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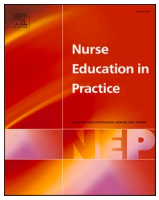

Culturally and linguistically diverse nurses' experiences of how competence facilitates integration into the working environment: A qualitative study

T. Isakov [a,*,1,2], S. Kamau [b,c,3], M. Koskenranta [b,4], H. Kuivila [b,5], A. Oikarainen [b], P. Ropponen [b,d], K. Mikkonen [b,e,6,7]

[a] Research Unit of Nursing Science and Health Management, University of Oulu, Oulu. Attendo Finland/Silkroad, Espoo, Finland
[b] Research Unit of Nursing Science and Health Management, University of Oulu, Oulu, Finland
[c] Department of healthcare and social services, Jyvaskyla university of applied sciences, Jyvaskyla, Finland
[d] Diaconia University of Applied Sciences, Helsinki, Finland
[e] Medical Research Center Oulu, Oulu University Hospital and University of Oulu, Oulu, Finland

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ABSTRACT

Aim: This study aims to describe culturally and linguistically diverse nurses' experiences of how they transferred their competence to meet professional competence requirements in non-English speaking environment.
Background: Competence is one factor that affects culturally and linguistically diverse nurses' integration into the working environment. In this study, knowledge, skills, values and personal traits are included in the holistic competence concept.
Design: Qualitative.
Methods: A total of 24 culturally and linguistically diverse nurses involved in Finnish health care participated in this qualitative study. Data were collected through snowball sampling during the summer of 2021 using semi-structured interviews. The collected data were analysed using inductive content analysis.
Results: The data analysis revealed a total of five main categories describing culturally and linguistically diverse nurses' experiences: 1) before immigration; 2) competence requirements in the country of immigration; 3) assessment of competencies; 4) support factors; and 5) hardships.
Conclusion: Degree recognition, colleagues' tolerance towards culturally and linguistically diverse nurses at the workplace and continuous education focusing on local language could improve culturally and linguistically diverse nurses' integration into the working environment.

1. Introduction

The decreasing number of nurses (ICN, 2019; WHO, 2020), rising number of patients (Niskala et al., 2020), increased need for high-quality care (Sameh et al., 2018) and demand for culturally competent care (Tie et al., 2017) have all made culturally and linguistically diverse (CALD) nurses' experiences a subject of interest. Health care organisations are becoming increasingly diverse, which can be seen through many publishing their own specific norms and values for working. However and although all nurses are aware of a common international Code of Ethics (ICN, 2019), the socio-cultural norms of a country can largely effect immigrants' acculturation. For this reason, the University of Oulu in Finland commissioned a study designed to examine CALD nurses' experiences of integration into the working environment. This represents a

* Corresponding author.
E-mail addresses: terhi.isakov@silkroad.fi (T. Isakov), Suleiman.Kamau@jamk.fi (S. Kamau), Miro.Koskenranta@oulu.fi (M. Koskenranta), Heli-Maria.Kuivila@oulu.fi (H. Kuivila), ashlee.oikarainen@oulu.fi (A. Oikarainen), paula.ropponen@diak.fi (P. Ropponen), kristina.mikkonen@oulu.fi (K. Mikkonen).
[1] ORCID: https://orcid.org/0000–0003-2990–0654
[2] Twitter: @terhimaija
[3] ORCID: https://orcid.org/0000–0003-0634–6013
[4] ORCID: https://orcid.org/0000–0001-7842–2703
[5] ORCID: https://orcid.org/0000–0001-8639–7640
[6] ORCID: https://orcid.org/0000–0002-4355–3428
[7] Twitter: @Kristinamikkon

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study outside of English-speaking areas that has investigated CALD nurses' experiences of how their competence, including knowledge, skills, values and personal traits, facilitate their integration.

2. Background

Previous studies have shown that CALD nurses' integration into working life is influenced by several internal and external challenges. These challenges can affect CALD nurses' choices in the workplace and during their free-time. Furthermore, it is important to note, that educators, managers and policy makers can develop strategies that minimise challenging factors and highlight the support systems, recruitment practices and working conditions which facilitate integration (Chok et al., 2017; Xiao et al., 2013). There is previous evidence that these positive actions may promote behavioural and psychosocial changes among CALD nurses, as well as help in adaptation and integration into working life. (Zhong et al., 2017; Newton et al., 2012; Pung and Goh, 2017).

Recent research has examined integration from the perspectives of cultural challenges and benefits, learning sources and value-based differences, as well as gauged the effects of these distinct factors (Brunton and Cook, 2018); the results demonstrate that CALD nurses working in diverse environments face conflicts and misunderstandings but were also willing to adapt to enhance their skills. However, there were occasionally inadequate opportunities or resources to facilitate this adaptation. The power distances involved in acculturation have also been studied, with previous research showing that a lack of clear organisational and collegial strategies may cause a situation where power distance disrupts CALD nurses' professional identity and confidence for extended periods of time; this can also be expected to affect patient safety (Choi et al., 2019). Also, Schilgen et al. (2019) noted that CALD nurses suffer from prejudice along with verbal and sexual harassment from clients, but they keep these experiences to themselves rather than mention them to their supervisors or colleagues. The same researchers also found language differences to be the main stressors impeding team collaboration as well as positive nurse-client interactions, moreover the CALD nurses perceived that their immigrant status meant that they belonged to a distinct community.

