budge et al., found that New Zealand nurses' perceptions of autonomy and control over their workplace were significantly lower and could be compared to that in non-magnet US style hospitals. As in the US study, they observed that the higher the satisfaction within the workplace, the greater the likelihood of better health within the nursing population. However, in contrast to the US study, New Zealand nurses reported low levels of perceived autonomy and control. They also reported

statistically significantly higher rates of satisfaction with nurse-physician relationships (Budge, et al., 2004) and attributed this to a more equitable team approach in the relationship between nurses and physicians, with less emphasis on a hierarchical structure as compared with their US counterparts.

A second explanation for their greater satisfaction is the management model in the New Zealand health system, in which nurses and physicians work within the same management structure and are "positioned more as colleagues then controllers" (Budge, et al., 2004, p. 266). Budge, et al. concluded that the experience of collaborative relationships improves the quality of nurses' health, as well as improving the quality of care and patient outcomes in these same environments.

Chiang and Lin (2008) report similar findings in Taiwan. Nurses were asked questions pertaining to the five magnet hospital concepts of professional autonomy, control over nursing practice, adequacy of staffing, supportive management, and the effectiveness of interprofessional relationships. Although similar to their Western nursing colleagues in reporting the influence of inadequate staffing and lack of adequate working supports, several cultural differences including Taiwan's clinical ladder system and different nurse – physician working relationships, were clearly demonstrated. Chiang and Lin identified that these differences could be reflected within the shared governance structure in Taiwan's nursing and health care organizations which reflect a more collectivist culture (p. 926).

The importance of a supportive work and learning environment can also be found within the Aboriginal nursing community. Triangulating data from four different data sources, nursing practice in rural and remote Canadian environments highlighted that these nurses rely on workplace orientation, continuing education opportunities, and collegial support from other

nurses as essential components to their practice. (Kulig, Stewart, Morgan, Andrews, MacLeod, Pitblado, 2006). Programs such as Competency Programs and the Nurse Internship Program developed by the First Nations and Inuit Health Branch (Health Canada, 2005) provide specific educational programs for RNs working in rural and remote areas, and reinforce the importance of experiential learning within these communities as a key component in meeting work and community expectations of practice (Kulig, et al., 2008).

What is important to note within these research results is the general understanding of how registered nurses perceive and enact their levels of autonomy, control, and quality of collaborative relationships within their various health care environments. IENs bring with them their previous experiences and perceptions. Recognizing the influence of previous socio-cultural practice environments will help to inform a process of transition into the new host environment. Newly transitioning IENs must be made aware of the levels of expected autonomy and control they will experience in their new practice environments, as well as the hierarchical system of nurse-physician relationships within these same environments (Chiang & Lin, 2008; Kawi & Xu, 2009).

But how can work and learning environments be explored and evaluated? The Nursing Work Index – Revised (NWI-R) (Chiang & Lin, 2008) is an instrument for measuring organizational attributes. In this questionnaire, 15 items reflect four of the above variables: (a) nurse autonomy, (b) control over practice, (c) doctor-nurse relationships, and (d) organizational support (Slater & McCormack, 2007). Although research instruments can provide insight into concrete variables within organizational cultures, factors such as time and monetary expense will inhibit the use of such exploration in many organizations.

Ea, et al. (2008) propose that the successful transition of IENs occurs when health care managers deliver effective acculturation programs. In their study of job satisfaction, 96 Filipino registered nurses already engaged in practice in the US identified that job satisfaction, as measured by the Index of Work Satisfaction Scale (IWS) was related to acculturation. The IWS tool was chosen for this study as it is a widely recognized instrument with a long history of use and sound psychometric properties (Cronbach's alpha 0.77 to 0.91) (Ea, et al., 2008, p. 48).

A second instrument, A Short Acculturation Scale for Filipino Americans (ASASFA) was also utilized to measure language use in social and residential settings. Ea et al.'s (2008) recommendation is to provide acculturation programming for support of IENs that contains content related to the health care delivery system, in addition to content that addresses the IENs' cultural backgrounds.

In addition to the work environment in an organization, the characteristics and level of support and sponsorship for IENs within the organization will have an influence on the professional practice environment, affecting quality of client care, nursing performance and job satisfaction and retention of registered nurses (Coffey, 2006; Wade, Osgood, Avino, Bucher, Bucher, Foraker, et al., 2008).

Organizational Sponsorship and Support - Employers

The effectiveness of organizational sponsorship and support for IENs as they transition into practice settings will have an influence on the professional practice environment, as well as the nursing performance and job satisfaction of new IENs (Coffey, 2006; Wade, Osgood, Avino, et al., 2008). Factors such as a nursing manager's ability and leadership (Drach-Zahavy 2004; Wade, et al., 2008), opportunities for professional growth and development (Lum, 2009), and

tailoring job orientation processes (Hanson & Stenvig, 2008) are likely to affect the acculturation of internationally educated nurses into clinical practice settings.

Drach–Zahavy's (2004) cross sectional research study aimed to reveal what influences the role that supportive management plays in relation to the performance of nurses engaged in primary nursing care delivery models. While one aspect of the questionnaire was designed to identify the extent to which primary care was enacted in participants practice settings (autonomy, available resources), another piece of the questionnaire asked participants' to qualify what supervisory support in their environments looked like (practical assistance, encouragement, supportive environment).

Although self-reported data is subject to bias, the very nature of the concept of support lends itself to personal interpretation and experiences. Drach-Zahavy's (2004) research has contributed to the understanding of supervisory support by "delineating a structure-process-outcome model for better predicting primary nurses' performance" (p. 13). Although the connection between high levels of supervisory support and strong nurses' performance was clearly demonstrated by Drach-Zahavy (2004), it also revealed a reciprocal relationship. As nursing leaders modeled supportive actions, so too did the nurses in these environments. As such, the creation of a supportive environment is reinforced by more than the actual supervisors or leaders themselves. It is the collective input from all staff in creating a supportive environment that fosters performance improvement.

IENs will seek out opportunities for professional growth and development. IENs' expectations of hiring organizations were highlighted in Blythe et al.'s (2009) study. For example, IENs expect increased financial benefits resulting in a higher standard of living and the ability to send remittances back to their country of origin, as well as career advancement. Failure

to meet these basic expectations often results in the IENs' departure from the organization or, in some instances, from the discipline itself. Other outcomes include increased sick time and under-productivity (Dessler & Cole, 2008).

Organizational capacity to tailor job orientation for IENs is another consideration, as more clinical nurse educators (CNEs) may be needed. Further, these CNEs will require an expanded understanding of the knowledge, skills and capacities of IENs as specialized learners (Hanson & Stenvig, 2008). Dessler and Cole (2008) challenge employers to evaluate the success of new employees transitioning through structured and explicit organizational orientation programs and suggest three specific issues to evaluate: (a) employee reaction, (b) socialization effects, and (c) cost/benefit analysis.

For internationally educated nurses in their new environments, understanding the type and level of supports being offered in their new host environments could provide the basis for the development of a transition plan. Further, understanding what types of support were offered in their previous practice environment also helps to inform leaders how to adapt and supplement this transition plan.

Sponsorship – Regulatory Body

Regulatory and governing bodies for nursing practice also contribute to the challenges faced by IENs. In BC, the licensing assessment process can take from three months to three years before a temporary/provisional registration is secured. This complicated and costly process may be a barrier for IENs who immigrate with the intention of securing employment within a short period of time (CRNBC, 2010).

Organizational support, sponsorship and cooperation at provincial and federal levels are equally important (CNA, 2005; Kolawole, 2009; Singh & Sochan, 2010). In 2005 the Canadian

Nurses Association released the results of a national project that examined the policies and practices of provincial and territorial regulatory bodies in their assessment of IENs. Although a total of nine recommendations were proposed, five strategic areas were relevant to IENs. These five strategic areas include: (a) the need to establish a national assessment service that endorses evidence based assessment approaches, (b) the need for a collaborative approach amongst all stakeholders, (c) the need to establish a national bridging program taking into consideration language, cultural difference and the financial challenge many IENs face in accessing education, (d) the need to create a national information and communication system, and (e) the need to manage the data and information through electronic records and the implementation of national identification numbers.

IENs in Ontario also voiced the need for a collaborative process between immigration agencies and professional regulatory bodies, through the development of a transparent, standardized credentialing process (Singh & Sochan, 2010). As IENs are unfamiliar with the levels of government and professional nursing bodies within Canada, cultural and linguistic misunderstandings within these processes foster a sense of confusion, frustration and despair (McGuire & Murphy, 2005). In contrast, IENs who migrate to the U.S. have the opportunity to write the National Council Licensure Examination (NCLEX) to obtain their licensure to practice. This examination can be written in a multitude of countries worldwide, thus reducing associated costs as well as premature immigration prior to obtaining a license to practice (Blythe & Baumann, 2008). IENs wishing to migrate to Canada must wait until they have arrived in Canada before they are eligible to write the national licensing examination (CRNE).

In one Canadian province, a new agency provides some assistance to IENs finding their way through the “red tape” and various procedures required for licensing. The Government of

Ontario introduced the Health Force One Initiative, in which any internationally educated health professional could access information and services pertaining to licensure or registration processes for his or her discipline (Government of Ontario, 2006). Although clearly articulating it is not an employment center, Health Force Ontario's resource center is a central access point for information pertaining to licensing, registration, assessment programs and alternative professional options.

Without a Pan-Canadian approach to assessment and licensing processes, IENs will continue to face confusion and frustration. Many of these frustrations will be associated with time delays and lack of consistency around obtaining information regarding the licensing and employment process within Canadian practice settings. These delays ultimately result in many IENs seeking job opportunities outside of their professional qualifications while continuing to navigate the pursuit of becoming an RN in Canada (Baldacchino & Hood, 2008; Sochan & Singh, 2007).

Explicit Learning Plans

IENs require information, education and support in the pre-licensure phase (Coffey, 2006), in the employment phase (Adeniran, Rich, Gonzalez, Peterson, Jost & Gabriel, 2008) and as an ongoing continuing education process. This should be either offered as continuing education opportunities with an employer (Kawi & Xu, 2009) or through post secondary education for ongoing professional development (Lum, 2009). IENs also require explicit, tailored transitional programs to facilitate their integration into various employment practice settings (Coffey, 2006; Hamilton, 2008b; Lindberg, 2008; Xu, et al., 2010).

Learning plans – pre-licensure.

Regulatory bodies have a role to play in the assessment and recommendations pertaining to the knowledge and skills competencies of IENs (CRNBC, 2010; Hamilton, 2008). Other recommendations reinforce the need to recognize competencies and experiences within the context of educational credentials, when recommending supplementary education (CNA, 2005; Gushuliak, 2004; Lum, 2009). Recommended processes to capture this knowledge may include: (a) national examinations (which are already in place), (b) Objective Structured Clinical Examination (OSCE) examinations, (c) skill or knowledge specific multiple choice examinations, (d) prior learning assessment and recognition (PLAR), and (e) a supervised clinical assessment experience (CNA, 2005; Lum, 2009). The PLAR process provides a broader depth and breadth of assessment that places knowledge competencies within the context of previous experience and has been identified as an effective assessment tool for delineating IEN practice knowledge (Blythe, et al., 2009).

The Saskatchewan Registered Nurses Association (SRNA) suggests that education and support for IENs should be considered at three levels: (a) support in the application process, (b) support in the examination process, and (c) support in the workplace (Hamilton, 2008b). To this end, SRNA provides educational sessions for IENs on applying for a license and preparing for the national CRNE exam and then collaborates with employers to offer a half day work-shop on scope of practice, nursing ethics and other issues pertaining to the profession of nursing (Hamilton, 2008b).

Alberta has created several strategies to improve the assessment and licensure process of IENs. Collaborating with academic, federal and provincial councils and associations, the Alberta Association for Registered Nurses (AARN), now known as the College and Association of

Registered Nurses in Alberta (CARNA), has created new practice models for assessing the prior learning of IENs through the use of prior learning assessment and recognition tools (PLAR), by establishing competency profile parameters and by continuing to advocate for changes in current practices and policies related to IENs (Gushuliak, 2004).

