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The Experience of Internationally Born Nurses Working in Twin Cities Hospitals

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THE EXPERIENCE OF INTERNATIONALLY BORN NURSES WORKING IN TWIN CITIES HOSPITALS

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This is to certify that **Jolene Baker** has successfully defended her Graduate Project entitled **"The Experience of Foreign Born Nurses Working in Twin Cities Hospitals"** and fulfilled the requirements for the Master of Arts in Nursing degree.

Date of Oral defense **May 3, 2010.**

Committee member signatures:

Advisor: Joan Brandt Date 5/3/10

Reader 1: Magdelene Aagard Date 3 May 10

Reader 2: Nelle Lane Date May 3, 2010

Dedication

To Jeff,
For your constant companionship and tireless encouragement throughout this educational journey. Without you I would surely have given up long ago.

Acknowledgements

This study would not have been possible without the willing participation of the courageous, thoughtful, and generous internationally-born nurses. They are living examples of the best of the nursing profession in the U.S. My advisor Joan Brandt contributed insightful questions and comments that sharpened my thinking as well as my writing. The final product would be impoverished without her guidance and expertise. Lastly, my daily encounters with the staff and students at the International Institute of Minnesota were constant reminders of the richness that New Americans add to the healthcare industry and what a privilege it is to welcome them into life in Minnesota.

Abstract

This qualitative study explores through a phenomenological process, the experiences of five Internationally Born Nurses (IBNs) working in four hospitals in the metropolitan area of the Twin Cities, Minnesota. The IBNs were interviewed using Brenda Dervin's Sense-Making theory. This communication methodology presents the human being in phenomenological terms, as a body-mind-heart-spirit moving through time and space, with a past history, present reality, and future dreams or ambitions. The nursing theory underlying this study was drawn from Jean Watson's *Caring Science as Sacred Science*. In addition, the Christian worldview articulated by Shelly and Miller with particular emphasis on the concept of *shalom* (health), the kind of health that allows people to live at peace in a God-centered human community with a sense of physical, psychosocial and spiritual well-being, provided the theological foundation for this study. Barry Johnson's Polarity Management tool was incorporated into the recommendations for nursing leadership as one avenue to build cohesiveness in a diverse nursing staff.

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The Experience of Internationally Born Nurses Working in Twin Cities Hospitals

Introduction

It is not uncommon these days for educational institutions and global businesses to offer, and sometimes mandate, diversity training. Although diversity is often left undefined when promoting these training programs it is frequently assumed to refer to gender, race or sexual orientation. Recently it has also incorporated generational diversity. However, with the rising numbers of study abroad programs and an increase in multinational corporations with employees around the world, learning to communicate and relate to people of divergent cultures in a competent manner is essential in the 21st century. This cross-cultural responsiveness is also critical in the health care sector.

Background

Since World War II, the United States has relied on nurses from outside the country to fill gaps in the labor supply (Davis and Nichols, 2002) which suggests that nurse immigration will continue. In addition, according to the report *Nursing Trends: 2009,* nurse immigration to the United States has tripled since 1994 to almost 15,000 nurses annually (Robert Wood Johnson Foundation, [RWJF], 2009). This flow of immigrant nurses intensifies the need for nursing leaders to bring enhanced understanding of cultural responsiveness to the health care workplace.

In 1998 the U.S. Department of Health and Human Services Office of Minority Health (USDHHSOMH) recognized the need for health care staff and institutions to be aware of and responsive to the cultural needs of clients by releasing 14 Culturally and Linguistic Appropriate Standards to "address, monitor, and evaluate care for culturally diverse consumers" (Leininger, 2006). The Transcultural Nursing Society published

"Proposed Standards for Transcultural Nursing" (Leuning, Swiggum, Wiegert & Zander, 2002) which provides a framework for nurses to provide culturally competent care to clients. In an Institute of Medicine (IOM) review of over 100 studies that assessed the quality of health care for various racial and ethnic minority groups, the report found, among other factors, that "providers' perceptions and attitudes toward patients are influenced by patient race or ethnicity, often in subtle ways." (IOM, 2003). They concluded that healthcare providers should be made aware that these disparities exist and that cross-cultural education may be one of the best tools in a strategy to eliminate healthcare disparities (IOM, 2003). Additionally, the IOM report noted that there is higher patient participation, higher satisfaction and greater adherence to treatment when patients identify culturally, racially or ethnically with their care providers (IOM, 2003).

Voluntary and involuntary individual migration, corporate global expansion, and international media and communication technologies allow for an amazing web of intercultural encounters on a daily basis. This is often referred to as the "shrinking of the globe" as people cross multiple cultures without leaving their own country, workplace or school. This meeting of cultures requires an enhanced understanding of worldviews and cultural values in order to communicate and relate in an appropriate manner regardless of one's position, status, title or education.

The term "international nurses" is used in this study rather than the more common "foreign nurses" based on the rationale from Xu and Kwak (2005) who state that "the adjective 'foreign' denotes a sense of being 'alien' and 'unwelcome.'" Secondly, several of the nurses interviewed for this study are U.S. citizens or legal permanent residents. For some readers, using the term "foreign" can obscure these nurses' legal status.

Purpose

The purpose of this research was to discover the lived experience of internationally born nurses (IBNs) working in major hospitals in the metropolitan area of Minneapolis and St. Paul, Minnesota. Allowing the IBNs to speak directly about their experiences provided the opportunity for their voices to be heard. The researcher's own experiences of living and working as a nurse in East Africa from 1988 through 2002 provided an understanding and recognition of the value a person feels when his/her significant life stories are heard by others, particularly when the others are members of the host or dominant culture.

Secondly, by relating their experiences, the nurses will contribute insights to the cultural diversity educational module being developed by the Minnesota Nurses Association's (MNA) education committee (www.mnnurses.org). Personal conversations with members of the education committee task force on diversity for the MNA provided the initial stimulus for pursuing this research project.

Significance

Understanding and being responsive to a variety of cultural perspectives is important because people carry their cultural values and perspectives into the workplace. Nurses bring their values and cultural constructs into the care settings in which they work (Mattson, 2003). It is imperative to uncover through direct research some of the cultural perspectives and constructs of the internationally born nurse working in an American hospital to enhance the knowledge base of all of the staff members.

Cultural knowledge and understanding of one's co-workers can translate into more culturally responsive care to a diverse patient population. Furthermore, discovering

the experience of the relationships between the IBNs and their American-born counterparts will contribute insights and awareness to nurse leaders who set the standard for culturally sensitive relationships with staff members and culturally responsive care for patients. According to Jane Swanson of the Institute for Professional Nursing Development, "Diversity is something almost all organizations espouse, but it is also one of the most daunting issues facing the healthcare community and nursing leaders today" (Swanson, 2004). If nurses are going to be culturally responsive to fellow staff members as well as clients they must develop the ability to understand and innovatively incorporate different perspectives (Swanson, 2004).

Theoretical Framework

Nursing knowledge is comprised of theoretical structure, research and practice wisdom that can be compared to a ladder with rungs that address the central tenets of nursing: the metaparadigm, philosophies, conceptual models and theories (Vicky, 2009). Theories that operate within specific historical or social contexts are known as situation-specific theories and they focus on finite phenomena limited to a particular context, practice field, or client population (Vicky, 2009). The lived experience of internationally born nurses working in hospitals in the Twin Cities is an example of a situation-specific theory. This situation-specific theory of knowledge is derived from the broader category of nursing theories which are based on conceptual models or paradigms that are, in turn, based on philosophies. This research was conducted within the framework of Jean Watson's Theory of *Caring Science as Sacred Science* (2005).