Prior research (Brunton and Cook, 2019; Clayton et al., 2016) has identified communicational difficulties between local nurses and nurses with different cultural and linguistic backgrounds as a major impediment to the smooth running of an operating theatre. Philip et al. (2019) suggested that the effectiveness of interactions is affected by hesitancy, lack of assertion and the lack of strategies to manage inadequate or aggressive communication by the team members and it should also be noted that poor clinical communication among peers is not always caused by CALD nurses, as positive interpersonal interactions such as laughter, language-switching and small talk have been observed among CALD nurses and their local colleagues. Mazaheri et al. (2018) stated that Persian speaking nurses in Sweden perceive themselves as not only caregivers, but caring people; as such, they tried to be caring persons and act according to their values, this cultural difference sometimes led to a troubled conscience.

Mikkonen et al. (2016) have pointed out that CALD students experience greater challenges in the clinical environment than in the academic setting and that CALD nursing students' experiences of the clinical learning environment are related to their mentors' competence in mentoring, the culturally diverse pedagogical atmosphere and aspects of diversity that influence clinical learning (Korhonen et al., 2019). Likewise, the interviewed clinical mentors stated that empathy motivated them in the development of intercultural communication. In contrast, mentors' experiences of intercultural communication competence in mentoring CALD nursing students point to a lack of resources and support from superiors, which caused both psychological and ethical strain and reduced mentors' motivation (Hagqvist et al., 2020). Previous research has also highlighted how important both professional development (Pung and Goh, 2017) and accreditation (Newton ym, 2012) are to the integration process. Moreover, Oikarainen et al. (2019) emphasised that internationally educated nurses can provide immense advantages in terms of professional skills and cultural diversity to any nursing unit; for this reason, addressing the cultural competency of nurses is crucial to the functioning of any health care organisation.

This study describes CALD nurses' experiences of continuous competence development and which competences they need to integrate into the working environments in a non-English speaking environment. Previous research including competence perspective in the non-English environment has predominantly focused on CALD nursing students' (Mikkonen et. al, 2016, Korhonen et. al, 2019) and mentors' (Hagqvist et al., 2020) experiences, whereas more descriptions are needed concerning CALD nurses experiences on how their competence facilitates the integration into the working environment. There is clear evidence that a nurse's competence is closely related to patient outcomes (Coster et al., 2017). This result is highly relevant to the functioning of integrated nursing teams and should motivate clinical nurses to actively develop their skills and learn from one another. Kutney-Lee et al. (2015) extended this knowledge base by identifying a connection between better results, a better working environment and continuous competence development. These empirical results show that it is important to study CALD nurses' experiences of integration into the working environment from a competence development perspective.

2.1. Concepts

This study adopts a holistic view of competence (Cowan et al., 2007) in that this concept encompasses various knowledge, skills, values and personal traits. The conceptualization of cultural competence was based on the dual definition presented by Oikarainen et al. (2019) which describes cultural competence as both an ongoing process (Caruso et al., 2016) in which the "healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family. community)"(Campinha-Bacote, 2002, 181) and a social construction grounded in critical reflection and action (Blanchet Garneau and Pepin, 2015, 12), or – in other words – the "health professional draws on to provide culturally safe, congruent and effective care in partnership with individuals, families and communities living health experiences and which takes into account the social and political dimensions of care".

The constructivist perspective (Blanchet Garneau and Pepin, 2015) consideres culture to be a dynamic process and the product of social constructions. This concept of culture is based on Leininger's (1991) definition of culture as the learned, shared and transmitted values, beliefs, norms and lifeways of a particular group that guide their thinking, decisions and actions in patterned ways. The constructivist perspective of culture also respects differences and uniqueness among individuals, families and communities (Gray and Thomas, 2006), a tenet which is in line with nursing's philosophical underpinnings (Gray and Thomas, 2006; Oikarainen et al., 2019) in the globalised post-modern setting. Intercultural communication in working life relates to individual experiences. In health care, workplace cultures are hierarchical, based on homogenous values and often governed by invisible norms that may lead to the marginalisation (Meleis, 1999) of immigrant employees (Magnusdottir, 2005). Cultural competence has also been linked with evidence-based practice. Engebretson et al. (2008) indicate that in both concepts, peoples' values and preferences are considered essential to providing equitable, high-quality care that meets individual needs.

In this study, language considered from the descriptive perspective, i.e., the concept of languageness as a culturally constructed system and unit with specific rules, elements, vocabularies and expressions is applied (Garner, 2004). On the other hand, the present research is also connected to language teaching which includes prescriptive conventions of teaching and testing predetermined grammatical rules and structures, as well as how language is seen in working environments. Laakso (2016)

assumes that "speakers of a language with a strong languageness ideology believe that their language with its' grammar and rules must be specifically learned, taught and developed" and that "speakers of codificated and standardized languages are more likely to understand linguistic diversity as the coexistence of distinct, autonomous systems or even parallel monolingualism". The concept of linguistic diversity that was used in this study considers that various languages are spoken in simultaneously in one area, potentially even by the same speakers. As such, the linguistic diversity discussed in this study covers both diversity of different languages and distinct situations and can thus also be termed superdiversity (Vertovec, 2007) or metadiversity (Laakso, 2016).