In BC, Kwantlen Polytechnic University provides both assessment and bridging services (CBIA, 2009). Assessors utilize a PLAR tool, but also provide opportunities for the IEN to demonstrate additional knowledge, skills and abilities acquired throughout their nursing career. If specific skills and knowledge competencies are required, these may be offered through post secondary bridging programs.

In some provinces, assessment and pre employment counseling centers have been created, with the intent of providing assessment and recommending supplementary education and support for IENs who are seeking employment. External to health employers, centers such as the Center for Internationally Educated Nurses in Ontario (CARE, 2006) and the Capacity Building for Internationally Educated Nurses Assessment (CIBA) Project in B.C. (CBIA, 2009) offer thorough assessment processes and specific course content.

McGuire and Murphy (2005) report that, out of 270 candidates enrolled in Ontario's Creating Access to Regulated Employment (CARE) program, nearly 50 percent of participants are already baccalaureate trained and an additional 40 percent possess a diploma in nursing, leaving the remaining participants with additional educational qualifications, including master and doctorate degrees. Although the completion of previous degrees must be taken into consideration, caution is advised when assuming equitable transfer of content to Canadian standards.

British Columbia's CBIA service assists IENs by employing four different strategies to assess the knowledge, skills and abilities from an RN generalist perspective (CBIA, 2009). This assessment includes a written diagnostic exam, an OSCE, and a formal process to assess problem solving and critical thinking skills as well as clinical judgment (CBIA, 2009, p.1). This form of comprehensive assessment aligns with recommendations from the CNA (2005) commissioned report on the national assessment process of IEN applicants, by taking into consideration competencies and experiences, in addition to formal educational credentials.

Although CBIA and the Ontario assessment services can provide robust information pertaining to gaps in knowledge and competencies for IENs, the processes involved to access them have several drawbacks. Although there is no cost to the BC service, an assessment can only be triggered through a request from the CRNBC when international credentials, knowledge, or skills cannot be fully validated through an initial regulatory body assessment process (CBIA, 2009). IENs in Ontario identified frustration with the CARE program because of changing course structures, time lines, and time commitment in the middle of their bridging programs, resulting in increased costs and time delays in securing employment (Sochan & Singh, 2007).

Accessing clinical upgrading courses recommended through an assessment process can be expensive and difficult to access. Ontario's CARE program resource counselors will custom tailor a learning plan for the IEN that usually begins with a review of clinical skills and health assessments as a starting point for a learning plan, to which IENs may add a variety of other courses at additional cost. These courses are usually spread over a six to twelve month time frame. Interested IENs can access the services of the center by attending an information session, successfully completing an ESL examination, and paying a nonrefundable registration fee.

BC's CBIA program offers similar services through competency assessment and recommendations. Aligning with Kwantlen Polytechnic University, recommended upgrading sessions are offered through the academic institution, but can only be accessed face to face in formal classroom settings located on campus in Vancouver, BC (CBIA, 2009). Although this may benefit IENs living in the mainland Vancouver BC area, it dramatically reduces the availability of educational opportunities for those living outside of that specific catchment area.

In the above programs, education can be delivered in a modular format to fill gaps in knowledge and skill competencies, but other programs consist of a more sequenced and a more robust process. The BScN for IEN program offered at York University in Ontario is an example of a clearly defined, multifaceted, staged, and sequenced learning plan for IENs (Coffey, 2006). This program is divided into two distinct components, a 13-week qualifying pre-session and a 20-month BScN bridging program. IENs wishing to enroll in the BScN program must successfully complete the qualifying pre-session: combining both credit and non-credit academic courses. These courses cover professional English language training and introduce the social, cultural, political, legal and regulatory concepts of nursing practice in Ontario. This process also provides an opportunity to determine further areas of knowledge or skill weaknesses and build on those areas through supported simulation and laboratory training (Coffey, 2006).

The BScN for IEN program provides IENs without an undergraduate degree an opportunity to gain formal academic preparation, with the successful completion of the qualifying pre-session courses. This methodology reinforces the education and experience IENs bring with them, while also providing academic preparation towards achieving success in obtaining Canadian licensure and employment (Coffey, 2006).

Although the above programs and services are offered when IENs have already arrived in Canada, Kolawole (2009) suggests that many of the components and processes of a learning plan could occur prior to migrating to Canada. If regulatory bodies and government sponsored agencies offered pre-immigration counseling services, IENs could commence ESL testing and bridging program courses prior to migrating. Opportunities such as these would not only assist in determining the viability of securing and retaining discipline specific employment, but they would also reduce the time delays often associated with qualification assessments, access to educational upgrading and underemployment in survival jobs.

Research evidence in support of Kolawole's proposal is provided by another American study. Edwards and Davis (2006) found that 93.2% of 3205 IENs, representing more than 30 countries, have indicated they would be interested in taking pre employment educational programs to prepare them for practice in the US.

Learning plans – content recommendations.

Learning plans should include education in technology, cultural behaviors, attitudes and collaborative roles of health care team members, communication and nomenclature within nursing practice, role of client and family, caring for palliative care patients, nursing decision making within an autonomous role, and nurse-physician relationships (Adeniran, et al., 2008; Edwards & Davis, 2006; McGuire & Murphy, 2005). IENs also report that additional education is required in the legal aspects of nursing practice, as well as in caring for mental health and psychiatric clients (Edwards & Davis, 2006).

In Canada, IENs have identified specific learning gaps, such as nursing practice in the Canadian context, professional roles (autonomy, client advocacy) and responsibilities, language, technology and the Canadian healthcare delivery system (Blythe, et al., 2009; Jeans, Hadley,

Green, DaPrat, 2005). In addition, bridging programs should be accessible, affordable, and delivered utilizing a pedagogically appropriate method for multicultural and ESL learners (Sochan & Singh, 2007).

Because IENs have demonstrated a level of unfamiliarity with the degree of autonomy and critical thinking expected of nurses within Canadian practice settings (CNA, 2005), these are aspects of the professional role to highlight in their learning plans. Being uncomfortable acting as patient advocates or unwilling to challenge a physician's orders are examples of IEN unfamiliarity with the scope of autonomy expectations for practicing RNs within Canadian practice settings (Blythe, et al., 2009).

Learning plans – for the transition into employment settings.

In 2010, Government Services of Canada, in partnership with the Minister of Public Works (Government Services Canada, 2010), produced an employer's handbook in which they have articulates tips, references and recommendations for Canadian employers hiring internationally educated workers. Four recommendations for employers include: (a) the importance of effective assessments; (b) the need for explicit bridge-to-work programs including structured guidance, regular evaluations and feedback; (c) recommended components for training programs that include skills, language, communication and organizational knowledge; and (d) the need to create an inclusive workplace through diversity and cross cultural training for all staff (p. 29). Additional recommendations from regulatory bodies such as the CRNBC (2009) outline the process for IENs to follow during the initial assessment period. Although these provide a framework of support for international hires, the onus of responsibility still lies with the employer for the development and implementation processes.

The Saskatchewan Registered Nurses Association clearly distinguishes the roles and responsibilities for assessing IEN knowledge, skill and competencies between the regulatory body and the employer. Hamilton (2008a) states that the role of the regulatory body, is to ensure the IEN is a competent practitioner of good character and has the educational qualifications to practice. The employer is responsible for assessing whether the knowledge, skills and abilities of the IENs previous experiences align with the expectations of practice in the Canadian workforce. Although this assessment may occur during the interview and orientation process, ongoing evaluation of the IEN's practice is required by the nursing manager to detect challenges early enough to intervene and effectively assist the new employee (Lindberg, 2008).

One of the challenges for health care managers and leaders is how to perceive the IENs' level of knowledge and skill competency in the practice environment (Blythe, et al., 2009; CNA, 2005; Kolawole, 2009). Many health care environments use various applications such as skills inventories and Competency Assessment and Performance Evaluation (CAPE) tools (VCH, 2010; VIHA, 2010) to determine a level of proficiency in nursing practice, either prior to hiring, or as a condition thereof. Heavily based in a self-disclosure process, nurses are asked to reflect on their previously acquired education, knowledge and skill proficiency in various domains of practice. Although nurses may go through this process at the commencement of their employment in a specific practice arena, they may need to repeat the assessment when required to move between units within the same worksite.

Employers who have had experience integrating IENs into practice settings recommend that new IENs take a minimum three month bridging program that includes course content specific to clinical practice, critical thinking, language and the Canadian health care system, through the lens of the role, scope and autonomy expected of RNs (CNA, 2005). Other

employers have identified that the greatest barrier to the integration of IENs results from communication difficulties, ranging from the ability to document clearly, confidence in speaking, and the cultural nuances of communication (Blythe, et al., 2009; Xu, et al., 2010).

Although there have not been any research studies conducted specifically to address IENs perception of their levels of knowledge and practice competence in Canadian practice settings, other research studies provide the opportunity to identify specific factors influencing individual perceptions within generalized nursing practice areas. Meretoja, Leino-Kilpi and Kaira (2004) set out to compare the perceived level of competence within a group of practicing nurses in various work environments. Seven distinct competency categories were examined and included: (a) helping role, (b) teaching-coaching, (c) diagnostic functions, (d) managing situations, (e) therapeutic interventions, (f) ensuring quality, and (g) work role. Although the researchers report nurses demonstrated higher levels of perceived competence in the areas of managing situations and the helping role, they also demonstrated that IENs felt least competent in the area of ensuring quality. Taking into consideration other demographic data, such as the age and experience of the nurses, variables like the perception of a supportive environment also contributed to nurses' self perceived level of competence. Additionally, nurses articulating higher levels of self perceived competence in the area of the managing situations and the helping role also "considered themselves most competent in the following areas of competency; in acting appropriately, autonomously, flexibility in practice, making decisions when taking the particular situation into account, and in providing ethical and individualized care" (Meretoja, et al., 2004, p. 334). The researchers noted that cultural differences in competency perceptions added to limitations of the study and that cultural impacts related to education, environmental differences

and an individual's mother language inhibited the generalizability of their research findings to all RNs.

This research data benefits nursing practice in two distinct formats: (a) nurses' perceived and actual competence can be influenced by the working environment, and (b) nursing leaders can structure working environments in a manner that reinforces nursing competence. For nursing leaders who hire IENs into their practice areas, having a clear understanding of their own environments, as well as recognizing the perceived level of competence of the IEN, fosters the development of a supportive learning environment by creating opportunities to address the gaps between perceived and actual levels of competency required for practice.

IENs may also rate their perceived competence higher than it is, based on several other factors such as the role, scope and function of the RN in their home country (Sochan & Singh, 2007) or the general population they cared for within their home practice areas (Blythe, et al., 2009; Kolawole, 2009). In these instances, IENs use previous experience as a guidepost to reference their knowledge, skills and abilities to practice within Canadian environments.

Although individual employers often develop specific learning plans, there are also examples in the literature of collaboration between provincial governments, academic institutions and employers. The IEN post licensure pilot program shared by Vancouver Coastal Health, Providence Health Care, Kwantlen University College, BC Ministry of Health and the BC Ministry of Economic Development is an example of a collaboratively developed program designed to integrate IENs into practice settings (Lawrie & Garossino, 2007). In this program, educators and preceptors support IENs' transition through formal classroom instruction and practical unit experience. Content such as how to document to Canadian standards, communication skills, and working with clients, family and other health care professionals

allows IENs to enhance their knowledge and experience while fostering critical thinking and decision making skills.

Cultural Competence and Ethnocentrism

The issues of cultural competence and ethnocentrism are of particular interest in supporting IENs in their transition to Canadian practice. Because IENs come from many countries and have varied ethnic origins, there is a caution in having nursing leaders attach a homogenous cultural label to IENs.

