FACILITATING CLINICAL TRANSITION IN THE MIDST OF CULTURAL DIVERSITY: CHALLENGES AND STRATEGIES

A Thesis

Presented to the School of Nursing, Midwifery and Paramedicine

Of Australian Catholic University

Graduate Research Office

In Complete Fulfillment of the Requirements for the Degree of

Master of Philosophy

by

Jennie Robinson

June 2014

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution. No other person's work has been used without due acknowledgment in the main text of the thesis. All research procedures reported in the thesis received the approval of the relevant Ethics Committees.

ABSTRACT

Background:

The clinical facilitator (CF) role has evolved to enable the clinical transition of the growing numbers of culturally and linguistically diverse overseas qualified (CALD OSQ) nurses who have brought nursing experience and knowledge to Australia. The presence of CALD OSQ nurses in Australia reflected globalisation patterns of nursing which contributed to the imbalance of the distribution of global health service delivery. The continued reliance on CALD OSQ nurses has added to the overwhelming health workforce shortages in developing nations. However the World Health Organisation (2010) proposed the origins of the health workforce crisis stemmed from the gulf between health professional education and standards of health service delivery. This study aimed to describe participant CFs' views of the clinical transition challenges faced by CALD OSQ nurses during clinical practicum and their views on strategies to address these challenges. A gap in research was found on this topic.

Methods:

Four CALD and four non CALD participants were selected using purposive quota sampling for this qualitative descriptive study. Data were collected using semi structured interviews which were recorded and transcribed verbatim. Transcribed data were coded and analysed to generate themes and subthemes relating to the study aim and research questions.

Results:

Three key challenges and three key strategies were identified which were represented by a main theme and up to two subthemes. Each key challenge was aligned with a key strategy. The key challenges and strategies comprised:

(1) *Lack of knowledge and understanding of CALD OSQ nurses*; *Gain cultural knowledge and understanding of CALD OSQ nurses' learning needs.* (2) *Loss of CF role autonomy: Mismatch between CFs' expectations and ward priorities*; *Strengthening CF role autonomy: Aligning CF expectations with ward experiences.* (3) *Differences in communication styles*; *Addressing differences in communication styles.*

Discussion:

To explain CFs' holistic facilitation of CALD OSQ nurses on clinical practicum, experiential learning theory was used to describe the participant CF in a partnership with CALD OSQ nurses in the learning and teaching process. An environmental model was used to explain that the learning and teaching process was impacted by multiple influences which challenged the participant CFs' role. This interpretation of the

study findings provided new local knowledge to address these challenges. Further distillation of the findings enabled incorporation of literature sources to strengthen this new local knowledge. Hence the key challenges and strategies were distilled into three main interpretations of the study for discussion in relation to the literature and comprised: 'Gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs'; 'Aligning CF expectations: CF role autonomy to facilitate CALD OSQ nurses' learning'; 'Participant CFs enabling the formation of therapeutic relationships and assertive verbal and non-verbal communication styles'.

Conclusion:

In conclusion this study affirmed that clinical facilitation strategies must be strengthened to empower CALD OSQ nurses with lifelong learning skills for transformative, deep learning. Implications for clinical practice include the need to use research evidence to sustain change to experiential learning practices applied to the whole body of culturally diverse nursing students. Potential benefits to the nursing profession comprise enriched CF strategies for facilitating CALD OSQ nurses' clinical transition, critical improvements in health service delivery and greater success with nursing workforce retention.

ACKNOWLEDGEMENTS

I wish to acknowledge many people who have inspired the completion of this thesis.

Acknowledgement first goes to my supervisors for steering this incredible learning experience through challenging terrain. Thanks also to the students who inspired this research and the study participants for their openness and willingness to contribute their valuable time to be interviewed. My mentors and close colleagues deserve a special expression of gratitude for their friendship and scholarly contribution in supporting my research efforts. Sincere gratitude also goes to my extended family and friends for their continued reassurance, patience and understanding.

Appreciation especially to my husband John for always being there, believing in me and giving me the encouragement to complete the thesis despite the many hurdles. My three daughters Prue, Amber, Brigette and my son Matthew gave their love and support for my studies in so many ways. Particular acknowledgement goes to Prue for providing motivation, superb technical support and precious time reading and checking my thesis. Tribute goes to Brigette for her encouraging conversations and actually reading early draft chapters. Amber and Matt provided advice and listened to my concerns on so many occasions.

It was all of these people as well as persistence and determination that made the difference. My sincere thanks to all concerned.

ABBREVIATIONS and ACRONYMS

ACRONYMS	DEFINITION
ABS	Australian Bureau of Statistics
AC	Abstract Conceptualizations (learning style)
ACT	Australian Capital Territory
ACU	Australian Catholic University
AE	Active experimentation (learning style)
AEI	Australian Education Institutions
AHPRA	Australian Health Practitioner Regulation Agency (Australia)
AMLE	Academy of Management Learning & Education
ANMAC	Australian Nurses and Midwives Accreditation Council
ANMC	Australian Nurses and Midwives Council
ANS	Advances in Nursing Science
AONE	American Organisation of Nursing Executives
BN	Bachelor of Nursing
BP	Blood Pressure
CALD OSQ	culturally and linguistically diverse overseas qualified
CE	Concrete experience (learning style)
CEU	Continuing Education Unit
CF	Clinical Facilitator
CGFNS	Commission on Graduates of Foreign Nursing Students
CINAHL	Citations for Nursing and Allied Health
CNR	Council of Nursing Representatives
CRICOS	Commonwealth Register of Institutions and Courses for Overseas Students
CSES	Cultural Self-Efficacy Scale
CSSP	Centre for Studies in Social Policy
DEEWR	Department of Education, Employment & Workplace Relations
DOI	Digital Object Identifier
EBP	Evidence Based practice
ELT	Experiential Learning Theory
EN	Enrolled Nurses
ESL	English as a Second Language
FAQ	Frequently Asked Questions
GT	Grounded Theory
HETI	Health Education and Training Institute
HREC	Human Research Ethics Committees
HWA	Health Workforce Australia
IBL	Inquiry Based Learning
ICN	International Council of Nurses
IELTS	International English Language Testing System

IJQM	International Journal of Qualitative Methods
JBI	Joanna Briggs Institute
LIC	Lecturer in Charge
NCTEI	Nursing Clinical Teacher Effectiveness Inventory
NHMRC	National Health and Medical Research Council
NMB	Nurses and Midwives Board
NOTARI	Narrative Opinion and Text Assessment and Review Instrument
NSW	New South Wales
NUM	Nursing Unit Manager
NY	New York
OECD	Organization for Economic Cooperation and Development
OJIN	Online Journal of Issues in Nursing
OSQ	Overseas Qualified
QD	Qualitative Descriptive
Qld	Queensland
QSR	Quality Solutions and Research
RN	Registered Nurse
RO	Reflective Observation (learning style)
RU	Research utilisation
SDNM	Strategic Directions for Strengthening Nursing and Midwifery
SON	School of Nursing
TCPM	Transition to Clinical Practice Module
TEQSA	Tertiary Education Quality and Standards Agency
UK	United Kingdom
UNESCO	United Nations Educational, Scientific and Cultural Organization
USA	United States of America
Vic	Victoria
WA	Western Australia
WHO	World Health Organisation

Table of Contents

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION and BACKGROUND

1.1 Introduction

A crisis in the global health workforce has resulted in over a billion people worldwide, being unable to access adequate health services (World Health Organization (WHO), 2011). This crisis was mainly due to critical shortages, imbalanced skill mix and uneven geographical distribution of health professionals (WHO, 2011). Controversy surrounded culturally and linguistically diverse (CALD) overseas qualified (OSQ) nurses transferring their qualifications to provide health services in Australia and other receiving countries (Organization for Economic Cooperation and Development (OECD) Health Statistics, 2011a). The result of CALD OSQ nurses' qualification transfer has been shown to contribute to the uneven ratios in major emerging economies compared to the OECD average (OECD, 2011b). According to the WHO (2010) the root of the health workforce crisis stemmed from the theory practice divide that has existed between health professional education and standards of health service delivery. Clinical facilitators (CFs) have been on the frontline of combatting the problems arising from this theory practice divide for CALD OSQ nurses.

Achieving health outcome targets in New South Wales (NSW), Australia has required focus on improvements in clinical education during the three million hours of clinical placements for clinical practicum across all health disciplines (NSW Health 2012a). Regardless of their cultural background, graduate nurses were expected to be ready to provide high standards of health service delivery once registered in Australia. The CFs have had the critical responsibility of ensuring these standards were reached during CALD OSQ nurses' transition to clinical practice.

This study's aim was to describe participant CFs' views of the clinical transition challenges faced by CALD OSQ nurses during clinical practicum and their views on strategies to address these challenges. Expected outcomes were to respond to a gap in the literature, answer the research questions and formulate facilitation strategies to potentially empower future CFs. Significance of the study to be detailed in 1.3.1 was derived from the need for CFs to address their role in CALD OSQ nurses' preparation to graduate as registered nurses (RNs). The study purpose included informing CFs' efforts to facilitate CALD OSQ nurses' clinical transition leading to readiness for health service delivery as registered nurses (RNs) in Australia.

The study participants were CFs with Australian nursing registration. The participant CFs were employed by the university to facilitate Bachelor of Nursing (BN) students toward making the clinical transition from theory taught at university. Since clinical practicum was financed and coordinated by tertiary institutions, CFs were ideally positioned to provide their views of challenges and associated strategies. Focus of the study has been placed on clinical transition during clinical practicum which was the experiential learning strand of the BN. The remainder of this Chapter firstly provided an overview of the background followed by the aim and rationale of the study. Finally, the significance of the study has been presented in relation to transformations in clinical models of nursing, stimulated by World Health Organisation (WHO) goals, and enacted by state health organisations. A Chapter summary and outline of the thesis have acted as a lead into the remaining four Chapters.

1.2 Overview of Background

The following sections described the relevant study background. Since the background provided an important context it was organised to incorporate the local, national and international context of the study. Contextualizing the study began with facilitation, the study participants and their CF role followed by clinical transition, information regarding arrival of CALD OSQ nurses in Australia, and clinical practicum. Subsequent to this was an in-depth discussion of the cultural standpoint of nursing in Australia which provided the lens through which this study was viewed. Finally the global context of CFs facilitating CALD OSQ nurses included migration, nursing shortages and workforce retention issues. Consequently the background included the following five subsections: Local background: facilitation the CF role and clinical transition; the participating site: CALD OSQ nurses and regulatory bodies; CFs, clinical practicum and CALD OSQ nurses; National background: the Australian nursing cultural standpoint; International background: CALD OSQ nurses' migration, nursing shortages and retention. Since this is a local study the next three subheadings refer to local background issues. The national and international backgrounds each have one subheading.

1.2.1 Local background: Facilitation, the CF role and clinical transition

The study participants who were the CFs facilitating CALD OSQ nurses on clinical practicum were not a separate population since they facilitated culturally diverse groups who may have been CALD and non CALD international and local students (Burrows, 1997; Dickson, Walker & Bourgeois, 2006; Ellis & Hogard, 2003; Hogard and Ellis, 2006; Lambert & Glacken, 2005). Relevant research studies into facilitation, the role of the CF, transition and the meaning of clinical transition have been reviewed in Chapter Two. A brief outline has been presented in this subsection as background information. It became evident that there was limited information regarding CFs facilitating CALD and non CALD international

BN students. Discerning what was known about the role of the CF in preparation for the current study was extrapolated from current knowledge regarding the CF facilitating predominantly non CALD, local BN student populations.

Overall, four main responsibilities enabled CFs to orchestrate the health facility clinical practice environment so that it provided an effective clinical practicum learning environment. These responsibilities included preparing the clinical practice environment, facilitating student transition into the clinical learning environment, maximizing learning opportunities and providing support (Lambert & Glacken, 2005).Clinical facilitation was differentiated from supervision by its supernumerary status whereby CFs were without the responsibility of a patient allocation (Lambert & Glacken, 2005). According to Henderson and Tyler (2011) the CFs' role was to enhance and support clinical practice as well as support RNs in their major role of supervising students with the development of a teaching and learning role. While CFs were expected to promote recruitment and retention of nurses, they were also expected to embrace self-directed, lifelong learning, critical reflection and research (Lambert & Glacken, 2005). Activities expected of them included developing alliances, demonstrating and enabling practice of skills (Dickson, et al., 2006).

Clinical facilitators were described as the essential element for facilitating successful clinical transition for student nurses' clinical experiences (Lambert & Glacken, 2005). In this context, clinical transition meant the different processes undergone to adapt to the changed circumstances in clinical practice (Kralik, Visentin & Van Loon, 2006). Successful clinical transition according to Kralik et al. (2006) inferred that feelings of distress were replaced with a sense of well-being and a sense of control over a change event. It was crucial that students had positive learning experiences during this time to enable them to make the transition from simulated nursing skills in laboratories to the actual health care environment with patients (Eyre, 2010; Lambert & Glacken 2005).

An important point was that defining facilitation incorporated its purpose. Instead of knowledge being provided by an expert instructor for students the CF and learner generated knowledge together through critical reflection and discussion in the context of clinical learning (Dickson et al., 2006). Henderson and Tyler (2011) emphasised that facilitation of clinical practicum was a key part of clinical educational preparation in nursing programs and that it was essential to optimise learning during this time. Awarding clinical pass to students provided some measure of the effect of educationally sound, clinical facilitation of BN students' successful clinical transition. However, as shown in Chapter Two, the literature provided

limited information regarding CFs' facilitation strategies to enable CALD OSQ nurses to achieve successful clinical transition in New South Wales (NSW), Australia.

1.2.2 Participating site: CALD OSQ nurses and regulatory bodies

This subsection introduced the participating site and the proportion and possible nationalities which constituted the subset of CALD OSQ nurses within the CALD international BN student population. In addition this data was related to trends occurring within Australia's skilled migration program. Educational and English language standards have been explained with reference to national regulatory bodies.

The CALD OSQ nurses being facilitated in this study were enrolled into the BN at the participating site in NSW Australia which was one of the campuses of a national university. As illustrated in Figure 1, CALD OSQ nurses constituted a unique subgroup within the CALD international BN student population. Figure One also illustrated that the proportion of CALD OSQ nurses to international students across the three year BN in NSW in March 2012 to April 2014 increased from 21% to 36%. Similarly, CALD OSQ nurses at the participating site in 2012 made up approximately 28% which increased slightly to 30.5% of CALD international students in NSW in April 2014. However, in previous years there has been a particularly high proportion (40 to 55%) of CALD international students in the undergraduate BN at the participating site (Wright & Gollan, 2008). Based on the university statistics and Australian Bureau of Statistics (ABS), the high proportion of international CALD BN students reflected a national trend (Australian Bureau of Statistics (ABS), 2006; Wright & Gollan, 2008).

Factors perpetuating the trend to steadily increase CALD international BN student enrolments in Australia in 2008-2012 included: Australia's skilled migration program; reliance on full fee paying international students to fund local students; global nursing workforce shortages and poor retention rates (WHO, 2011). There were 379,214 enrolments by full fee paying students in Australia on student visas in June 2013 which represented a 2.2% decline from June 2012 from a 5.8% average increase over the preceding 10 years (Australian Education International (AEI), 2013). Although there has been a decline in enrolments since June 2012, there has been growth of 15% in Higher Education international student visas granted to offshore applicants in the first quarter of 2013 (AEI, 2013). In addition, CALD international BN students' pathway have been eased as student visa increases have been attributed to Australian Government reforms to streamline student visa processing and improvements for post study work visas (AEI, 2013).

Educational institutional standards also have Australian Government regulations for enrolling CALD OSQ nurses. The Tertiary Education Quality and Standards Agency (TEQSA) Act (2011) has been applied to international education providers seeking to offer higher education such as the BN in Australia (TEQSA Act, 2011). A requirement delineated by the Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) included that endeavours must be made by the educational institution to socially and academically integrate all CALD OSQ nurses and CALD international students with local students during their studies (Department of Education, Employment & Workplace Relations (DEEWR), 2013).

The top five nationalities which contributed 53.7% of all nationalities to Australia's international student enrolments in all sectors were: China (29.7%), India (9.2%) Republic of Korea (5.3%) Vietnam (4.8%) and Malaysia (4.7%) (AEI,2013). The CALD OSQ nurses were assessed along with other international students for qualification transfer of registration to Australian requirements before their student visas were issued (Hawthorne, 2005). In addition to overseas nursing qualifications the international CALD students' standards of English were carefully monitored by nursing registering authorities. All CALD students including CALD OSQ nurses with less than five years of recent English education required a minimum of 7 overall for an international English language testing system (IELTS). This meant that an IELTS of 7 was required between the four skills in the English language comprising: listening, reading, writing and speaking. While some CALD OSQ nurses students may have been able to write at level 7.5 yet could only speak at level 6.5. Standards have recently been raised from CALD international students requiring an overall IELTS of 6.5 to 7 in response to continuing difficulties with English language during transition to study and clinical practice in Australia.

The Nurses and Midwives Board (NMB) which became part of a national health practitioners' body in 2010 called Australian Health Practitioners Regulation Authority (AHPRA, NMB, 2010) raised English language requirements for all health practitioners. The NMB has stipulated from 2010 that the IELTS for nursing registration in Australia must be 7 in all four skills (NMB, AHPRA, English Language Requirements, 2010). Consequently the CALD OSQ nurses being facilitated in the current study are expected to have achieved an overall IELTS of 7 with anticipated improvements to 7 in all four skills before applying for nursing registration. Without achieving these high levels of English, graduating CALD OSQ nurses could not become registered to contribute to health service delivery as RNs in Australia

The smaller proportion of CALD OSQ nurses were a unique subset within the CALD international BN student population. The student population of the participating site in NSW reflected a national trend. This

trend ran in parallel with the skilled migration program whereby Australian government agencies have been proactive in encouraging increases in CALD international BN students. The benefits to Australia included funding of local students and filling nursing workforce shortages without having to address poor retention rates. This has been partially achieved by streamlining visa processing and post study work visas. In addition, CALD OSQ nurses were regulated by the NMB, AHPRA requirement to meet minimum standards of English and recognition of overseas qualifications which were assessed before applying to the Australian universities. On the other hand educational institutions were government regulated through the TEQSA Act (2011) and the DEEWR, CRICOS regulations to ensure standards were maintained for CALD OSQ nurses.
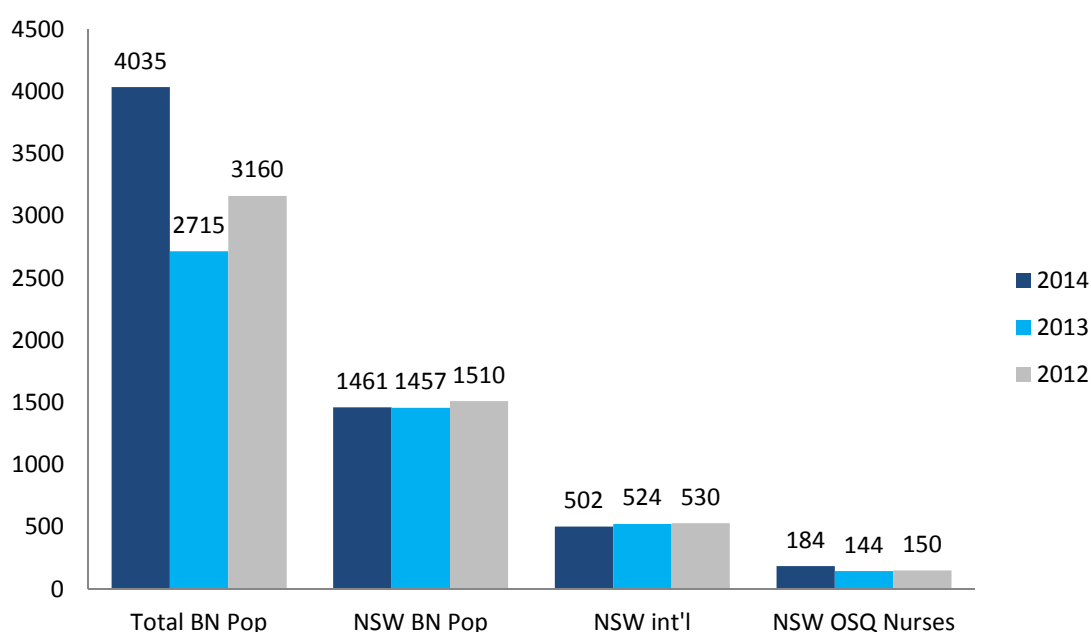
Figure 1: Proportion of CALD OSQ nurses enrolled at participating site compared to total BN population and international BN students in NSW, Australia (April 2013 and March 2014).