The relationship between language and culture is often considered from the sociolinguistic point of view, with Blommaert and Rampton (2016) stating that language is an important marker of a speakers' cultural identity, but also the dynamic nature of interaction between language and culture is emphasized. The concept of culturally and linguistically diverse (CALD) communities was previously studied by Pham et al. (2021) in the Australian context, restricted in an English-speaking setting. In this study, the concept of cultural and linguistic diversity describes people who represent a distinct culture from that of the country to which they have immigrated to for work and who do not speak the official or minority language(s) of their country of residence at home.

2.2. Aim, objective and research question

The aim of this study was to describe CALD nurses' experiences of transferring their competence to meet the professional competence requirements of non-English speaking healthcare working life. The present research also focussed on the assessment of competence and the strategies used to support learning. The research question was: What kinds of experiences do CALD nurses have of transferring their competence to meet the professional competence requirements of healthcare settings?

3. Methods

3.1. Research design

The qualitative research design and critical realism approach of this study were based on a naturalistic research philosophy, which assumes that reality is the product of social construction, as such, it changes and can only be understood indirectly, through the interpretation of people (Kyngäs, 2020). Critical realism allows researchers to collect and understand phenomena in a natural setting, as well as describe lived experiences and perspectives that are analysed (Denzin and Lincoln, 2018), with the aim of providing true insight into reality, even though it is known that this goal cannot be totally achieved. The quality assessment is based on the framework presented by Lincoln and Guba (Lincoln and Guba, 1985; Guba and Lincoln, 1994), which focusses on the research process and researcher's actions, choices, rationales, documentation and critical examination. The qualitative study was conducted in accordance with the Standards for Reporting Qualitative Research (SRQR) checklist (O'Brien et al., 2014) which is a validated instrument and was equally chosen from the equator network for the purpose.

3.2. Participants

The participants were either Registered Nurses in the country of immigration or in their native country. The inclusion criteria were: 1) the participant was working or had worked full- or part time in a health care organisation in a country other than their native country; 2) the participant expressed desire to take part in the research. The exclusion criteria were: 1) the nurse had been born in the country where they currently worked, or 2) the nurse has not worked in a health care organisation in the country of immigration. The researchers did not have any current relationships with the participants.

The nurses who met the selection criteria and were willing to participate in the interviews (n = 24) answered questions related to their background details on the web-based inquiry implemented by program Webropol (Webropol, Helsinki, Finland), after which the researcher contacted participants electronically to agree time interview times. The participants originated from 11 different countries (Table 2) and could be organized into age groups of 20–29, 30–39, 40–49 and 50–59 years (Table 1). The participants included both nurses who had completed their nursing studies and registered in Finland, as well as foreign-educated nurses who had first registered in their native country. In terms of educational background, 18 participants had a Bachelor's degree while six participants had a Master's degree (Table 1).

3.3. Data collection

The participants were selected through snowball sampling (Polit and Beck, 2017). More specifically, the two researchers (TI, SK) identified a certain potential participant via their colleagues, contacted them through email and those who were successfully recruited suggested additional potential participants. This sampling technique was selected since the researchers would have had a difficult time reaching the sampling group alone.

Semi-structured interviews were conducted by two researchers (TI, SK) using the distance meeting program Teams (Microsoft Corporation, Redmond, WA). During the interviews, the researchers were in Finland while the interviewees were in Finland, Sweden and Hungary. Each researcher and the participants were at home, with no other persons in the same room. Semi-structured interviews were chosen because they allow participants to describe authentic experiences (Polit and Beck, 2017). This approach also allows the researcher to ensure that the content of the interview is relevant to the researched topic. The semi-structured interviews included themes collected from previous evidence found in an umbrella review (Kamau et al., 2022). More specifically, the final themes were: 1) finding work and integration into working environments; 2) transferring competence to meet professional competence requirements; 3) the competences and support CALD nurses need for smooth integration; 4) and acculturation experiences of CALD nurses in Finnish healthcare settings. Concerning background characteristics, the participants were asked for their age, native country, native language, self-assessment of language skills, highest degree, years of total work experience and years of nursing work experience. The interviews, which were conducted in Teams during May – July 2021. lasted from 30 min to 1,5 h. Of the interviews, 19 were held in English while five were held in Finnish. Data saturation was reached after twenty-four interviews. The interviews were recorded, and the data were transcribed word-for-word into a Microsoft Word document.