Cultural competency requires two distinct levels of understanding: (a) understanding one's own worldview and how culture influences nursing practice, and (b) understanding the worldview of the patient and how culture influences his or her behaviors (Capell, Dean & Veenstra, 2008). Canadian nurses demonstrate a high level of autonomy and accountability for patients as compared, for example, to nurses in India or China, where assertiveness is not encouraged and physicians direct all care (Sherman & Eggenberger, 2008). Nurses immigrating from Asian countries are educated and trained to honor, respect, and never challenge physician authority, even in circumstances where the physicians may be wrong (Xu & Kwak, 2006). Tasks required within the scope of Canadian RN practice, such as performing personal care on members of the opposite sex, may have been culturally inappropriate in the IENs' country of origin (Blythe, et al., 2009). Although some theorists would suggest cultural competence is best accomplished through educational programming for health care professionals, Capell, et al. (2008), contend that understanding cultural competence and ethnocentrism is a very complex process.

What is important to understand is how our concept of cultural practices, beliefs and education are enacted through our nursing practice. Raghuram (2007) points out that there is a

significant difference between integration and assimilation. She cautions against essentializing culture based on our own assumptions, ideologies or stereotypes. Thus, the constructs of cultural competence and ethnocentrism must be explored. These constructs affect the practice environment, as well as the nurses, other professionals, and patients within the environment.

Additional Issues of Concern for IENs Transitioning Into Practice

This integrative review revealed additional questions that had not been considered during the initial literature search phase of this project. For example, it is unclear how IENs maintain their practice competence while going through the licensure process. McGuire and Murphy (2005) point out that IENs have articulated challenges with maintaining their level of practice competence while going through the licensure process, as they cannot work in nursing during this time (p. 27). For those IENs who are employed in nursing roles, their employment is more likely to be as care aides or in some other level of nursing below that of a qualified RN.

Professional regulatory bodies such as the CRNBC require that IENs must have met the basic qualifications to practice before they can secure a temporary license. Once hired by an employer, IENs must satisfactorily demonstrate 250 hours of supervised practice and have secured a CRNE examination date within six months of receiving a temporary license, in order to meet both licensing and immigration requirements (CRNBC, 2010). Further, McGuire and Murphy state that IENs who write their national licensure exam as close as possible to their application date for licensure have demonstrated higher rates of success.

Another unanticipated challenge occurs when trying to transfer specialized practice knowledge and skills from their country of origin to the new host country. Some IENs assume clinical positions within highly acute care settings, such as cardiac care and intensive care practice environments (Xu & Kwak, 2006). In Canada and the US, nurses enter into practice as

generalists and become advanced practice nurses through either masters or specialty education. However, many countries offer nurses the opportunity to gain specialization at the entry level, in their basic educational programs (Edwards & Davis, 2006). There is a risk in assuming that educational qualifications and level of experience in a specialty knowledge practice area will be equivalent between the host country and the country of origin. This further reinforces the need for thorough assessments and competency testing.

Impact/Relevance to Nursing Practice, Education and Research

There is currently a need to address the challenges, barriers, and voiced concerns of IENs, regulatory bodies, and employers before creating a Pan-Canadian approach to the integration of IENs (CNA, 2005). This requires taking an in-depth review of existing procedures and processes, including assessment and bridging programs currently being utilized by regulatory bodies and employers across the country.

Although many regulatory bodies do not advocate for the active recruitment of IENs, many IENs are already in Canadian communities and are either unemployed or underemployed in survival jobs. There is a moral and ethical responsibility to assist these nurses in achieving employment and education that is discipline specific (Hamilton, 2008a). Policies should reflect this moral and ethical responsibility for all stakeholders involved in the transition and support of IENs.

Education within the health professions requires thoughtful consideration regarding pedagogically appropriate and content specific courses, throughout all phases of career development. As IENs have identified several distinct learning styles, there is a need to challenge current educational practices to align with any new methodology (Lum, 2009). Evidence based frameworks of support are required.

Further research is required in the development, implementation, and evaluation of a framework of support for IENs as they integrate into Canadian practice settings. Evaluation of specific content and staging/sequencing of course content could help inform potential employers, about how to best prepare and support IENs, from the time of their application through their employment career.

Recommendations

Through this literature review I have discovered a variety of recommendations on how to support IENs in their transitions to the Canadian health care system. This literature has reflected several theoretical perspectives and paradigms aligning with each researcher. Utilizing my epistemological perspective of constructivism and my theoretical underpinnings of phenomenology, I offer the following recommendations that were identified through my review of the literature.

There is a clear need to examine the validity and utility of support processes and learning frameworks to ensure that desired outcomes align with the needs of IENs and their employers. These same frameworks should be tailored not only to integrate IENs into specific practice settings, but also to retain and support them throughout their career. Although due diligence to ensure high standards of education and safe quality patient care is vital, there is also a responsibility to provide access and resources for upgrading and ongoing education. My five specific recommendations are: (a) the development of a learning plan framework specific to IENs, (b) the provision of access and resources for IENs, (c) the ongoing process of support and education as it relates to IEN's, (d) the integration of IENs – rather than the assimilation, and (5) the need for more research that will explore the support and transition needs for IENs who are not successful in achieving licensure to practice.

Development of learning plan frameworks.

Each IEN who enters into a Canadian practice environment should have the opportunity for a robust competency, knowledge and skills assessment resulting in an explicit learning plan. Recognizing the influence of culture on learning this learning plan should include:

- communication – nursing nomenclature and cultural nuances,
- documentation – legal requirements within Canadian practice,
- generalized knowledge of the Canadian healthcare system,
- social, cultural, political, legal, regulatory and practice concepts within Canadian practice,
- the role of the RN in Canada – autonomy, collaborative practice,
- client care – geriatric, palliative care clients,
- pharmacology and principles of medication administration,
- use of technology – equipment and electronic health records,
- resource allocation – disposable products,
- human rights – racism, violence in the workplace, and
- a strategy for achieving academic success (Appendix B).

Although the list of recommended learning plan competencies appears lengthy, each IEN will progress through these competencies at different rates of speed, based on his or her moments of learning need. What is important to note is the explicit nature of each competency. For health care leaders and educators, having the opportunity to engage the IEN in this style of learning plan provides two distinct benefits: (a) IENs become more aware of the expectations within the practice areas, and (b) leaders and educators become more aware of where and how they can

support the IEN in the transition process and in meeting those expectations. This includes choosing a pedagogically appropriate method of educational content delivery (Appendix E).

The process of creating an explicit learning plan also fosters the development of a supportive learning environment by engaging leaders and IENs in the process. Regular feedback on learning achievements builds confidence for the IEN as well as for the nursing leader. Although additional time and effort may be required in developing unit specific or IEN specific learning plans, this tailored process is expected to increase the rate of successful integration of IENs into practice settings.

Providing access and resources for IENs.

A Pan-Canadian approach needs to be developed to ensure IENs receive accurate, timely, and consistent information on processes for the transition into Canadian practice. This requires:

- consistent messaging on electronic information websites,
- accelerated assessment processes, – shared between regulatory bodies and future employers,
- greater access to academic upgrading, and
- financial reimbursement for some expenditures.

For example, conducting didactic education through a Monday to Friday, nine to five session decreases the viability of academic upgrading for many IENs employed in survival jobs. Consequently, face-to-face academic upgrading courses should also be offered on weekends and in the evenings. A further recommendation to support IENs in the transition phase is to ensure that accessibility to information and resources is available in a variety of formats, including electronic and print media in a variety of languages.

Providing access and resources for IENs has been demonstrated through this integrative literature review as a key component to securing professional employment. Increasing the accessibility and affordability of information and resources is expected to increase the success rate of IENs in achieving a license to practice as a registered nurse in Canada.

Ongoing support and education.

IENs require time and ongoing support to integrate fully their existing knowledge and skills into Canadian practice settings. Support is required at three different stages: (a) pre-employment, (b) at the point of commencing employment, and (c) post employment beyond the initial processes of employee orientation.

Each stage of transition may require specific support and education. For instance, in the pre-licensure or pre-employment phase, IENs require education on (a) the application process, (b) the licensure process, and (c) adapting to practice in Canada. Support within the employment or licensure phase may include (a) formal orientation programs, (b) supernumerary mentorship, and (c) peer support networks. Support within the post-employment or licensure phase may include (a) understanding nurse/client relationships, (b) the creation of mentoring networks within the employment site and with other community agencies, and (c) opportunities for professional growth, development, and career advancement (Appendix C).

What is worthy to note in the recommendations for health care leaders, educators and IENs is the iterative nature of lifelong learning and the ongoing support that will be required in throughout this transition journey.

Integration of IENs – not assimilation.

There is a need to examine current policy and practices and perhaps to adopt a pragmatic approach, whereby the emphasis shifts from the acquisition of knowledge and leans more

towards an understanding that thinking and learning are practices to be fostered on an ongoing basis. Theory is knowing what to do, however practice is knowing how to do it. Policies and practice guidance should ultimately connect our knowledge, experience and previous practice. For IENs who bring different knowledge, experience and cultural practices, practice experiences and learning processes need to reflect a focus of integrating this diversity into Canadian practice settings, rather than trying to assimilate them into Eurocentric environments.

One method of fostering the integration of IENs is to understand what is already known from the IEN's perspective. This can initially be achieved through the use of assessment tools that permit cultural interpretations that are consistent with the IEN's past practice and knowledge. Some assessment tools include: (a) ESL testing – e.g. the CELBAN tool as it is nursing centric (Lum, 2009); (b) competency assessment processes – case study scenarios; (c) PLAR; (d) the matching of skills, knowledge and competencies within workplace settings, e.g. for critical care areas; and (e) simulation testing (Appendix D). A final recommendation would be to incorporate more than one assessment tool to allow for different learning styles and cultural interpretations of nursing practice situations.

IENs can bring richness to nursing units, client care, and professional relationships by sharing how nursing practice and care for clients may vary within different cultural contexts. This collaborative sharing within practice areas encourages all team members to practice from a culturally competent frame of reference.

Recommendations for research.

There is a need to conduct evaluations on existing pilot projects and programs that are currently supporting IENs in Canada. This would include examining IEN competency assessment processes and tools for assessment that are currently being utilized by regulatory

bodies and assessment agencies. Other research should examine closely how employers currently orient and mentor IENs into their various practice environments, in order to determine what processes are effective and which ones are not. Comparing Canadian educated nurses to IENs may also provide additional insight into the effectiveness of orientation and mentorship processes within an organization.

Although the majority of policy and practice developments regarding IENs have occurred within responsible Canadian regulatory bodies, little has been done within the organizational or employment phase regarding ongoing support for IENs. It is at this juncture that the greatest need has yet to be explored and where further research and development should occur.

Further research is required to determine if IENs preferred learning styles as divergent learners can be fostered and developed throughout all stages of support, from pre-licensure through to ongoing support in the employment setting. This would require the development of new frameworks of support that are built with enough fluidity to adapt to individual needs, without diluting the structure and rigor required within existing educational benchmarks and standards.

Additional research should also be conducted on IENs' who have already achieved landed immigrant status and who are not employed in profession-specific employment. As this comprises the largest number of IENs in Canada, there is a need for a better understanding of what support is required to transition these IENs into nursing practice areas.

The dominant discourse suggesting IENs are not prepared for practice in Canadian environments both perpetuates and legitimizes ideologies interwoven within every stage of the process of integration for IENs, including pre-licensure, employment and post employment experiences. Without clear methods of assessment, education, mentoring and integration of IENs

into clinical practice settings, many of them will continue to face what for some will appear insurmountable challenges. As identified within the literature, this lack of clarity suggests that many IENs will not even begin their journey towards licensure.