1.2.3 CFs, Clinical Practicum and CALD OSQ nurses

The reason that CFs were employed for clinical practicum in this study was partially because of CALD OSQ nurses' course requirements to have made the clinical transition to Australian clinical practice. However CALD OSQ nurses entry to university and clinical practicum was different to other CALD international students. All CALD OSQ nurses were exempt from introductory level clinical practicum as they commenced with an alternative entry pathway to completing the BN. One of the reasons was the participating site in NSW offered 40 to 80 credit points as an advance standing toward the 240 credit point BN degree in recognition of CALD OSQ nurses' overseas qualifications. Furthermore the number of credits granted to CALD OSQ nurses toward the BN in Australia depended on analysis of standards at the

institution within the country of origin. Entering clinical practicums at second year level potentially meant different CF expectations of CALD OSQ nurses.

Throughout their time at university CALD OSQ nurses' assessments were aligned with a web enhanced, campus based transition program, lectures, tutorials and clinical simulation laboratory activities in preparation for clinical practicum. All CALD OSQ nurses were required to complete a 10 credit point course introducing them to Australian clinical practice before attending clinical practicum. Pass for clinical practicum integrated with theory also awarded 10 credit points. Depending on the university clinical model, the clinical practicum required for the BN curriculum were completed in blocks to align with the theory provided on university campus. The educational theory underpinning clinical practicum during the BN curriculum was based on the experiential learning theory (ELT) discussed in Chapter Five. The clinical model in use to fulfil the clinical experience requirement for CALD OSQ nurses in this study involved clinical placements of three or four week blocks spread over the two to two and a half years of the BN. Clinical practicum comprised approximately 18 weeks in total. Each clinical practicum was designed to progressively prepare CALD OSQ nurses to be proficient graduates ready for health service delivery as RNs.

During clinical practicum CFs utilised an assessment tool for clinical psychomotor skills by Tollefson (2010) which used the ANMAC clinical competencies for the RN (discussed in 1.3). In addition, there were also written reports to be completed by the CF and written reflections by the CALD OSQ nurses. Upon completion of the clinical practicum, the CF either recommended clinical pass or at risk of clinical fail to the campus based clinical lecturer in charge who used the CF's report and written documentation to make the final decision. Students could repeat a clinical practicum once, after a clinical fail. Academic regulations required that a student's enrolment could be terminated (pending an appeal) if they received a second clinical fail. An academic from the university who was the clinical lecturer in charge would discuss the report and support the CF recommendation to pass or fail the student.

One of the important differences with CALD OSQ nurses from other CALD international students was entry in second year for clinical practicums. Although mainly recent arrivals in Australia they attended progressively more difficult 3-4 week clinical practicum blocks in order to successfully make the clinical transition to the Australian health care system. Preparation involved theory and simulations with accompanying assessments at the tertiary institution which supported use of ELT underpinning clinical practicum. During clinical practicum, CFs decided to pass CALD OSQ nurses' competency assessments as well as award positive written reports in order for them to progress or graduate. Students were required

to write reflections on the process. Reflective writing was aimed at enabling self-examination of how reactions affected interactions to help CALD OSQ nurses' understanding of how self- knowledge and theory can provide insight into those reactions (O'Toole, 2012). Stringent academic regulations allowed for only one clinical fail which would be finally upheld by the university based clinical lecturer in charge. The cultural standpoint of nursing in Australia in the following section provided the national backdrop of this study.

1.2.4 National background: Australian nursing cultural standpoint

This section explored the lens through which this study was viewed by examining the cultural standpoint of nursing in Australia. Initially this was achieved by reviewing the most recent census data publications from the ABS Cultural Diversity Overview (2006); cultural competency standards from the Australian Nursing and Midwifery Accreditation Council (ANMAC); the National Health and Medical Research Council (NHMRC). In addition this section examined initiatives which have been developed in two of the most highly populated of the six Australian states: Victoria and NSW. Cultural diversity projects and current related research were examined. It was found that Australian nursing cultural competency standards were supported by national and state government agencies in setting policy aims and objectives to support equity and fair practice. However, there was little evidence to ensure that these policies were being successfully implemented.

Information produced by the Australian Nursing and Midwifery Accreditation Council (ANMAC) stated a clear commitment to cultural diversity and innovation. Members of the ANMAC (2013) articulated that accreditation standards, criteria, assessment and monitoring processes should support diversity and innovation. These standards must have met the continuing needs of the Australian and international nursing and midwifery professions (ANMAC, 2013). This commitment was underpinned by core competency standards which provided the framework for assessing cultural competence used by Australian states and territories as part of the initial and annual renewal process for nursing registration (Australian Nursing and Midwifery Council (ANMC), 2005). The dominant culture of the population of Australia has been Anglo-Celtic and English speaking. However 43% of citizens had a CALD background and 25% were born overseas (ABS, 2006). It was highlighted in 1.2.4 that as part of globalisation of nursing the Australian government has encouraged the migration of CALD OSQ nurses to compensate for nursing workforce shortages (ABS, 2006). This highlighted the necessity of a strong commitment to accreditation standards to support cultural diversity and innovation. Maintaining assessment and monitoring processes remained the key to the success of achieving these standards.

Standards which represented the Australian nursing cultural standpoint of cultural competence were clearly highlighted in the national cultural competency standards expected of all RNs including those employed as CFs. Further to this ANMAC was currently updating the RN competencies from 2005 when it was previously called the ANMC. One of the relevant core competencies from ANMC (2005) represented the current standard and stated that the RN must practice in a way that acknowledged the dignity culture, values, beliefs and rights of individuals and groups (ANMC, 2005). This competency standard specifically delineated culturally competent practices which included: advocacy for individuals or groups when rights were overlooked and/or compromised; acceptance of individuals/groups to whom care was provided regardless of race, culture, religion, age, gender, sexual preference, physical or mental state; ensured that personal values and attitudes were not imposed on others; undertook assessments which were sensitive to the needs of individuals/groups; recognized and accepted the rights of others (ANMC, 2005). These standards provided a powerful national commitment to cultural competence which was published and freely available online.

The Australian Government agency, the National Health and Medical Research Council (NHMRC) supported the principles of the ANMC (2005) competency standards. This support was demonstrated by emphasizing that a health system which was culturally competent should articulate specific skills for culturally competent practice. Additionally it should support individuals and health organizations to value and achieve culturally competent practice (NHMRC, 2005). The NHMRC has set an agenda with the broader aim of producing a culturally competent health system. An objective to achieve this aim was stipulated (NHMRC, 2005). Consequently, the NHMRC policies provide a broad umbrella for the ANMAC standards. However there was limited evidence of successful implementation of culturally competent practices which were discussed below in regards to Victoria and NSW state government initiatives.

In Australia a Victorian Health Services Project commissioned by the Victorian Government edited by Higgins (2009) contained a literature review of current cultural and linguistic diversity and cultural competence reporting requirements. This project included minimum standards and benchmarks for health services. It was anticipated that interventions developed from the report would then be implemented. Conclusions from this review and report included that cultural competence practice was problematic in health settings. In addition, implementation and reporting of cultural competence in Victorian health settings was fragmented (Higgins, 2009). Higgins (2009) stipulated that a key outcome of the report was to develop a set of standards of cultural responsiveness which was clarified as simply an awareness and capacity to operate within the context of cultural difference. Cultural responsiveness involved knowledge

capacity at differing levels of intervention including systematic organisational, professional and individual (Higgins, 2009).

As a result of Higgins (2009) report cultural competence was also re-defined in terms of systems. Hence cultural competence involved a set of behaviours, attitudes and policies which supported health professionals to work together to enhance culturally competent health service delivery (Higgins, 2009). Recommendations from the executive summary included a Cultural Responsiveness Framework for Health Services which contained four domains comprising: development of an effective workforce; organisational effectiveness; risk management; and consumer participation. Among the six standards stipulated were requirements that staff at all levels should be provided with professional development opportunities to enhance cultural competence capabilities (Higgins, 2009).

Policy produced by NSW Health (2012b) concurred with Victorian Health. It developed a NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016. In addition, the implementation plan utilized research evidence regarding multicultural health issues. The plan aimed to maintain and continue to improve the capacity of the NSW Health system to effectively identify and meet the specific needs of all CALD groups in NSW (NSW Health, 2012b). This demonstrated a policy commitment to cultural diversity. In addition the plan acknowledged that it was imperative to develop capacity within the health system that was culturally competent and recognized the benefits that diversity brought to Australian society (NHMRC, 2005, p.4).

However, there was limited research regarding policy implementation outcomes. Studies detailed in Chapter two provided mainly qualitative evidence that these outcomes were unmet for CALD OSQ nurses and other CALD BN students. These studies illustrated that core cultural challenges represented a significant part of the transition experience during nurse education experiences in Australia. Cultural challenges included feelings of inferiority related to being misunderstood, nursing role conflict, inflexibility of organisational culture with excessive levels of individualism as well as experiences of loneliness and isolation (Konno, 2008; Brown, 2005).

In summary, national and state governments as well as ANMACs' policy aims and objectives concurred in advocating culturally competent practices. As an example a Victorian Government commissioned project identified that cultural competence practiced in health settings was problematic and implementation and reporting of practices was fragmented. Hence, while it was recognised that cultural diversity supported a healthy work environment in health care there were many transitional barriers for CALD OSQ nurses.

Additionally Australian Federal government policies encourage CALD OSQ nurses to fill workforce shortages and improve health service delivery. However there were failures to implement policies relating to cultural competence which acted as barriers to achieving the intended higher standards in health service delivery. Consequently, the cultural standpoint of nursing in Australia contained many major cultural barriers for entry to practice for CALD OSQ nurses and was represented by policies supportive of cultural diversity and innovation. However a critical need has been highlighted to implement strategies to initiate cultural responsiveness to support equity and fair practice.

1.2.5 International background: CALD OSQ nurse migration, nursing shortages and retention

The OECD which had thirty member countries, including Australia, reported that there were vast differences in the number of nurses per capita in the member countries (OECD Health Statistics 2011a). Moreover this ratio was low in major emerging economies compared to the OECD average. The OECD supported this finding with estimates that in 2009 there were approximately 14 nurses per 1000 population in several Nordic countries while in the major emerging economies such as India, Brazil, Indonesia and China there were as few as 1.5 nurses per 1000 population. In some countries the OECD had noted this ratio had continued to rapidly deteriorate in the previous few years (OECD, 2011b, p. 72).

Adeniran et al. (2008) pointed out that CALD OSQ nurse migration had increased exponentially and related this trend to globalization in the 21st century. Evidence of this trend was provided by a 2003 report by the OECD which included Australia with Canada, the United Kingdom, and the United States of America as having 25% of CALD OSQ nurses to make up their nursing and medical workforce (OECD, 2011b; Adeniran et al.,2008).Those CALD OSQ nurses, who applied to make the clinical transition to the Australian health care system, have been welcomed by government agencies to partially fill labour shortages in nursing (ABS, 2006; Hawthorne, 2005). The migration of CALD OSQ nurses has been implicated to incur a loss of skilled personnel and economic investment from the donor countries (Kline, 2003; Hawthorne, 2002a). According to Kline (2003) this pattern has been occurring simultaneously in the UK, US, Canada and the Middle East. Primary receiving countries have been Australia, Canada, Ireland, UK and the USA which receive CALD OSQ nurses to fill critical shortages. Remarkably, while the Philippines and South Africa are primary donor countries however receiving countries including Australia, Canada and the UK are also donor countries (Kline, 2003).

In Australia the continued reliance on CALD OSQ nurses was reflected in the census figures from the ABS (2006). With an increase of 15% of people working as nurses since 2001 to 219,800 in 2006, 4.4% (or 9,671) had arrived in Australia from overseas since 2002 compared with 3.2% of all employed people

(ABS, 2006, Cultural Diversity Overview p. 156). This clearly reflected overseas nurse recruitment which was directed at filling skill shortages. In 2006, 25% of Australia's overall population were born overseas (ABS, 2006, p. 156). In addition to the view that nurse migration was a direct product of globalization was that underlying adverse conditions have resulted in poor RN retention rates. Losses were proposed to have occurred either during transition to practice at university or in the workplace (Hawthorne, 2002a). This view was depicted in the following statement: "Migration is predicted to continue until developed countries address the underlying causes of nurse shortages and until developing countries address conditions that cause nurses to leave" (Kline, 2003, p.110). With increasing overseas recruitment of CALD OSQ nurses it has become imperative to improve strategies to ensure successful clinical transition (Hawthorne, 2002b). This provided an important rationale for the current study.

1.3 Aim and rationale for the study

The aim of this study was to describe participant CFs' views of the clinical transition challenges faced by CALD OSQ nurses during clinical practicum and their views on strategies to address these challenges. A key rationale for the study was to address the lack of Australian research in this area and to provide an understanding of the issues that can contribute to participant CFs challenges and develop associated strategies. It was anticipated that standards of nursing proficiency could potentially be improved by highlighting that participant CFs required culturally appropriate strategies to facilitate CALD OSQ nurses' unique learning needs. This underlined the rationale for carrying out this study which was to explore CFs' views of addressing the gap that has been identified between theory and health service delivery amidst cultural diversity. The following discussion of the significance of the study further expounded this rationale.

1.3.1 Significance of the Study

This study has important clinical practice significance since it was focused on participant CFs' strategies to enable successful clinical transition of CALD OSQ nurses. Results of this study will potentially contribute to achieving recent national Australian targets which have been directed toward achieving improved health outcomes by ensuring BN graduates have made successful transition to clinical practice. Regardless of their cultural background, graduate nurses were expected to be employable for high standards of health service delivery as RNs as soon as they have registered. Plans have been implemented for changes which transform models of applying clinical education to improve patient care by the Health Education and Training Institute (HETI) in New South Wales (NSW). These plans have been developed as a response to the crisis in global health workforce due to critical shortages, imbalanced skill mix and

uneven geographical distribution of health professionals resulting in more than a billion people worldwide lacking access to adequate health services (WHO, 2011).

Attention to meeting improved health outcomes targets in NSW has been concentrated on the three million hours of clinical placements for clinical practicum which have been allocated across all health disciplines (NSW Health, 2012a). A major focus has been directed toward clinical education for clinical facilitation of clinical placements of all health care disciplines (NSW Health, 2012a). Coordination of clinical placements as an inter-professional project adds impetus to this study as it has brought broader, more significant clinical implications. Transformative changes to clinical education by the HETI have been aligned with the WHO's newly updated strategic directions for strengthening nursing and midwifery (SDNM) 2011-2015. Changes have included the NSW Clinical Supervision Support Project (CSSP) which was based within HETI's Centre for Learning and Teaching (HETI, 2012).The WHO (2009) has been the trigger to set plans in motion to combat the problems arising from the gap between health professional education and the standards of delivery of health services. This gap was encapsulated in the following statement: "At the root of today's crisis lays the gulf that exists between health professional education and health service delivery" (WHO, 2011).

Evidence that action was underway was the funding provided by Health Workforce Australia (HWA) to enable the HETI CSSP's main aim which was to expand clinical facilitation/supervision capacity and competency for all health professionals. Nursing and midwifery has been nominated as one of the four core discipline modules which was to act as a template for other health professions (NSW Health, 2012a). Objectives of one of the WHO's (2011) five recently updated key result areas was to: "optimise nursing workforce performance by fostering a positive work environment with supportive supervision [facilitation] (WHO, 2010, p.16)."

The background to how supportive facilitation made improvements possible in health service delivery in nursing can be traced to the HETI CSSP. The CSSP is NSW Health's response to plans announced by the WHO for an exponential increase of health professional education. In addition, this was an initiative to increase the number of health professionals as well as strengthen their impact on population health (WHO, 2011).). Strategic directions for strengthening nursing and midwifery services for the period 2011 to 2015 had a core vision statement which included improved health outcomes using culturally sensitive, evidence-based nursing and midwifery services to patients, families and the community (WHO, 2011).

Along with the movement to an interdisciplinary, clinical placement booking system, a new initiative by the HETI CSSP (2012) meant that subject matter experts were selected from each discipline. In addition, health services and education providers such as university based Schools of Nursing were to be change champions. Subject matter experts were to be consultants and coordinate education to users who would provide further local training to CFs and others involved in clinical education. The HETI CSSP plans to provide support to clinical supervisors/facilitators through training and resources. Facilitation strategies built from quantitative studies confirming the results of this study had the potential to provide valuable resources for coordinators of these 'teach the teacher' initiatives. These evidence based strategies would potentially address the needs of CFs facilitating the rapidly increasing numbers of CALD OSQ nurses in Australia.

Information has been brought together in a 'Superguide' for nursing completed in 2013 (NSW Health, 2012a). A 'Superguide' has also been written for supervising medical doctors in training and allied health professionals (NSW Health, 2012). The HETI CSSP project team will identify gaps between required and actual supervisory skill levels and between training needs and training opportunities through the NSW Clinical Supervision Mapping Study. Importantly, part of the Clinical Supervision Curriculum and Training Project involved developing a discussion paper on articulated pathways in clinical facilitation/supervision and an online application to facilitate clinical supervision (NSW Health, 2012a).

The study significance included that the results of this study were aligned with the NSW HETI CSSP response to the national target to improve health service delivery in Australia. Strategies developed would potentially empower participant CFs to facilitate successful clinical transition for CALD OSQ nurses and address an identified area which required robust cultural responsiveness toward equity and fair practice discussed in 1.3. Finally, this study contributed knowledge to a current on-going project to assist in providing best research evidence regarding challenges and strategies proposed from current participant CFs' views of facilitating CALD OSQ nurses.

1.4 Summary and Outline of the thesis

The remaining sections comprise a summary of this Chapter One and a brief outline of the remaining four chapters.