Table 1
Participants' background characteristics.

	n	Percent (%)
Gender		
Male	7	29.2
Female	17	70.8
Age range		
20–29 years	4	
30–39 years	14	
40–49 years	5	
50–59 years	1	
Degree		
Bachelor's degree	18	75
Master's degree	6	25
Work experience in nursing, years		
1–3	5	
4–6	3	
7–9	9	
10 <	5	

Table 2
Participants' native country.

			n	%
Origin				
	Africa		**9**	
		Ghana	1	
		Kenya	5	
		Nigeria	2	
		Zimbabwe	1	
	Asia		**10**	
		China	1	
		Philippines	8	
		Vietnam	1	
	Europe		**5**	
		Hungary	2	
		Romania	1	
		Russia	1	
		Ukraine	1	

3.4. Data analysis

The transcribed data were collected in password-protected Microsoft Excel tables. The data were analysed using inductive content analysis (Kyngäs, 2020). To begin the analytical process, the researcher read through the data several times. Once familiar with the material, the researcher identified original expressions that answered the research question. The data were split into meaning units, which were combined into codes and then further grouped into subcategories, categories and main categories (Kyngäs, 2020). Data saturation was progressively checked by two researchers and the data were considered saturated when the analysis of further interview responses did not provide new insight into the studied phenomenon (Polit and Beck, 2017). The researchers applied researcher triangulation during the analysis process to improve trustworthiness so that the analysis was conducted by one researcher (TI), while the results were continuously checked and confirmed by another researcher (KM). The coding tree is described in Table 3.

3.5. Ethical considerations

The study process adhered to good scientific practice and considered all relevant ethical issues (Guba and Lincoln, 1994; Pietilä et al., 2020). The research was conducted according to the World medical Association Declaration in Helsinki (WMA, 2013). Research permission to conduct the study was applied for and received from the participating higher education institution University of Oulu. ICMJE Recommendations for the Protection of Research Participants was conducted in participants' protection (ICMJE, 2022). All of the participants were informed in written form about the study aims prior to their decision to take part in the interviews and were made aware that they were free to withdraw from the research at any time during the study. Written informed concent was obtained for participation and the participants were asked for permission to record the interviews. After the interview finished, the participants were afforded the possibility to discuss any questions and sensitive topics with the researcher. The participants' personal data were handled by assigning each participant a pseudonym whish was separate from the recordings and the transcript used during content analysis process (Pietilä et al., 2020). The data were handled according to the European Union's General Data Protection Regulation (Anon, 2018) so that the research process would not cause any harm to the participants.

4. Results

The participants identified various experiences concerning transferring their competence to meet the professional competence requirements of healthcare settings. The five main categories that emerged

Table 3
A coding tree used in the inductive content analysis.

Sub-category	Category	Main category
Work related reasons	Reasons for immigration	1. Before immigration
Education related reasons		
Personal reasons		
General knowledge gained in the native country	Knowledge gained in the native country	
Professional education in the native country		
Culture education in the native country		
Professional experience before immigration	Skills gained before immigration	
Language skills before immigration		
General work experience before immigration		
Bachelor's degree in nursing from the EU/ETA area	Formal requirements to work as a nurse in the country of immigration	2. Competence requirements in the country of immigration
LPN education		
License to work as a RN		
Limited knowledge of formal requirements in the country of immigration		
Professional knowledge, nursing theory	Knowledge required in the country of immigration	
Basic knowledge of language		
Professional language skills	Skills required in working life	
Professional nursing skills		
Communication skills		
Cultural skills		
English language skills		
Math skills		
Teamwork skills		
Digital skills		
Attitude towards work	Attitudes and personal traits needed in working life in the country of immigration	
Ability to work in a team		
Accountability in work		
Honesty in work		
Strength in work		
Patience in work		
Punctuality in work		
Ability to learn a language		
Similarities in the theory of nursing	Similarities in competences	3. Assessment of competences
Similarities in clinical nursing expertise		
Similarities in clinical nursing courses		
Differences in digital technology skills	Differences in competences	
Differences in nursing culture		
Differences in medical care		
Differences in patient guidance		
Differences in the health care system		
Need to redo ethics educate	Need of improve competences to reach the standards in the country of immigration	
Need to redo medication studies		
Need to improve language skills		
Need to gain some more weeks of training		
Need to study the health care system of the country of immigration		
Process for recognition of professional qualifications	Recognition of professional qualifications	
Limited knowledge of who has authority when applying for a license		
Unrecognition of educational competence	Recognition of previously gained competence	

(*continued on next page*)

Table 3 (*continued*)

Sub-category	Category	Main category
Differences between curricula		
Recognised and compensated competence in education		
Recognised but uncredited competence in education		
Learning from model	Strategies to support learning	4. Support factors
Learning language at work		
Peer learning		
Platform for competence development		
Support from managers	Getting support to learning	
Structured support program at workplace		
Support from colleagues at workplace		
Support from the government in the country of immigration		
Support from school		
Perceptions of support		
Preparing the students before bridging program		
Lack of support in improving language skills		
Unstructured competence development		
Belonging to a peer group outside of work	Coping	
Peer support from colleagues		
Empowerment		
Good working environment		
Attitudes that promote coping		
Personal traits that promote coping		
Staying calm in adversity		
Starting in easy work tasks		
Abusive attitude of colleagues	Abuse	5. Hardships
Abusive attitude of patients		
Stigma of being migrant		
Unfair workload distribution		
Unfair managerial practices		
Overqualification to work tasks	Deskilling	
Undervaluation of nursing skills		
Lack of language skills as a challenge	Challenges	
Understanding the culture as a challenge		
Adjusting to the weather as a challenge		
Difficulty to study language and do professional studies at same time		
Feeling unloved	Influence upon well-being	
Feeling scared		
Feeling tired		
Pitying oneself		
Feeling inadequate		
Lack of leniency at the workplace	Reasons to leave	
Difficulty to get a permanent work contract		
Salary is bad		
Bad atmosphere at workplace		
Lack of independence in nurse's work		
Registered nurses must do practical nurses' work		
Lack of support to use the competences that have been gained in studies		