Conclusion

Little is known about the support internationally educated nurses require as they transition into practice settings in Canada, in spite of the research and content expertise offered to date. This will become critical if more IENs seek employment in health care environments with the creation of a Pan-Canadian approach to assessment and licensure. There is a need to examine policy and education closely within the global context of nursing practice, in order to create evidence informed decisions regarding IENs. It is about challenging the current discourse that suggests IENs do not have the entrance knowledge or skills to perform as registered nurses in Canadian health care environments. It is about seeking out the underlying ideologies of competence, cultural influences, and organizational cultures that continue to legitimize and perpetuate the tacit knowledge deeply engrained within current nursing practice, policies and our Eurocentric mindset. Finally, it is about the moral and ethical responsibilities shared among all stakeholders, as they seek to develop a framework of support for IENs in their journey towards achieving success in the Canadian workforce.

Only a small percentage of IENs who begin this challenging journey are currently successful in achieving their licensure to practice. For the others who begin and do not complete this journey, there are undoubtedly profound financial, moral and ethical impacts. Some are forced to return to their country of origin, while others may be relegated to working in non-discipline-specific survival jobs. Many IENs are currently working as housekeepers, waitresses and cab drivers throughout our Canadian communities (Baldacchino & Hood, 2008).

Throughout this integrative literature review, I have proposed a number of recommendations aimed at increasing that dismal success rate.

Perhaps the greatest need is to examine and challenge our own hegemonic position and return to nursing theory and theoretical underpinnings, as we seek to understand the epistemology, ontology, and phenomenological perspectives of IENs. To move beyond the entrenchment of our positions is of vital importance and can be seen as the first step in supporting IENs as they transition into practice.

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Appendix A – Coding Sheet

Coding Sheet – Concept of Support

Article Title: _____

Author(s): _____

Qualifications of Author(s): _____

Affiliation with Academic Institutions, Professional Organizations: _____

_____

Database: _____ Ancestry: _____ Hand search: _____

Journal: _____

Year: _____ Volume: _____ Pages: _____

RESEARCH QUESTION: _____

Quantitative:

Design:

☐ ……. ☐ …….. ☐ ……

Setting: _____ Sample Size: _____

How data were gathered: (single format? multiple sources?)

-
-

Variables identified: (Subject matter) – (implied or explicit in nature)

- Mentorship _____
- Explicit learning/education plans _____
- Educational theory/pedagogical approaches _____
- Organizational support/sponsorship _____
- Connection with Community _____

- Work & learning environment _____
- Other? _____

Data Analysis: (what data analysis techniques were used and are they appropriate for the research tradition?) (Ethical considerations?)

Qualitative Studies:

Design: *(which research tradition best matches the research question?)*

☐ …….. ☐ …….. ☐ ……..

Setting: _____ Sample Size: _____

How data were gathered: (single format? multiple sources?)

-
-

Variables identified: (Subject matter) – (implied or explicit in nature)

- Mentorship _____
- Explicit learning/education plans _____
- Educational theory/pedagogical approaches _____
- Organizational support/sponsorship _____
- Connection with Community _____
- Work & learning environment _____
- Other? _____

Data Analysis: (what data analysis techniques are appropriate for the research tradition?)(Ethical considerations?)

For specific analysis – Use Polit & Beck - "Evaluating Research Reports"

- Guidelines for critiquing *literature review* (p.658)
- Guidelines for critiquing *theoretical and conceptual frameworks* (p. 659)
- Guidelines for critiquing *research designs* in quantitative studies (p.660)
- Guidelines for critiquing *qualitative and mixed-method* designs (p.661)
- Guidelines for critiquing *quantitative sampling* designs (p.661)
- Guidelines for critiquing *qualitative sampling* designs (p.662)
- Guidelines for *data collection* procedures (p.662)
- Guidelines for critiquing *self-reports* (p.663)
- Guidelines for critiquing *observational methods* (p.663)
- Guidelines for evaluating *data quality in quantitative* studies (p.664)
- Guidelines for evaluating *data quality in qualitative* studies (p.665)
- Guidelines for critiquing *quantitative analyses* (p.665)
- Guidelines for critiquing *qualitative analyses* (p.666)
- Guidelines for critiquing the *ethical aspects* of a study (p.666)

Summary

What findings were reported? (*anything unanticipated?)*

Impact/relevance to nursing practice:

Recommendations put forth:

Recommendations for future studies:

☐ Coded ☐ Synthesized ☐ Included in reference list

☐ Meets inclusion criteria ☐ Excluded

Literature Critique Criteria

All literature has been critiqued utilizing the guidelines for evaluating research reports provided by Polit & Beck (2004).

All literature has been subjected to three levels of analysis:

First – Coded for relevance to IEN and the concept of support. IENs have been clearly identified as the population of interest and identify one or more concepts of support. Studies meeting the criteria have been provided with a coding level of (A). These studies have been included and have greater significance in the data analysis.

Second – Coded for relevance for generalizability of research findings to IENs. Study identifies concepts related to support but have not utilized IENs as the primary population of interest. Studies meeting the criteria have been provided with a coding level of (B). These studies have been included but have contributed less in the data analysis stage.

Third – Coded for study's worthiness utilizing three out of the five dimensions of research critique: (a) substantive and theoretical dimensions, (b) methodological dimensions, and (c) interpretive dimensions. (Polit & Beck, 2004, p. 656).

The study will receive one full point for each of the sections answered in complete for a total of ten points. A half point will be assigned if the questions are only partially answered or the answers not readily identifiable.

Studies which have not met or have not clearly identified the ethics process within the research study will be deducted one point from the total methodological score or have been eliminated from this analysis.

Research critique dimensions	**Score assigned**	**Total scoring available**
Substantive/theoretical	1/10	1/10
Methodological	1/10 study design 2/10 sampling plan 2/10 data collection plan 3/10 data analysis	8/10
Interpretive	1/10	1/10
Total score		10/10

Critique Criteria – Methodological Score:

	Criteria for Assessment	Assessment Score (0-10)
Substantive - Theoretical Dimension	Research problem identified? Is it clear? Scope identified? Are key concepts/variables identified? Does the problem have significance for nursing? Nursing practice? Education? Is there congruence between research problem and paradigm research was conducted within? Do hypothesis flow from a theory or previous research?	/1
Methodological Dimension	Quantitative study *(Design, sample, data collection, data quality, data analysis)* Is the research design clearly articulated? Does the research design correspond to the research question? What types of comparisons are specified in the design? Is the sample population identified? Are eligibility criteria clearly identified? How many subjects were recruited? Does the method suggest potential biases? Is the sample population a representative sample? Were there any other factors identified affecting the representativeness of the sample? How was data collected? Who collected the data? Could the	/1 /2

	data collector's relationship with the study participants undermine the collection of unbiased, high-quality data? Where and under what circumstances were data gathered? Did the collection of data place any burdens on the participants? Could this have affected the data quality?	/2
	Is there congruence between the research variables as conceptualized? Does the study offer evidence of the reliability of measures? Does the study offer evidence of the validity of the measures? Does the evidence come from the research itself or is it based on other studies? Was the research hypothesis supported?	
	Does the study include any descriptive statistics? Does the study include any inferential statistics? Does the study provide a rationale for the use of the selected statistical tests? Are the findings clear and logically organized? What were the results?	/3
	_____	_____
	<u>Qualitative study –</u> *(Design, setting & study participants, data sources, data analysis, quality enhancement)*	
	Does the research tradition match the research question?	/1
	Is the setting or study participants identified? Characteristics? Has the sampling strategy been identified? Is the sampling approach appropriate? Is the sample size adequate? Does the sample adequately represent the phenomenon under study?	/2
	How was the data collected? By whom? Was the setting and timing of the data collection appropriate? Were there any factors identified which contribute to any biases? Did the collection of data place any burdens on the participants? Could this have affected the data quality?	/2
	Was the data analysis techniques appropriate for the research design? What evidence does the study provide that the analysis is accurate and replicable? Was data displayed in a manner that verifies the researcher's conclusions? Was the context of the phenomenon adequately described?	
	Does there appear to be a strong relationship between the phenomena of interest as conceptualized? Does the study identify efforts to enhance the trustworthiness of the data?	

	What techniques were used to enhance and appraise data quality? Were the procedures used to enhance and document data quality adequate? How much faith can be placed in the results of this study based on credibility, transferability, dependability and confirmability of the data?	/3
Interpretive Dimension	Are the interpretations of the findings identified? What types of evidence are offered in support of the interpretation? Are results interpreted in light of findings from other studies? Are alternative explanations for the findings offered? Are the implications of the research for nursing practice, theory or research identified? Are specific recommendations made how the study could be improved? Are there recommendations for future research?	/1
	TOTAL SCORE	/10
	RELEVANCY SCORE: Content specific to IENs = A Content demonstrating generalizability to IENs = B	

Low score: 1 – 3; Mid-range score: 3 - 7; High score: 8 – 10

(Polit & Beck, 2004, p. 655-672).

Appendix B

Recommendation for Content for Transition/Support Programs

Recommendation	Pre-licensure	Employment	Post-licensure	Author
Communication • English language • Nursing nomenclature • Cultural nuances	✓	✓	✓	Edwards & Davis (2006) Xu, Zaikina-Montgomery & Shen (2006) Tregunno, et al., (2009) Sochan & Singh (2007) Baldacchino & Hood (2008) Coffey (2006) Adeniran, et al., (2008)
Documentation		✓		Blythe, Baumann, Rheaume & McIntosh (2009)
Knowledge of health care system • Social, cultural, political, legal, regulatory & practice concepts	✓			Edwards & Davis (2006) Sochan & Singh (2007) Coffey (2006) Blythe & Baumann (2008) Adeniran, et al., (2008)

Role of the RN • Autonomy • Collaborative practice • RN-Physician relationships • Collegial relationships with peers • Cultural awareness • Client workload assignments	✓	✓		Xu & Kwak (2006) Tregunno, et al., (2009) Sochan & Singh (2007) Blythe, Baumann, Rheaume & McIntosh (2009) Sherman & Eggenberger (2008) Coffey (2006) Adeniran, et al., (2008)
Client Care • Geriatric clients • Palliative care clients • Intensive care clients • Client assignments • Informed consent • Performing personal care	✓	✓	✓	Xu, Zaikina-Montgomery & Shen (2010) Tregunno, et al., (2009) Blythe, Baumann, Rheaume & McIntosh (2009)
Clinical skills & nursing procedures (including assessments)	✓	✓		Edwards & Davis (2006) Sochan & Singh (2007) Coffey (2006)
Pharmacology and Medication administration	✓	✓		Edwards & Davis (2006) Coffey (2006)
Use of technology	✓	✓	✓	Edwards & Davis (2006) Sochan & Singh

				(2007) Blythe, Baumann, Rheaume & McIntosh (2009)
Resource allocation • Disposable products • Product waste		✓		Tregunno, et al., (2009)
Human Rights • Racism • Discrimination • Workplace violence	✓	✓	✓	Tregunno, et al., (2009)
Strategies for achieving academic success	✓			Coffey (2006)

Appendix C

Recommendation for Staging and Sequencing of Education and Support for IENs

Recommendation	Pre-licensure	Employment	Post-licensure	Author
Qualifying pre-session	✓			Coffey (2006)
Educational Program to adapt to practice in host country	✓			Edwards & Davis (2006) Coffey (2006) Sochan & Singh (2010)
Support in Application process	✓			Hamilton (2008) Coffey (2006) Sochan & Singh (2007)
Support in Licensure process	✓			Hamilton (2008) Gushuliak (2004) Coffey (2006) Sochan & Singh (2007) Jeans, et al., (2005)
Organizational support • From organization • From leaders • From colleagues & peers		✓	✓	Wade, et al., (2008) Lindberg (2008) Coffey (2006) Sherman & Eggenberger (2008) Jeans, et al., (2005) Adeniran, et al., (2008)
Hospital & Unit orientation programs		✓		Edwards & Davis (2006)