Watson's (2005) text *Caring as Sacred Science* is her latest work on the development of her theory of human care. Her first work was *Nursing: The Philosophy*

and Science of Caring, published in 1979, followed by *Nursing: Human Science and Human Care - A Nursing Theory* published in 1985. She describes nursing as a human science, with the major focus being the process of human care for individuals, families and groups. The theory has its origins in metaphysics and is based on a philosophical form of humanism (McCance, McKenna, and Boore, 1999). The core of professional practice for Watson is identified in her original *10 Carative Factors* which are timeless and enduring (Watson, 2005). These *Carative Factors* have evolved to incorporate an explicit relationship between caring and love that Watson refers to as "Caritas" (Watson, 2005), conveying a more transpersonal caring and love that come into play in the caring-healing perspective (Watson, 2005).

Whether international nurses were educated outside the U.S. or not, the professional competency standards they are expected to meet are the same as those for American born nurses. As such, one should expect that IBNs would receive the same level of respect from co-workers, patients and families. Watson's theory of Caring Science underlies this competent care expectation with an understanding that caring about clients, patients, families and co-workers is essential for the nurse (Watson, 2005). "It is when we include caring and love in our science, we discover our caring-healing professions and disciplines are much more than a detached scientific endeavor, but a life-giving and life-receiving endeavor for humanity." (Watson, 2005).

As nurses practice caring-healing work in the world, and specifically among themselves, they must recognize that "information is not necessarily knowledge; knowledge is not understanding; understanding is not wisdom." (Watson, 2005). Accordingly then, information about international nurses does not automatically infer

there is understanding about the individual international nurse. Nurses need to move further into understanding the knowledge they have and translate that knowledge into behavior which demonstrates the wisdom of caring. This caring can only be effectively demonstrated and practiced interpersonally.

If IBNs believe they are not cared for or respected or well-accepted by their American colleagues their sense of belonging will deteriorate along with their job satisfaction and may lead to their departure from the field of nursing. This could contribute to the current and expected increase in the shortage of experienced nurses in the U.S. Additionally, if IBNs leave the workforce it will decrease the ethnic diversity in the health care system. Lack of ethnic diversity in the staff may contribute to a decrease in culturally responsive care for a diverse patient population. Encouraging mutual respect and caring among nurses will lead to greater work satisfaction, better patient outcomes and increased employee retention rates.

The leadership framework that guided this research was Barry Johnson's Polarity Management™ (Johnson, 1996). Johnson's framework distinguishes between problems that can be solved and those that are unsolvable but must be managed. Polarities are sometimes referred to as paradoxes: "A paradox involves two interdependent opposites. Both points of view are accurate, but neither is complete. In fact, both points of view are essential for either of them to be successful" (Johnson, 1996). Examples of cross-cultural polarities that might be found among a multi-ethnic staff are individualism and collectivism, achieved and ascribed status, sequential and synchronous behavior, or relationship-focused and task-focused perspectives. Each of these poles, or polarities, has negatives and positives. According to the Polarity Management™ perspective, sets of

opposites are interdependent and the goal is to affirm and leverage the best of both sets of polarities while avoiding the limits of each (Johnson, 1996). Effective leadership will focus its energy on managing the opposites rather than attempting to solve what it believes to be a problem. The challenge for leaders is to learn how to manage these opposites with effective tools.

Nurse leadership is most effective when it is adept at maximizing the positives of each polarity while minimizing the negatives of each polarity. Providing nurse leaders with information about existing polarities among staff members as well as tools and skills to manage those polarities is much needed in today's diverse health care settings.

Many health care professionals are now calling for interdisciplinary collaboration. Using Johnson's polarities framework from the field of leadership theory, along with Dervin's Sense-Making, from the field communications theory, can help to identify new dimensions within nursing leadership and management. This in turn will advance nursing science.

Literature Review

Demographics

The composition of the U.S. nurse workforce has become increasingly international. By 2005, 14% of the RN workforce was made up of internationally-born RNs. The growth in employment of IBNs accounted for nearly one-third of the growth of RN employment in the U.S. during the years 2002 -2005 (Buerhaus, Auerbach, and Staiger, 2007). Historically, many hospitals in large urban centers have recruited nurses from outside the United States to fill their staff-nurse vacancies (Brush, 2008). As a nursing shortage looms, due in part to the large number of nurses reaching retirement age,

it can be assumed that the recruitment of international nurses will continue and perhaps increase as a partial solution to filling the vacancies around the country (Bieski, 2007; Brush, 2008; Buerhaus, Auerbach, and Staiger, 2007).

The issues associated with migration for both donor and receiving countries include interference with the international nurse workforce goals set by the World Health Organization (WHO) and the International Council of Nurses (ICN) (Bieski, 2007; Brush, 2008). There are several countries that both send and receive nurses; while other countries have become increasingly reliant on immigrant nurses or are experiencing significant nurse shortages because of the migration trends (Brush, 2008). Donor countries that struggle with staffing their own health care facilities must wrestle with this loss of skilled nurses leaving behind inexperienced nurses to carry the load (Bieski, 2007). On the other hand, receiving countries benefit by having skilled nurses who can enter the workforce to fill serious shortages (Bieski, 2007).

The National Sample Survey of Registered Nurses (NSSRN) is mandated by the Nurse Training Act of 1975 to provide national and state level estimates on the number, distribution, employment status, compensation, activity status of RNs and the number of nurses from other countries (Brush, 2008; Xu and Kwak, 2007). The latest survey was conducted in 2004 and indicated that of the nurses educated in another country and working in the United States (100,791) most emigrated from the Philippines (50.2%), Canada (20.2%), and the United Kingdom (8.4%) with the remainder coming from Nigeria, Ireland, India Hong Kong, Jamaica, Israel and South Korea (Health Resources and Services Administration, 2006). The migration of nurses is relatively unchecked,

uncoordinated, and individualized, with some countries benefiting and others facing negative consequences (Brush, 2008).

The 2000 United States Census reports that Minnesota had a foreign-born population of approximately 260,454. This is approximately 5.3% of the population in Minnesota. In federal fiscal year 2002 the Office of Immigration Statistics reported that 13, 522 immigrants came to Minnesota from 160 countries around the globe (Minnesota State Demographic Center, 2004). This number represents those who came legally and does not include any secondary migrants i.e. immigrants who moved from another state to Minnesota. These immigrants came as refugees, as students, for employment, to join family members already here, or through the U.S. government's Diversity Lottery program. Some of these immigrants were nurses in their home countries and have joined the nursing workforce in Minnesota. The Minnesota Board of Nursing does not keep statistics on the numbers of IBNs in the workforce so it is possible to determine the number of IBNs only by data extrapolation or by anecdotal evidence. It can be assumed that since the Twin Cities has the largest proportion of immigrant residents that it would also have the greatest number of IBNs working in the healthcare sector.

Before an immigrant nurse can be employed he/she must go through a process of credentialing such as that of the Commission on Graduates of Foreign Nursing Schools or CGFNS (Bieski, 2007; Brush, 2008; Davis and Nichols, 2002; Ea, 2007; NFAP, 2007).

The Commission on Graduates of Foreign Nursing Schools (CGFNS) is an internationally recognized authority on credentials evaluation and verification pertaining to the education, registration and licensure of nurses and health care professionals across the world. The CGFNS Certificate Program has three components: a credentials review, a

test of nursing knowledge, and an English-language proficiency examination (CGFNS, 2009). An applicant must successfully complete the qualifying exam and one of four tests or combination of tests that are approved by the Departments of Education and Health and Human Services (CGFNS, 2009). All applicants must also take the Nursing Council Licensure Exam (NCLEX) as the final step in their certification to work as nurses anywhere in the U.S.

Cultural Issues

Once IBNs have passed the NCLEX and begin employment, they may experience a variety of cultural adjustment issues such as language competency, role of the nurse in relation to other healthcare providers and to patients, and the expectations of the responsibilities of the nurse in the American hospital setting (Sherman, 2007; Hayne, Gerhardt, Davis, 2009; Mattson, 2003)

Mattson (2009) describes areas of professional differences that international nurses bring to the workplace. They include language or accents that may hinder effective communication and different concepts of nursing duties, particularly related to the expectation that families will be heavily involved in providing personal cares for the patient such as bathing and grooming.