from the CALD nurses' descriptions of their experiences were: 1) before immigration; 2) competence requirements in the country of immigration; 3) assessment of competencies; 4) support factors; and 5) hardships. The main categories, as well as the corresponding categories and sub-categories are described in Table 3.

4.1. Before immigration

This main category includes the reasons for immigration, the knowledge gained in the native country and the skills gained before immigration. This category covers work aspirations, education and personal reasons. The reasons for immigration describe why a nurse has decided to immigrate from their native country to a new country. The reasons are related to the competence transferring intentions so that in some cases the intentions to immigrate did not include the intention to stay. Some nurses shared the work-related reasons, most of the immigrating nurses intended permanently stay in the country, but some nurses also shared an intention to work for a couple of years to earn money enough, to return home. When discussing education, the nurses shared both intentions to stay and intentions to earn a Bachelor's degree in an English nursing program, after which they would return to their native country or move to another country. One participant stated: "*And the reality is that some nurses are not here to stay. They are just here to study.*" (Interview 4). Although the most common personal reason for the immigration was family ties, i.e., immigration to a spouse's home country, some participants also intended to permanently move with spouse, children and other relatives (Table 4). Ethical dilemmas arose from the CALD nurses' experiences of leaving their families, often including minor children, in their native country.

The knowledge gained before immigration varied mostly among the nurses that had immigrated for family reasons. The nurses who had immigrated for educational reasons had rarely gained any special knowledge after graduating from high school. On the other hand, the nurses who had immigrated for work–related reasons had all earned a Bachelor's or Master's degree in the field of health sciences in their native country. Furthermore, the nurses felt that they were able to apply their knowledge, even if the lack of a nursing license set some limitations (Table 4). The skills gained before immigration were based on professional and general work experience in either the native country or another foreign country. This concerned only nurses who had immigrated for work-related reasons. According to the interviews, the reasons for immigration contributed to language skill development. For example, nurses who immigrated for work-related reasons had often already achieved a basic level of the language skills needed in the country they were immigrating to.

4.2. Competence requirements in the country of immigration

This main category relates to the formal requirements to work as a nurse in the country of immigration, the required knowledge and skills and the attitudes and personal traits needed in working life. The participating CALD nurses stated that the most important formal requirement was a degree in nursing recognized in the EU/ETA area or, if education had gained abroad, a national license (Table 4). According to the results, CALD nurses did not consider reaching the professional knowledge requirements to a problem, but these nurses did experience

Table 4
Quotations representing participants' experiences.