1.4.1 Chapter 1: Summary

In summary this Chapter initially provided the study background information which set the study context. Firstly this included: facilitation, the CF role and clinical transition. Participant clinical facilitators have

been shown to be ideally placed to provide views of facilitation challenges and associated strategies. Secondly CALD OSQ nurses, the CALD BN international student population at the participating site as well as regulatory bodies have been described. The context of CALD OSQ nurses as a smaller proportional subset of the CALD international student population has been highlighted and illustrated. Third was an outline of the background of CALD OSQ nurses on clinical practicum. This outline identified that entry to the BN at the second year clinical practicum level at the participating site provided a significant difference to entry from other CALD international students.

Fourth the global context of CALD OSQ nurses in Australia and effects on worldwide nursing workforce shortages and retention rates have been delineated. It was shown that increases in CALD OSQ nurses in Australia represented part of globalisation of nursing resulting in reported imbalances in the distribution of health service delivery. This has ostensibly contributed to major workforce shortages in developing nations. Fifth the cultural standpoint of nursing in Australia provided the lens through which this study was viewed. It has been shown that National, state and local policies support equity and fair practice as well as cultural responsiveness. However there was little evidence to show these policies have been implemented.

Finally, the rationale of the study was to address the gap in Australian research providing local knowledge on the topic. This was followed by the significance of the study which was presented in relation to transformations in clinical models of nursing, stimulated by WHO goals, and enacted by state health organisations. The significance of the study lies in having identified a gap in the literature and the urgency to identify CF challenges and associated strategies. The purpose of this was to potentially ensure future CFs can facilitate CALD OSQ nurses to successfully make the clinical transition to safely deliver health services as RNs.

1.4.2 Chapter 2 Literature review

Chapter two has presented a review of the literature from which it was concluded that there was a lack of previous studies on the topic of CFs views of facilitating CALD OSQ nurses. Instead two groups with multiple subgroups emerged representing two bodies of literature which have been reviewed. Furthermore these groups and subgroups shown on Table 1 were entitled firstly 'facilitation and the role of the CF' and secondly 'Transition, transition programs and experiences of transition for CALD OSQ nurses'. Each group resulted in an aim and five subgroups which were discussed in relation to existing literature and result in narrative summaries. The two groups have been integrated with further examination of the narrative summaries to illustrate the relationship between findings of this review. This integration was

achieved with the use of a model of environmental influences presented in Figure 2. This model linked the findings of the two groups of research literature within the review together and focused on environmental influences on CFs and CALD nurses in the clinical learning environment of clinical practicum. The chapter concluded that there was a gap in local research regarding participant CFs' views of challenges and strategies associated with facilitating CALD OSQ nurses which this study has addressed.

1.4.3 Chapter 3 Methodology and methods

Chapter three presented the rationale for selection of the qualitative research paradigm, the justification for use of qualitative descriptive (QD) research methodology. An account has also provided for selection of semi structured interviews for data collection instead of other qualitative methods such as participant observation or focus groups. Alternative ways of collecting descriptive data have been examined by considering quantitative surveys, participant observation and focus groups. Furthermore QD research methodology has been differentiated from grounded theory and phenomenology to clearly differentiate its' atheoretical epistemological underpinnings. Similarities and differences with other qualitative methodologies have been elucidated. Qualitative methods have been related to the study by providing details of the research methods including study design, research participants, sampling approach, selection and recruitment procedure, data collection and analysis methods. Finally the interview process and threats to validity have been explained followed by outlining data analysis processes and procedures to ensure research quality.

1.4.4 Chapter 4 Results

Chapter four has presented the participant demographics on Table 6 and results of the thematic data analysis. Data analysis comprised three key challenges and three key strategies which were each represented by three themes and up to two subthemes displayed on Table 7 and supported by verbatim quotes from the interview transcripts. In addition, patterns of difference between CALD and non CALD CFs have been presented and integrated with the themes and subthemes. Participants' verbatim quotes have been clearly identified as CALD or non CALD participant CFs. The chapter has concluded with a summary of the results of the study which have been displayed on Table 8.

1.4.5 Chapter 5 Discussion and Conclusion

Chapter five has presented a discussion of all aspects of the findings of the thesis in relation to existing relevant literature. Two important concepts helped to provide an explanation of participant CFs' struggle to facilitate CALD OSQ nurses on clinical practicum and answer the research questions. One of these concepts was experiential learning theory (ELT) and its association with the ELT cycle and with learning

styles. A second concept was the environmental model of influence first introduced in Chapter 2. Examples from study findings are related to the ELT cycle and the environmental model of influence which enabled discussion in relation to the literature. Following this the focus of Chapter 5 comprised discussion of the three key interpretations which were distilled from the three main themes and subthemes also with reference to the literature. Finally the strengths and limitations of the study, implications of the findings for clinical practice, recommendations for further research and the thesis conclusions have been presented.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

This comprehensive search explored clinical transition for graduate nurses with the purpose of identifying and appraising articles that discussed facilitation by CFs of CALD OSQ nurses during clinical practicum. The review identified a gap in knowledge as there were no local studies found which primarily focused on CFs and CALD OSQ nurses. Instead two separate bodies of literature were found and each was described separately below. The reason why there was little known about CFs' views of facilitating CALD OSQ nurses' transition to practice was unclear.

Over the past 30 years the number of CALD OSQ nurses requiring clinical placements as part of upgrading qualifications to work in Australia has been rapidly increasing (OECD, 2011 a). As highlighted in Chapter 1, over three million hours of clinical placements were allocated across all health disciplines in 2009 in NSW (NSW Health, 2012a). According to Fleming (2008) nursing was the largest health occupation in Australia so that BN students occupied almost half of these placements. Due to the large scale and importance of successful clinical transition there has been a major focus placed on clinical education for facilitation of clinical practicum. It was found that CFs were in a prime position to potentially provide information for future planning to improve clinical transition experiences for CALD OSQ nurses during clinical practicum.

The two separate bodies of literature (see Appendix G and H) were organized into two groups shown on Table 1. The first group was 'facilitation and the role of the CF'. The aim of the first group was to distinguish features of facilitation and the CF role. In order to fulfil this aim changes in nurse education, educational theories and models of nursing were related to the emergence of clinical facilitation to replace clinical instruction in nursing. In addition, the concept 'facilitation' has been distinguished in the clinical learning environment by contrasting it with facilitation in the nursing practice environment. The latter required facilitation of implementation of research utilisation (RU). Finally influences on the CF role will be discussed with reference to tertiary education, CF role clarity and teaching style.

The second group has been entitled 'transition, transition programs and experiences of transition for CALD OSQ nurses'. The aim of the second group was to gain insights from transition, transition programs and experiences of transition for CALD OSQ nurses. To fulfil this aim, insights from research studies on transition and transition programs illuminated CALD OSQ nurses' experiences of transition

from international, national and local research. Included in this group was an integrative review and meta-analysis of the term transition and studies on the stage theory of transition and efficacy of transition programs for CALD graduate nurses. In addition, this group included studies of experiences of transition for predominantly CALD OSQ nurses when they began to apply theory to the clinical practice environment. These studies were mainly from the CALD OSQ nurses' perspective.

To illustrate the relationship between findings of this review the two groups were integrated. This was initiated by further examination of the narrative summaries of the two groups and their subgroups. Integration of findings was achieved with the use of a model of environmental influences presented in Figure 2. This model linked the findings of the two groups of research literature within the review together and focused environmental influences on CFs and CALD nurses in the clinical learning environment of clinical practicum. The remainder of this Chapter will provide an aim, results and narrative summary of each of these groups and subgroups displayed on Table 1. The Chapter conclusion has brought this information together to identify that a gap existed in local knowledge about facilitation challenges and strategies employed for clinical transition of CALD OSQ nurses as viewed by participant CFs.

Clinical facilitator (CF) was used to describe the following terms: facilitator, clinical education facilitator, clinical educator, clinical teacher, clinical supervisor, supervisor of clinical education; nurse educator, health educator, clinical mentor.

Transition was used to describe the following terms: adjustment, adaptation, integration, tailored support.

Table 1: Abstracts returned - included and excluded

	Group 1		Group 2				
Abstracts	Concept of Facilitation.	Role of CF	Concept of transition	Transition programs	Clinical transition experiences: International research.	Clinical transition experiences: National research.	Clinical transition experiences: Local research.
Returned	2	19	2	8	9	5	4
Included	2	16	2	6	CALD OSQ RNs =5, mixed participants CALD BN students//CALD OSQ nurse/ Lecturers =1 Total N=6.	CALD OSQ RNs = 2, mixed participants CALD BN students / CALD OSQ nurses /lecturer = 1 Non CALD grad RNs = 1 Total =4.	CALD OSQ RNs = 1, Mixed participants CALD students and and CALD BN students = 1. Total = 2.
Excluded	0	2	0	2	3	1	2
Reason for exclusion		Teachers as facilitators in classroom setting.		New BN graduate transition programs. Transition to university not clinical practice.	Non CALD BN undergraduate exchange students.	Undergraduate experiences of transition to clinical laboratory simulations.	New BN graduate transition experiences.

2.1 Search Strategy

Academic databases were searched: Google Scholar, Ovid and CINAHL. Further database searches were initiated however relevant meta-synthesis, systematic literature reviews, integrative literature review and meta-analysis of qualitative studies were found to strengthen the included, individual qualitative studies.

Appendix G shows a table detailing studies focusing on facilitation and the clinical facilitator role. Details are provided of the analysis carried out for relevant meta-synthesis and systematic literature reviews which have brought together small qualitative studies from searching CINAHL, Medline and Synergy with key terms: clinical, facilitation, practice, education and teacher. Appendix H shows a table detailing studies focusing on transition, transition programs and experiences of transition in nursing. These studies included an integrative literature review and meta-analysis of qualitative studies. Data bases searched for the review and meta-analysis include CINAHL, Socioprofile, Psychlit using the keyword 'transition'.

As well as reviewing these studies a search of relevant literature from international, national and local organisations was carried out using the following terms and phrases: internationalization; globalization of nursing; qualification recognition; clinical facilitator, facilitation, nurse teacher, educator, supervisor; foreign nurses, international nurses, CALD OSQ nurses and migrant nurses; theory practice gap, clinical practicum, transition; clinical transition, transition programs, experiential learning, workforce diversity. Organisations searched for documents and recent reports included: Organization of Economic Cooperation and Development (OECD); International Centre on Nurse Migration; World Health Organisation (WHO); Council of National Representatives (CNR) of the International Council of Nurses (ICN); Commission on Graduates of Foreign Nursing Schools (CGFNS); Australian Bureau of Statistics (ABS); Australian Health Professionals Registering Authority (AHPRA); Australian Nurses and Midwives Accreditation Council (ANMAC). Small qualitative studies focusing on CFs, CALD OSQ RNs, nurses and CALD student nurses were included to provide insights into what is known on the topic. It was noted that there were many discussion papers on issues concerning globalization of the nursing workforce while there was minimal research focusing on the local context of CFs' views of transition and CALD OSQ nurses' clinical transition.

2.1.1 Inclusion and Exclusion Criteria:

Literature was included if it defined the key terms including transition, facilitation in nursing and it contributed to providing a context of CALD OSQ nurses on clinical practicum, working overseas and in Australia. In addition, reference lists of retrieved articles were searched as well as manually searching full text journals. Frequently, literature pertaining to CALD student nurses and non CALD graduate nurses was included in the review as it was not differentiated from CALD OSQ nurses. In addition, any articles relating to cultural diversity in nursing in health care settings such as learning models, barriers and enablers to clinical transition were included. The large amount of material relating to migration and transition of culturally diverse populations which did not relate to nursing was not included. The review

excluded articles of the literature pertaining to OSQ health professionals in other disciplines such as medicine, pharmacy and dentistry. Articles that were in languages other than English were also excluded.

2.1.2 Limitations

In order to capture the dramatic issues relating to CFs and CALD OSQ nurses in Australia, literature was searched with no particular cut-off date. The search for meta-synthesis and systematic literature reviews and research articles was limited by availability. Findings of small qualitative studies of non CALD, CALD and CALD OSQ graduate nurses were included as they gave important insights and were supported by other larger studies. Research articles relating to non CALD student nurses were excluded. Any research articles regarding clinical facilitators was included and not limited to those who facilitated CALD OSQ nurses due to scarcity of research information. No other limitations were set.

2.1.3 Aims, groups and subgroups from literature search

The aims, groups and subgroups introduced in 2.0 from the literature search were developed from the body of literature related to the aim and research questions of the current study. Results of the search of the literature to distinguish facilitation of teaching and learning and the CF role in nursing were discussed below. The aim, group and subgroups were displayed below on Table 2.

Table 2: Aims, groups and subgroups

Aims	**To distinguish facilitation of learning and the CF role in nursing.**	**To comprehend transition and transition programs in relation to CALD OSQ nurses' experiences of transition.**
Results	**Group 1**	**Group 2**
	Distinguishing facilitation of learning and the CF role in nursing	Insights from transition, transition programs and experiences of transition for CALD OSQ nurses
Subgroups	Didactic instruction to facilitation	Transition as a process
	Facilitating implementation of RU and facilitating education	Insights from transition programs
	Influences on the CF role: tertiary education	Experiences of clinical transition for CALD OSQ nurses: international research
	Lack of CF role clarity	National research
	Teaching style for CALD OSQ nurses	Local research

2.2 Group 1: Distinguishing facilitation of learning and the CF role in nursing.

The aim of group one was to distinguish facilitation and the CF role in nursing. Initially literature regarding the changes to the CF title from didactic 'instructor' to 'facilitator' in nursing was shown to mirror the changes in models of nursing and educational theories. These changes were proposed to underpin the move from task oriented to holistic nursing. Studies exploring models of facilitation in nurse education which incorporated student nurses as partners in learning as opposed to being instructed by an expert were delineated. Facilitation of implementation of research utilisation (RU) in clinical practice has been differentiated from facilitation of learning in clinical practice. The clinical practice environment was differentiated from the clinical learning environment. Influences on the role of the CF were reviewed under the subgroups: tertiary education, lack of role clarity and teaching style for CALD OSQ nurses. Each group and subgroup were summarized as they provided a major contribution to distinguishing facilitation and the role of the CF.

2.2.1 Distinguishing facilitation in nursing: didactic instruction to facilitation

The purpose of facilitation in the context of clinical learning comprised the facilitator and learner creating knowledge together through critical reflection and discussion instead of knowledge being provided by an expert instructor for students (Dickson et al., 2006). This purpose has evolved over the last thirty years whereby the title clinical facilitator (CF) has been substituted for clinical instructor or educator. Changing from clinical instructor to CF was seen as part of an attempt to move nursing from a task-centred approach to a problem solving approach (Burrows, 1997). In addition, this was proposed to reflect the humanistic outlook of Carl Rogers (1985). Outcomes of humanistic approaches included learners becoming more responsible for their own learning while developing lifelong learning skills. Nursing has aspired to move to the more humanistic approaches underlying concepts of holistic nursing (Beckett & Hagar, 2002; Burrows, 1997).

A need was recognised for new approaches to nursing and the objective, positivist stance was to be seen as only one of the ways of gaining new knowledge (Rogers, 1985). Instead new ways of gaining knowledge were advocated which were based on the investigator taking a subjective, interpretive stance which involved perceiving feelings, attitudes and perceptions from the study participants' perspective (Rogers, 1985; Buhler, 1971). Carl Rogers' influenced educational theories which focused on holism with the understanding of humans as a whole person requiring knowledge of the person's life history to understand their present actions (Beckett & Hagar, 2002; Burrows, 1997).

Changes in approaches to clinical practice principles were underpinned by holism along with changes in principles of facilitation in teaching and learning. In response to these changes, concepts of the clinical instructor role changed so that students would be facilitated to learn by a clinical facilitator (CF) rather than didactic teaching by an expert clinical instructor. Concepts of holism were explained by Fleming, Foster and Taylor (2008) who proposed that a significant health care practice principle involved working with the 'person-in-environment' (p.169). This clinical practice principle focused on the premise that the health and wellbeing of any person was the result of the interaction between their physical state, personal context and the characteristics of their environment (Beckett & Hagar, 2002). Later holistic, multidimensional practice responses were recommended so that individual problems were seen in context (Fleming et al., 2008; Beckett & Hagar, 2002). Instead of using the traditional task oriented model of nursing student nurses were to become adaptable critical thinkers, analytical practitioners, committed to lifelong learning (Burrows, 1997; Beckett & Hagar, 2002).

A concept analysis of facilitation related to nurse education was carried out by Burrows in 1997 which remained relevant to the models of facilitation referred to in more current literature (Dickson et al., 2006; Lambert & Glacken, 2005). The analysis of facilitation was developed from the premise that if teachers were to act as facilitators of learning then the concept of facilitation, as a strategy for nurse education, needed to be clarified. Four critical attributes which emerged as central to the CF role were: genuine mutual respect, the development of a partnership in learning, a dynamic goal oriented process and the practice of critical reflection. Burrows (1997) developed the following definition: 'Facilitation is a goal-oriented dynamic process, in which participants work together in an atmosphere of genuine mutual respect, in order to learn through critical reflection (p. 401).' Avoiding misconceptions of facilitation required inclusion of a description of antecedents, consequences and a model of facilitation shown below (Burrows, 1997).

The clinical facilitation model advocated by Burrows (1997) included four critical attributes as well as antecedents to produce the desired consequences. Antecedents of facilitation involved a self-aware teacher with effective interpersonal skills and both students and teacher understood how the model was implemented. The consequences of the clinical facilitation model were that students became motivated self-directed life-long learners. In addition, the CF then became co-learner which resulted in control moving away from the CF role towards being student centred. Finally, the facilitation model required that all four critical attributes were represented. It was deduced that if genuine mutual respect or critical reflection were absent from the facilitation model for example then it was the least effective, contrary case and reduced to negotiation and resource provision (Burrows, 1997). It became clear from this educational

model of facilitation for nurse education that the focus was placed on the students' interpersonal relationship with the CF.

While CFs were expected to be dynamic and goal oriented, Burrows (1997) warned that the role could be reduced to providing resources and negotiation instead of facilitating learning through critical reflection. In addition, the CFs requirement to use competency based assessments could inadvertently return nursing to task orientation instead of holistic models of care. Watson, Stimpson, Topping, & Porock (2002) highlighted that changes in models of nursing practice from task orientation, leading to competency based assessments in the 1970's have continued to be controversial. This form of assessment was proposed to diminish the growth of holistic models of nursing. A need was identified for clear and consistent roles, increasing teaching skills and improvement in preparation programs for managing culturally diverse groups (Watson et al., 2002).

In summary, the subgroup didactic instructor to facilitator in nursing represents the literature which elucidates the changes in models of nursing and approaches to teaching and learning. Instead of 'clinical facilitation' the title 'clinical instruction' represented the move in nursing from a task-centred approach to a problem solving approach. Clinical facilitation reflected the humanistic stance of holistic nursing. Didactic instructional approaches moved to facilitative approaches whereby the student became a partner in learning instead of being instructed by an expert. However researchers have cautioned that without acquiring the critical attributes and antecedents of being a CF the consequences were unattainable. Critical attributes include: mutual respect, a partnership in learning, a dynamic goal oriented process and critical reflection. Antecedents were a self-aware teacher with effective interpersonal skills to communicate the facilitation process to students. In addition, competency based assessments were proposed to hinder the development of holistic models of nursing and potentially reduce facilitation to negotiation and resource provision. Following this, the concept of facilitation will be further distinguished by differentiating ways the term has been used in implementing research utilization in clinical nursing practice compared to nurse education in the clinical learning environment..