A phenomenological study of internationally recruited nurses working in the UK produced the following themes and sub-themes: conceptualization of the culture, influence of primary culture on nurses' adaptation process (e.g. language), influence of secondary culture on nurses' adaptation process (e.g. home country nurse training), the amount of required paperwork (e.g. more than in home countries), and support

mechanisms for the immigrant nurses (e.g. preparation, accommodations, orientation) (Matiti and Taylor, 2005).

The IBNs' psychosocial skills vary in relation to their cultures of origin, These may involve, for example, using direct or indirect eye contact when speaking with others, using direct or indirect speech when making requests or observations, using a directive approach toward patients rather than a partnership approach, extent and nature of personal touch, and reluctance to admit lack of knowledge or understanding about assigned tasks or instructions (Galanti, 2007;Hearnden, 2008; Kwai and Xu, 2009; Mattson, 2009; Sherman, 2008). Even between nurses from the same culture, communication can be complex. The complexity increases when the communication is between nurses of different cultural, ethnic, or linguistic backgrounds (Hearnden, 2008).

Cultural differences can also occur in the areas of family obligations, such as when the nurse requests time off for family-related reasons that may be considered important by the nurse, but are not viewed as valid by the supervisor. Another cultural difference may involve time orientation, when, for example, staff from diverse cultures may be tardy or take excessive time for breaks, thus failing to complete their work within the specified time. In addition, some nurses from outside the US may expect the nurse manager to engage in social conversation before making assignments (Mattson, 2009), a cultural difference relating to social etiquette.

The issue of racism experienced by IBNs is taken up in DiCicco-Bloom's (2004) study on nurses from India working on the east coast of the U.S. Many of them are viewed as people of color on a daily basis, based on their place of origin, accent and skin

color. They view this social construction as racism. (DiCicco-Bloom, 2004; Hearnden, 2008).

Theory Application

Watson's theory of caring is derived from the human science disciplines and is based on the premise that nursing is a human science. Two of the principles that Watson outlines as a foundation for a human science include the philosophy of human freedom -- choice and responsibility -- and a scientific worldview that is open (McCance, McKenna, Boore, 1999). This suggests that nurses can freely choose how they will view and treat people and that they will assume responsibility for their choices. It also assumes that the worldview that a nurse holds must be a scientific worldview. If the worldview must be a scientific one, then what happens if the nurse has a different worldview?

All data is processed in light of some theoretical framework (worldview) that a person has adopted for understanding the world and every system of thought begins with some ultimate principle (Pearcey, 2004). It would be a mistake to think that there is such a thing as unbiased or neutral theories that are unaffected by any religious and philosophical assumptions. For Watson the ultimate principle is human science. For the author of this study the ultimate principle or starting point is God, who is the only self-existent reality on which everything else depends for its origin and continued existence (Pearcey, 2004).

According to Miller, "Worldviews generally reflect one of three frameworks: mechanistic, organismic or Christian (which with some variations is shared with the other monotheistic faiths)" (Miller, 2002, p. 9). An organismic worldview is one that sees the

universe as a unitary, interactive and developing organism which is consistent with Watson's theory of caring (Miller, 2002). Since nursing theories have practical application and are not simply abstract concepts, it is recognized that ideas have consequences and demand decision making and action. In other words, the way nurses view the world determines how they treat it and specifically how they treat those in their care (Miller, 2002). While this study utilizes concepts from Watson's theory of caring, the foundation or worldview that informs or shapes the understanding of the study's author comes from a Christian worldview.

This worldview affirms good empirical science as a gift from God to be used for the benefit of humanity while also acknowledging the limits of science to explain personal and spiritual phenomena (Shelly and Miller, 2006). The Christian worldview also includes the reality of the spiritual and what is unseen and acknowledges that there may be forms of physical energy that we are unable to measure with current tools, knowledge or capacity. The uniqueness of the Christian worldview is in the emphasis on caring for the whole person as embodied, respecting each person as made in the image of God. The person is not an energy field or boundary-less entity. "In the Christian worldview, spirituality is essentially relationship – a relationship of the whole person to a personal God and to other people (or other spirits). The spiritual is always personal. It is not an impersonal energy force." (Shelley and Miller, 2006, p. 96).

In the Christian worldview the nursing metaparadigm begins with God. God created the world (environment) and everything in it. God created human beings (people) and placed them within this created environment, to live in *shalom* (health). This kind of health allows a person to live at peace in a God-centered human community with a sense

of physical, psychosocial and spiritual well-being. Nursing then, works toward *shalom* among individuals and the community (Shelley and Miller, 2006). The word *shalom* is often translated as "peace" but it actually incorporates peace, prosperity, rest, safety, security, justice, happiness, health, welfare, and wholeness: -- all the elements involved in a God-centered community (Shelley and Miller, 2006). This concept of *shalom* is broad and not the goal of nursing but it provides a perspective through which we can frame our understanding of health and points us to how a healthy person functions physically, psychosocially, and spiritually (Shelley and Miller, 2006).

The nurse who holds a Christian worldview strives to hold in balance three elements: recognizing that the world is the created goodness of God, fighting the corruption of ongoing sin and brokenness, and working toward the healing of creation and the restoration of God's purposes in the cosmos (Pearcey, 2004). This study therefore seeks to recognize and affirm the goodness in all people, regardless of their ethnic origin. It also strives to oppose behaviors or policies that prevent IBNs from experiencing and working in *shalom* with all those they encounter in the hospital setting. Finally, this study will offer insights about ways to restore *shalom* for IBNs as well as ABNs.

Watson's goal of nursing centers around helping people to gain a higher degree of harmony within the mind, body and soul and this is achieved through caring transactions (McCance, McKenna, Boore 1999). The framework for these caring transactions is built on what Watson calls "ten carative factors" that are the core of professional practice and that are timeless and enduring (Watson, 2005). Three of these carative factors are particularly relevant to this study:

- The cultivation of sensitivity to one's self and to others.

- The development of a helping-trusting relationship.
- The provision for a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment.

The IBNs work in the hospital community and need to have sensitivity to others while being aware of and sensitive to themselves. They need to have relationships with ABNs that are helping and trusting. The IBNs need to know that they are in a safe community in their work settings, in a workplace that shows evidence of *shalom* that incorporates peace, prosperity, rest, safety, security, justice, happiness, health, welfare, and wholeness. In Watson's carative wording this is described as a supportive, protective, physical, socio-cultural and spiritual environment.

Method

This research was conducted using a phenomenological methodology. "Phenomenology is a science whose purpose is to describe particular phenomena or the appearance of things, as lived experience" (Speziale and Carpenter, 2007, P. 76). As a method it is rigorous, critical, and systematic and explores phenomena holistically. This makes it very suitable for nursing research, practice, education and leadership where attending to the whole person and the whole experience is affirmed and honored (Speziale and Carpenter, 2007). Since the goal of phenomenology is to describe lived experience, it was a valuable method of investigation for gaining understanding of what is experienced as real by the IBNs. It allowed them to speak for themselves and describe what they perceive, feel and experience in their work in American hospitals with American-born colleagues. The phenomenology method provided for the richest and most descriptive data of the nursing experience of the IBNs.

The phenomenology method requires the investigator to possess the ability to communicate clearly while making the participants feel comfortable expressing their experiences. It is imperative that the investigator recognize that characteristics such as manner of speaking, age, gender, or other personality traits may interfere with data collection. Therefore, the investigator must be certain that she is the appropriate person to access a particular person's experiences. The investigator for this research study had extensive experience living and working as a nurse outside the United States which gave her sensitivity to aspects of language in particular that might interfere with the interviewing process. In addition, the investigator's cross-cultural experience intensified her belief in the importance of providing an opportunity for IBNs to tell their stories in their own words.

Because of the personal nature of this phenomenological research study, Institutional Review Board (IRB) approval was obtained prior to the recruitment of participants for the study. This IRB approval provided protection for the privacy of the participants. A total of five internationally-born nurses, ranging in age from 22 – 50, were interviewed. It was felt that no new themes were arising, and the themes began to be repeated by the time five interviews were conducted. This suggested data saturation and therefore no additional interviews were conducted. According to Speziale and Carpenter (2007), "data collection must continue until the researcher is assured saturation has been achieved." (p. 95).