Categories	Quotations representing participants' experiences
Before immigration	*"And the reality is that, some nurses are not here to stay. They are just here to study."* (Interview 4) "*It's just that it could be better if we go here at the same time. However, we were actually thinking of our son, so that's why I was the one who came here first."* (Interview 10) "*… the knowledge, which we actually gained and learned from our school there and our professional experience. We actually applied here as well, but there are limitations we have to follow, because at this moment we do not have a license."* (Interview 10) "*I worked in an operation room for almost eight years, so in my mind – that was a good experience to have before looking for work abroad."* (Interview 8)
Competence requirements in the country of immigration	*"I think that first and foremost you have to have the skill to work, to a certain to degree."* (Interview 15) "*I think I meet the competence requirements. The language is the only thing that is a problem.*" (Interview 22) "*'In my opinion, the language seems to be something that they really, really value. I would expect them to look at the fact that I'm a nurse, I have skills, I have been trained in nursing."* (Interview 12) "*They really require language skills … writing those nursing care plans in the computer – you really need that skill. So I think that's the number one thing a foreign nurse should have."* (Interview 20) "*Obviously, every nurse has that competence. The only thing you need to have, is the motivation to apply for jobs, the confidence to go and apply, even if you get negative feedback."* (Interview 19)
Assessment of competencies	*"But all those major courses in nursing such as surgical, internal medicine, emergency nursing … Yes, everything is almost the same. I think that in terms of the technology, there will be a big difference."* (Interview 1) *"How all patients and people are treated equally – just like an aim that you work positively and effectively. That the equality and the kindness and understanding, especially understanding the patient, since the patient is an expert of their own body, so you always have to consider their needs and desires. When I compare this to my home country it does not work like this."* (Interview 9) "*I think it might end up that someone misjudges and thinks that maybe you don't know something just because you don't speak the language."* (Interview 17)
Support factors	"*The only thing is that you need to be willing to learn and you have to be motivated."* (Interview 11) "*And then I learned in these years, learned how to defend myself. How to say it back. And I said to this doctor 'okay my colleagues are protecting me, by not assigning me to her operation' but I said directly. I can let this happen once. But if you say this again, I will make an official announcement of discrimination – And she didn't say that shit anymore."* (Interview 16) "*Then, year after year, the challenges that I face diminish little by little. Not completely gone, but a little. I don't cry anymore."* (Interview 3)
Hardships	*"Before I started my practical nurse studies, I didn't know that I can send my papers to Valvira and then start as a registered nurse. Because I didn't have knowledge about that, I first started as a practical nurse. But of course, if I knew, I would have started the process to be a registered nurse immediately. I did not go on to be a practical nurse."* (Interview 5) "If given a chance, I would like to continue my studies to be a registered nurse here. Because I miss working in the operating room. But I don't know what the process is." (Interview 21) "*I have received insults from patients so many times. I just shrug them off, but still. sometimes they are sarcastic that you do not know proper Finnish grammar and then they kind of sarcastically copy you, the way you're talking. And it's kind of insulting for foreign people, for foreign nurses.*" (Interview 20) "*I'm a dark skinned person, I'm a black person so at work most of my colleagues will probably always have white skin and, so you'd always hear one or two things being said behind your back. They probably just dismiss you and call you the N-word so to speak.*" (Interview 17) *"Your ability to do the work will be questioned. Because you can't express yourself in Finnish."* (Interview 21) "*I cannot really apply what I know because I am still an assistant nurse here. – Because they might feel bad if I always push myself in the front. This is explained by an ego. Because we're foreign and I don't know if it's good or not good [from the perspective of Finnish colleagues] that we are here as nurses."* (Interview 22) *"if I can have better language skills, then I would feel that I am perfect and competent."* (Interview 3) "*There are not lenient enough, that's the biggest problem. – They expect that we are exactly like the other Finnish student once we finish our training. And that's why most people are leaving."* (Interview 4) "*The work should be more independent, or at least include a hope for getting more independent work, that is an important thing for me as a foreigner, that I can think about being promoted during my working life in Finland, but if it is like it is now, then no, it is not interesting."* (Interview 23) "*The assistant nurse salary is not enough, so it doesn't fulfill the inquiry requirements, to take our family here with us."* (Interview 8) *"And the salary, the salary also is really bad. I don't know understand how we do so much work as registered nurse, and at the end we make almost the same amount as practical nurses. These are the main issues for why international nurses are not staying."* (Interview 4)

problems related to insufficient language skills (Table 4). CALD nurses shared experiences of language skills being stressed more than professional skills: "*In my opinion, the language seems to be something that they really, really value. I would expect them to look at the fact that I'm a nurse, I have skills, I have been trained in nursing."* (Interview 12). The participants felt that writing skills were especially crucial (Table 4). The CALD nurses also reported several attitudes and personal traits that were important to successfully transitioning to working life (Table 4). The CALD nurses listed attitude towards work, honesty, patience and punctuality, as well as the ability to learn a language as important competences which have a positive impact on integration into working life.

4.3. Assessment of competences

This main category covers the similarities and differences in competences between the native country and country of immigration, the need of improve competence to reach the standards of the country of immigration, as well as recognition of professional qualifications and recognition of previously gained competence. The internationally

educated nurses stated that there were no, or only minor, differences in professional nursing competencies between their native countries and the country of immigration. In the case that a participant identified competence differences, these were mainly related to the care culture and patient guidance, the health care system, medical care and in technology (Table 4). The CALD nurses also stated that the equal treatment of patients differed between their native countries and the country of immigration (Table 4). Even though the CALD nurses recognized that they need to improve their competence in ethics, medical care, language, local clinical practice and knowledge of local health care system, they felt that language skills were excessively emphasized in the assessment of professional competence. For example, an interviewee stated: "*So I think it might end up that someone misjudges and thinks that maybe you don't know something just because you don't speak the language.*" (Interview 17). They also felt competent at doing medical calculations, but felt that they were given too little time to complete the local medical calculations exam, which was in Finnish.

Recognition of professional qualifications was related to formal education, which included the requirement that internationally educated nurses apply for a local nursing license. CALD nurses educated in EU/ETA countries had knowledge about the process, but recognition was only simple if they held a degree in nursing. CALD nurses who had completed a degree in another discipline than nursing, did not meet the requirements of the country of immigration and had to obtain another a Bachelor's degree; this also held true in case that the CALD nurse had education in a field other than nursing but had been registered as a nurse in their native country. Ethical dilemmas arose when CALD nurses felt that they were overqualified for the work of a nurse assistant. Some of the CALD nurses also reported a lack of knowledge of the educational and professional requirements when applying for a license, with some of the nurses feeling as though they could not solve this problem. Moreover, the nurses who had completed relevant education in the EU/ETA found the formal recognition process easy yet found it difficult to find work in a hospital and had to work in nursing homes although they had excellent language skills and special health care experience from their native country.