				Lindberg (2008) Tregunno, et al., (2009) Blythe, Baumann, Rheaume & McIntosh (2009) Adeniran, et al., (2008)
Extended Supernumerary position/orientation – with mentors		✓		Lindberg (2008) Lawrie & Garossino (2007) Tregunno, et al., (2009).
Work & learning environments		✓		Wade, et al., (2008) Chiang & Lin (2008) Capell, et al., (2008) Budge, et al., (2003) Coffey (2006) Tregunno, et al., (2009)
Explicit learning & education plans	✓	✓	✓	Lindberg (2008) Lawrie & Garossino (2007) Coffey (2006) Baldacchino & Hood (2008) Jeans, et al., (2005) Adeniran, et al.(2008)

RN Role & expectations within practice • Autonomy • Clinical decision making • Leadership role	✓	✓	✓	Tregunno, et al., (2009) Coffey (2006)
Nurse-client relationships • Consent for treatment • Client advocacy • Client rights • Role of family • Religious beliefs • Treatment decisions	✓	✓	✓	Tregunno, et al., (2009)
Mentoring networks	✓	✓	✓	Xu & Kwak (2006) Lindberg (2008) Coffey (2006) Baldacchino & Hood (2008)
Connection with Community	✓	✓	✓	Xu & Kwak (2005) Sochan & Singh (2007)
Professional development opportunities			✓	Chiang & Lin (2008) Baldacchino & Hood (2008)
Transitional work settings		✓		Xu & Kwak (2005)

Appendix D

Recommended Tools for Assessment

Recommendation	Pre-licensure	Employment	Post-licensure	Author
Pre-qualification courses	✓			Sochan & Singh (2010) Coffey (2006)
ESL Testing ✓ CELBAN				Coffey (2006)
Competency Assessment Process	✓			Hamilton (2008) Gushuliak (2004) Coffey (2006)
Prior Learning Assessment and Recognition (PLAR)	✓			Sochan & Singh (2007) Baldacchino & Hood (2008) Jeans, et al., (2005)
Matching skills, knowledge and competency within the workplace		✓		Hamilton (2008)
Skills & knowledge testing	✓		✓	Edwards & Davis (2006) Coffey (2006)
Qualifying pre-session	✓			Coffey (2006)
Simulation training	✓			Coffey (2006)

Appendix E

Recommended Pedagogical Approaches, Resources and Tools

Recommendation	Underlying principles & considerations	Benefit	Resources & Tools	Author
Benner's (1984) "From novice to expert" as guiding model	IENs may be clinical experts but cultural novices		Mentorship	Tregunno et al., (2009)
Student directed learning	Facilitate teaching/learning of multicultural and multilingual learners	Students responsible for directing own learning Individuality recognized & supported	ESL content	Sochan & Singh (2007) Blythe, Baumann, Rheaume & McIntosh (2009)
Narrative Pedagogy	Adult learning principles	Client centered Empowering From rote to active learning		Coffey (2006)
Information Literacy	Distance education	Accessibility Affordability	CD Rom, videos	Edwards & Davis (2006)
Relational Pedagogy	Ability to access Clinical Nurse Educator Ratio of educators to IENs (6:1) Creating learning environments	Translate theory into practice Learning maximized Capacity building Knowledge transfer Cultural awareness for all staff	Supervised practicum/support experiences	Henderson, et al., (2009) Lawrie & Garossino (2007)
Situated learning	Collaboration between regulatory	Continuity Problem solving	Shared educational sessions	Hamilton (2008)

	bodies and employers	Collaboration Shared resources		Gushuliak (2004)
Process Orientated learning	BScN specialized program for IENs 20 months full time study Theoretical and clinical instruction prepares IENs for CRNE Provides English language assessment and support Successful completion of pre-qualifying session facilitates eligibility for admission into BScN for IEN university pgm.	Creating access while maintaining rigor Recognizes previous IENs knowledge & skills Fosters acculturation to Canadian nursing	Classroom – didactic instruction Supervised clinical experience Formal & informal mentoring experiences	Coffey (2006)
Sequential Learning	Cognitive fatigue & psychological stress	Time required to adjust	Repetition Slower paced delivery	Blythe, Baumann, Rheaume & McIntosh (2009)
Kolb's Experiential learning theory	IENs preference for divergent thinking Experiential learning cycles	Allows for movement through all 4 quadrants Design	Small group activities Simulation and lab training	Joy & Kolb (2009) Lum (2009)

		activities to move through all 4 quadrants	Individualized instruction Learning with diverse learners	

Appendix F

Methodological Critique

Citation	Substantive Theoretical Critique	Methodological Critique	Interpretive Critique	Validity Score	Relevancy Score
Ea, Griffin, L'Eplattenier, Fitzpatrick (2008)	To determine the (a) levels of acculturation and job satisfaction, (b) relationship between acculturation & job satisfaction, and (c) effects of select sociodemographic variables in predicting job satisfaction	Quantitative - Descriptive Correlational. Non-probability sampling technique – voluntary participation in questionnaires. Completed questionnaires received a $5 Starbucks gift certificate Sample population – Filipino RNs (N=96) educated in the Philippines and who are working in the US (out of 139 participants) Setting – data collected during Philippine Nurses Association of America (PNAA) conference in Baltimore, MD. Potential for response bias & generalizability of findings. Data Analysis: Instruments used: (a) Part B Index of Work Satisfaction Scale (widely recognized instrument, long history of use & sound psychometric properties), (b) A Short Acculturation Scale for	Interpretive Dimensions: Demographic profile of sample comparable to RNs in US. Filipino RNs demonstrate level of acculturation closer to US culture than Filipino. Filipino nurses have adopted use of English language, dominant cultures norms & attitudes. Average length of US residency and years of US practice within study participants = 15 years. Moderate positive correlation between acculturation and job satisfaction indicating as level of acculturation increases, job satisfaction will also increase		

		Filipino Americans instrument (validity achieved through pilot testing, expert panel review, factor analysis). High reliability scores consistent with other studies using same instruments. Demographic profile of sample comparable to overall profile of RNs in the US. Acculturation mean 2.97 out of 5 indicating acculturation closer to American than Filipino culture. Report moderate level of job satisfaction. Pearson correlation co-efficient calculated to determine relationship between variables. Moderate positive correlation exists between acculturation & job satisfaction (r=.32, n=96, p=.001) Multiple linear regression analysis performed to determine effects of covariates. Results identified.		10/10	A
Meretoja, Leino-Kilpi, Kaira (2004)	Comparison of practicing nurses' self assessments of their level of competence and frequency of using items of competence in different hospital work	Quantitative – Visual Analogue Scale Questionnaire Design clearly articulated. New instrument developed for data collection – Visual Analogue Scale.	Limitations: cultural differences & environmental differences (education, mother language) can affect generalizability of findings. Study does not reveal competence related to quality of		

	environments. Questionnaire format. Operational definition of "competence" as "functional adequacy and capacity to integrate knowledge and skills to attitudes and values into specific contextual situations of practice" (p. 330-331)	Reliability & validity of new tool through pilot study, content expertise and competence categories derived from Benner's (1984) Novice to Expert competency framework. Further analyzed through deductive content analysis Sample population: RNs (n=593) working in a major Finish University Hospital. Nineteen units selected. Data Collection: Data collected over 8 week period. Anonymity & confidentiality secured – envelope to principle investigator, no coding system used to identify respondents. 87% response rate. Data Analysis: SPSS 10 and Statistica '99 software utilized. Statistical differences between groups were tested by analysis of variance (ANOVA). Linear regression analysis used to correlate the sum variables and background factors. Demographic variables identified. On average - RNs identified most competent in skills and tasks in managing situations, helping roles and diagnostic functions. Least	care. Instrument utilized in data collection demonstrated good feasibility, but does not take into consideration cultural considerations. Recommendations/Implications: Importance of combining ethics and value, reflective practice and context specific knowledge and skills into programs of support. Comparative studies of nursing competencies in other practice environments are needed. Identification of contextual variables in practice environments may help to support competency development and improve quality of care.		

		competent in ensuring quality. Individual competencies – nurses considered themselves most competent in acting autonomously, flexibly, making decisions. Correlation between nurses' background factors and overall level of competence – the older the nurses, or longer work experience, the higher the self-assessed level of competence.		10/10	B
Drach-Zahavy (2004)	Aims of study: (a) to examine impact of primary nursing on performance of nurses, (b) test impact of two factors – supervisor support & perceived costs of seeking support, and (c) assemble structure and process variables in a comprehensive model predicting performance of nurses. Literature review conducted	Quantitative – Cross sectional survey. Sampling plan: six major hospitals in Israel. 56 nursing units representing medical, surgical, internal and critical care participated. All RNs in these areas were surveyed (n=520). Questionnaire response rate 71% or 368. <u>Data Collection</u>: Confidential questionnaires. Researcher designed. Research presented back to units if requested <u>Instruments:</u> Data pertaining to *primary nursing*	<u>Recommendations & Implications:</u> Findings agree with previous studies & literature. Study results support Structure-Process-Outcome proposed model for predicting primary nurses' performance Implementation of primary nursing model implies an empowerment process Supervisory support is a suggested process to improve performance of nurses Nursing managers should		

		captured through three phase Likert scale questions: (a) degree of primary nursing, (b) supervisory support, and (c) cost of seeking support. Data pertaining to *nursing performance* captured through 7 item measurement tool – supervisors ratings on nursing performance - adopted from Settoon et al., (1996). Unable to determine external reliability/validity of this tool. <u>Data analysis</u>: Non significant correlation between primary nursing and nursing performance, supervisory support & costs of seeking support suggests no direct impact of primary nursing on other study variables – supporting hypothesis Positive correlation between supervisor support and nurses' performance- suggesting supervisory support will impact performance of primary nurse Negative correlation between costs of seeking support and nurses' performance – suggests the	support nurses to overcome perceived barriers/costs to seeking support <u>Limitations</u>: self reported data subjected to biases. Cross-sectional design of study – difficult to determine nature of supervisor support and nurses performance as causal links.		

		perceived cost of seeking support will be negatively associated with performance		9/10	B
Budge, Carryer & Wood (2003)	Examine health correlates of autonomy, control and professional relationships in the work environment within New Zealand Replicate previous US studies examining three aspects of nursing work environment – autonomy, control, professional relationships	Quantitative – Correlational design <u>Sampling design</u>: All RNs (total 359) who worked 32 hrs/week in a general hospital in New Zealand. Response rate 62.6% - sample of 225 <u>Data collection</u>: Questionnaire. Two instruments utilized: SF-36 and NWI-R. Reliability & validity of instruments documented <u>Data analysis</u>: Comparison of average ratings suggests comparison to US non-magnet hospitals – except Nurse-physician relationships rated more positively than US counterparts Low to moderate correlations between nurses perception of workplace and health – suggesting the more positive perceptions of workplace can be linked to better health Regression analysis conducted to examine relationships between autonomy, control, external	Variations: study results demonstrate low levels of autonomy and control alongside high nurse-physician relationships – in contrast to similar US studies Researcher suggests nurse-physician relationships in New Zealand seen as less formal – different socio-cultural history Management model in New Zealand different than US. Same management structure for nurses and physicians – collegial, co-existence model When RNs perceive greater control over nursing care delivery and autonomy within hospital structure, improvement can be seen in interprofessional relationships which further impacts self perception of generalized health and wellbeing		

		relations, age and eight health related quality of life variables. Multivariate pattern consistent with correlational analysis. Only external relations variable contributes significantly to perception of better health		10/10	B
Capell, Dean & Veenstra	Examine the relationships between cultural competence and ethnocentrism among health care professionals Operational definition of cultural competence "ability to understand and work effectively with patients whose beliefs, values and histories differ from one's own: (p. 121) Operational definition of ethnocentrism "view of things in which one's own groups is the center of everything and all others are scaled and rated with reference to	Quantitative – Cross sectional study <u>Sampling Plan</u>: Convenience sample of three health care disciplines: Physical therapists, occupational therapists, nurses (400 recruited). Recruited from three acute care hospitals. Overall response rate 18% <u>Data collection</u>: questionnaire format utilizing two assessment tools- (a) Inventory to Assess the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) and Generalized Ethnocentrism Scale (GENE). Both instruments previously assessed for reliability & validity. <u>Data analysis</u>: Sample did not demonstrate any significant differences. Predominately European (n=58 or 82%), 38% spoke more than one language, 33% self	Study findings provides preliminary support suggesting a relationship between cultural competence and ethnocentrism Study findings can be of use in designing cultural competence programs for health care professionals Limitations: low sample response rate may reflect self selection bias Small subsamples by cultural group representation too small for analyzing relationship Recommendations: Study should be replicated with larger sample size		

	it" (p. 121)	identified international health care experience. No statistically significant differences reported across professional groups Cultural competence moderately and negatively correlated with ethnocentrism – suggesting cultural competence may comprise of a larger set of characteristics than those examined		8/10	B
Slater, McCormack (2007)	Aim is to examine the factor structure of the 15 items that comprise the four factors (autonomy, control over practice settings, nurse-doctor relationships, organizational support) of the Nursing Workload Index – Revised Research instrument	Quantitative – Survey Method Survey method was used to obtain information on specific indicators of an effective learning culture. Sampling plan: All RNs working in acute care hospitals in UK within each clinical grade (D-I). 20% sample randomly selected from within each experience grade. <u>Sampling Plan</u>: Total sample = 342 RNs, resulting in a 50% response rate (n=172) <u>Data collection</u>:	Understanding organizational culture is important – measurement of culture is essential and measurement instrument must meet acceptable statistical standards. Study findings could not replicate original research - utilizing this instrument could decrease reliability and validity of other research results Original four constructs should be grouped together and renamed		