There were four females and one male participant representing the following countries of origin: Ethiopia, Kenya, Philippines and Nigeria. All of them spoke English as a second language. Three of the participants received their nursing education in their

countries of origin while the remaining two graduated from nursing schools in the U.S. Participation was limited to licensed registered nurses who had been employed for at least six months and were currently working in a hospital in the Twin Cities metropolitan area. A six-month employment criterion was used because it allowed for sufficient time for an IBN to complete the employment orientation process and have several months of experience in the RN role in a hospital. Hospital-based employment was chosen because hospitals generally have a more diverse nursing workforce than do long-term care facilities. In the long-term care environment there are far fewer ABNs employed as nurses so that the IBNs do not experience as much interaction with ABNs. It was felt that limiting the data collection to IBNs working in a hospital would allow for better data comparison and analysis. In addition, the majority - if not all - of the nurses employed in most hospitals are registered nurses rather than licensed practical nurses. Again, collecting and assessing data from nurses who are licensed at the same level provides for a more even-handed analysis. The study did not control for gender, length of time in the U.S., location of nursing education or type of hospital unit where the IBN was employed.

The research participants were identified through personal contacts and recommendations from the Medical Career Advancement Program (MCAP) coordinator at the International Institute of Minnesota. The MCAP coordinator works with immigrants who have either had a career in some aspect of health care or who want to pursue a health care related career. Each participant signed a consent form that described the focus of the research, the methodology, the risks and benefits of participating and the measures taken to protect confidentiality (Appendix 1). To minimize the risks of participation the names of the participants and other identifying information such as place

of employment were changed or omitted for the written results of the study. Participants were informed that contact information for counseling services was available in the event that reliving painful experiences caused emotional distress or trauma. In addition, participants were informed that they were free to withdraw from the research study at any time without obligation.

The procedure of the study involved two steps: 1) completion of a survey to gather baseline information about the education history and nursing employment history of the participant (Appendix 2); and 2) participation in one private interview session with the investigator of no more than ninety minutes (Appendix 3). Initially the researcher planned to conduct the interviews face to face at a location of the participant's choosing. However, as possible participants were contacted it became evident that in-person interviews were not viewed favorably by the participants. When the option of a telephone interview was given, several contacts responded affirmatively. Consequently, the interviews were conducted via telephone at a time of the participant's choosing. Interviews were audio recorded and transcribed by the study author.

Interview questions and methodology were based on the Sense-Making Methodology (Dervin, 2003). Sense-making builds on over thirty years of communication research. It is a communication process that in its most general sense is an approach to studying the constructing that people do to make sense of their life experiences. (Dervin, 2003) This highly structured approach illuminates the core assumptions, mental models, intentions, and sense-making underlying any individual's story. As each person makes sense of their life experiences, those experiences are connected to a particular time and space. Sense-Making Methodology presents the human

being in phenomenological terms, as a body-mind-heart-spirit moving through time and space, with a past history, present reality, and future dreams or ambitions (Dervin, 2003). Asking questions that allow a person to explore the experience, the emotions and decisions attached to the experience at the time it occurred, allows for a richer harvest of data for reflection. According to Dervin, the essence of Sense-Making theory is that all every person has only one way of making sense of his/her world.

> "They observe, they listen to others, they read, and so on. But when push comes to shove, each individual person is locked alone inside his/her own head. No one else lives exactly where he/she does. Ultimately people have to make their own sense – create their own ideas, define their own situations, and follow their own paths…. In essence, then, sense-making says there is no way for any of us to get inside any one else's head. The other person's mind can be seen as a maze to which that other person has all the keys. If we want to know what is in that mind we have to let the other person use his/her keys to open the door….Sense-making questioning is designed to…let talkers open up the doors of their minds to us." (Dervin, 1991, p. 10).

Sense-making questioning reduces the bias of the investigator and reduces the possibility of posing leading questions to the participant. Although there are several categories of questions, it is not necessary to ask questions from every category, or to ask every question in a particular category. What is necessary is that the questioner be a very good listener and ask questions based on what the interviewee has already said (Dervin, 1991). It is vital to the research focus that the participants verbalize their experiences in their words and not be constrained to answer questions that do not explore their lived experience. For example, if the participants were asked to answer the question "What negative or difficult experiences have you had working with American born nurses?" the underlying assumption is that they had negative experiences and that is what they should report on. A more neutral question would be this one: "What experiences have you had working with American born nurses?" According to Dervin, "Sense-making questions

are a tool then for getting inside people's heads in a way that makes sense to them and allows them to talk to us on their terms. At the same time, sense-making questions allow us to see fully how the thoughts of others apply in their lives." (Dervin, 1991, p. 16).

Data Analysis

Information from the data collection forms of each respondent was arranged in a table format for clarity of analysis and comparison. Audio recordings were listened to after the interview to hear the descriptions of each nurse's experience a second time. The recordings were then transcribed verbatim. The transcripts were read repeatedly by the interviewer in three phases.

The first phase of transcript reading involved looking at each respondent's sense-making of their experiences over time. Prior to conducting the interviews it was determined that the starting point of the timeline of experience would be prior to immigration to the U.S. and the end point of the timeline would be their current work situation (see Figure 1). No other time divisions were determined until after the transcripts were read several times.

Figure 1. First divisions of sense-making.

The interviewer then looked for natural breaks in the lived experiences of each participant. This resulted in two additional divisions in the time line first contact as a nurse in a U.S. healthcare institution and the middle time period (see Figure 2). Often the

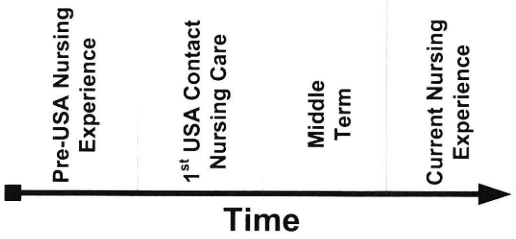


Figure 2. Second divisions of sense-making.

middle term was when the nurse moved from a nursing home job to the hospital, or gained more education or certification. For others it was simply the period of time - one or two years into their job - before the current time.

Studying the participants' responses revealed that there was a significant variable that changed over time. That variable was the participants' sense of a having a successful nursing experience. A successful nursing experience included their assessments of skill competence and relational satisfaction (see Figure 3). The participant's used words such as *happy, good, frustrating, satisfying, stressful, positive*, and *challenging*, when describing their technical competence and their relationships with fellow nurses. These emotive words were repeated in many forms in each of the interviews, supporting the conclusion that a successful nursing experience was significant to each nurse. Using the model with time across the horizontal axis and successful nursing experience along the vertical axis, each participant's sense-making of his or her experiences was graphed on the figure.

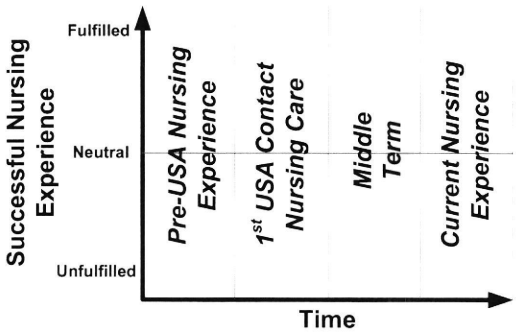


Figure 3. Successful nursing experience variable.

The next phase of data analysis involved synthesizing the findings by comparing variables among the participants to determine which ones impacted their sense-making over time up to their current situation. The graphs of each participant were combined onto one figure.

The third phase was a deductive process to identify whether any of the themes from the literature review were present in the IBNs descriptions of their experiences (See

Table 1). This analysis of the data did not account for when the themes emerged over time in each participant's experience, but simply if the themes were evident in the data.