2.2.2 Distinguishing facilitation in clinical nursing: facilitating implementation of RU or facilitating learning

The concept of facilitation has been applied in multiple ways in nursing which has implications for associated role responsibilities. Facilitation of learning in the clinical learning environment was distinguished from facilitation of implementation of research utilization (RU) in the clinical practice environment. According to Milner, Estabrook and Humphrey (2005) instrumental RU was defined as the

'concrete application of research findings to make decisions or direct an intervention' (p. 901). Dogherty, Harrison & Graham (2010) conducted a focused systematic review of concept and meaning explicitly concentrated on searching databases for original studies on facilitation of RU. The review focused on how facilitation was enacted in a direct nurse patient situation for implementation of RU (Dogherty et al., 2010). This highlighted the practical elements of operationalizing facilitation at the point of care, focusing on instrumental knowledge utilisation and implementing facilitation (Dogherty et al., 2010). Application of the term facilitation for implementation of RU has been outlined below.

Dogherty et al. (2010) explain what facilitators are doing to enable changes in nursing practice using specific strategies involved in facilitation of RU which are: increasing awareness of a need for change; leadership and project management; relationship-building and communication; importance of the local context; ongoing monitoring and evaluation. Concepts of facilitation as well as role responsibilities were therefore combined to produce a practical way to implement facilitation of RU. A taxonomy was constructed which synthesized review findings by outlining activities involved in facilitation of implementing RU in nursing. In addition, this taxonomy was organized into specific stages related to the process of facilitating implementation of RU which are: planning for change, leading and managing change, monitoring progress and ongoing implementation and evaluating change (Dogherty et al., 2010). This taxonomy outlined the processes involved in enabling RNs to facilitate implementation of clinical practice change to RU.

Alternatively, the concept of CFs facilitating learning in the clinical learning environment was proposed to be 'abstract with a myriad of subjective descriptive perspectives' (Lambert & Glacken, 2005, p. 668). Some of the interpretations of the elements of facilitation in nurse education were: teaching, supervision, empowerment, self-direction, enabling, resource provision, critical reflection, goal attainment, quality, research, empathy, respect, trust, negotiation and participation (Lambert & Glacken, 2005). Cangelosi, Crocker and Sorrell, (2009) found that clinical facilitation involving the clinical learning environment was not a derivative of clinical practice expertise such as implementing RU. Instead it required a skill set of its own. However, similar to facilitation in RU, facilitation in the clinical learning environment was seen as a process. Differences lay in their function whereby the former applies to implementation of a change process in the clinical practice environment while the latter applies to the teaching-learning process in the clinical learning environment. Facilitation of teaching-learning processes in the clinical learning environment will be elaborated in the following.

The clinical learning environment which includes teaching–learning processes has been considered the focal point of nurse education (Henderson, Twentyman, Heel & Loyd, 2006; Clarke, Gibb & Ramprogus, 2003; Williams and Calvillo, 2002). In addition, Henderson et al. (2006) stated that clinical learning environments included the vast array of relationships affecting the teaching–learning process which were influenced by services and resources provided by the learning facility. These resources included access to appropriate learning experiences during clinical practicum including supported visits to inter professional clinics such as podiatry, physiotherapy and the operating theatre. The clinical learning environment contained elements which were unpredictable and learning opportunities which were often unnoticed (Saunders et al., 2006; Henderson et al., 2006). Similar to classroom settings, learning experiences required particularly careful planning due to the nature of the clinical learning environment (Lambert & Glacken, 2005). The clinical practicum with a CF employed by the tertiary institution using the facilitator model was considered a typical planned learning experience which will be discussed below.

Insights into clinical learning environments and particularly the facilitation model during clinical practicum were elucidated by comparing three clinical placement models (Henderson et al., 2006). Data were collected by using survey method by Henderson et al. (2006) to study psychosocial characteristics of clinical learning environments which were based on three clinical placement models: Preceptor Model; Facilitation Model (CF model); clinical education unit model (CEU) across 25 different clinical settings in one tertiary health facility. Student nurse perceptions of the psychosocial aspects of the CF model were compared with two other placement models. By using the specifically designed Clinical Learning Environment Inventory the following factors were compared: individualization; innovation; involvement; personalization; task orientation; satisfaction. These factors were considered highly desirable by students if their learning was to be facilitated (Henderson et al., 2006).

Henderson et al. (2006) supported by a study by Saunders et al. (2006) shared the view that the advantages of the facilitation model included: the CF's time was dedicated to learning and used evidence based practice (EBP); equitably unrestricted CF and peer discussion of negative experiences; peer debriefing opportunities allowing the sharing of experiences. However, limitations of the CF model included: academic staff acting as CFs may be unfamiliar with aspects of the health facility; CFs have difficulty being available to provide sufficient supervision; CFs needed continuing support with facilitating unsatisfactory students (Saunders, White, Davis, Gavin, Hill, & Sarich, 2006; Henderson et al., 2006). Overall Henderson et al. (2006) concluded that the success of all clinical placement models related to clear CF role description, consistency of staff and establishment of relationships.

Previous studies have alluded to CFs' role responsibilities of assessment becoming contentious when students were at risk of failing clinical practicum. Areas of CF focus when assessing students' clinical performance were studied and findings included communication, learning style, bedside manner and personality factors which were the main groups for assessment of 'good students' (San Miguel & Rogan, 2011).However, potential problems with CFs' assessment responsibilities emerged when students' performance was unsatisfactory (San Miguel & Rogan, 2011). Study findings inferred that CFs' positive assessments often remarked on students with appropriate personality factors such as enthusiasm and cheerfulness. Lamentably, students assessed as unsatisfactory or requiring improvement in this study were not assessed for personality factors and allegedly not informed to be more enthusiastic or cheerful for example. These personality factors were attributes which ultimately influenced clinical pass or fail outcomes for students (San Miguel & Rogan, 2011).

Several discerning attributes of the facilitation model were elucidated in the study by Dickson et al. (2006) who identified that the lived experience of clinical facilitators was represented by five essential themes. These themes included: knowing your own limitations; the notion of stepping in or stepping back; developing alliances; acknowledging the reciprocity of the learning experience; identifying appropriate clinical buddies. These themes were proposed to reflect the dynamic nature of the CF role which required mutual respect for learning to take place. Although Dickson et al's (2006) themes could not be generalized they did provide insights into recent experiences of use of the clinical facilitation model. Recommendations from this study included that CFs were returned to the same health facility in order to develop clinical alliances. The supervising RNs as well as CFs required education to learn facilitation methods because RNs spend the most time with students (Dickson et al, 2006).

In summary facilitation in the clinical learning environment during clinical practicum has been elucidated by firstly differentiating it from facilitation of implementation of RU. Similarities include that: facilitation refers to a process; involves relationship-building and communication; ongoing monitoring and evaluation. Differences in the meaning of facilitation have been clarified. These differences relate to application of facilitation of teaching–learning processes in the clinical learning environment in contrast to facilitation of implementation of RU which relates to the clinical practice environment. Secondly, facilitation in nurse education was distinguished by presenting a study of psycho social aspects of clinical education models including the facilitation model. The Clinical Learning Environment Inventory was outlined and comprised highly valued criteria for the facilitation model of student learning and teaching which included individualization, innovation, involvement and satisfaction. Finally facilitation in nurse education has been further distinguished by delineating research relating to advantages and disadvantages

of the clinical facilitation model of education. The main advantages included having a CF role dedicated to student learning and being able to encourage peer supported discussion of negative experiences. Disadvantages included CFs' lack of familiarity with the clinical practice environment and problems associated with assessments. In addition these problems included CFs feeling inadequate to support students who have difficulties and were at risk of clinical fail. Recommendations for use of the facilitation model included returning CFs to the same facility and providing RNs and CFs with education to learn facilitation methods.

2.3 Influences on the CF role: tertiary education

The move to tertiary education for nurses has been a catalyst for creating the CF role. A significant international turning point in the history of nurse education has been the move to tertiary education institutions from being based at health care facilities during apprenticeship style of training (Henderson & Tyler, 2011; Lambert & Glacken, 2005; Lee, Cholowski, & Williams, 2002).Changing preparation of RNs to tertiary institutions raised concerns that nursing would lose its practical, clinical foundations. There was some consensus that it was essential that nursing continued to be a practice-based profession so that theory was integrated with practice despite the relatively recent changes (Henderson & Tyler, 2011; Dickson et al., 2006).

In response to moving RNs' preparation to tertiary institutions, multiple attempts were made to resolve the theory-practice divide in the clinical practice environment (Henderson and Tyler, 2011; Lee et al., 2002). The theory-practice divide was manifested when RNs in health facilities found BN graduates unprepared for work as RNs for health service delivery. In addition, RNs who specialised as university lecturers had difficulties as they attempted to fulfil clinical teaching roles. Consequently, clinical teachers were employed in the 1980s and received mixed responses regarding their effectiveness (Lambert & Glacken, 2005). In addition, during this period failed attempts in Australia to appoint ward RNs to alternative dual roles of manager as well as mentor, were accredited to: demands of primary patient care; excessive work responsibilities; lack of time; inadequate professional development. According to Henderson and Tyler (2011) the more contemporary support roles evolved from these difficulties and moved from lecturer/practitioner link roles between higher education and health care institutions to the CF role. Lambert and Glacken (2005) exemplified existing views when the CF role was referred to as 'an emerging new post' (p. 667). Employment by tertiary institutions meant that initially expectations were that the CF had prime responsibility for bridging the theory-practice gap for BN students. In addition, having such a short history since creation of a CF role may illuminate the lack of role consensus that began to emerge.

Although Eyre (2010) and Lambert and Glacken (2005) have described CFs as the linchpin in the process of facilitating clinical transition of BN students, yet the literature highlights the need for consensus on role responsibilities. While Ellis & Hogard (2003) highlight that it was imperative that clinical transition takes place in supportive clinical learning environments however concepts of facilitation as well as role responsibilities have been found to be inconsistent. Studies focusing on lack of CF role clarity were examined below.

2.3.1 Influences on the CF: lack of role clarity

The role of the CF was designed to enhance and support diverse groups of up to eight students' clinical practice as well as providing a support role for ward RNs' teaching and assessing skills (Heale, Mossey, Lafoley & Graham, 2009; Henderson et al., 2006; Lambert & Glacken, 2005; Paton, 2007; Saunders et al., 2006). However, external obstacles to use of the facilitation model included lack of CF role clarity (Henderson & Tyler, 2011; Lambert & Glacken, 2005). Some evidence of this was in the results of a survey of BN students and CF self-report which indicated that CFs were more effective in their role with students than with RNs (Henderson & Tyler, 2011). A communication audit using survey method by Hogard and Ellis (2006) was aimed at evaluating the effectiveness of a CF objective to improve communication between university and hospital. Findings of this audit revealed insufficient communication for roles to be carried out effectively. Another finding however, was that this audit revealed a positive level of trust between staff, students and the CF (Hogard and Ellis, 2006). Although there was a positive level of trust the CF role of support of RNs was diminished because of inadequate communication leading to lack of role clarity.

The clinical facilitation model in Australia was differentiated from other models by the presence of a RN acting as CF who did not have a patient load and was employed by the university (Saunders et al., 2006; Henderson et al., 2006). There was some evidence that misconceptions of the role of CF occurred when experienced RNs employed as CFs felt unprepared to move from the clinical practice environment to the clinical learning environment. Under these circumstances, role clarity was lacking for RNs who found many barriers to acting as facilitators of these groups of students using educational principles instead of clinical practice skills (Cangelosi, Crocker & Sorrell, 2009). Cangelosi et al. (2009) used interpretive phenomenological inquiry to highlight that clinical expert RNs soon became aware that they experienced tension, anxiety and fear in learning to facilitate to enable them to become novice CFs.

Further CF role misunderstanding became apparent when Heale et al. (2009) studied inter-professional clinical mentors including CFs who were only moderately confident in their roles in the following ways:

introducing and interpreting current protocols and procedures; communicating philosophy of the clinical environment. Few CFs had the confidence to understand the following: expectations of the clinical learning environment, particularly curriculum issues; the clinical practice environment; student learning needs; facilitating EBP; assessing students' performance; resolving challenges in student learning. Negative influences preventing an effective CF role according to Heale et al. (2009) included lack of resources, time, orientation, contact with curriculum based education programs and balancing multiple roles. Kai, Spencer and Woodward (2001) identified barriers specifically relating to CFs facilitating CALD students included current experience of training in ethnic diversity in health care. In addition CF challenges of developing and delivering training included: unsupportive institutional responses; personal challenges to understanding ethnic diversity (Kai, et al., 2001).

A major collaborative project to assess and improve the quality and scope of clinical education including understanding influences on the CF role was conducted in Western Australia (WA). Researchers were from Edith Cowan University in collaboration with Royal Perth Hospital, Sir Charles Gairdner Hospital and Graylands Hospital (Saunders, White, Davis, Gavin, Hill, & Sarich, 2006).The project employed qualitative methodology using critical hermeneutics to study all conceivable aspects of clinical placement of nurses. Data were collected using 14 focus group interviews including a group of CFs and 20 individual interviews of RNs at Graylands hospital in supervisory roles. Key findings of the research provided some evidence in WA of the need to improve preparation for the role of CF. In addition this project identified the need for on-going education and training for the CF role particularly with regard to assisting and assessing students having difficulties who were likely to fail (Saunders et al., 2006). Further influences on the CF role were tense relations due to performance inconsistencies between hospital employed RNs in current practice and university employed CFs who had inconsistent skill sets (Saunders et al., 2006).

In summary several non-randomized quantitative and qualitative studies found numerous influences contributing to a lack of CF role clarity pointing to the need to strengthen CF preparation. A crucial finding was that expert RNs had difficulty in becoming novice CFs.The reverse applied because of the different skill sets required in the clinical practice environment compared to facilitation of student learning in the clinical learning environment. In addition, CFs were found to lack confidence in their role and they were often perceived by RNs in health facilities to have inconsistent skill sets. Moreover this was frequently attributed to being employed outside the health facility by the tertiary institution. These studies indicated the need for further larger studies to strengthen evidence for the need to improve preparation of CFs particularly when facilitating CALD OSQ nurses. Influences of cultural competence on CF teaching style for CALD students will be addressed in the following.

2.3.2 Influences on the CF: CF teaching style for CALD students

Influences supporting CFs teaching style for facilitation of CALD and non CALD students were highlighted in several studies. Allan (2010) conducted an ethnographic interpretive study using mixed data collection to study barriers to effective and non-discriminatory mentoring [facilitation] practices of OSQ nurses. Participants included 93 CALD OSQ nurses and 24 national and 13 local managers and mentors from 6 research sites in the United Kingdom (UK). The main barrier was found to be lack of preparation caused by: lack of awareness of cultural differences; concern that overseas skills were not equivalent to British standards; the need to nurse the British way; bullying and discriminatory practices in the workplace. Allan (2010) recommended better preparation of mentors and to treat CALD OSQ nurses respectfully as RNs rather than students. This preparation included being able to achieve cultural competence and developing appropriate interpersonal relationships.

A formative study by Yoder (1996) provided insights into the potent influence of teaching style and preparation on the effectiveness of the CF with CALD students. Yoder's study identified the most beneficial instructional responses by CFs to CALD nursing students. The influences of different teaching styles for CALD students in nursing educational programs were investigated (Yoder, 1996). This qualitative study obtained data through in-depth interviews with 26 CFs and 17 CALD OSQ nurses representing three populations: Asian Americans; African Americans; and Mexican Americans. Results of the data analysis were that a high level of cultural awareness was found to be the most significant factor influencing variation of responses by CFs to CALD students. Influencing factors were measured by the following data: documenting the personal experiences of CFs as an ethnic minority person; being able to relate to students' experiences; the measure of value placed on diversity; and their preparation educationally (Yoder, 1996). The patterns of teaching that emerged from this study were significant to identify the needs of CFs while facilitating CALD students and have been explained in the following.

Five patterns of teaching emerged from the data including: generic pattern, culturally non tolerant pattern; mainstreaming pattern; struggling pattern; bridging pattern (Yoder, 1996). Yoder (2001) identified these teaching patterns beginning with the most negative to the most positive. The most negative was the generic pattern which was least culturally tolerant with poor recognition that ethnicity should influence the educational processes. Conversely, the most positive teaching pattern in terms of consequences for CALD students according to Yoder (2001) was the bridging pattern. Bridging teaching pattern referred to CFs who attempted to bridge two cultural worlds which related to the CALD students' culture and the culture of the university or clinical teaching and learning environment (Yoder, 2001). The consequences of

bridging teaching pattern for students included becoming motivated self-directed learners along with the teacher as facilitator or co-learner (Yoder, 2001).

Reasons for cultural awareness attributed by CFs with bridging pattern teaching included informal preparation which was predominantly due to being from a CALD background. However Yoder (2001) also pointed out formal preparation which included anthropology of health, research experience and intensive cultural courses. Bridging pattern CFs encouraged students to retain their ethnic identity and modified their strategies to adapt to the various CALD OSQ nurses' needs. Following Yoder's formative work, a study by Amaro, Abriam-Yago and Yoder (2006) found that bridging pattern CFs who valued cultural diversity and respected difference were found to be extremely important to CALD students. By contrast, the culturally non-tolerant pattern of teaching meant that there was reduced tolerance and poor recognition of the need to consider that ethnicity should influence the educational process. Finally, the generic pattern of teaching by CFs was found to be the least culturally tolerant and least able to benefit students (Amaro et al., 2006).

In regional Australia Lee, Cholowski & Williams (2002) conducted a quantitative descriptive study using the Nursing Clinical Teacher Effectiveness Inventory (NCTEI) containing a 48 item checklist which was administered to 104 second year students and 17 CFs. The aim of the study was to replicate a previous study of the best and worst characteristics of CFs. Lee et al. (2002) used the NCTEI with nursing students and CFs in an Australian University School of Nursing. The discrete characteristics of the NCTEI were clustered into five subscales or categories: teaching ability; interpersonal relationships, personality traits, nursing competence and evaluation. Results from the study by Lee et al. (2002) were that interpersonal relationships were ranked as the most important characteristic of effective CFs by nursing students and CFs. The study concluded that more importance was needed to be placed on CF teaching ability. In addition CFs needed to understand that teaching style should vary according to student learning style characteristics influenced by age and prior nursing experiences. Lastly it was recommended that CFs were encouraged to value interpersonal relationships with students as well as clinical competence (Lee et al., 2002).

In summary, teaching style including interpersonal relationships have been discussed as critical influences on the CF role of facilitating learning for nursing students and CALD OSQ nurses. Limited studies have pointed to the need for CFs to be provided with transcultural education as preparation for their role in facilitating CALD students. However, the recommended bridging teaching style identified by Yoder (2001) and supported by Amaro et al. (2006) was found to be the most able to benefit CALD students.