		Factor analysis limited to 15 items of interest rather than complete NWI-R survey questionnaire. Confidentiality, anonymity and safe storage of data clearly identified <u>Data analysis</u>: Study results analyzed utilizing Statistical Package for Social Science 11.0 (SPSS) Inclusion of cross-factor loading made original NWI-R model difficult to replicate Descriptive statistics were generated according to emerging factors – High positive correlations present among three factors: (a) adequate staff and support, (b) doctor – nurse relationship, and (c) nursing management – at statistically significant level	<u>Limitations</u>: Small sample size – reflective of a single hospital site. <u>Recommendations</u>: Replicate new findings with further research – utilizing larger sample size across multi-national settings Reassess data from original research with a secondary analysis	10/10	B
Henderson, Twentyman, Eaton, Creedy, Stapleton &	Assess the impact of an intervention aimed to build capacity of RNs to enhance the clinical learning environment	Quantitative – quasi-experimental design Measurement of student's perceptions of psycho-social learning	Students who were in their clinical practicum during the intervention period rated psycho-social clinical learning environment significantly		

Lloyd (2009)	for undergraduate nursing students.	environment during and outside of intervention period used to evaluate capacity building intervention. Capacity building intervention conducted over six weeks for RNs in two acute surgical wards. Capacity building intervention – every second day for 6 weeks, educator on unit for 3 – 4 hours. Conducted in-services (20-25 minutes), informal interaction with unit RNs. Intervention encouraged RN to verbalize knowledge about patients needs that underline their practice – making explicit what is implicit in practice Sampling plan: All RNs from two acute surgical wards in Australia who were scheduled for the afternoon shifts. All RN students who undertook their practicum before, during and 6 months after intervention phase (n=62). Students organized into control group and intervention group.	higher than those outside of the intervention period. Experienced educators who conduct capacity building sessions can effectively support unit RNs in their support of students in the clinical learning environment Sustainability of data results may not be sustained over time – intervention only temporary measure Limitations: study results specific to workplace in areas receiving intervention – practice environments will differ Recommendations/implications: Capacity building interventions can be successful but must be embedded and fostered within leadership practices Capacity building and support processes require acceptance into workplace values and everyday practice		

		Data collection: data gathered prior to and six months after intervention (control group) and data collected during intervention phase (intervention group). This was done to address issues of staff turnover and external demands in clinical practice associated with intervention. Instrument: Clinical Learning Environment Inventory – consists of 42 questions grouped into 5 subscales reflecting core concepts for student learning environments. Internal reliability of subscale calculated and presented. Data analysis: SPSS 13.0 statistical software utilized Significant increase reported across all subscales during intervention phase. Three subscales: student involvement, innovation & personalization were also significant – reflecting unit RNs engaged with student learners more actively		9/10	B

Chiang & Lin (2008)	Test the reliability & validity of Chinese version of the Nursing Practice Environment Scale (C-NPES) Require reliable instrument to explore Taiwan's nursing work environment to provide evidence for future practice environment improvements	Quantitative – Cross sectional design. Self administered questionnaire. Sampling plan: purposive convenience sample 842 nurses (out of 3068) recruited from 5 acute hospitals in Taiwan. Nursing administrators and RNs < 3 months employment excluded. Data collection: 1000 questionnaires distributed. Voluntary, anonymous responses placed in sealed envelope in box at nursing stations. Overall response rate 842 (87.4%). Instrument: C-NPES translated. Reliability and validity of translation process conducted through back-translated versions and original versions through bilingual expert examinations. Bilingual Taiwanese nurse with PhD in nursing confirmed semantic equivalence and cultural relevance of tool. Data analysis: reliability of total	Psychometric properties of C-NPES instrument established Professional development is an essential element of nursing practice environment in Taiwan. Original factor of nurse – physician relationships was not a factor in this study – Taiwanese nurses could consider positive relationships as an advantage for professional collaboration and advancement Limitations: C-NPES constructs may be considered incomplete without further testing to capture the cultural nuance related to differences between Taiwan nurses and nurses in Western countries. Generalization of nursing practice environment throughout Taiwan health care settings may be limited Recommendations/Implications: C-NPES can provide health care administrators an overview of		

		scale and all subscales evaluated through Cronbach's alpha coefficient. Construct validity established by exploratory factor analysis using a principle component analysis method with Varimax rotation C-NPES comprises of 5 factors and its construct validity and criterion related validity have been confirmed Results demonstrate: (a) Taiwanese RNs dissatisfied with amount of staffing and resources (n=2.06), (b) adequate support for spending time for patient care (n=2.23), (c) low opportunities for participating in policy decisions. Implementations related to professional and career advancement rated higher (n=3.21) through the availability of career development and clinical laddering opportunities	magnet hospital nursing practice characteristics Shared governance models in Taiwan's health care structures are different from Western countries because of a collectivist culture	10/10	B
Kulig, Stewart, Morgan, Andrews, MacLeod, Pitblado (2006)	Confirm the importance of supportive work environments and continuing education on nursing practice in rural and remote	Mixed Methods – documentary analysis, survey In-depth analysis of 159 policy documents to gain contextual understanding of rural & remote nursing practice in Canada	Aboriginal nurses will return to their home communities due to satisfaction with personal and work environment RNs practicing in rural and remote areas require ongoing		

	Canada Operational definition "rural" – "populations living outside the commuting zones of centers with a population of 10,000 or more"	<u>Sampling plan</u>: stratified random sample RNs (3933) – questionnaire and opened ended question section at end of questionnaire All 12 provincial & territorial colleges of RNs participated in sampling process to obtain representative sample All RNs working in territories or outpost nursing stations included to capture remote nursing experiences. <u>Data collection</u>: mailed questionnaire. Response rate 68% <u>Data analysis</u>: documentary analysis suggests there is a need to increase the enrolment of aboriginal people in nursing schools – aboriginal healthcare providers more likely to stay and work within their own cultural context. 69.9% originally from communities with population < 5,000. Nurse-Internship Program developed for aboriginal RNs to enhance their working environment – development of clinical skills and mentoring experiences	accesses to continuing educational opportunities <u>Limitations:</u> were not clearly identified in this study <u>Recommendations/implications</u>: Demographic information and physical isolation of communities concludes the need for access to education and mentoring support		

		Only 15.5% of respondents felt health agency was adequately meeting their educational needs Demographic data reports 5.3% of respondents identified as being of aboriginal/Metis ancestry, province of registration predominantly Manitoba, Saskatchewan or Ontario. Further suggests aboriginal nursing education efforts in these 3 provinces are demonstrating a level of success		7.5/10	B
Wade, Osgood, Avino, Bucher, Foraker, French & Sirkowski (2008)	Investigate the effect of organizational characteristics and perceived caring attributes of managers on nurses' job enjoyment	Quantitative- predictive correlational design Examine causal relationships between: nurse participation in hospital affairs foundations for quality of care, nurse manager ability, leadership & support of nurses, staffing/resource adequacy; collegial nurse-physician relationships and perceived caring attributes of managers (independent variables). Job enjoyment (dependent variable) <u>Sampling plan</u>: convenience sample RNs employed in large health system in US (n=731).	Organizational variables: Nursing foundations for quality of care, nurse manager ability, leadership, support of colleagues, nurse-physician relationships, resource adequacy are predictors of job enjoyment – 30% of variance in job enjoyment is consistent with other research studies <u>Limitations</u>: the appropriateness of the PES instrument for nurses in all healthcare practice settings – approx. 20.4% of participants worked outside of acute care hospital setting or in non-direct client care roles (under representation in some		

		Participants worked in a variety of settings including: acute care, long-term care home care, research and outpatient clinics Data collection: survey mailed to home address of each active licensed nursing employee (n=3160). Response rate 33.6% - only 68% of returned questionnaires complete & used for analysis (n=731) Data analysis: SPSS/WIN 15.0 statistical software utilized Multiple regression analysis for variables predicting job enjoyment All study instruments had previously established reliability Job enjoyment scores increased with age of respondent - Based on the beta coefficient APNs demonstrate greater job enjoyment than nurses in non-direct care roles (education, management) Unanticipated finding – nurse manager ability, leadership & support of nurses was a statistically significant predictor of job	areas) Some participants revealed concern of about being identified through participation in the study Recommendations/implications: Nurse job satisfaction should be studied using qualitative & quantitative measures that are able to distinguish variations in practice setting, job type and age		

		enjoyment whereas caring attributes was not		10/10	B
Tregunno, Peters, Campbell, Gordon (2009)	To gain insight into the experiences of newly registered IENs as they enter into Ontario's health care workforce to determine degree of safe and competent practice upon registration.	Qualitative - Constant – comparative method Semi-structured interviews Sampling plan: IENs who had received initial registration in Canada over a 3 year time period. Equal number of RNs and RPNs from each year of registration were randomly selected (n=400). Solicited by telephone. Data collection: Consensual, confident, in person interviews. Taped interviews, approx. 1 hr. Transcribed verbatim, field notes recorded after each interview. Transcripts verified against audio-recording for accuracy & completeness. Data analysis: NVIVO 7 statistical software utilized to facilitate data coding and sorting. Typology of practice setting reality themes identified Participants included: 30 nurses representing 20 countries employed in 3 healthcare sectors. 27 participant	Three themes identified which are consistent with other studies: standards of care, language and being the outsider Research findings contribute the dimensions of: role of patients and families in decision making processes and resource utilization Research findings highlight delivery of safe and ethical care could be compromised when IENs first enter Canadian practice environments – nursing in Canada will differ from nursing in their home countries IENs are cultural novices. Research findings consistent with other studies suggesting language and communication are barriers Limitations: workplace complexity and IEN education Recommendations/implications: Link research findings through		

		female, 3 male. Years of nursing experience (n=15) 15 participants worked in long-term care, 2 in community and 13 in acute care Five themes identified: expectations of practice, nurse-client relationships, resource utilization, language, being the outsider Challenges for IENs identified: feeling overwhelmed with local expectations, informed consent for treatment, patient advocacy, care for specific patient populations, knowledge of culturally competent care, self regulation, regulatory framework	Benner's (1984) From Novice to Expert as a guiding framework for developing workplace transition programs IENs require: cultural orientation, postlicensure workplace transitional support, language skills, increased orientation time, supervised practice, pharmacology, physical assessment skills Current IEN orientation and education programs require further evaluation and research	10/10	A
Xu , Zaikina-Montgomery & Shen (2010)	Profile of characteristics of IENs in US workforce – from 2004 National study	Quantitative - Secondary analysis – Several events that may have influenced characteristics of IENs: overseas testing centers established (CGFNS), increased international recruitment efforts <u>Sampling plan:</u> self reported survey designed to examine demographic trends, education and employment characteristics of RNs living in the US	Most variables remained relatively unchanged between 2000 & 2004 study Different between job satisfaction ratings between IENs and US RNs – IENs will experience workplace challenges related to language, socio-cultural knowledge Three top countries of origin for IENs were: Philippines,		