Table 1

Themes from the Deductive Analysis

Literature Themes	Nurse A	Nurse B	Nurse C	Nurse D	Nurse E
Language Competency					
Medical Technology		X		X	
Medical Terminology				X	
Racism	X				
Nurse Role & Responsibility		X		X	X
Conceptualization of Culture	X	X		X	
Adaptation process/nurse training in home country		X		X	X
Support mechanisms	X	X		X	X
Psychosocial skills	X	X	X	X	X
Family obligations					
Time Orientation					
Determination and perseverance	X	X	X	X	X
Resiliency & development of coping mechanisms	X	X	X	X	X

Findings

In the following section each participant's journey is summarized in text form. To protect their privacy they are identified only as Nurse A or Nurse B, etc.

Nurse A.

Nurse A received a college education in Nigeria and immigrated to the U.S. at the age of twenty-one. Her degree from Nigeria was not in nursing or a health-related field. Her husband preceded her to the U.S. by several years and was the source of her cultural information about life in this country. Nurse A did not reveal details about her employment prior to starting her current job but between her arrival in the U.S. and the start of her first hospital job there were approximately thirteen years (see Figure 4).

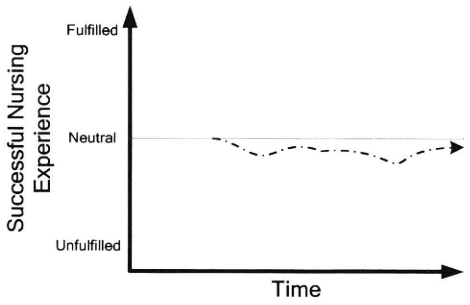


Figure 4. Nurse A's nursing experience.

Nurse A received her nursing education at a community college in the Twin Cities and worked in a nursing home before securing a job on a telemetry unit in a hospital. She describes her first experience in the hospital as stressful due to the work load and relationships with other nurses. Despite the stress she felt, she remained optimistic that things would improve saying, "You think at that time it will get better because you are new." However, as time went on, things got worse, "but when you've been there for two and a half years and it seems like it is getting worse, you say that is how it is." It appeared that what hope she had for improvement was gone and in the middle stage of her experience she passively accepted her situation: "I told myself that I have to fend for myself because I can't count on anybody else."

Nurse A's passive acceptance in the middle phase was replaced by an aggressive or combative position toward others on her staff in the transition to her current situation. At one point she declared, "Just know that I'm here to stay. I'm not going away unless I find something better, so just get used to it." She now believes that she must "stand her ground' and that "if they don't find a way, they will make up a way to get rid of you" or "stress you to the point that you leave."

Nurse A describes her professional performance as good: "I have gotten many good reports from my manager that the patients have reported I have done a good job of caring for them." She is confident about her nursing skills in her current situation but unhappy about staff relationships. She has been in her current position for approximately three years.

Nurse B

Nurse B received her nursing education in Ethiopia and worked in a hospital as well as a clinic before immigrating to the U.S. at age twenty-nine. When she arrived in the U.S., she had no idea about how to get licensed as a RN: "I started from scratch and went to school for nursing assistant." Then she went to work in a nursing home. This setting was very different from her clinic work in Ethiopia where she functioned "like a doctor. In her words, "We do diagnosis, we give medication, I order medication." She remained in the nursing assistant position for several years (see Figure 5).

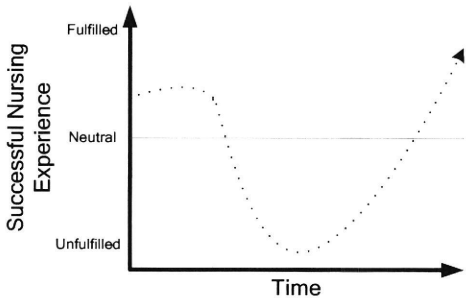


Figure 5. Nurse B's nursing experience.

Eventually she was able to get her RN license but was unable to find work in a hospital until she gained more experience. She returned to the nursing home as a RN to gain that experience. She was not allowed to complete her orientation as a RN in the facility because of insufficient staffing and this made her transition to the new role more difficult. During this period she found that co-workers were often too busy to answer her questions or explain things to her. "When you start first, it is hard to get somebody who understands you." She described this time as a "big, big challenge" and that "it took me a while to get used to it." She also experienced a lack of respect for her previous experience and knowledge in Ethiopia and felt that "some people treat you like you don't know anything."

When she started at her current hospital job, Nurse B felt the lengthy orientation process prepared her well for the work she is doing. The orientation, coupled with her experience in the nursing home, gave her confidence in her skill level. In addition, she had positive experiences with the staff and remarked, "Everybody was nice. The people are very nice." She enjoys working with the large number of international staff at the hospital where she is currently employed. Nurse B finds satisfaction in seeing patients improve while under her care and believes that she makes a difference in peoples' lives. She also helps other immigrants with nursing information when they arrive: "We are like resource people for them." She has been in this current job for approximately six years.

Nurse C

Nurse C was twenty-two years old when she arrived in the U.S. from Kenya. She received her nursing education in Iowa and worked in a group home and a nursing home before her first hospital job. The gap between her arrival in the U.S. and the start of her

current employment was twelve years. During the interview process Nurse C did not elaborate on her previous employment or the nursing education time frame. She has been in her current job for approximately six years.

When Nurse C began her job, she indicated that she felt welcomed at the hospital. She sensed the "goodness" among the nursing staff. There was an attitude of "loving and working together" as well as "support and encouraging each other." Nurse C saw that "they were like a very good community that you want to be a part of. That kept me although there was very weak leadership" (see Figure 6).

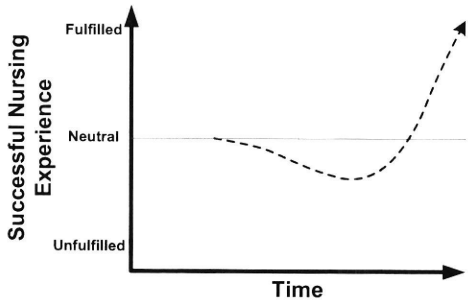


Figure 6. Nurse C's nursing experience.

During the middle phase Nurse C was frustrated with the leadership style, the lack of communication from people in leadership and the lack of professional recognition. However, she believed it was important to express her frustrations, ask questions and say what was on her mind: "…I am not passive, if I see something wrong, I don't keep quiet I say my mind." She also encouraged others to do the same: "You need to speak up and bring your frustrations to the table so people hear you."

Two years ago the leadership changed at the hospital and Nurse C expressed much more satisfaction. Frequent and personal communication from management staff has given Nurse C a feeling of being appreciated and valued. She made note of the tangible communication of "a letter or card from the CEO appreciating whoever was here." She went on to say, "I'm happy with the current people I work with. The leadership is very strong."

Nurse D

Nurse D immigrated to the U.S. at age thirty-two. He has been in the country for thirteen years and has been working as a RN in the hospital for seven years. Nurse D completed his nursing education in Ethiopia. He worked as a clinic manager and in community health education. He did not have any hospital experience prior to coming to the U.S.

Like Nurse B, Nurse D had to start all over again in the nursing field by training as a nursing assistant. He spent four years working in that position before becoming an LPN. Nurse D spoke about the differences of being a nurse in the U.S. compared to Ethiopia: "This is actually a completely different experience. Everything was different." He faced challenges as an LPN at the nursing home because he became the supervisor of the same nursing assistants he had worked alongside: "In some sense it is challenging to carry out your leadership position." As time went on, he described it this way: "I was comfortable as time goes on…once I started working, things were getting better" (see Figure 7).