Further insights regarding CF teaching style most beneficial to CALD OSQ nurses from research studies on experiences of transition are in the second group to be reviewed in 2.5.

2.4 Narrative summary: Distinguishing facilitation and influences on the CF role

The first group of this review aimed to distinguish what is known about facilitation and the CF role. Facilitation in nurse education has been differentiated from facilitation of implementation of research utilization for EBP. The former described facilitation as a learning process in the clinical learning environment and the latter described facilitation as a process for implementing change to clinical nursing practice. The concept of facilitating for both education and implementation of EBP change overlap yet have distinctly different objectives.

The CF role of facilitating student learning has been proposed to have evolved from changes in nursing education to tertiary institutions. In a similar timeframe, task oriented clinical practice has theoretically been evolved to holistic models of nursing practice. In addition, these changes have produced a dual need to meet the teaching needs of ward RNs as well as the culturally diverse learning needs of BN students making the transition from theory and simulations at university to real patients in clinical practice. The move to RN preparation at tertiary institutions instead of the preceding apprenticeship grounding was a catalyst for the relatively recent emergence of the CF role. The CF role originated as a response to the needs of health facilities to address the perceived theory–practice gap becoming evident in underperforming nursing graduates. Another function of the CF role in facilitating nurse education has been to improve communication between the university and the health care facilities.

The literature reviewed, has revealed that there were CF role influences resulting in discrepancies with CF role definition. It was found that, antecedents, consequences and critical attributes of early models of facilitation were not always able to be achieved in CF practice. In addition objectives were unmet particularly with implementation of assessment and communication responsibilities of the role. There were limited studies found which focused on the impact of the facilitation model on facilitating non CALD or CALD graduate nurses. An extensive study by Allan (2010) revealed that the main barrier to effective non-discriminatory mentoring [facilitation] was lack of preparation of [facilitators]. Preparation programs were recommended with emphasis on transferring ethical teaching principles to facilitation of CALD OSQ nurses. Yoder's (1996) study found that bridging pattern CFs with cultural awareness during instructional responses facilitated the most positive learning experiences for CALD OSQ nurses. Small qualitative studies provided further support for the view that CFs were integral to student success on clinical practicum. However, no local studies were found regarding facilitation strategies specifically

designed for use with CALD OSQ nurses. A gap in knowledge regarding the local context of CFs' views of facilitating CALD OSQ nurses during clinical practicum was identified.

2.5 Group 2: Comprehending transition and transition programs in relation to CALD OSQ nurses' experiences of transition.

The results of the literature search of international, national and local research studies of transition as a process and transition programs are correlated to experiences of transition of CALD OSQ nurses. Growing evidence globally revealed that poor retention rates of CALD OSQ nurses have been linked to poor clinical transition (Rush, Adamack, Gordon, Lilly, & Janke, 2012; Johnstone, Kanitsaki, & Currie, 2008; Omeri & Atkins, 2002). Priorities have been to increase retention of CALD OSQ nurses and address international and national nursing workforce shortages (Omeri & Atkins, 2002). It was found that successful clinical transition was the key to narrowing the theory-practice gap particularly between CALD and non CALD BN students and graduate RNs entering the workforce (Rush et al., 2012). Presented below are the second literature review aim, group and subgroups.

2.5.1 Transition as a process

The aim of group two was to comprehend transition and transition programs in relation to CALD OSQ nurses' experiences of transition. In Australia the transfer of nurse education to the tertiary sector in1984 was a major impetus to focus on clinical transition in nursing (Levett-Jones & Fizgerald, 2005; Rush et al., 2012). Ostensiblygraduates were unprepared to make the clinical transition from university to the clinical environment, propelling transition to a central concept in nursing (Kralik, Visentin & van Loon, 2006). Similarly CALD OSQ nurses migrating to Australia were faced with making the clinical transition to the Australian health care system. The literature revealed that focusing on transition and developing transition programs has been driven by the need to ensure retention of CALD OSQ nurses and local graduates through experiencing successful clinical transition (Rush et al., 2012).

Transition has been examined using concept analysis by Kralik et al. (2006) which resulted in an investigation of several concepts including: theoretical frameworks of transition; definition of transition; and transition as a process. Firstly, theoretical frameworks have been examined to understand the influence of a three phase approach to transition. Recent frameworks proposed that transition was not necessarily linear where it was previously thought to involve three phases: a beginning then an ending and an empty time between (Kralik et al., 2006). Instead of this, Boychuk-Duchscher (2008) proposed that transition was a continuing process which moved in many directions.

Secondly, transition was defined as an important concept and involved people's response during a path of adjustment which occurred over time and entailed change and adaptation (Kralik et al., 2006). According to Kralik et al. (2006) transition took time and involved major changes to all aspects of a person's life and actually incorporated reconstruction of a clear, valued self-identity. Transition in nursing was referred to as a journey which represented the changed view that it was not linear, prescriptive or progressive instead it was evolutionary and transformative. Lastly, a recent stage theory of transition from novice practitioner to professional nursing practice in the first 18 months after graduation by Boychuk-Duchscher (2008), proposed a process of 'becoming'. In this context 'becoming' meant that transition entailed a personal and professional evolutionary and transformative journey of doing, being and knowing. In addition, continuing but transient regressions were found to be caused by new events or complex practice. The journey, according to Boychuk-Duchscher (2008) encompassed organized processes including: anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring and engaging. However, it was highlighted that graduate nurses needed to have recognized the need to change within themselves Boychuk-Duchscher (2008).

In summary interpretations of transition have changed from a more static linear view which had an ending to a journey which involves a process which moved in many directions. As a process transition encompassed transient regressions and was an evolving journey which transformed graduates if they recognised the need for change. Within the transition journey organised processes were proposed which included evocative actions such as anticipating, performing, revealing and exploring. In Australia, it has been proposed that actual transition from graduate to confident RN was frequently unsupported and traumatic. This has been elaborated in 2.6.1.

2.5.2 Insights from transition programs in nursing

Successful clinical transition programs have been linked to recruitment and retention of new nurses (Rush et al., 2012; Levett-Jones & Fitzgerald, 2005). However several studies challenged the effectiveness of transition programs by explaining that there has been limited evidence that transition programs enhanced the transition from RN graduate to proficient practitioner (Zizzo & Xu, 2009; Levett-Jones & Fitzgerald, 2005). In addition, it was argued that current formal transition programs could be replaced with improvements in a supportive clinical practice culture which was conducive to learning. This proposition was not necessarily supported by Rush et al. (2012), as was described below.

Rush et al. (2012) conducted an integrative review of new graduate transition programs to examine transition program literature using four themes: Education; support/satisfaction; competency critical

thinking; and workplace environment. Though it was found that there were few rigorously designed studies a strong theme was that formal transition programs improved graduate nurse retention. It has been shown also that preceptors required formal training and the clinical practice environment required improvement. In addition, new graduates benefitted from mentors and peer support opportunities (Rush et al., 2012). Rather than replacing formal transition programs, improving clinical learning environments as well as clinical practice environments was identified as an aspect of formal transition programs requiring urgent change. San Miguel, Rogan, Kilstoff & Brown (2006) reported positive results after designing a supportive program to improve communication and confidence for CALD BN students. However, entry to this program was limited to CALD BN students who had received a clinical fail rather than being offered to students who wished to ensure success.

Johnstone, Kanitsaki & Currie (2008) who studied the nature and implications of support in graduate RN transition programs in an Australian context concluded the core component of support was attitudinal rather than material. Suitably qualified supervising RNs with appropriate attitudes required the following examples of attributes: benevolent, non-judgemental, respectful, constructive, reassuring, patient, polite, friendly, approachable, encouraging, validating and enabling (Johnstone et al., 2008). In addition, graduates' support in transition programs was described as a process that helped, encouraged and strengthened consequently providing the courage and confidence to make the transition to safe, effective and competent practice (Johnstone et al., 2008).

A recent study of a transition to clinical practice module (TCPM) was conducted at the participating site by Webster, Harding, **Robinson,** Yeboah, Hutchison & Mountain (2014). This study was a pre post intervention assessment using questionnaire to evaluate how well students performed after attending the TCPM. The TCPM was a collaborative program conducted by nurse academics in collaboration with academic skills advisors. Initially it was embedded in the curriculum by being conducted in parallel with the first year units of BN study. The CALD and non CALD students were referred or self-referred to clinical communication workshops and academic skills programs. There were 380 participants including 10.8% CALD OSQ nurses. Results of the study found that 82% rated the program better than expected and 96% found that the TCPM helped develop skills. Ultimately it increased attendance at all support programs as a proactive measure to ensure success on clinical practicum instead of a remediation focus when students experienced a clinical fail. The study concluded that the TCPM contributed positively to academic and clinical demands as well as supporting a sense of value and identity in the nursing profession. It was aimed at improving the first year of study and clinical practicum experiences and to

grow undergraduate BN retention rates. It was recommended that the TCPM should be expanded to all campuses beyond the participating site (Webster et al., 2014).

In summary, transition programs have been linked to retention in nursing however there has been debate regarding their effectiveness. There was evidence of the need to improve and measure the effectiveness of transition programs. In addition, the meaning of support in the context of graduate nurse transition programs was proposed to have primarily attitudinal rather than material core components. Recommendations have been made to improve support in preparation as well as during clinical transition in the clinical learning environment and clinical practice environment. Ultimately clinical transition programs were needed to safeguard success for CALD BN students instead of providing remediation for failure.

2.6 Experiences of clinical transition for CALD OSQ nurses: international research.

This section has reviewed international research presented by global organisations, meta-synthesis and qualitative studies in order to explore experiences of clinical transition for CALD OSQ nurses within the context of global health workforce issues described in 1.5. Initially issues that provided this context included a crisis in global health workforce due to critical shortages, imbalanced skill mix and uneven geographical distribution of health professionals. These factors have resulted in more than a billion people worldwide lacking access to adequate health services (WHO, 2011). Amidst this global health crisis, critical issues have been raised, regarding the development of evidence-based transition programs to facilitate adaptation of CALD OSQ nurses (WHO, 2009; ICN, 2009; Xu, 2008). Following presentation of these global health issues, review of meta-synthesis of qualitative studies of international studies of CALD OSQ nurses experiences of clinical transition and several individual qualitative studies have provided deeper understanding of experiences of clinical transition for CALD OSQ nurses

Global concern by multinational organizations for recruitment of CALD OSQ nurses in terms of social justice has been embodied in the title, "Creating a Positive Work Environment for Internationally Recruited Nurses". This title was for a recent series of conferences held in London, San Francisco and Chicago and were sponsored by the International Council of Nurses (ICN) and the Commission on Graduates of Foreign Nursing Schools (CGFNS). Other destination countries have included Australia in 2013. Attention was drawn to these conferences as the first global attempt to address the transition of CALD OSQ nurses by the ICN and the CGFNS (Xu, 2008).

The ICN and CGFNS commissioned the document "Positive Practice Environments: Key Considerations for the Development of a Framework to Support the Integration of International Nurses." According to Xu (2008), this sends out a strong human rights message regarding the need for equitable treatment for international nurses. Xu (2008) also recommended evaluation of existing transition programs, to be followed by development of a model curriculum to be tested for validity before dissemination and adoption.

A review of issues and trends which involved a broad-based scan of national and international organisations every five years, identified migration of CALD OSQ nurses and workforce shortages as among the biggest issues in 2008 (Council of National Representatives (CNR) of ICN, 2009). Migration and workforce shortages must be viewed alongside the other issues which included funding issues, ageing issues and chronic illness. Priorities included the need for basic and continuing clinical education, quality improvement in nursing and working conditions which were an absolute priority. Focus to address these issues was then directed toward nursing leadership, recruitment and retention, nursing image and contribution and nurse regulation (CNR of ICN, 2009).

Focus was clearly placed on the clinical learning environment of CALD OSQ nurses when considering the strategic priorities of the CNR (2009) for addressing the issues relating to migration and nursing workforce shortages. Goals have been formulated for nursing throughout all countries in the world. Relevant to this study, is the goal to advance nurses and nursing with five key results including: a common nursing language; continued careers/leadership development; development of supportive clinical environments; as well as focus on education and clinical practice (CNR of ICN, 2009). International studies of CALD OSQ nurses experiences of clinical transition have been presented below.

Firstly, unique transition challenges constituted the final themes from Xu's (2007) meta-synthesis of the lived experience of specifically Asian CALD OSQ nurses working in Western countries. This meta-synthesis informed this review as it represented the first scholarly effort to synthesize what is known from the multitude of qualitative studies on the topic. According to Xu (2007) CALD OSQ nurses have been studied since the 1970s using qualitative methods and the use of meta-synthesis is invaluable as it allows for an enlarged interpretation of included studies. Moreover what was known about transition for CALD OSQ nurses referred to as 'Asian' working in Western countries from previous studies globally was synthesized using Noblit and Hare's 7-phase procedures (Xu, 2007). To a small degree, Australia was represented with one study (Omeri & Atkins, 2002 in Xu, 2007) among the 14 included studies. In addition, Kawi & Xu (2009) have provided a meta-synthesis of CALD OSQ nurses working in foreign

environments. These two metasynthesis have made a significant contribution to understanding clinical transition challenges for CALD OSQ nurses working in foreign countries.

The results of Xu's (2007) meta-synthesis included four themes that outlined the unique challenges. Firstly these comprised communication as a daunting challenge, in terms of accents and informal use of language and most feared was telecommunication. A vicious cycle of communication deficiency resulted in language proficiency being delayed, due to fear of making mistakes. Secondly, differences in nursing practice was a theme that encompassed cultural differences in role of the nurse, scope of practice as well as differences in the technological and legal environment. Theme three was entitled marginalization, discrimination and exploitation. This theme represented major challenges which highlighted nursing as a gendered experience, unfair treatment and lack of equal opportunity, bullying, harassment and the requirement to prove self. Finally theme four was cultural differences referring to cultural displacement, negative attitudes toward the elderly as well as interpersonal challenges (Xu, 2007).

Another meta-synthesis by Kawi and Xu (2009) contended that facilitators and barriers co-existed during the transition period for CALD OSQ nurses. In addition, these facilitators and barriers were clustered into two classifications. Firstly internal factors which were controlled by the CALD OSQ nurse such as continuing education. Secondly, external factors which were unable to be controlled such as orientation programs. Facilitators included: positive work environment, persistence and logistical support; assertiveness training; continuous learning. Barriers included: language and communication difficulties; cultural differences; lack of support; inadequate orientation; differences in nursing practice (Kawi and Xu, 2009).

Sherman and Eggenberger's (2008) qualitative study resulted in similar findings to support the results of the two metasynthesis. Participants included 21 CALD OSQ RNs with an average of 10 years of nursing experience, 10 nurse leaders with experience of supervising 2 to 40 nurses in the USA. Themes from the nurse leaders comprised cultural challenges during transition included non-assertiveness, role and technical differences; significance of leadership support key to success; contributions CALD OSQ RNs make to nursing units overwhelmingly positive. Themes from the CALD OSQ RNs included: differences in nursing practice; challenges transitioning to a different culture and educational need during orientation. Additionally, the study found that the significance of leadership support was the key to success and the contributions that CALD OSQ RNs made to nursing units was overwhelmingly positive (Sherman & Eggenberger, 2008).

Recommendations identified in Xu's (2007) meta-synthesis were firstly, a focused transition program as well as the facility's orientation programs that specifically addressed Asian CALD OSQ nurses' needs. Particular emphasis needed to be placed on explaining the cultural differences and how they affect patient safety and quality of care. Differences to be explained were particularly found in nursing practice, legal issues, policies, procedures and their implications (Xu, 2007). Kawi & Xu (2009) refer to these recommendations as logistical support. Secondly, strategies were needed to be put in place by Western healthcare employers which included support mechanisms for transition, retention and success (Kawi and Xu, 2009). Thirdly, recommendations included cultural competence pre-arrival recruitment training that facilitates mutual understanding of all aspects of culture which were: beliefs, behavioural and communication patterns. Recruitment training should have comprised assertiveness preparation and continuous learning (Kawi & Xu, 2009). This training was for all stakeholders, and not only for the CALD OSQ nurses, if it was to be mutual.

Implications for practice Xu (2007) proposed included better preparation for dealing with interpersonal conflict which needed to begin prior to arrival.Exercises such as role plays should have been enacted to practice for emotionally charged situations which were embedded in history and framed by socioeconomic forces outside organisational control (Xu, 2007). Western employers needed to gain an understanding of language acquisition. There were many variables with this recommendation due to differing proficiency levels from different individuals from countries with different official language requirements. Xu (2007) emphasized that many years, cultural immersion and persistent effort were required to develop a working knowledge of English as a second language.

A New Zealand study by Eyre (2010) aimed to provide greater understanding of transition challenges that influenced CALD students' ability to communicate effectively in clinical settings. Data from Eyres' (2010) qualitative study using data from interviews of CALD students' views of CFs were explored and findings included that the CF was seen as crucial to student success. Eyre (2010) conducted a study informed by grounded theory and case study research methodology using semi structured interviews and focus groups. The study was based at a university in New Zealand where undergraduate CALD students were on final clinical placement in a health care facility (Eyre, 2010).The participants included 7 final placement CALD students, one of whom was a CALD OSQ nurse, 2 preceptors and 4 lecturers for focus groups. Similar to Australia, in New Zealand preceptors are described as hospital employed RNs with whom the students are paired and follow the same work roster. Eyre's (2010) study results underline the challenges of facilitating CALD students' transition to placement, the community of practice and access to its interactions. In addition, challenges that influence effective communication include extrinsic factors

such as the quality of the CF, preceptor, attitude, training and tone of placement. Intrinsic factors include proficiency with English language, socio-pragmatic language skills and proactive learning strategies (Eyre, 2010).

A Canadian qualitative study by Tregunno, Peters, Campbell and Gordon (2009) provided rich, in-depth data resulting from interviews of thirty CALD OSQ graduates regarding transition to clinical practice. The concept of clinical expert to cultural novice emerged from the data as well as five themes which included firstly, expectations of practice such as: more involvement; patient responsibility; more assertiveness; less hierarchy. Secondly nurse-client relationships theme included: patients more knowledgeable, culturally diverse and have more rights, consent required. The third theme was resource utilization which included: disposable products, advanced technology, religious beliefs and treatment decisions. The fourth theme was language: stress related to understanding difficulties, constant vigilance required, work slower and use of humour. Finally the fifth theme was being the outsider and included: racism, aggression, lack of trust, resentment and unequal workload assignments (Tregunno et al., 2009).

In summary, international research regarding clinical transition of CALD OSQ nurses has been shown to have come to the attention of global organisations. These organisations include the CNR of the ICN and the WHO due to its link with retention and workforce shortages. Literature sources revealed the issues surrounding global workforce shortages may be improved by enhancing clinical learning environments and clinical practice environments to ensure retention. In addition, multiple studies have been presented regarding the challenging experiences of clinical transition for CALD OSQ nurses. International research into these transition experiences for CALD OSQ nurses revealed unique challenges regarding: communication, differences in nursing practice, marginalization, discrimination and exploitation. In addition cultural differences present challenges including cultural displacement and negative attitudes toward the elderly. Recommendations comprised strengthening of transition programs to meet the unique needs of CALD OSQ nurses and cultural competence training for all concerned including RNs in Western health facilities.