		Data collection: secondary analysis on data sets from 2004 NSSRN Data Analysis: SPSS statistical software utilized Frequencies were used to describe categorical variables, means and standard deviations used to describe continuous variables Chi-square and t-tests used to compare IENs with US nurses for variables where appropriate	Canada, UK Significantly higher proportion of IENs identified baccalaureate degrees (81.1%) as compared to US RNs (30.4%) Top three employment settings for IENs: hospital, extended care, ambulatory care – compared to US RNs: hospital, public/community health, ambulatory care Recommendations/implications: Transitional programs needed to facilitate integration & retention of IENs	10/10	A
Blythe & Baumann (2009)	To create a profile of IENs who are employed in major jurisdictions	Quantitative - Published literature and secondary data analysis conducted Sampling plan: 10,165 RNs, 1084 RPNs and 37 RNs (EC) were categorized as IENs Data collection: review of statistical reports on registered members, unpublished workforce data on IENs Data Analysis: IEN workforce primarily located in urban centers, are > 30 years of age	Ability to write NCLEX overseas encourages IENs to migrate to US Limitations: self reported data Lack of statistical data tracking IEN migration Many nurse migrate to Canada but are not eligible to practice – despite programming efforts (CARE programs), many applicants do not complete registration		

		with nursing experience One third of IENs educated in Philippines (3114), followed by UK, India, US	<u>Recommendations/implications</u>: Further research is required to explore differences amongst IENs Policy makers need to recognize the heterogeneity of IEN practice & competency knowledge	7/10	A
Xu & Kwak (2005b)	Characteristics of IENs in US	Quantitative - Secondary analysis of data from 2000 NSSRN Literature review conducted <u>Sampling plan:</u> self reported, voluntary survey providing longitudinal data on demographic, education & employment characteristics of RNs in US. All RNs holding license credentials in US Original data commenced in 1997 <u>Data collection</u>: 3 separate mailings to selected participants – followed by telephone call Return rate: 72% - 3.7% further self identified as IENs	IENs have been utilized to address nursing shortage issues albeit controversial <u>Limitations</u>: self reported data <u>Recommendations/implications</u>: Policy makers need to develop long-term workforce policy to reduce cyclic nursing shortage		

		Data analysis: STATA statistical software utilized to perform univariate & bivariate analysis Means & standard deviations obtained for all continuous variables Chi-square tests and t-tests performed to examine differences between IENs and US RNs Little mean difference between age, gender, marital status, family structure between IENs & US RNs Significantly higher number of IENs living in urban areas (90.4%) as compared to US RNs (77.5%) IENs located in culturally similar urban environments for psychosocial support, connection with ethnic foods & entertainment Statistically significant rates reported between IENs working in hospital settings (72.1%) compared to US RNs (58.2%)		10/10	A
Xu & Kwak (2006)	Examine trends of demographical, educational and	Quantitative - Secondary analysis – NSSRN data sets	IENs are motivated to work, meeting needs of traditionally hard to fill shifts		

	employment characteristics of IENs during 1977 – 2000.	Sampling plan: sample sizes varied from 20,417 in 1977 to 54,000 in 2000. Data collection: response rates varied from a low of 71.7% in 1977 to a high of 82.2% in 2000 Missing data excluded from analysis Data analysis: STATA statistical software utilized In situations where data were unavailable for some variables of interest for selected years – available data from nearest year were substituted to trend the data Characteristics of age, marital status proportionally similar to US RNs Number of male IENs doubled from 2.6% to 6.2% Primary countries of origin: Philippines, Canada, UK, India Significant increase noted in migration from Philippines (from 36.4% to 38.9%) and India (from 9.1% to 10.9%)	Limitations: Resource restraints Recommendations/implications: Cultural beliefs, professional values, communication, practice initiatives & practice variations require additional orientation and mentoring support Transitional programs should be created whereby existing IENs can mentor new IENs Cultural competence training is required for IENs as well as US RN counterparts		

		Positive trend noted in IEN educational characteristics – increased baccalaureate degrees IENs predominately work full time, in hospital settings as frontline staff nurses		9.5/10	A
Edwards & Davis (2006)	Determine learning needs of IENs – by determining how IENs felt their education has prepared them for practice in the US	Qualitative - Self – reported questionnaire <u>Sampling plan</u>: RNs taking CGFNS certification program examination in countries around the work asked to participate in survey Test site managers recruited sample of IENs – voluntary participation <u>Data collection</u>: "Clinical Competency Survey" assessment tool utilized – designed for study Mean & standard deviation for perceptions of clinical competence dimensions identified Survey administered at CGFNS test sites – collected by managers <u>Data analysis:</u> 3.205 RNs representing 30 countries grouped into categories with high	Gaps in clinical competence dependent on previous education and experience <u>Limitations</u>: self reported data <u>Recommendations/implications</u>: Continuing education programs should take into consideration learning needs of IENs Should include a variety of delivery methods including workshops, training CD-ROMs, videos Increased time is required in orientation and mentoring experiences Further research required to develop an assessment tool to determine IEN learning needs as they commence practice in US		

		representation from Philippines (60%), India (30%), Nigeria (3%), Other (7%). 43% of IENs identified baccalaureate education as compared to 56% diploma prepared 92.5% of IENs identified they felt they were prepared for clinical practice in the US		8/10	A
Blythe & Baumann (2008)	What are the characteristics of Ontario IEN workforce? What factors are likely to influence IEN supply in future? What are the implications for workforce planning?	Prepared report. Sampling plan: statistical information available for IENs in Ontario Data collection: existing statistical information collated for report Data analysis: one third of IENs in Ontario come from Philippines, work in direct practice employment, primarily within hospital settings regardless of previous educational experience Philippines & India educated nurses for export with the UK acting as a migration conduit prior to entry in US or Canada	Over half of IENs in Canada live in Ontario and 10.78% are within the Ontario workforce Limitations: Report limitations not identified. Recommendations/implications: IENs could be permitted to take licensing examination prior to migration process Ethical recruitment practices & policies should be implemented Support for IEN in licensing process could include working as personal support workers to obtain Canadian experience requirements for licensure Improve workplace orientation		

		IENs demonstrate a low pass rate in licensing examinations	programs for IENs which are culturally competent	7.5/10	A
Xu & Kwak (2005a)	IENs working in long-term care settings in US – changes in trends of employment settings Operational definition IEN "RNs who have obtained their basic nursing education from other countries and have a legal license to practice in US"	Quantitative - Secondary analysis – NSSRN data (1997-2000) <u>Sampling plan</u>: RN's who US license to practice <u>Data collection</u>: analysis from existing longitudinal data <u>Data analysis</u>: Decrease of IENs working in hospital in 1992 while increased in other areas – Long-term care settings became second largest employer of IENs Long-term care settings undesirable to US RNs – lower prestige, lower clinical challenges, higher physical demand Long-term care settings advantages to IENs- slower pace, lower patient turnover	Aging society prompting increase in demand for long-term care - IENs in long-term care settings fill nursing vacancies <u>Limitations</u>: not clearly identified <u>Recommendations/implications</u>: Further research required to determine exact factors contributing to increasing IENs in long-term care settings Research to explore possibility of long-term care settings as transitional workplaces for IENs entering practice in US	7.5/10	A
Lum (2009)	Identifying learning styles in bridging education programs for Internationally educated health professionals	Mixed methods design <u>Sampling plan</u>: Purposive sampling of internationally educated professions enrolled in post-secondary bridging programs in	Many bridging educational programs are not as successful as anticipated Workplace integration problematic despite highly		

		Ontario – recruited in 2 phases Data collection: quantitative data collected using 3 survey instruments: Kolb's learning style inventory, Guglielmino's Self Directed Learning Readiness Scale (SDLRS), The Bridging Education and Professional Work Survey (BEPWS). Qualitative data collected through focus group interviews – utilizing interpretive naturalistic approach to understand phenomenon – thematic issues identified Participants (n=138) Response rate ranged between 30% - 80% Instrument: Bridging Education and professional Work (BEPW) questionnaire developed Data analysis: SPSS version 15 statistical software utilized to analyze quantitative data. Descriptive & correlational statistics identified as completed. Reliability of SDLRS instrument evaluated utilizing Cronbach's alpha.	educated international professionals Majority of internationally educated professionals educated in Philippines, India & Egypt. Limitations: small number of participants in comparison to total available Bridging programs differences – variability of responses could be influenced by program characteristics IENs had to have English language skills in order to participate Recommendations/implications: Research findings support distinct educational approaches & strategies aligning with learning styles and preferences of internationally educated professionals Research findings can be used to help inform post secondary institutions & faculty in adapting educational programming		

		Internationally educated professionals possess a distinct learning style – Kolb's Learning Styles Inventory provides framework to support learning needs	Internationally educated professionals require professional socialization opportunities to transition into practice Improved access to bridging programs is required	10/10	A
McIntosh, Torgerson, Klassen (2007)	Ethical recruitment of internationally educated health professionals Passive recruitment – individual independently decides to apply for position in another country	Canadian Policy Research Policy Report <u>Data collection</u>: Key informant interviews Secondary analysis of statistical information available on subject matter <u>Data analysis</u>: Unethical recruitment practices include: sending out e-mails, setting up booths at job fairs in developing countries, advertisements in professional journals in developing countries, bringing health providers to visit community	<u>Recommendations/implications</u>: Guiding principles for ethical recruitment should include: global justice, personal autonomy, transparence/accountability, fairness, mutual benefit or reciprocity between countries, provider competency, equitable workplace practices, workplace and cultural integration.	8/10	A
Raghuram (2007)	Exploring the concept of "integration" of IENs to facilitate retention	Grey literature, peer reviewed. Existing literature reviewed. Integration requires – responsibility	Integration is multi-faceted and complex Institutional racism exists in many practice environments		

		of host society to ensure processes in place for IENs to engage in economic, cultural life of host country without relinquishing their own identity (p. 2247) Assimilation requires – IENs to merge into indigenous culture (p. 2247) IENs are required to assimilate by integrating into current practices rather than shape practices based on existing practice and knowledge they already possess Integration measures often essentialize cultural differences (eg. Special dietary requirements) while larger socio-political issues are ignored	Recommendations/implications: Institutions employing IENs must be aware of the difference between assimilation and integration Anti-racism training should be considered as part of integration policies	5/10	A
Joy & Kolb (2009)	Are there cultural differences in learning style? Operational definition of *culture* – "shared motives, values, beliefs, identities, and interpretations of significant events" (p.70)	Quantitative - Provided operational definition of constructs Sampling plan: 17,370 managers from 951 organizations in 62 societies (n=251) – GLOBE study Data collection: secondary analysis of past studies including GLOBE study	Kolb's Experiential Learning Theory Learning Styles Inventory utilized as a supporting framework in identifying impact of culture and other demographic variables on learning styles Limitations: sampling technique - online data collection method – biased by being not		