After one year as an LPN Nurse D got his RN license and eventually left the nursing home setting to work in the hospital. He found among the preceptors with whom he oriented that "some are polite and gentle, some are rushing," yet he was comfortable asking questions whenever he was unsure of something. However, he did relate an experience when a preceptor responded with impatience and sarcasm when he

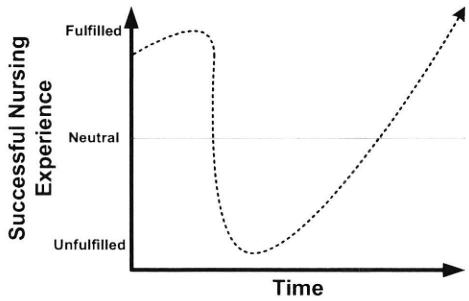


Figure 7. Nurse D's nursing experience.

questioned something she was doing. Initially, some of the procedures such as blood administration caused him anxiety, but he felt he had the support he needed from the other staff. "Everybody is willing to help, especially when you are new in a position."

In his current situation Nurse D says, "We do have a very good relationships. We cover each other. We do have very good working relationship." He clearly feels comfortable in his setting and believes he has been acknowledged for his high level of care: "Often times I get notes from the Director of the Rehab Center of how patients and families are admiring the care I was giving. It makes me feel so good." Nurse D's current position requires a lot of communication with patients and families, including teaching for discharge and home care needs. He sees himself as very competent in this area: "As far as communication, I am very good at it. I get along with patients and families." Lastly, he sums up his experience saying: "Being a nurse is my natural thing. I have a good approach with people."

Nurse E

Nurse E is a graduate of a nursing school in the Philippines who took her licensure exam in Singapore in order to immigrate to the U.S. She actively sought out a nurse recruiter to intentionally come to the U.S. to work as a nurse: "I came here by choice but I had to find a recruiter to help me out" (see Figure 8).

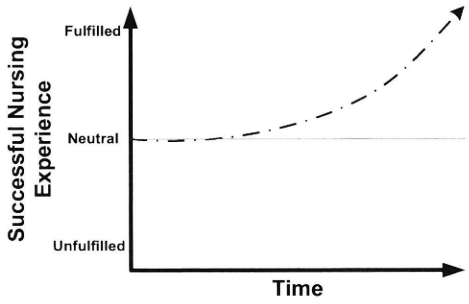


Figure 8. Nurse E's nursing experience.

Prior to coming to the U.S. Nurse E worked in the post-anesthesia care unit (PACU) in a hospital in the Philippines. When she moved to Singapore she worked in an operating room and on an intensive care unit in a hospital there.

Nurse E's contract with the recruiter required her to work for two years in a nursing home in the U.S. While she was fulfilling this contract, she also worked on-call on a PACU at a local hospital. When her contract was complete, she applied for full-time work at the hospital. She has been employed full-time in her current employment for approximately one year.

Nurse E did not talk about her nursing home experience in the U.S. She did talk about her PACU experience saying that "my recovery room experience which I also did in the Philippines - we also call our unit there PACU - we are also basically doing the same things." She was familiar with using the computer in the Philippines so it was not much of an adjustment to use it in the U.S. setting, except for the particular software program she had to learn.

Nurse E spoke the most about her current situation working in the Birth Center of the hospital. This was a new experience for her, which she said was not difficult for her because "everybody has been really good at helping out. My orientation did really well. I was given a good set of preceptors to work with. My manager has been very supportive too." She said there were specific skills she needed to learn in order to work competently with babies but that on her unit "they have been very helpful in educating their nurses." She has acquired additional certifications beyond what she needed for the PACU and feels she has everything she needs now in terms of nursing skills.

When Nurse E talked about relationships with her co-workers, she classified them as almost all positive. When there were exceptions to this, her response was "I just don't take it negatively. As a new person I think it is already in me that I have to adjust." Nurse E expected that people should communicate carefully and not use sarcasm. When there was a conflict with someone based on communication, Nurse E spoke directly with her nurse manager and expected the nurse manager to deal with it. She spoke very highly of her nurse manager: "She acknowledges me with compliments and for me that is support." Nurse E describes herself as having a high respect for authority and high regard for people in general. Overall, she believes she has been "welcomed with open arms."

The themes from the deductive analysis that were common to all five IBNs were the following: psychosocial skills, determination and perseverance, developing resiliency and development of coping mechanisms. The theme of support mechanisms was common to four of the nurses while nurse role and responsibility, conceptualization of culture, and adaptation process/nurse training in home country were common to three of the nurses. One nurse identified racism as an experience. Another nurse identified medical terminology in the interview. None of the nurses identified language competency in the interviews.

Implications

In the sense-making analysis of the data, the pattern of moving toward a fulfilled, successful nursing experience that emerged over time was identified individually for each IBN. In Figure 9 the patterns are shown

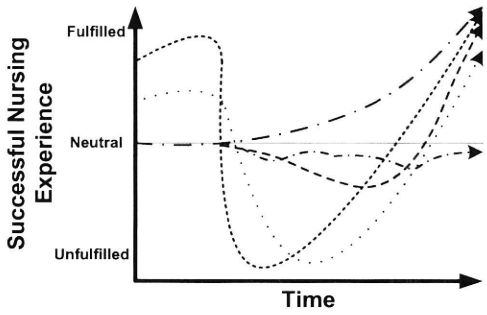


Figure 9. Composite of nursing experiences.

together to illustrate the comparison among the nurses. Four of the five are at a high level of fulfillment in their current situations. Of those four, three of them experienced a less than fulfilling period of time between their first contact with a U.S. healthcare facility and their middle term experience. For two of these nurses, the process of having to start their nursing careers all over again after having successful experiences in their home country was the most difficult for them.

The three nurses who were educated outside the U.S. believed that it was their responsibility to adapt, be positive, or make the best of their situations rather than expecting changes to come from someone else. For the two nurses who were educated in the U.S., the expectation was that their leaders should do something to bring about changes in the work setting. Of these two, Nurse C's sense of fulfillment increased when the leadership in her organization changed in ways that she saw as positive. Nurse A is the only participant who did not show a sense of fulfillment in her nursing experience. She was unhappy about the perceived failure of the leadership to bring about effective change in the relational culture of her unit.

Although language competency was not mentioned, all of the nurses indicated that style of communication between nurses was important. The issue was broader than simply vocabulary as mentioned in the literature. Use of sarcasm or showing a lack of respect for the IBNs knowledge was especially hurtful to the participants. The way nurse managers or charge nurses communicated about mistakes the IBN made were very sensitive topics for the three nurses educated outside the U.S. The issue of accent was identified by Nurse A as contributing to the lack of respect she felt from her co-workers.

It is apparent that the role the nurse manager/leader played in creating a culture of acceptance and comfort was important to each nurse. The leaders who did not demonstrate behaviors of support to the nurse undermined the IBN's confidence level and failed to create a sense of belonging for the IBN whereas those that offered support verbally and in other ways contributed to increased feelings of confidence for the IBN. Three of the IBNs spoke specifically about ways that nurse leaders demonstrated their support, e.g. writing cards of encouragement, posting compliments on staff bulletin boards and staff newsletters, giving positive verbal feedback, and reaffirming how important the IBN was to the overall team. The IBNs responded very positively to these tangible expressions of support.

There is clearly overlap between the topics identified in the deductive analysis and the sense-making analysis. For instance, both methods identified the characteristics of determination and perseverance of the IBNs. The distinction between the two methods is that the deductive method is essentially subject-based. It labels the presence of determination and perseverance, but it does not show how these characteristics were evident in the IBNs nursing experience, when they emerged in their experiences or how those characteristics changed over time.

For example, the deductive analysis does not show how long an individual nurse may have taken to develop her coping mechanisms or how long she may have had to persevere to gain a sense of stability in her situation. Consequently, the data provides less information to nursing leadership about what role they may have in addressing areas of concern for their international nurses because they would not know where the IBNs were in their process of moving toward feeling fulfilled in their nursing experience.

So while deductive analysis is helpful for nursing leadership to be aware of topics of concern, it does not give nurse leaders any information about the length of time it may take for a particular IBN to become comfortable and successful in their nursing experience. Subject-based analysis also does not provide the insight needed as to how those concerns could be addressed at various points in the IBNs journey to a successful nursing experience.