4.4. Support factors

This main category describes the strategies which support learning, how CALD nurses can receive support for learning and how CALD nurses cope with work. The interviewed CALD nurses stated the learning form model, peer learning and observation as learning strategies they had available for them. The CALD nurses also suggested they wished to have language courses at the workplace and a platform for competence development. The CALD nurses' descriptions of their own experiences revealed an intrinsic motivation to learn (Table 4). The CALD nurses reported that they received support for their learning at their workplace. For example, both the supervisors and colleagues supported their learning. Moreover, the interviewed CALD nurses felt that their colleagues' and superiors' choices to start them on easier tasks was a support mechanism. The interviewees also felt that coping supported integration into the working life. The CALD nurses experienced belonging to a peer group outside of work as well as peer support from colleagues as empowering. The participating nurses felt that a good working environment and a positive attitude towards learning promoted coping, with one interviewee describing about with discrimination during as follows: "*And then I learned in these years, learned how to defend myself. How to say it back. And I said to this doctor 'okay my colleagues are protecting me, by not assigning me to her operation' but I said directly. I can let this happen once. But if you say this again, I will make an official announcement of discrimination – And she didn't say that s * *t anymore.*" (Interview 16). The CALD nurses experienced that – over time – their coping skills empower them to integrate into working life (Table 4).

4.5. Hardships

This main theme describes the kinds of hardships which affect CALD nurses' integration into the working environment. Based on the CALD nurses' interview responses, hardships arise from society, managerial practices as well as colleagues' and patients' attitudes in the working environment. The results also revealed instances of racism. Structural racism was related to a limited knowledge of how the health care system was governed. For example, nurses who had completed their degree outside of EU/ETA countries reported problems in the process of applying for a national license, which could last several years. An interviewee described: *"Before I started my practical nurse studies, I didn't know that I can send my papers to Valvira (Authority for Welfare and Health) and then start as a Registered Nurse, something like that. Because I didn't have knowledge about that, I first started as a practical nurse. But of course, if I knew that I can send my papers to Valvira, I would have started the process to be a Registered Nurse immediately. I did not go on to be a practical nurse."* (Interview 5). The interviews also revealed that some of the interviewed CALD nurses were enrolled in vocational education without knowledge of how to continue, or how to apply for a license (Table 4). The CALD nurses also reported that colleagues and patients were sometimes abusive towards them and that abusing also included explicit racism concerning their black skin colour in an environment with white-skinned colleagues (Table 4). In addition, the interviews revealed CALD nurses' experiences of unfair workload distribution and managerial practices. The CALD nurses stated that they do more work shifts and are used to working for eight or twelve hours, sometimes even 16 or 18 h, a day and that their manager has different expectations for different employees. The participants also described experiences of deskilling; in certain cases, the deskilling was closely linked to linguistic challenges with one interviewee stating: *"Your ability to do the work will be questioned. Because you can't express yourself in Finnish."* (Interview 21). The CALD nurses discussed how this unfair treatment and abuse influenced their well-being, with one respondent analysing a situation where they assisted practical nurses even though they possessed the knowledge of a Registered Nurse (Table 4). Moreover, insufficient language skills affected a CALD nurse's well-being (Table 4).

The interviewed CALD nurses also reported colleagues' intolerant attitude towards culturally and linguistically diverse nurses at workplace and wished their colleagues had been more tolerant towards them (Table 4). The newly graduated CALD nurse shared her experience that tolerance, or as she expressed, leniency, is crucial to the integration process, and that it is unrealistic to assume that education or training can change each CALD nurse to be more like a nurse who has lived in Finland their entire life. "*There are not lenient enough, that's the biggest problem. – They expect that we are exactly like the other Finnish student once we finish our training. And that's why most people are leaving*" (Interview 4). The CALD nurses also stated that they leave because they do not get a good enough contract (Table 4). Those CALD nurses who had left their families overseas mentioned that the salary is an important factor of their working life, as it imparts the largest influence on the possibility to bring their family to Finland (Table 4). Some of the interviewed CALD nurses stated that they are leaving to another country because the salary in Finland is not competitive (Table 4).

5. Discussion

The findings from this study suggest that challenges in linguistic competence are a major impediment to CALD nurses' smooth integration into the working environment. A previous study reported that CALD nurses did not always find opportunities which facilitated common understanding and accommodation; this could lead to communicational conflicts or misunderstanding (Brunton and Cook, 2018). It has also been stated (Brunton et al., 2019; Clayton et al., 2016) that the smooth running of a working environment is related to communicational difficulties between individuals from different cultural and linguistic

background. Even though Clayton et. al. (2016) studied perioperative nurses in Australian settings and there was a common language, the presence of nurses and doctors from multiple cultures and different training backgrounds was considered a challenge and they suggest, that a sense of camaraderie and fostering good relationships between staff through regular social gatherings can improve communication and the working atmosphere.

In this study, CALD nurses mentioned differences in care culture, patient guidance, medical care and technology skills, between their native country and the country of immigration. Moreover, the CALD nurses felt that they needed further competence development in the local language and medical care. When discussing the local medical calculations test, the participants stated that they were given insufficient time to finish, as they were not familiar enough with the vocabulary. The CALD nurses also expressed a desire for further education in ethics, clinical practice and knowledge of the local health care system.