2.6.1 Results: national research

This section has reviewed national research presented by systematic review, meta-synthesis and qualitative studies in order to explore experiences of clinical transition for CALD OSQ nurses within the context of national health workforce issues described in 1.3. It has been acknowledged that Australian nursing cultural competency standards have been supported by national and state government agencies in setting policy aims and objectives to support equity and fair practice. However, potent results of national

research indicate that CALD OSQ RNs' transition to clinical practice in Australia has been difficult (Higgins, 2009; Takeno, 2010; Konno, 2006; Brown, 2005).

According to a review of literature focused on graduate nurse transition programs in Australia Levett-Jones and Fitzgerald (2005) pointed out the actual transition from graduate to competent and confident nurse was frequently traumatic and unsupportive. In these cases the transition experience was more about fear of failure, responsibility and making mistakes than being able to follow organised processes such as exploring and engaging. In addition, it has been estimated that 25% of graduates experienced lack of support from clinicians and that conflict and bullying of graduates in the workplace was a national problem (Levett-Jones & Fitzgerald, 2005). The following studies summarise the best available research results regarding transition experiences predominantly for CALD OSQ RNs.

Firstly a systematic review of qualitative and quantitative studies by Konno (2006) focused on experiences or adjustment issues of CALD OSQ nurses working in Australia. The Joanna Briggs Institute (JBI) evidence hierarchy was used so that research articles included those using: meta-analysis, randomized controlled trials, quasi randomized controlled trials, cohort, correlational and descriptive studies as well as interpretive studies. The main synthesized findings relevant to the aim of this review under the group of cultural incongruence included: attitudes and actions encountered in workplace relations caused difficulties with collegial relations; feeling of being a stranger was common; feeling of inferiority to mainstream who made no effort to understand diversity; conflict and tension existed between the role in clinical practice as opposed to the culturally accepted role at home (Konno, 2006). According to Konno's (2006) review clinical transition was difficult due to: attitudes at work; poor collegial relationships loneliness at work; major language issues; lack of support; being inferior and no effort to understand; conflict and tension between expected work roles. In addition it was found that feeling lonely or isolated exacerbated difficult experiences of settling into nursing in Australia. The CALD OSQ RNs found entry into Australian culture very difficult however informal networks could help (Konno, 2006).

Following on and supported by the systematic review, Konno (2008) completed a PhD thesis employing hermeneutic phenomenology, which examined the lived experience of CALD OSQ nurses in Australia. The 24 participants from 11 countries had all successfully obtained nursing registration in Australia prior to the study. This sample was proposed to resemble the newly arrived OSQ nurses' demographic distribution. Data were collected from individual interviews using a conversational unstructured style and analysed using a narrative approach to answer the research question regarding experiences in nursing practice. A thematic analysis method was used to address the second research question regarding common

or shared experiences among the participants. The analysis was presented using Joanna Briggs Institute, Narrative, Opinion and Text Assessment and Review Instrument (JBI NOTARI) which provided a clear outline of the decision trail (Konno, 2008).

Konno (2008) found that participant CALD OSQ nurses overall were found to deliberately act to formulate a strong character in the clinical practice environment. More precisely, the lived experience of the CALD OSQ nurses' working in Australia is described as the process of obtaining a new identity in the English language (Konno, 2008). New nursing knowledge formulated from the study included insights into the complex, multi-dimensional nature of CALD OSQ nurses lived experience as well as providing illuminating perceptions of Australian nursing culture from the CALD OSQ nurses point of view (Konno, 2008). Positive aspects of the latter include, that the Australian nursing health care culture was perceived to be very supportive, democratic and friendly with high standards of education and working conditions. However the negative aspects included the bureaucratic and inflexible organisational culture with a perceived level of excessive individualism which was seen as a source of alienation. It was emphasized that experiences were temporal and should not be understood as concrete or fixed or extremes of good or bad (Konno, 2008).

A broad ranging qualitative study by Brown (2005) provided the first attempt to study experiences of nursing education of CALD BN students in multiple Australian universities. Data were collected from 32 nurse teachers and 40 undergraduate student nurse participants representing 18 different countries including Australia. The sample was from universities in New South Wales (NSW), Victoria (Vic) and Western Australia (WA). Further data sources included field observations of student nurses in clinical practice and classroom settings. Memos of field notes were included and analysed using constant comparative method associated with grounded theory. Brown (2005) concluded that socio-cultural discord was a core challenge shared by all CALD students interviewed. Socio-cultural discord referred to being different and not fitting in. Discord was perpetuated by differences in all forms of verbal and non-verbal communication (Brown, 2005). Other studies by Takeno (2010) and Konno (2006) confer that the experience of loneliness and isolation acted as a barrier to entry into Australian culture. Takeno (2010) added the finding that too much help may have been a form of covert discrimination. Alternatively too little help was also found problematic by graduate nurses in a study by Cubit and Lopez (2011) to be described below.

Insights may be gleaned from the study of non CALD graduates who had been enrolled nurses (ENs) by Cubit and Lopez (2011) which resulted in five themes. These themes included firstly stepping out of their

comfort zone, being taken advantage of and needing support like any other RN. Cubit and Lopez (2011) concluded that concerns about unrealistic expectations occurred after revealing their previous EN experiences. The study informed the understanding of the experience of EN graduates converting to RN status in Australia. Parallels may be drawn with CALD OSQ nurses who are graduate nurses from overseas however seek support in the new, culturally different health care system.

While acknowledging that the findings from the aforementioned studies were limited by the design and the number of studies which have been conducted on the topic, however there were a number of valuable recommendations for future practice. Konno's (2006) Australian based review recommendations were as follows: firstly address the clash of cultures between CALD OSQ nurses and the dominant Australian culture through transition programs; secondly enhance clinical transition by developing strategies to assist CALD OSQ nurses to develop formal and informal networks of colleagues and friends; thirdly collaboration recommended with English language education specialists; fourthly strategies needed for for CFs, clinical nurses and team leaders to support the linguistic needs of CALD OSQ nurses (Konno, 2006). In addition to these recommendations from quantitative studies, a meta-synthesis of qualitative papers was supportive of the findings from other studies (Konno, 2006). Recommendations by Brown (2005) included that further research was needed into how academics and CFs worked with CALD students in recognition of the complexity of the trans-cultural branch of nurse education. Cubit and Lopez (2011) recommended that experienced graduate nurses needed support as much as any other newly graduated RNs

In summary national research into experiences of CALD OSQ nurses' revealed that transition experiences were problematic due to cultural differences and difficulties being accepted. In addition, transition experiences were made harder because it was difficult to gain entry to Australian culture because of issues with language and communication. There were positive aspects of Australian culture including friendliness, being democratic with high educational and working standards. However there was disproportionate perceived individualism as a source of alienation, heightened feelings of loneliness along with the bureaucratic and inflexible organisational culture. Recommendations included the use of transcultural transition educational programs for academics and further research into how academics and CFs worked with CALD students including CALD OSQ nurses. Further research was recommended to develop strategies to support clinical transition and particularly the linguistic needs of CALD OSQ nurses.

2.6.2 Results: local research

There were limited local studies found for inclusion in this review however, Omeri and Atkins (2002 conducted a study in NSW, Australia. The study was aimed at understanding CALD OSQ RNs' lived experiences in order to gain insights into reasons for their under representation in the workforce. In order to achieve this Omeri and Atkins (2002) applied Heidegarian phenomenological research approach with five open ended interviews of CALD OSQ RNs for data collection. Findings concerning the lived experience and meaning from phenomenological analysis included: professional negation; experience in lack of support; otherness, experience in cultural separateness, silencing, experience in language and communication difficulties and other related experiences. Results of Omeri and Atkins (2002) study of negative experiences of CALD OSQ nurses were supported by findings from international and national research studies discussed in 2.6 and 2.6.1.

Wright and Gollan (2008) produced a qualitative research report on the psycho-social needs of international students who were enrolled at the participating site in NSW. It involved 23 key stakeholders who were both academic and general staff at the campus for between 5 to 10 years or more. In addition, the other 48 participants were mainly female CALD students, representing 17 countries with over half from the School of Nursing. At that time the 17 countries included the following home countries beginning with the largest representation to the smallest: Indian Sub-Continent (India, Pakistan, Bangladesh and Nepal): China and Hong Kong; South East Asia (Thailand, South Korea, Indonesia and Malaysia); Japan; Europe (The Czech Republic, Germany); Africa (Kenya, Uganda); South America (Brazil); West Indies. Grounded theory research methodology was used and data were collected using focus groups and individual interviews which were not audiotaped. The thematic analysis resulted in 5 substantive codes under the core theme of personal and interpersonal issues. The overall psycho-social needs of international students were found to include experiences of loneliness, isolation, lack of connectedness and belonging. The key stakeholders, who represented both academic and general staff at the campus, consistently linked the experience of loneliness to grief and loss (Wright and Gollan, 2008).

Although Wright & Gollan (2008) conducted a small qualitative study and interviews were not audiotaped, these authors point out that it gave voice to the experiences of CALD OSQ nurses, CALD international students and key stakeholder participants. For the purposes of this study it contributed to an understanding of some of the CALD students unmet psycho-social needs which may have created learning barriers during transition to practice in Australia. One of the key recommendations was to adopt a proactive approach in responding to the needs of CALD international students. It was recommended that trans-cultural communication training was compulsory for all staff (Wright and Gollan, 2008).

Consistency was found with Australian literature (Wright & Gollan, 2008). An example of this was the study of sense of security of international students by Sawir, Marginson, Deumert, Nyland & Ramia (2008).

Data collection for the study by Sawir et al. (2008) comprised 200 intensive interviews of international CALD students who were resident in Australia at that time. Results of this study found 65% of students experienced loneliness or isolation and added cultural loneliness to social and personal loneliness. Cultural loneliness was found to be due to absence of the preferred culture and linguistic environment which can be exacerbated by experiences affecting the teaching and learning environment at institutional sites (Sawir et al., 2008). These findings were supported by a previous study by Williams & Calvillo (2002) which found that use of colloquial language, tuition costs and feelings of isolation were the most significant problems for international CALD students.

In summary there was limited research into the experience of transition from a local perspective for CALD OSQ nurses. The studies reviewed were supported by previous studies which emphasised language and communication difficulties as well as cultural and personal loneliness, professional negation and lack of support for CALD students.

2.6.3 Narrative summary of transition and experiences of transition for non CALD and CALD OSQ graduate nurses

To conclude, this section has integrated current understanding about clinical transition challenges from an international, national and local research perspective and wherever possible targeted CALD OSQ nurses. Relevance of findings has been extrapolated from studies of international CALD students. These challenges originated from organisational issues, the clinical work environment and from communication and psycho social issues of the nursing graduates experiencing transition. Although Xu's metasynthesis pointed to the need for better preparation strategies in place pre-arrival there was also a need for better understanding of language acquisition for all associated with Asian CALD OSQ nurses. National and local studies were supported by findings from the more numerous international studies. The findings supported the need for further research focusing on strategies CFs propose specifically for facilitating CALD OSQ nurses' clinical transition. The next section integrated the two groups and subgroups to illustrate the relationship between findings using an adaptation of an environmental model of influence by Bronfenbrenner (1994).

2.7 Integrating groups and subgroups: Environmental Model of influence.

This section has linked the findings of this review and focused on influences on CFs and CALD nurses in the clinical learning environment of clinical practicum. To illustrate the relationship between findings of this review the narrative summaries of the two preceding groups and subgroups were integrated and further examined. Figure 2 presented the levels of influence surrounding CFs facilitating CALD students in the clinical learning environment which was an adaptation of Kolb and Kolb's (2009) conceptualisation of a learning space. Centrally located on this multilayered circular model was the clinical learning environment which provided the structure to depict the central micro-system, a surrounding mesosystem, exosystem and macrosystem as an application of Bronfenbrenner's (1994) empirically developed ecological model (see Figure 2).

Microsystem: Learning space of clinical learning environment CFs' role with students and norms of trust and mutual respect to construct knowledge and understanding, facilitating learning objectives.

Mesosystem: influences of concurrent settings of RNs in the clinical practice environment caring for patients, facilitating RU objectives.

Exosystem: cultural influences of formal and informal structures of university and health facility and their institutional policies and procedures.

Macrosystem: influences of overarching patterns of wider culture including the international, national and local cultural contexts.

Figure 2: Integrating groups and subgroups: Environmental Model of clinical learning environment influences (Adapted from Kolb & Kolb, 2009; Bronfrenbrenner, 1994).

The central microsystem of this model depicted the clinical learning environment as CFs facilitating CALD OSQ nurses' learning. The mesosystem of concurrent settings included RNs caring for patients in the clinical practice environment. Positioned further outward was an exosystem of university and health

facility formal and informal structures. The outer skin of the multilayered circular model contained an overarching macrosystem as the shared blueprint of international, national and local cultural patterns of influence in nursing.

This review has identified a relationship between CFs facilitating CALD OSQ nurses' transition experiences in the clinical learning environment and contiguous environmental influences. The two most observable environments have been differentiated in the literature as firstly the clinical learning environment microsystem. Secondly the mesosystem with RNs administering patient care in the clinical practice environment of the hospital wards. In addition the mesosystem included RNs facilitating implementation of RU objectives. The CF role in the clinical learning environment microsystem had a close association with the concurrent setting containing RNs and patients in the clinical practice environment mesosystem. However these influences also included less observable yet powerful organizational structures in the exosystem with an outer skin macrosystem which contained pervasive, overarching international, national and local cultural patterns of influences.

2.7.1 Microsystem: Clinical learning environment

The clinical learning environment at microsystem level was the focal point of the current study. As discussed in group one of this review the concept of facilitation and the emergence of the CF role were relatively recent. The change to teaching models using a CF and facilitation from models using clinical instructor, mirrored the changes to holistic approaches in models of nursing. Within the microsystem an essential element in preparation of CFs facilitating CALD OSQ nurses included strategies which assisted the development of an understanding of multi-professional and transcultural care (Cuellar, Brennan, Vito & De Leon Siantz, 2008). According to Allan (2010) and Bondas (2006) preparation should also include cultural competence as well as knowledge of nursing care measured as clinical competencies. An overview of inputs for a facilitation model which incorporated cultural competence included: understanding the CALD OSQ nurses' background, the learning process and the clinical learning environment microsystem where learning could be maximized (Cuellar et al., 2008).

2.7.2 Mesosystem: Clinical practice environment

The clinical practice environment at mesosystem level was of extreme importance because it contained the RNs who supervised CALD BN students and patients who were expected to give consent to treatment by students. Although the CF played an integral part in CALD students' clinical transition it was acknowledged that the most time was spent with the supervising RNs. These RNs' cultural competence required an ability to function within the challenges of a certain culture's integrated patterns of behavior

which could include multiple cultural patterns (Cuellar et al., 2008). Hence RNs were expected to have developed sufficient cultural competence to appropriately supervise culturally diverse students. However inconsistencies in developing of cultural competence in the clinical practice environment were reflected in the literature in relation to nursing in general (Allan, 2010; Higgins, 2009; King, Nielsen & Colby, 2004). Cultural competence in nursing was therefore further explored.

Cultural competence was defined as a set of attributes which included cultural awareness and cultural tolerance and which incorporate knowledge, understanding, sensitivity and skill (Cowan & Norman, 2006). Culture included rules and norms that CFs and RNs lived by and their shared cognitive, affective and behavior patterns (King et al., 2004). Competence was similar to proficiency and had multiple definitions including that it was a process which must be accompanied with a desire to become involved (Momeni, Jirwe, & Emami, 2008). According to Allan (2010) and Amaro et al. (2006) RNs absence of cultural competence can be a barrier to CALD students' overall clinical transition.

It has been shown that receptiveness to transcultural education and growth of cultural competence was difficult to measure for the dominant culture of the population of Australia which was Anglo-Celtic and English speaking (ABS, 2006). Although 43% of the Australian population had a CALD background and 25% were born overseas, cultural competence remained difficult to estimate and measure (ABS, 2006). Previous attempts to measure cultural competence in the nursing literature using the Cultural Self-Efficacy Scale (CSES) have been problematic as the CSES measures confidence in providing culturally competent care (Grant and Letzrig, 2003). However it was acknowledged that self-reporting was not necessarily accurate in that people may have an exaggerated self-opinion of cultural knowledge (Grant & Letzring, 2003). Inconsistencies in apparent levels of cultural awareness were reflected in the literature (Cowan & Norman, 2006). Minimal information was available on the status of cultural competence in nursing particularly regarding measuring the effectiveness of strategies used for teaching cultural competence (Grant & Letzring, 2003).

2.7.3 Exosystem: University and health facility policies and procedures

At exosystem level, university and health facility regulations, policies and procedures have been elucidated as a major background feature of the study in Chapter One. The main influences from exosystem level were that institutions needed to collaborate to organize continuing clinical placements from year to year. Universities and health facilities also arranged for periodic employment and preparation of RN hospital employees as CFs. As part of building a resilient student reputation, University Schools of

Nursing were responsible for adequately preparing CALD OSQ nurses for clinical placements. Adequately prepared students were also as an assurance of patient safety to health facilities.

2.7.4 Macrosystem: Overarching international national and local cultural influences in nursing

The macrosystem level of the environmental model represented the powerful overarching international, national and local cultural patterns of influences in nursing. Group two of this review provided essential insights into the macrosystem level of the ecological model. These insights were obtained from research results contained in multiple studies. Particularly representative of CALD students experiences of transition was the integrative review of previous studies of CALD OSQ nurses' clinical transition experiences by Kawi & Xu (2009) and an interpretive study by Allan (2010). Allan (2010) particularly found that CALD OSQ nurses were professionally devalued and received inadequate support in their adjustment to new work environments in health facilities. Unsupportive attitudes and behaviors led to CALD OSQ nurses' feelings of disappointment, misunderstanding and mistreatment (Kawi & Xu, 2009). Previously, Xu (2007) identified that CALD OSQ nurses referred to as 'Asian' experienced marginalization, discrimination and exploitation during transition to Western countries with limited reference to Australia.

Review of research regarding CALD OSQ nurses' clinical transition experiences at national level revealed difficulties due to cultural differences, lack of acceptance, loneliness and communication difficulties. In addition national perspectives were reviewed in the Australian cultural standpoint described in Chapter One as part of providing the lens through which this study was viewed. It was revealed that Australian nursing cultural competency standards have been supported by national and state government agencies in setting policy aims and objectives to support equity and fair practice (NHMRC, 2011). However there was minimal evidence to demonstrate that these policies were being successfully implemented (Higgins, 2009). In addition this review found that there was limited research on the experience of transition from a local perspective for CALD OSQ nurses. Previous studies which emphasised language and communication difficulties as well as cultural and personal loneliness, professional negation and lack of support for CALD students supported the few studies that were reviewed.