The broadest implication from the study findings is that nurse leaders must first of all recognize the importance of their leadership performance to the development of an inclusive, affirming, and confident staff. Nurse leaders must recognize the power their communication patterns have on their staff and seek ways to develop their skills in this area of leadership. They would be wise to augment their learning and skill development with appropriate cultural information that will enhance communication with their internationally born staff.

A further implication is that nurse leaders should be aware of the length of time each nurse was in the country before being employed as a RN in a hospital. In general, the longer the time in the country, the more cultural adaptation there is in terms of language, communication, social interaction and knowledge of the health care industry. Secondly, knowing where the IBN received her nursing education will provide the nurse leader with insight about potential gaps in knowledge regarding professional or cultural expectations. For instance, if the IBN was educated in Africa, the nurse leader may be more conscious of providing mentoring in the area of understanding the nursing role and responsibilities in the American hospital setting. Thirdly, the nurse leader should be conscious of the overall percentage of internationally born staff in the hospital and how

that may impact the IBN's sense of inclusion or acceptance. If the vast majority of the staff is American-born, the IBN is less likely to feel understood or included as an equal unless the nurse leader intentionally develops a sense of inclusiveness on the unit. The nurse leader can clearly set a tone of welcome and acceptance that permeates the staff.

The nurse leader can also provide more effective mentoring to the IBN if she has a general awareness of the broad cultural characteristics of the IBNs country of origin or ethnic group. Is the IBN from a culture that has a strong emphasis on submission to authority? Does the IBN's culture of origin use a direct or indirect communication style? Perhaps just as importantly, is the nurse leader aware of American cultural traits and how they may differ from traits of the IBNs culture? Does the nurse leader expect the IBN to be self-reliant and autonomous while the IBN expects direct help and partnership?

Implications for Further Study

This study looked only at the IBNs and their experience in nursing in the U.S. It would be beneficial to learn what the ABN of color experiences in the same setting. What commonalities and differences might exist that would provide insight to nurse leaders who are working to create a more diverse and inclusive nursing workforce?

Another study to compare the experience of IBNs with that of new nursing graduates in their first hospital employment could provide specific input into the development of best practices for orientation programs. Improved orientation programs should lead to smoother "on-boarding" of new staff, higher productivity earlier in the new hire's employment and greater work satisfaction that leads to higher retention rates.

Limitations

The small sample size of this study limits the scope of generalizing the findings. Conducting the same study with a larger group, with a more intentional sampling to assure that a broader range of organizations and IBNs are represented would yield additional valuable information. Variables that may have impacted the findings include: 1) the country where the IBN received his/her nursing education, and 2) that an ABN was the interviewer. Nursing education varies around the world and therefore shapes a nurse's expectations and experiences. This in turn, may have altered the responses in the interviews. Secondly, the participants may have been reluctant to relate experiences they thought would offend the ABN interviewer.

Recommendations

This study revealed some of the experiences of IBNs working in the American healthcare industry. Based on the numbers of immigrants currently in Minnesota and the expected growth in those numbers, it can be safely assumed that there will be an increase in the number of immigrants entering the nursing profession. A visit to almost any of the skilled nursing facilities in the Twin Cities reveals that the majority of current nursing assistants appear to be internationally born. Like some of the participants in this study, many of these nursing assistants are taking steps to further their education and become nurses.

As nurses become increasingly responsive to the multiple cultures represented by the patients they care for, they must also be culturally responsive to their fellow nurses. If nurses claim to have theory-guided practice about the dignity of people, then it behooves them to apply their theory not only to patients but to professional colleagues as well.

The advanced practice nurse is in a position to affirm and work toward incorporating the concepts of *shalom* as mentioned earlier in this report. These are the very concepts that emerged as the important themes for the IBN participants in this study: the concepts of peace, safety, security, justice, happiness, and wholeness that lead to a successful nursing experience. In Watson's (2005) carative wording it is a supportive, protective, physical, socio-cultural and spiritual environment. It is not only the IBNs who will benefit, but the ABNs also, because *shalom* does not occur outside of relationships.

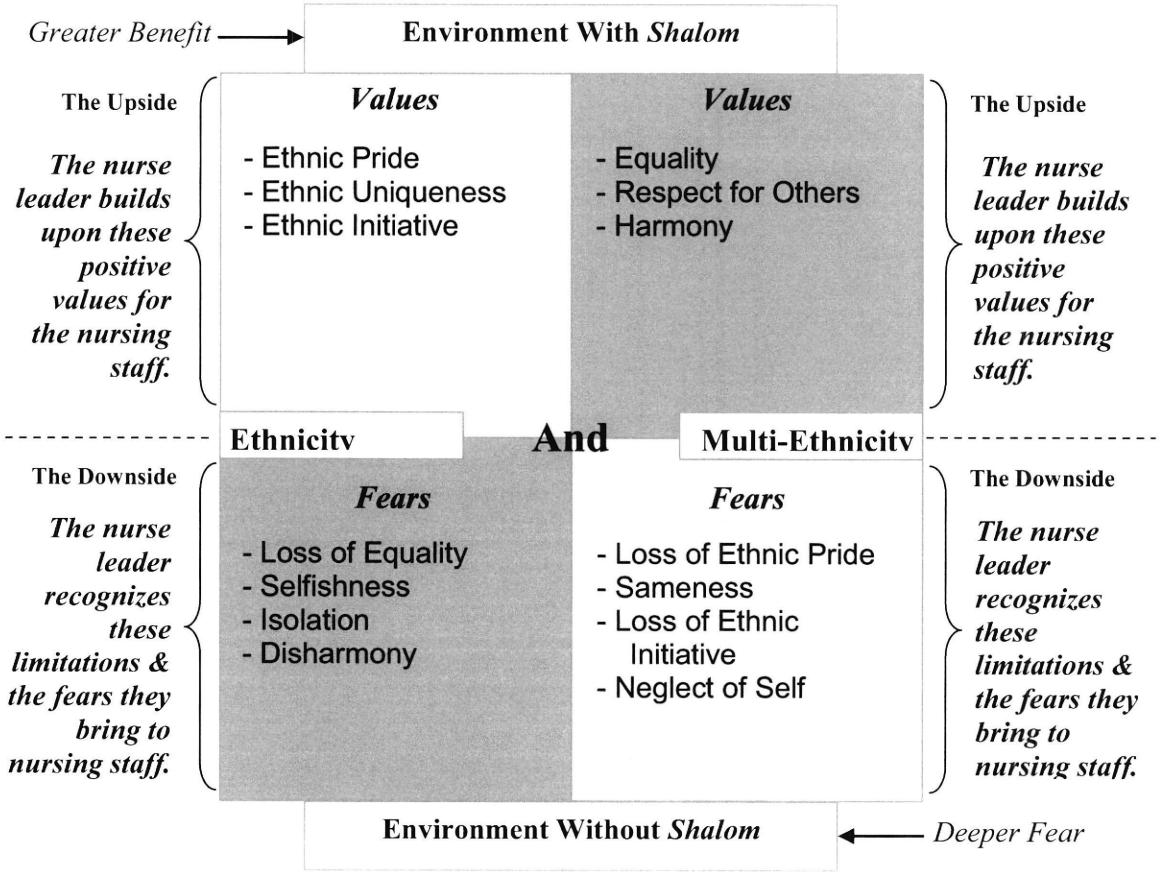
Yet how does a leader work toward establishing an environment characterized by *shalom*? How does the advanced practice nurse work toward the goal of helping IBNs and ABNs gain a higher degree of harmony within the mind, body and soul? How does a nurse leader demonstrate the caring of a helping-trusting relationship with her staff?

Some nurse leaders may feel that in order to have *shalom* among the staff, they should emphasize that "underneath we are all really the same" and try to minimize the ethnic differences. Other leaders may try to emphasize the "uniqueness of everyone" by minimizing the similarities. The problem with either approach is that it uses a problem solving approach in a situation that is really a polarity, i.e. two attributes that are interdependent and must coexist. The successful nurse leader does not choose one side of the pair over the other but recognizes that each must be afforded value and that they are interdependent.