In this study, CALD nurses shared experiences of discrimination, abusive treatment in the working environment, including even open racism, and their colleagues' intolerance towards them. Even though some of the interviewees reported that they learned to cope with discrimination and abusive situations, these hardships affected CALD nurses' well-being. The participants also reported about racism and identified the lack of leniency and difficulties in fulfilling career goals as reasons to leave. Hagqvist et.al (2020) have previously reported that mentors share CALD students' fears of discrimination in the ward setting. Mikkonen et al. (2016) shared similar findings concerning CALD nursing student's experiences. Cultural diversity (Leininger, 1991) and linguistic metadiversity (Laakso, 2016) can be achieved in working environments in various ways, such as CALD nurses' training and instruction, but the local staff's competence in English, participation in orientation and lenient attitude towards new colleagues (both local and CALD nurses) can have a significant impact on the working environment.

The CALD nurses who participated in this study stated that they were not aware of the official structures or strategies that were meant to support competence development in the working environment. CALD nurses shared that they had limited knowledge of who possessed relevant authority and that applying for a national license could last several years. The CALD nurses working as nurse assistants were also hesitant to apply their nursing competence at work. Choi et.al. (2019) have previously emphasised that the lack of clear organisational and collegial strategies can disrupt a CALD nurses' ability to develop a professional identity and confidence for extended periods and even detrimentally affect patient safety.

One of the limitations of this study was that even though the participants represented several nationalities (see Table 1) and provided rich material of experiences, the participants' cultural background was not linked to the results. Furthermore, in snowball sampling, people with larger social networks are more likely to be recruited into the study since they are easier to reach. When the participants recommend additional participants, it is impossible to define the people who are not willing to participate, since the researchers are not in contact with them and this might cause cultural bias. For example, in this study, there were no participants from Estonia and only one participant from Russia (Table 2), although according to Anon (2020), half of the immigrant nurses came to Finland from Estonia and the second biggest country of origin was Russia. Also, the working environment includes both CALD and local nurses; as such, the inclusion of a group of local nurses or nurse managers in the study could have yielded more complex results.

5.1. *Trustworthiness of the study*

The trustworthiness of this study was considered according to qualitative research criteria (Lincoln and Guba, 1985; Kyngäs et al., 2020). The trustworthiness of the presented research was been according to the criteria of credibility, dependability, confirmability, transferability and authenticity, which were first explained by Lincoln and Guba (Lincoln and Guba, 1985; Guba and Lincoln, 1994). The fields of qualitative inquiry and qualitative research are wide and in transition (Denzin & Lincoln, 2017); therefore, the trustworthiness of the entire research process must be assessed by comprehensive critical review (Guba and Lincoln, 1994). The trustworthiness of this study was also evaluated using the criteria that Kyngäs et al. (2020) applied when assessing the results of a conducted content analysis; furthermore, data richness and saturation were considered throughout the study process.

6. Conclusions

A CALD nurse's linguistic competence can make it challenging for them to integrate into the working environment. When this dynamic is extended to the cultural diversity and linguistic metadiversity of a non-English speaking working environment which includes a strong languageness ideology of the own national language, as is case in Finland, CALD nurses may find it very difficult to integrate, which will result in the deskilling of their professional competences. Based on the presented results, CALD nurses' integration into the working environment could be facilitated by developing CALD nurses' degree recognition, improving tolerance at work, taking into account language difficulties when administering tests and helping foreign colleagues develop their language skills. However, further research is needed, as quantitative data can provide additional evidence about the connection between CALD nurses' native language, competence and support for developing their linguistic skills. Further studies should also focus on patient guidance and ethics from the cultural point of view. Another topic that should be further investigated is degree recognition for CALD nurses who finished their education outside of EU/ETA countries and the process through which they can obtain a national license.

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Conceptualization; Terhi-Maija Isakov, Suleiman Kamau, Miro Koskenranta, Heli Kuivila, Ashlee Oikarainen, Paula Ropponen, Kristina Mikkonen. Methodology; Terhi-Maija Isakov, Suleiman Kamau, Miro Koskenranta, Heli Kuivila, Ashlee Oikarainen, Paula Ropponen, Kristina Mikkonen. Formal analysis; Terhi-Maija Isakov, Kristina Mikkonen. Investigation; Terhi-Maija Isakov, Suleiman Kamau, Miro Koskenranta, Heli Kuivila, Kristina Mikkonen. Data Curation; Terhi-Maija Isakov, Kristina Mikkonen. Writing - Original Draft; Terhi-Maija Isakov, Suleiman Kamau, Miro Koskenranta, Heli Kuivila, Ashlee Oikarainen, Paula Ropponen, Kristina Mikkonen. Writing - Review & Editing; Terhi-Maija Isakov, Suleiman Kamau, Miro Koskenranta, Heli Kuivila, Ashlee Oikarainen, Paula Ropponen, Kristina Mikkonen. Visualization; Terhi-Maija Isakov, Kristina Mikkonen. Supervision; Kristina Mikkonen. Project administration; Heli Kuivila, Kristina Mikkonen.

Conflict of interest

The authors have no conflict of interests to declare.

Data availability statement

All data generated during this study are included in this published article.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.nepr.2023.103553.

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