		Online data collection survey Data analysis: ANOVA statistical software utilized, t-tests Societal & organizational dimensions of culture tested & validated through factor analysis process. Empirical validity of identified clusters tested through discriminant analysis Culture has significant effect in deciding individuals preference for abstract conceptualization over concrete experience learning	representing full population Recommendations/implications: Multilevel regression model capable of supporting multiple levels of analysis would be more appropriate analytical method	10/10	B
Sochan & Singh (2007)	Exploring the experience of IENs in Ontario as they gain entry to practice Identify what is known and what is assumed about acculturation and socialization experiences while in bridging programs	Qualitative - Biographical narrative research Literature review conducted Sampling plan: convenience sample, 12 IENs enrolled in CARE program. Representative of five countries with Data collection: audio taped, personal interviews. Transcribed verbatim. SQUIN method used (lightly	Delays in securing license to practice results in deskilling of nursing knowledge & expertise IENs face language difficulties and cultural learning while grieving loss of family support, income, professional status Recommendations/implications: Health care leaders must be aware of complex processes IENs go through to obtain		

		structured interview) – to minimize influence from interviewer Data analysis: differences identified in the "told stories" from the "untold stories" Three themes identified within the "told" stories: fulfilling a dream of becoming an RN in Ontario, discovering home countries qualifications are minimized, redefining Canadian dream of returning to school for upgrading Three themes identified within the "untold" stories: hope, disillusionment, navigating disillusionment.	licensure to practice PLAR process is a positive move towards clarifying credentialing process	10/10	A
Sochan & Singh (2010)		Qualitative - secondary analyses of previously conducted research Sampling plan: convenience sample, 12 IENs enrolled in two bridging programs. Representative of five countries: Philippines, China, India, South Korea, Ukraine. Data collection: original data audio taped, personal interviews. Transcribed verbatim. SQUIN method used (lightly	Inconsistencies in licensing process and educational bridging programs adds frustration and financial costs for IENs seeking licensure to practice as RNs Limitations: narrow sample and scope of research Recommendations/implications:		

		structured interview) – to minimize influence from interviewer <u>Data analysis</u>: Common theme – IENs have experienced significant difficulties with credentialing bodies and educational bridging programs There is significant financial burden for IENs to obtain licensure to practice There is a human cost for IENs – devalued credentials	Three recommendations for policy change: transparency in credentialing process, standardization of the credentialing process and integrated processes between immigration and credentialing bodies Licensing process should commence in IENs home country to alleviate time and financial burden Additional research should incorporate a larger sample size to reveal additional experiences, perspectives and challenges	10/10	A
Blythe, Baumann, Rheaume & McIntosh (2009)	Discover how the migration process, regulatory procedures,, issues with national licensing examinations & finding employment influence workforce uptake	Qualitative - Focused conversation barriers and facilitators on becoming a nurse in Ontario & recommendations for future development <u>Sampling plan</u>: IENs who were unemployed, attending school or employed Representatives of institutions supporting IENs Recruited through posters at	IENs require transparent information on the migration process to strategize how to re-establish their lives and professions after migration <u>Recommendations/implications</u>: Many IENs will abandon nursing after a long absence from practice		

		workplaces or educational programs & through snowballing technique <u>Data collection</u>: audio taped, focus groups & individual semi-structured interviews conducted Additional researcher taking field notes Conducted in educational & health care settings in Ontario Interview guides created & supplied 39 IENs participated in 5 focus groups and 10 interviews <u>Data analysis</u>: QSR NVivo (version 1.3.146) statistical software utilized to transcribe & code data through thematic analysis Unlikely data saturation was reached in identifying all barriers & facilitators IEN participants represented 23 countries with top two: Philippines, India Delays in registration processes creates long periods of absence from practice – the longer out of the			

		system, the more upgrading and education is required Barriers for IENs included: migration process, navigating regulatory system, attaining educational standards, meeting language requirements, passing licensing exam, integration into the workplace Integration into the workplace requires a variety of strategies CARE programs has improved IEN licensure pass rates		10/10	A
Sherman & Eggenberger (2008)	Investigate the educational and support needs of IENs	Qualitative – semi-structured interviews Gather data to describe the transitional experiences and challenges of IENs Literature review conducted <u>Sampling plan</u>: geographically diverse, purposive sampling provided by staffing agency 21 IENs & 10 nursing managers	Impact of cultural differences must be acknowledged especially in area of nurse autonomy, accountability for patient assessments & technology Supportive leadership & assignment of nurse mentors essential in transition process <u>Recommendations/implications</u>: Nursing leaders must build a unit environment that respects values and cultural diversity of		

		IENs represented 7 different countries with majority from India <u>Data collection</u>: 1 hr. telephone interviews – interview guide supplied <u>Data analysis</u>: interviews transcribed verbatim data coded into themes and concepts- verified with participants IEN characteristics: age (n=33), nursing experience (n=10 years), predominantly in med/surg areas 10 managers – all had direct experience with IENs assigned to their units in last 2 years Themes from nursing leaders: cultural challenges, significance of leadership support, orientation needs of IENs, contributions IENs make to nursing units Themes from IENs: differences in nursing practice, transition challenges, orientation needs	all staff Leadership & coaching strategies should be used to develop leaders to support IEN transition Extensive orientation programs are required to transition IENs into practice settings	10/10	A
Baldacchino & Hood	Identifying the challenges that are	Qualitative: Survey questionnaire	IEHPs do not migrate alone – they come with their spouse and		

(2008)	faced by internationally educated health professionals in PEI & Atlantic Canada	Research project forms part of Atlantic Health Connection initiative funded by Health Canada Participants encouraged to share narratives and experiences of coming to Atlantic Canada <u>Sampling plan</u>: 39 IEHPs (54%) of total known population in Atlantic Canada Sample represented 21 countries, 17 languages across health sectors Participants predominantly female, varied educational backgrounds <u>Data collection</u>: standardized web based questionnaire – guide supplied Some participants filled in hard copies of questionnaires. One evening conducted for group of Chinese IEHPs who required assistance of a translator to complete questionnaire <u>Data analysis</u>: PEI & Atlantic Canada population considered homogenous blend of "White, Anglo, Christian, straight"	family IEHPs do not have access to professional development opportunities for themselves or their family members Social integration of IEHPs influenced by: profession related, civic-political, linguistic, educational and/or residential <u>Limitations</u>: difficulty in volunteer responses from target group <u>Recommendations/implications</u>: Respondents recommend more family focused retention strategies Policy changes required to reflect IEHP services & supports		

		culture (p. 10) – integration of IENs into community is very difficult IEHPs in PEI & Atlantic Canada have limited access to professional upgrading and continuing education opportunities All 39 respondents claimed to read, speak & understand English – however translator services had been required Out of 20 of the respondents (61%) who identified current occupation, over half indicated they were underemployed or unemployed at time of study		10/10	A
Minister of Public Works & Government Services Canada (2010)	Foreign Credentials Referral office – employers roadmap to hiring & retaining internationally trained workers	<u>Grey Literature -</u> Provides tips for preparing for a diverse workforce Assessment processes require additional candidate questions: 1. Describe their years of experience in field/job in performing specific tasks 2. Explain skills or demonstrate them in practical tests 3. Demonstrate their knowledge	<u>Recommendations/implications</u>: Bridge to work programs should contain: 1. Structured guidance – coaches/mentors 2. Opportunities for professional development 3. Regular evaluations & feedback Training programs should include:		

		through formal examinations There is a need to create inclusive workplace training – welcoming all employees – should include: 1. Formal orientation process 2. Pair with a mentor – preferable with someone who shares the same cultural background 3. Connect with people in the community supports – will assist in helping them & their families integrate into new community 4. Provide diversity training to all staff 5. Identify individuals in the organization who will champion diversity	1. Specific skill training 2. Language training 3. Cultural & communication training 4. Organizational training	6/10	B
CNA (2005) Jeans, Hadley, Green Daprat (2005)	Navigating to become a nurse in Canada – Assessment of international nurse applicants	<u>Commissioned report for CNA</u> Mixed Methods – qualitative & quantitative, literature review Sampling: IENs, health care leaders, policy developers throughout Canada Exploring: knowledge of licensure & integration of IENs, impact of legislation on licensure, identifying	<u>Recommendations/implications:</u> Comprehensive strategy required to: improve validity of assessment process, increase availability of educational programs designed for IENs, increase success rates of integration into workforce Current bridging programs		

		opportunities for convergence There are challenges in the integration process for IENs and employers including: education, linguistic and cultural	should undergo an in-depth review Establish national assessment service utilizing evidence-based standardized approaches Language fluency is a serious patient safety issue	10/10	A
Adreniran, Rich, Gonzalez, Peterson, Jost, Gabriel (2008)		<u>Grey Literature -</u> Guiding framework "Transitioning Internationally Educated Nurses for Success (TIENS)" Transition challenges for IENs are not a result of lack of knowledge or clinical skills – but can be linked to socio-cultural differences Socio-cultural differences include: structure of health care system, language subtleties, unfamiliarity with new settings 4 overlapping areas for consideration in developing transition programs: 1. Socialization to professional nursing role 2. Acquisition of language & communication skills 3. Development of clinical & organizational workplace	IENs must adapt clinical practice & communication to new environment settings Successful transition requires motivation of IEN <u>Recommendations/implications:</u> A policy is required to standardize transition programs for IENs in US A stakeholder coalition should be developed to facilitate policy & programming development		

		competence 4. Availability of resources to support IEN needs TIENS program is a 4 phase, transitional program developed by Hospital of the University of Pennsylvania in 2003 4 phases of program include: 1. Pre-arrival 2. On-boarding phase 3. Formal classes 4. Clinical orientation		6/10	A
Kolawole (2009)	To analyze issues of underemployment or unemployment of IENs in Ontario	<u>Grey literature –</u> opinion piece Examination of existing research & literature on subject pertaining to IENs Retrieving accurate data on actual number of IENs is difficult – not all IENs apply for licensure 7.4% of all RNs in Canadian workforce have been identified as IENs Issues of human capital loss seen in: nursing shortage, social & cultural costs, global costs Current initiatives in Ontario (CARE	IENs face significant barriers in the integration process – including a lack of understanding of the full depth & breadth of licensure process <u>Recommendations/implications:</u> Strategies should occur at all phases of integration for IENs All IENs should complete a language proficiency examination prior to migration Current support programs should re-evaluate program direction and content to align with needs of IENs		

		program) provide assistance but limited success 40% of IENs fail to complete licensure process in Ontario – resulting in underemployment or unemployment		6/10	A
McGuire & Murphy (2005)	Explore what is known about IENs and the challenges they face in the licensure process	<u>Grey literature –</u> Opinion piece Existing research explored – literature reviewed IENs are referred to as the "forgotten nurses" (p. 26) due to the limited information known about them IENs are not a homogenous group – there are variations in skills sets, experiences and competencies In 2003, out of 270 IENs enrolled in the CARE program in Ontario, close to 50% were in possession of a baccalaureate degree Confusion in licensure process can be attributed to: language, cultural differences, repeated requests for missing information IEN experience difficulties with maintaining clinical skills while	Active recruiting is unethical and without adequate supports for integration – IENs will face significant barriers <u>Recommendations/implications</u>: Reduce lag time between application process and licensure exam Support in the integration process is required from all stakeholders		

		proceeding through licensure process Challenges are experienced in the clinical setting: language and language subtleties, caring for specific patient populations, role of collaboration, technology		6/10	A
Coffey (2006)	Educating IENs through a BScN bridging program	<u>Grey Literature</u> - Guiding framework BScN in Nursing Bridging program – specific to IEN BScN program developed for IENs <u>Program structure</u> – 20 months full time study IENs must complete qualifying pre-session prior to admission. Qualifying pre-session includes: social, cultural, political, legal, regulatory and practice concepts related to nursing practice in Canadian environments. Pre-session includes: 1. ESL training (average 100 hours of specific education) 2. Individualized assessments focusing on specialized nursing knowledge & skill (simulation based	Program provides comprehensive education for IENs Entry to BScN achieved through successful completion of qualifying pre-session <u>Recommendations/implications:</u> There is a moral and ethical responsibility to support IENs in the transition process as they are our colleagues		

		assessments) 3. Creating mentorship networks (formal & informal with members of community) 4. 13 week program of credit & non-credit courses (pharmacology, common nursing procedures) Content specific to IENs includes: 1. Theoretical, clinical instruction support to successfully pass CRNE exam 2. ESL language education & support 3. Acculturation to Ontario workforce through formal & informal mentorship experiences Appropriate pedagogical approaches used with all content delivery (client centered & empowering)		6/10	A