Figure 10 illustrates how a nurse leader would construct a polarity map using one interdependent pair – which in this example, is *ethnicity* AND *multi-ethnicity* - to reflect on her leadership practices in leading a nursing staff toward the greater purpose of positive staff relationships. The map is divided into four quadrants. The top two are the

upside or virtues of the pair and the bottom quadrants are the negative results of over-emphasizing either side of the pair. A more advanced development of the map will show the next level, which incorporates action steps that the leaders can take to develop a well-balanced polarity, along with the warning signs that indicate that their leadership is moving toward an imbalance.

By actually constructing a polarity map, the nurse leaders can more clearly see the possible deterrents to building a cohesive, respectful and supportive work environment for a multi-ethnic staff. They can also see the benefits of keeping the interdependent poles in balance. Less time will be spent trying to sort out relationship tensions if nurse



leaders can recognize when the staff is focusing too much on one pole because of their fears related to the opposite pole. It will be much more productive than writing memos

urging people to "just get along", or telling people in staff meetings to become more tolerant.

Another outcome of mapping the polarities and action steps is that leaders can see what the leader is already doing well, which is affirming to both leaders and staff. If leaders look only at what needs improvement without recognizing what is going well, they risk having their followers feel criticized but never affirmed. This further lowers morale, which can then lead to increased relationship tensions.

To gain the most benefit from using the mapping tool it must be used for ongoing or periodic evaluation because it represents the reality in which leaders work. They are always managing some polarities in the daily work setting. Therefore, by using the tool more consciously at the beginning of a polarity issue, it can lead to more long term behavioral change. As nurse leaders refer to the map and use the words and action steps associated with it, the words become the normal language on the unit. When words change by understanding and using the polarity map, then conversations change. When con

Figure 10. A polarity mapping tool (Adapted from Johnson, 1996).

Conclusions

Throughout the interviews for this study, it was apparent that there were positive relationships in the various nursing settings for most of the participants. Clearly there were actions taken by nurse leaders in those settings that contributed to the culture of *shalom*. For IBNs who may be struggling in their current situations, these positive findings should be encouraging. When IBNs discover that it took other IBNs some time before they began to feel successful in their nursing roles, they should experience a sense of hope that with time they, too, can find their way to successful, *shalom*-filled nursing

experiences. It may take more time than they originally expected or it may take a move to a different unit or hospital, but there is hope for them.

There is also hope for the nurse leaders who may be wondering if their multi-ethnic staff will ever work together with synergy and harmony. This study suggest that leadership can play a positive and powerful role in forging and environment of caring and *shalom*. When leaders persevere like the IBNs have persevered, everyone benefits.

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Appendix 1

The Experience of Internationally-Born Nurses Working in Hospitals in the Twin Cities
Consent Form

You are invited to be in a research study of the experience of foreign-born nurses working in a Twin Cities area hospital. You were selected as a possible participant because you are a licensed RN currently employed for at least six months. I ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by me as part of my master's project in Nursing at Augsburg College. My advisor is Dr. Joan Brandt.

Background Information:
The focus of this research is to discover what the experiences are of foreign-born nurses (FBNs) working in a hospital in the greater metropolitan area of the Twin Cities. With the increasing numbers of FBNs in the Twin Cities it is important for nursing leaders to be aware of what FBNs experience working in a hospital setting that is dominated by American-born nurses (ABNs). Knowing something about the FBNs experiences will encourage mutual respect among nurses of diverse ethnic and national backgrounds. Greater cultural knowledge and understanding will lead to enhanced work satisfaction and increased staff retention.

Procedures:
If you agree to be in this study, I would ask you to do the following: Complete a questionnaire to gather baseline information about your education and nursing employment history. Upon completion of the questionnaire the investigator will schedule a private interview session with you that will last approximately 90 minutes. The interview will be conducted in person and outside of your place of employment at a time and location convenient for you. The interview will be audio recorded for later transcription by the investigator.

Risks and Benefits of Being in the Study:
The study has several risks:
First is the possible invasion of privacy.
This risk is due to the nature of the questions that will be posed in the interviews. Questions about experiences and relationships with co-workers may reveal information that you have previously kept private. The risk is minimal.
Second is the probing for personal or sensitive information in interviews.
Some questions during the interview process may elicit emotional responses from you as you recount past experiences because you will be re-living experiences that may have been troubling. The risk of this is minimal.
A counseling referral is available if you desire or need this service.

Benefits to your participation are:
1) development of cultural awareness education in settings where IBNs are employed,
2) contribution to knowledge of and for creating positive nursing work environments,
3) program development for improved nurse retention,
4) the opportunity to describe your experiences may be helpful to you and serve as a positive experience.

Confidentiality:
The records of this study will be kept confidential. Findings from this research will be disseminated through a written report and oral presentation to the nursing faculty committee responsible for thesis approval. A final copy will be kept at the Augsburg library. If I publish any other kind of report, I will not include any information that will make it possible to identify you. All data will be kept in a locked file in my home and only my advisor, Dr. Joan Brandt and I will have access to the data and any audio recordings. If the research is terminated for any reason, all data and recordings will be destroyed. While I will make

every effort to ensure confidentiality, anonymity cannot be guaranteed due to the small number to be studied.

Audio recordings will be destroyed by the investigator upon completion of transcription. Raw data will be destroyed by May 31, 2013.

Voluntary Nature of the Study:
Your decision whether or not to participate will not affect your current or future relations with Augsburg College, your place of employment or the investigator. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:
The researcher conducting this study is Jolene Baker. You may ask any questions you have now. If you have questions later, you may contact me at: 763-219-2339 or through my advisor: Dr. Joan Brandt, Department of Nursing, 612-330-1214.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information or have had it read to me. I have received answers to questions asked. I consent to participate in the study.

Signature _____
Date_____

Signature of investigator _____
Date_____

I consent to be audio-taped

Signature _____ Date _____

I consent to allow use of my direct quotations in the published thesis document.

Signature _____
Date_____

Appendix 2

The Experience of Internationally-Born Nurses Working in Hospitals in the Twin Cities

Data Collection Form

Principal Investigator: Jolene Baker, RN, BSN
Email: baker1@augsburg.edu Cell Phone: 763-219-2338

This form may be completed electronically and returned via email attachment or can be printed, completed by hand and mailed to: Jolene Baker 7323 52nd Ave. North, Minneapolis, MN 55428.

Contact Information

Name:	*Age:*	*Gender:*
Birth Place:	*Length of Time in U.S.A.:*	
Phone #:	*Email:*	

Current Work Experience

Where did you receive your RN education?	
How long have you worked at this current job?	
How many hours do you work in 1 pay period?	
What is your position (e.g. staff nurse, supervisor, etc.)?	
What type of unit do you work on (e.g. med/surg, OR, ICU, etc.)?	
What is the approximate # of staff on your unit?	

Previous Nursing Experience

Type of Facility (Hospital, LTC, etc.)	*Position*	*Length of Time (Months)*

Appendix 3

The Experience of Internationally-Born Nurses Working in Hospitals in the Twin Cities

Interview Questions

Principal Investigator: Jolene Baker, RN, BSN
Email: baker1@augsburg.edu Cell Phone: 763-219-2338

Present

- Describe your current work setting.

Past

- Describe what led to this current work setting.
- State 1 – 3 experiences of the past that contributed to this current setting.
- Probe with Sense-Making questions between each action step of the experience.

Situation
- Describe your situation at this moment.
- What is occupying your mind?

Questions
- What questions come to your mind?
- What are you trying to figure out?

Emotions
- What emotions do you have at this moment?
- What do you think brings that emotion to you at this moment?

Conclusion/Decisions
- What are you deciding to do?
- What conclusions are you making?

Wishes
- What do you wish would happen at this moment?
- How would that help?

Future

- What needs to be addressed in your current setting?
- What are the limitations as you see them?
- If you could realistically have this situation work out ideally, what would it look like?

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