In summary the environmental model presented in Figure 2 has brought together the two bodies of information presented in the two groups of reviewed literature. The model provided an understanding of many influences on the clinical learning environment for CFs and CALD OSQ nurses. However little was known locally about CFs views of facilitating CALD OSQ nurses' clinical transition. Overall this section has introduced influences on CFs facilitating CALD students in a learning space microsystem in relation

to the literature. Kolb and Kolb's (2009) conceptualisation of a learning space has been adapted for this study as an application of Bronfenbrenner's (1994) empirically developed ecological model. As displayed on Figure 2 the microsystem represented CFs facilitating in the clinical learning environment. The more robust influences surrounded and impacted on this learning space and included varying levels of cultural competency within the clinical practice environment of the mesosystem. The next outer level of influence was the essential relationship between university and health facility policies and procedures of the exosystem. Finally the macrosystem represented the overarching national, international and local cultural influences in nursing was shown to contain results from individual studies, metasynthesis and integrative review of qualitative research depicting international, national and local patterns of cultural stress with inadequate support for CALD OSQ nurses and CALD students generally. The Chapter conclusion has followed below.

2.8 Chapter conclusion

In conclusion a comprehensive search of the literature endeavoured to identify and appraise articles that discussed CFs facilitation of CALD OSQ nurses' clinical transition during clinical practicum. The review identified a gap in knowledge as there were no local studies found which primarily focused on CFs and CALD OSQ nurses. Instead two separate bodies of literature were found and each was described separately with an aim and narrative summary of the results of the search. The aim of group one was to distinguish facilitation and the CF role in nursing. The aim of group two was to comprehend transition and transition programs in relation to CALD OSQ nurses' experiences of clinical transition.

Facilitation and influences on the CF role have been clarified by the findings of the first group and subgroups of literature. Insights were gained into how the role was currently operating in the clinical learning environment with CALD OSQ nurses. Although a significant lack of CF role clarity was identified it was found that facilitation and the CF role have become central to being able to respond to the theory practice gap for local graduates and CALD OSQ nurses. In this context the gap has been attributed to current changes to tertiary nurse education and the recent arrival of CALD OSQ nurses from vastly different cultural and nursing practices.

The findings of the second group and subgroups of literature examined transition and transition programs in relation to experiences of CALD OSQ nurses. It was found that transition to new learning environments was no longer viewed as linear but a process of transformative changes that moved in different directions. International organisations alarmed by global nursing workforce shortages and poor retention rates were shown to highlight the central importance of clinical transition. Reviewing research studies of experiences

of clinical transition of CALD OSQ nurses revealed common challenges to clinical transition in international, national and local studies. These unique experiences of clinical transition included cultural displacement, marginalization, discrimination, exploitation, communication difficulties, cultural loneliness and significant nursing practice differences. Transition programs and transcultural education programs were some of the recommended strategies to address these issues.

These two groups and their subgroups were then discussed and integrated in a multilayered circular environmental model of influence to show how they relate to each other. This discussion incorporating the model provided an understanding of many environmental cultural patterns of influence on the clinical learning environment for CFs and CALD OSQ nurses. Finally the Chapter has elucidated that there was a need for further studies to develop strategies to address participant CF's views of clinical transition challenges for CALD OSQ nurses. Specifically, there was a gap in research because there were no local studies found of participant CFs' views of challenges of facilitating CALD OSQ nurses' clinical transition on clinical practicum and strategies employed to address these challenges. Chapter 3 presented the methodology and methods of the study that have addressed this gap.

CHAPTER 3: METHODOLOGY and METHODS

3.0 Introduction

This Chapter presented my selection of the qualitative research approach and the justification behind this choice. It also illustrated the features of qualitative descriptive (QD) methodology, the qualitative paradigm alignment of QD research selection, and selection of qualitative methods. I have set out the selection and recruitment, data collection and analysis methods employed. In addition, this Chapter has elucidated strategies to enhance research quality which included mechanisms to ensure ethical considerations associated with the study were implemented throughout the research process.

3.1 Selection of qualitative research methodology

The selection of qualitative research for generating knowledge in the current study has been related to the following points: the aim of the research and research questions; the nature of the issue being explored; selection of best fit for process and outcomes; the researcher and research outcomes (Whitehead, 2013, Liamputtong, 2013b; Hardy and Bryman, 2004). This section therefore has explained why qualitative research has been selected to guide this study by discussing each of these points.

3.1.1 Aim of the research and research questions

The aim of the research was to describe participant CFs' views of the clinical transition challenges faced by CALD OSQ nurses during clinical practicum and their views on strategies to address these challenges. The research questions probed for facilitation challenges and strategies employed by CFs. A study such as this has not been done before so that it was designed to investigate the need for a larger study. It was therefore imperative to seek the views of CFs in a way that would obtain meaningful, rich descriptions in order to fully understand the challenges they experienced and their suggested strategies. This was achieved by initially developing the aim of the research. Two research questions were developed. The first question asked for the challenges of clinical transition of CALD OSQ nurses during clinical practicum according to the views of the CFs who were facilitating their transition to clinical practice. The second question asked what strategies were proposed by CFs to address the challenges of facilitating clinical transition of CALD OSQ nurses during clinical practicum. Therefore, with the research aim and questions clearly articulated I endeavoured to select an appropriate research approach to enable me to gain knowledge about the subjective nature of the issue being explored.

3.1.2 The nature of the issue being explored

The nature of the issue being explored was to answer the research questions with data obtained from the subjective views of the participants. I examined the type of knowledge that can be obtained from different research approaches. This examination necessitated understanding of differences in the overarching paradigms and underlying ontological, epistemological positions and methodologies of four research approaches. Multiple and unique characteristics and convergences of qualitative, quantitative and mixed methods research were therefore discerned.

The combinations of my epistemological, ontological and methodological beliefs that guided my research activities have represented my worldview. My worldview has been based on a set of values and philosophical assumptions about how and what I have learnt during the inquiry (Whitehead, 2013; Denzin & Lincoln, 2011). Epistemology was demarcated as the study of the nature of knowledge to be obtained and how I acquired it (Liamputtong, 2013b; Denzin & Lincoln, 2011). Therefore epistemology was represented in this study by the relationship between me as the researcher and how I acquired knowledge either objectively, subjectively or using both forms.

First to be considered was the positivist paradigm, second was constructivism followed by post positivism and pragmatism. Underpinning the beliefs of positivist researchers using quantitative approaches were ontological beliefs whereby the world was objective and not influenced by me as the observer (Denzin & Lincoln, 2011). As ontology related to the nature of being I considered whether I was seeking a single objective reality (Grbich, 2013; Creswell, 2011). This meant that the research process would take an objective, detached approach with minimal bias. Quantitative research based on positivism used mainly deductive, quantitative methods (Liamputtong, 2013a; Neergaard, Oleson, Anderson & Sondergaard, 2009). An example of a quantitative method included measuring Likert scale responses to questionnaires. These methods were largely based on the belief that there was an objective reality, to seek answers to questions regarding objective measurement of the real world. Deductive reasoning approaches were mostly used by quantitative researchers to test hypothesis which were derived from theory (Whitehead, 2013).The current study however did not aim to test a hypothesis and was seeking subjective views of participants.

The second approach to be investigated was qualitative research which was mainly placed in the constructivist paradigm (Liamputtong, 2013b; Denzin & Lincoln, 2011). As their name suggests, constructivists considered truth to be constructed. According to Creswell (2011) and Liamputtong (2013a) constructivist ontological beliefs, rejected the positivist view. Instead, constructivists construed that the

world was constantly changing and was essentially shaped by understanding the experiences of people from a subjective position. Likewise, there could be multiple realities with variable meanings. Constructivism was used by qualitative researchers to refer to an epistemology which rejected the notion of a single truth. This approach maintained the belief that reality was constructed by multiple truths which were shaped by social factors which included culture and gender (Liamputtong, 2013b). Truth could vary according to naturally occurring situations and how I interpreted them (Whitehead, 2013; Denzin & Lincoln, 2011). Another feature of qualitative research was that it could arguably have acted as a paradigmatic umbrella for related methodologies such as phenomenology and qualitative descriptive (QD) research (Whitehead, 2013; Parahoo, 2006). These features had major implications for the selection of qualitative methods that I had considered for constructing knowledge. They were particularly in accordance with the subjective nature of the issue being explored. However qualitative research could also be conducted using post positivist approaches which I then considered.

A third approach post positivism as a variation to positivism was considered (Denzin & Lincoln, 2011). Post positivist proponents claimed that reality could only be approximated and therefore relied on multiple methods to align the study as closely as possible to reality. However, post positivists strayed from the basic premise that quantitative research was placed in the positivist paradigm and qualitative research was mainly placed in the constructivist paradigm (Bryman, 2012; Denzin & Lincoln, 2011). By contrast, an emerging convergence was that qualitative methods as well as modified quantitative methods could be based within post positivist ontological and epistemological positions (Lincoln, Lynham & Guba, 2011; Liamputtong, 2013b; Whitehead, 2013). It has been argued that post positivists moved past the beliefs of positivism and embodied the belief that objectivity can only be achieved partially because there are weaknesses in all methods (Whitehead, 2013; Denzin & Lincoln 2011; Parahoo, 2006).

Nonetheless, a censure directed toward researchers using post positivism for qualitative research was that it remained strongly influenced by positivism and post positivism as they 'linger like long shadows over the qualitative research project' (Denzin & Lincoln, 2011, p.9). Claims of research being atheoretical by researchers doing practical, applied research was actually more likely to be within the positivist or post positivist framework. This censure stems from the historically located positivist origins of qualitative research whereby 'qualitative researchers attempted to do good positivist research with less rigorous methods and procedures' (Denzin & Lincoln, 2011. p. 9).

More recently Parahoo (2006) contended that post positivists endeavoured to adhere to stringent standards of research rigor, however they maintained the belief in a single objective truth. Post positivists

acknowledged that truth was difficult to access (Parahoo, 2006). Post positivists may have used statistics to locate a group within a larger population without using complex inferential statistics (Denzin & Lincoln 2011; Parahoo, 2006). In addition, they may attempt to generalise their research findings though will be more likely to seek correlations between variables. Post positivism was not selected because the current study was exploratory and I did not seek objective truth, correlations between variables or generalizable findings.

The fourth approach to be considered was mixed methods research. Assertions that pragmatism was a third paradigm remain controversial and the 'paradigm debate' continues (Creswell, 2011, p.275). Arguably, the mixed method approach was contentious as knowledge claims could be traced to the pragmatic paradigm or transformational-emancipatory perspective (Whitehead, 2013; Creswell, 2011). While pragmatism emphasised the value of research questions, experiences and realistic, practical outcomes the transformational-emancipatory perspective introduced justice and democracy into the research process (Creswell, 2011). Mixed methods approaches were criticised due to allegedly misappropriating designs from other fields possibly creating 'a false binary distinction between quantitative and qualitative data and research' (Creswell, 2011, p.280).

On the other hand, Liamputtong (2013b) and Whitehead (2013) acknowledge the controversy and discuss mixed method research within the pragmatic paradigm. This discussion differentiating these research approaches was limited to the premise adopted by Whitehead (2013) Grbich (2013) and Bryman (2012) that the pragmatic paradigm underpins mixed method approaches. Fundamentally pragmatists proposed that knowledge was both constructed and based on the physical world realities as people experience life (Liamputtong, 2013b; Creswell, 2011). In addition, there was not a hard distinction between qualitative and quantitative research, even though they have different knowledge claims. Each research strategy may have characteristics of the other so that the mixed method design could combine quantitative and qualitative approaches in one study (Bryman, 2012).

Qualitative research however was selected for my research study even though selecting the mixed-method approach could add more meaning, purpose and completeness than can be achieved using singular qualitative or quantitative approaches (Whitehead, 2013). Nevertheless, qualitative research was preferable to mixed methods for the current study as Bryman (2012) cautioned that mixed method research is not the same as combining research methods which come from one research approach. Combining research methods Whitehead (2013) and Charmaz (2011) asserted was common with grounded theory (GT) for example, which can be conducted using both positivism and constructivism as

perspectives. An explanation for this was that the theoretical framework evolved during the research process. Epistemological differences in versions of GT included positivist GT and constructivist GT. Charmaz (2011) expounded that 'grounded theory contained the seeds of divergence from its' beginnings' (p. 365). It became clear that the research aim and questions of the current study did not require mixed methods. Combining research methods from qualitative approaches was more suitable for the subjective, exploratory nature of the issue being researched.

In summary four research paradigms have been investigated in order to select the approach which was appropriate for the exploratory nature of the study which required subjective views of participants. These paradigms included positivism as well as post positivism, constructivism and pragmatism. It was found that constructivism enabled me to construct knowledge from the subjective views of participants to answer the research aim and questions.

3.1.3 The researcher and practical research outcomes

The final selection criteria were consideration of my responsibilities, experience and knowledge as researcher and expectation of research outcomes. I deliberated the impact of being a beginning researcher with family, employment, candidature time limits and cost constraints. These factors meant there were limited time and resources for a large quantitative research study. In addition, the study purpose was exploratory with an expectation of practical research outcomes which included developing strategies and identifying the need for further research. A larger quantitative study would be anticipated in future in order to make generalisations from the results. I have discussed how I initially investigated the suitability of quantitative descriptive or different qualitative methodologies. Quantitative descriptive methods were a consideration as they could result in developing descriptive statistical analysis (Pierson, 2013). Questionnaire surveys were reviewed followed by an examination of differences between using qualitative methods.

After a literature search it became apparent that CFs, facilitation, CALD OSQ nurses and clinical transition have been researched from many different dimensions using a range of methods. For example, quantitative methods using questionnaire, focus group and descriptive statistical analysis were used appropriately when focusing on evaluating a teaching and learning support program for CALD OSQ nurses by Seibold, Rolls and Campbell (2007). Alternatively, Konno (2008) employed a phenomenological approach using interview data collection methods to gain insights into the lived experience of CALD OSQ nurses' transition to working in Australia. Another study by Brown (2005) using grounded theory methods examined and described the nursing education experiences of CALD

undergraduate students across three Australian states. However, my interest was in probing the experiences of CFs who facilitated groups of CALD OSQ nurses in the clinical environment which had not been carried out in Australia before. The quantitative approach could have been considered by choosing a survey which could have been sent to CFs. Survey questions could inquire into participant CFs' views of challenges and strategies associated with facilitating CALD OSQ nurses. However, there are several reasons why a quantitative survey was inappropriate for my study which have been summarised.

Firstly, the research topic with its focus on subjective experiences did not require research strategies that accentuated objective measurement in data collection and analysis resulting in generalizable findings. In addition, quantitative research would not enable the acquisition of rich descriptions of views of participants of experiences during clinical practicum. Similar to qualitative studies, quantitative descriptive studies aimed to use a variety of methods to measure variables in order to describe phenomena about which there is limited information (Shields & Watson, 2013; Imms & Greaves, 2013). These methods included: observation, questionnaires or interview. Measurement of questionnaire responses, for example, could have been used to answer research questions. However, the data would be collected objectively and a survey or questionnaire would have limited response classifications. The data would be used to develop patterns or trends and possible links between variables observed. Emphasis would then be placed on description of the phenomena rather than the experience and views of the participants (Shields & Watson, 2013; Parahoo, 2006).

Although both approaches potentially captured the participants' point of view, qualitative researchers were able to get closer to the participants' perspective through detailed interviewing and observation. This closeness was not possible with quantitative approaches because these studies relied on more remote, inferential methods and materials (Shields & Watson, 2013; Denzin & Lincoln, 2011; Taylor, Kermode & Roberts, 2011). Consequently I found qualitative methods were most suited to reach my aim of eliciting CFs' views and to develop key challenges and strategies.

In summary, final selection criteria were consideration of the researcher and expected research outcomes. A small qualitative study was found to be appropriate when considering the research aim and questions, researcher experience, time and resource limitations. The rationale for choosing qualitative methods for the current study related to the aim to support more meaningful and multifaceted explanations as opposed to seeking generalisations. Consideration was given to methods used in previous studies reviewed in Chapter 2 including observation, questionnaire surveys and interviews. Questionnaires were therefore

deliberated as an example of a possible quantitative descriptive data collection method resulting in statistical measurements. However it was shown that this method would not have enabled me to achieve the research outcome of answering the research questions. The following section provided the essential features of qualitative research and distinguished QD methodology as it was used in the current study.

3.2 Features of Qualitative Research and QD methodology

In this section, I have presented the distinguishing features of qualitative research methodology. In addition, the emergence of QD methodology has been discussed as an atheoretical approach firmly underpinned by qualitative epistemology. The QD approach has been shown to have developed along with progression of pragmatic, flexible approaches within qualitative research. In addition, the QD approach was shown to have become popularised in response to complex research questions arising in multiple research contexts. Initially qualitative methodology was delineated before QD methodology was introduced and differentiated from other forms of qualitative research.

Distinguishing features of qualitative research methodology made it most suitable for the current study. These included a close relationship between the researcher and participants, as well as a better understanding of personal experiences and opinions from the participants' subjective view (Denzin & Lincoln, 2011). Qualitative research was also renowned for being inductive, interactive, perceptive, and holistic by use of flexible and reflexive methods (Liamputtong, 2013a; Harding & Whitehead, 2013; Denzin & Lincoln, 2011; Parahoo, 2006). In addition, Denzin & Lincoln (2011) referred to the 'interpretive bricoleur'(p.4) which was an important concept associated with the atheoretical QD approach being considered for the current study. These terms have been defined as common features of qualitative research and the QD approach which influenced its selection.

Firstly, researchers using inductive reasoning approaches intended to develop concepts and themes from observations or interviews (Harding & Whitehead, 2013; Parahoo, 2006). In addition, inductive reasoning was described as a key characteristic of qualitative data analysis as it generated ideas from the data (Harding & Whitehead, 2013). Similarly, interactive processes of qualitative research brought the researcher closer to participants and the researcher became an apparatus of data collection (Liamputtong, 2013a; Parahoo, 2006). These interactive processes meant that the researcher was required to build trust with participants in order for them to relate their personal experiences (Liamputtong, 2013a; Parahoo, 2006). Participant interaction highlighted the importance of reflexive processes which were an attempt to minimize researcher bias (Liamputtong, 2013b; Creswell, 2011; Thomas & Magilvy, 2011). In addition, reflexive processes required me to acknowledge the effects of my personal perspectives seen through the

lens of cultural, experiential, environmental and contextual influences upon my beliefs and emotions as shown in 3.4.4 and 3.5.3 (Thomas & Magilvy, 2011).

Another feature of qualitative research included flexible methods. A term for this pointed out by Denzin and Lincoln (2011) is the researcher as 'interpretive bricoleur' meaning that researchers use whatever methods were needed to understand the personal world of participants (p.4). Finally, Bryman (2012) and Parahoo (2006) proposed that holistic exploration refers to how it was possible to construct participant experiences historically, culturally and socially to provide contextual understanding so that the whole experience was described. Similarities and differences of QD methodology with these qualitative methodological features have been explained in the following.

According to Sandelowski (2000) QD methodology has been a research approach within the qualitative paradigm which does not subscribe to any particular theoretical underpinnings. However, QD methodology fits with the emergence of the qualitative researcher as 'interpretive bricoleur' as it contains research methods that were 'fitted to the specifics of a complex situation' (Denzin & Lincoln, 2011, p. 9). Nonetheless, censures of QD methodology being atheoretical were addressed in 3.2.1. Proposed reasons for the popularity of QD methodology was a response to the complex and contextually embedded research questions which arose in clinical health care contexts (Whitehead, 2013; Thorne, Kirkham & O'Flynn-Magee, 2004). At one point Thorne et al. (2004) defined the QD approach as a qualitative approach that was specifically designed for the practice based professions. According to Whitehead (2013) it has been embraced by the nursing profession. However the flexibility of the QD approach ensured it has been suitable for addressing complex research questions in diverse contexts. These features of the QD approach enabled me to generate an interpretive description which was used to generate key strategies to address facilitation challenges.

In summary, conducting a qualitative study meant that research activities placed me as the researcher in the context of the study whilst using a selection of data collection and analysis methods. Furthermore common features of qualitative research and the QD approach have been summarised and include being inductive, interactive, perceptive, holistic, flexible and reflexive. The QD approach was different to other traditional qualitative methodologies because it had more flexibility. In addition, methods were not required to adhere to theoretical traditions as detailed in 3.2.1. This enabled me to use whatever qualitative methods necessary to answer the research questions. Similar to other qualitative methods, the outcomes of the QD approach used in this study were anticipated to be rich descriptions. The following aligned QD methodology within the qualitative paradigm by comparing and contrasting it with GT and

phenomenology methodologies as well as addressing criticisms of the approach. In addition, essential differences of applying QD methods have been presented.

3.2.1 QD methodology: criticisms and qualitative paradigm alignment of methods

Criticisms have been launched against using QD methodology which was considered to be atheoretical. To address criticisms this section compared and contrasted QD methodology with grounded theory and phenomenology to clearly illustrate their similarities and clarify differences. Reasons for this were to align methods used in the QD approach with qualitative research. QD methodology has been aligned with the constructivist paradigm explored in 3.1.2 which provided the qualitative epistemological foundations for the research design. The rationale has been discussed for QD methodology remaining outside the conventions of traditional theoretical qualitative approaches. These methodological criticisms have been addressed in the following.

The QD approach controversially adopted common aspects of all qualitative approaches which provided a means to work outside the conventions of the more traditional methodological approaches (Whitehead, 2013; Sandelowski, 2000). In addition, Whitehead (2013) contended that the QD approach had become the most common form of qualitative research in nursing and midwifery studies. The QD approach had been estimated to have overtaken phenomenology, grounded theory (GT) and ethnographical approaches which are the next main traditional approaches (Whitehead, 2013; Willis & Anderson, 2010). However, the practice of working outside traditional approaches has been controversial and has attracted criticism of the QD approach for reasons discussed below.

Some criticisms of the QD approach included difficulties that may have arisen from its distinct characteristics which have overtones of some of the more theory-based qualitative methods (Sandelowski, 2010; Neergaard et al., 2009; Milne & Oberle, 2005; Caelli, Ray & Mill, 2003). However, Morse (2005) argued that qualitative health research was sufficiently specialised and justified in requiring specialised knowledge, research design and modification of research methods. According to Milne and Oberle (2005) many QD researchers have felt compelled to designate their work as grounded theory or phenomenology for example, in order to achieve credible epistemological underpinnings for their study.

The inappropriate designation of the QD approach may be partially explained by Thorne et al. (2004) who traced the use of the QD approach in nursing research particularly to the need to "push at the edges of the methodological rulebooks" (p. 2). This need to change research methodology was in the context of addressing complex experiential clinical questions. Consequently, the applied disciplines frequently used

the QD approach rather than being constrained by traditional methodology. Although QD was not the only approach that could allow study of clinical settings Caelli et al. (2003) proposed that reasons for the popular use of QD included the clinical nature of the research topic and time constraints for achieving masters by research.

Thorne et al. (2004), debated the difficulties of using a QD approach and emphasised that since it was a "non-categorical method of research" and at risk of "method slurring" (p.3) it must have coherent epistemological foundations to distinguish it. This supported the need for clarification of epistemological foundations presented in 3.1.2. Previously, Baker, Wuest and Stern (1992) drew attention to this risk and used grounded theory and phenomenological approaches as examples of how there can be "blurring" or confusion between qualitative approaches. Epistemological foundations which distinguish the QD approach from phenomenology and grounded theory were discussed in the following.

Traditional qualitative approaches were considered to require more complex detailing of philosophical positions than the QD approach because they were governed by lengthy theoretical positions that have evolved over many years (Whitehead, 2013). An example was phenomenology which was described as focusing on the way that individuals experience phenomena and was concerned with the lived experience of participants (Carpenter, 2013). Similar to the QD approach, the goal of phenomenology was to gain understanding through the human experience of the phenomenon without seeking a causal explanation (Whitehead, 2013).

Two traditions in phenomenology both focus on consideration of the effect of the researcher on the participant which was also the focus for the QD approach. Originally, Husserl had been credited to have begun the historical tradition of descriptive phenomenology which was seen as an alternative to positivism (Whitehead, 2013; Denzin & Lincoln, 2011). In addition, descriptive phenomenology was known to incorporate 'bracketing' of the researcher's preconceptions during data collection. Bracketing allowed researcher presuppositions to be put to one side so they did not impose meaning on the research (Taylor, Kermoda, & Roberts, 2011). As a student of Husserl, Heidegger had been credited with developing the second tradition, hermeneutical interpretive phenomenology. This was identified as ontological because it was focused on people being in the world (Carpenter, 2013). Hermeneutics was used in qualitative research as an approach to the analysis of texts to investigate how people formulate interpretations of their lives in relation to their life experiences (Liamputtong, 2013a; Denzin & Lincoln, 2011). Similar to the QD approach Carpenter (2013) asserted that the interaction between the participant and the researcher was

considered the main aspect of the data collection process. This interaction had led to reflexivity being built into the QD research process and addressed the researcher's influence on data collection (Carpenter, 2013. Qualitative Descriptive researchers have adopted reflexivity which involved continuous critical reflection on the research processes to ensure that the researcher's deep-seated views and biases or judgements were made explicit. It became an essential component of qualitative research and has been shared by being used in phenomenology and QD methodology (Liamputtong, 2013a; Maynard, 2004). Phenomenological perspectives have further assisted the QD approach as they provided a means to gain understanding of events, actions and values through the participant's eyes (Liamputtong, 2013a; Yates, 2004). The QD approach employed several of the unique phenomenological procedural steps to assist with analysing and interpreting the data (Whitehead, 2013). Phenomenologists used these steps which have been devised mainly by Giorgi and Collaizzi to simplify phenomenological methods (Carpenter, 2013). Without having to strictly adhere to these steps, QD analysis procedures may be derived from both authors and include: distinguishing the data into meaningful units referred to as codes or nodes in NVivo; generating essential categories and themes as detailed in 3.4. In addition, there was a clear distinction between researchers using QD analysis techniques from phenomenological researchers who are required to maintain strict adherence to the selected procedural steps by Giorgi or Collaizzi (Carpenter, 2013; Whitehead, 2013).

In contrast to GT, the QD approach did not contain techniques to generate a middle range theory. However, GT methods have been adopted for use in QD methodology. Similar to phenomenology, complex historical traditions can be found in multiple versions of GT which began with Glaser and Strauss (1967) and were further developed by Corbin and Strauss and others (Liamputtong, 2013a; Charmaz, 2011). Many versions of GT originated from techniques devised for generating a substantive, middle range theory about social processes (Whitehead, 2013). The theory became grounded because it emerged from the research data.

Some of the GT methods were considered for use in the current study and therefore required clear definition. Techniques used in GT included data saturation and a process of constant comparison methods of simultaneous data collection and analysis (Charmaz, 2011). Firstly, data saturation was described as a way of justifying the number of research participants by data becoming saturated when no new data were being generated and new data fitted into the categories that had been developed (Skeat, 2013). Secondly, constant comparison in GT was designated as the process of grouping raw data together into bits or codes and developing an understanding of how the groups work and linked together (Skeat, 2013; Pidgeon & Henwood, 2004). Constant comparison allowed me to identify patterns in the data by comparing incidents within a category until the properties of that category emerged. Data saturation occurred by

simultaneously analysing data during data collection and constant comparison in the development of categories and themes. Both GT methods were used in the current study and detailed in 3.3.6 and 3.4.1. Within the spectrum of qualitative methods, QD methods had many similarities and a few differences. Similar to qualitative methodological approaches such as phenomenology and GT, QD methodology was able to incorporate diverse perspectives which had implications for research methods (Greene, 2006). As an example of difference, I did not set out to develop a theory which characterised GT, however I used the analysis technique of constant comparison in the development of themes. In addition, I incorporated memos as a way of implementing reflexivity and therefore critically reflected on myself as the researcher in order to minimise researcher bias as detailed in 3.4.4 and 3.5.3.

The selection of qualitative methods for the QD approach was based on what was needed to answer the research questions. Since the QD approach was aligned with qualitative approaches and I was not bound by a particular method of data collection and analysis, I have selected the use of the following from a range of qualitative approaches: semi-structured interview; reflexivity; purposive quota sampling; use of memoranda; data saturation and constant comparison technique in data analysis. In addition, Harding and Whitehead (2013) proposed that specific analysis techniques have been suggested for the QD approach and include inductive coding by ranking lists of concepts and re reading the participants' transcripts to identify categories. As shown in 3.4 this techniques was used in the current study.

The selection of qualitative methods for the QD approach was based on what was needed to answer the research questions. Specific QD analysis techniques such as inductive coding into categories and ensuring best fit have been used in this study and described in 3.4.1-3. As a result of using these and GT data analysis techniques, I was able to develop descriptions of participants' experiences in a similar language which according to Sandelowski (2000) was characteristic of the QD approach. However, I was aware that using similar language still required low-inference interpretation. Perfect description was not possible due to my own perceptions and beliefs (Sandelowski, 2000). Similar to other qualitative methods, QD methods enabled development of rich description of the experience, staying close to the data in analysis and presentation of data (Neergaard et al., 2009).

In summary, the QD approach has been elucidated to have incorporated common aspects of all qualitative methodologies. This section has provided examples of how traditional qualitative methodologies required clear adherence to historically derived methods. Traditional qualitative methodologies were more complex to provide detail of the theoretical positions than the QD approach. Phenomenology and GT have been used to illustrate these complexities and to address criticisms of the QD approach. Finally, these examples

have also been used to illustrate how the data collection and analysis techniques were related to the methodological approach. Highly relevant to this study was that the QD approach had some unique analysis techniques and has been shown to enable researchers to select methods from a range of qualitative approaches.

3.2.2 Justification of QD methodology

The QD approach has evolved over the past twenty years because the pragmatic nature of qualitative research has progressed and become more flexible (Whitehead, 2013; Denzin & Lincoln, 2011; Liamputtong, 2013a). In addition, scholars have utilised this flexibility to develop methods which were more useful to the experience-based questions (Whitehead, 2013; Thorne et al., 2004). Being designated as belonging under the auspices of constructivism, the QD approach enabled the study of phenomena in the clinical setting as opposed to a laboratory (Whitehead, 2013; Denzin and Lincoln, 2011). The QD approach enabled interpretation of phenomena according to the meanings that participants gave to them (Denzin & Lincoln, 2011). These particular features of the QD approach were appropriate for the aim of the study which was to seek participants' views about experiences of clinical facilitation (Whitehead, 2013; Greene, 2006).

Justification for using the QD approach was provided by the research purpose and researcher constraints in terms of my time and cost limitations. However, the advantages over other more traditional qualitative approaches were that it was a liberating and more manageable form of qualitative inquiry. The QD approach was not constrained by the requirement, for example in phenomenology to understand the experience as a whole or the outcome expected of GT to produce a substantive theory (Whitehead, 2013). The QD approach could simply seek CFs' views of challenges of facilitating CALD OSQ nurses' clinical transition and strategies employed to address these challenges. In addition key challenges and strategies could be represented by the development of themes and subthemes without the formation of a substantive theory grounded in the data.

Another advantage of the QD approach was that it had practical outcomes since it allowed more freedom in expressing and reporting findings than other qualitative approaches (Whitehead, 2013). The practical outcomes in the current study that were being sought were strategies that could potentially be employed by future CFs. These could be developed through understanding of the unique challenges of facilitating CALD OSQ nurses during clinical transition. The QD approach was not governed by a complex theoretical position that required scrupulous adherence to detail of methods required by the more traditional methodologies.

In summary the QD approach was justified for the purpose and researcher constraints of the current study. Advantages of the approach included clear links to qualitative epistemology detailed in 3.1.2. It was aligned with qualitative methods without having to subscribe to any particular theoretical underpinnings. Another justification for using the QD approach was its pragmatic quality. Being an integral component of qualitative research, pragmatic qualities meant that I could use whatever research tools were appropriate to meet the study aims (Denzin & Lincoln, 2011). The QD approach became critical to answering clinical questions related to the practice-based disciplines (Whitehead, 2013). The strength of using this design was that it enabled selection from multiple qualitative methods to develop rich descriptions, using a largely inductive approach, to develop strategies with practical application as detailed in 3.4 (Neergaard et al., 2009).

3.2.3 Selection of qualitative data collection methods

This section has reviewed possible data collection methods as well as described how the interviews were carried out. Final selection of the semi structured interview was based on considering several qualitative methods that may have been appropriate. Selecting a method that was suitable for generating knowledge using a QD approach required a review of the three main qualitative methods which were participant observation, focus groups and interviews. Since it was important to choose the appropriate method to address the research questions and fit with the knowledge required. These three methods have been briefly discussed below.

First to be considered was participant observation which has mainly been used in ethnographic studies (Willis & Anderson, 2013; Liamputtong, 2013a; Parahoo, 2006). Participant observation carried out in conjunction with interviews allowed for a more complete understanding of the phenomenon being studied. There were several ways this could have been carried out, however participant as observer was considered for this study. This involved what Liamputtong (2013a) described as the researcher acting as both researcher and participant and not concealing the research which allowed freedom to come and go. Bias could be introduced through the power relations of an investigator being an 'outsider' and an 'insider' and possibly over identifying with the participant, making it problematic (Erickson, 2011; Parahoo, 2006). Another problem would have been the time constraints of adjusting to being with participants which was considered prohibitive. I also recognized that the clinical practicum was constantly changing over a three to four week period. These changes meant the full spectrum of challenges could not be simply observed over a shorter participant observation period. Long periods of observation would be too expensive and

extremely difficult to arrange with prevailing time constraints. In addition, it would only provide data on observed practices rather than the views of participants on how they experienced the facilitation process. Secondly, the use of focus groups had been used to give participants an opportunity to share and discuss ideas which provided the researcher with an efficient way to gain a broad understanding of the phenomenon from various perspectives (Parahoo, 2006). Focus groups "elicit and validate collective testimonies and give voice to the previously silenced by creating a safe place for sharing one's life experiences" (Denzin & Lincoln, 2005 p. 648). This was a possible way to collect the data required, however once again time constraints of organizing participants to be available at the same time was considered problematic. In addition, purposive quota sampling of CALD and non CALD participants was being considered. This would have required two focus groups as Bernard (2006) highlighted that it was preferable to have homogenous groups. The type of knowledge being sought from data collection was frequently related to personal clinical facilitation experiences and participants may not wish to speak as freely in a group.

The literature reinforced the decision not to pursue focus groups by pointing out their limitations. Advantages included that they provided supportive group interactions, a useful way to complement surveys and could be used to find out why people think and feel as they do. However Lopez and Whitehead (2013b) and Bernard (2006) stipulated that focus groups should not be relied on for collecting data about content and process or personal attributes. Focus groups had several limitations in comparison to individual interviews including: failing to explore issues as deeply, they were not as intimate and private; they often did not uncover sensitive or embarrassing information; possibly specialised gatekeeper skills have been required to ensure balanced contributions and avoid 'group think' outcomes (Lopez & Whitehead, 2013).

Finally, conducting semi structured interviews was found to be appropriate for the aim of the study as representing the insider perspective in QD research ensured overall credibility of the study (Liamputtong, 2013a; Lopez & Whitehead, 2013; Milne & Oberle, 2005). An interview literally meant to develop a shared perspective and understanding (Yates, 2004). In addition, semi structured interviews in research, focused on eliciting rich and detailed accounts of the participants understanding, feelings, knowledge and views (Liamputtong, 2013a). It was found to suit this study because interviews were able to elicit responses which were rich in meaning, depth, range and variety. Allowing open ended questions without prescribed answers assisted with grasping the complexity of the issues and made sense of the multiple meanings and specific actions or cultural practices (Liamputtong, 2013b). This required the interview schedule that was planned for the study. Bernard (2006) advocated that the interview schedule was a

conversational guide to assist with managing the interview. In addition, it had broad areas of questions but allowed for additional questions and prompts to encourage the participant in a particular direction. Hence, the interview schedule for the current study was piloted with a colleague who made suggestions for minor changes to questions.

There were some validity threats to the use of semi-structured interviews. These included the effect of the interviewer introducing a number of biases such as participants giving socially acceptable answers or moulding their response according to the relationship they had developed (Lopez & Whitehead, 2013; Parahoo, 2006). I planned to address this by ensuring I developed trust and rapport with participants so that they felt comfortable to speak openly by initiating informal conversations and assurances before during and after the interview. In addition, as advocated by Lopez & Whitehead (2013) and Parahoo (2006) the validity of responses was to be enhanced in the semi structured interviews by my presence as the researcher whereby I could explain the questions and clarify meanings for the participants.

In summary, the final selection of the semi structured interview as the data collection method was based on considering several qualitative methods that may have been appropriate. The aims and research questions of the study and type of knowledge to be generated were a major influence. Other potential problems such as cost and time constraints were also major factors. Semi structured interviews were preferred because they enabled me to elicit more meaningful responses. The purpose of using an interview schedule to guide and manage the interview was articulated. Validity threats of the researcher introducing possible biases during interviews were addressed by informal conversational assurances, development of rapport with participants and clarifying questions and meanings for the participant.

3.3 Methods of this study

The remainder of this Chapter has presented the research aim and research questions and outlined the study design and methods used for this study in detail. Strategies and techniques used to collect data included: purposeful quota sampling; semi structured interviews; verbatim transcription of recordings with researcher memos; use of the software program NVivo 9.2 for coding, storage of data to assist further analysis. Methods used to analyse data included: coding; categorising and development of themes; use of memos and reflexivity. In addition research quality was addressed in detail under the following headings: procedural rigour, representativeness and respondent validation; reflexivity and integrity; transferability; and ethical considerations.

3.3.1 Research Aim:

To describe participant CFs' views of the clinical transition challenges faced by CALD OSQ nurses during clinical practicum and their views on strategies to address these challenges.

3.3.2 Research Questions:

What are the challenges of clinical transition of CALD OSQ nurses during clinical practicum according to the views of the participant CFs who are facilitating their transition to clinical practice?

What strategies are proposed by participant CFs to address the challenges of facilitating clinical transition of CALD OSQ nurses during clinical practicum?

3.3.3 Study design

The research study design entailed the planning and designing of specific methods to be used for this investigation. Explicit portions of the research process that were more concerned with the actual conducting of research have been articulated. In the current study the design features of qualitative research and the QD research approach identified in 3.2 and 3.2.1 meant that it had some features of GT and phenomenological methods. The elements from these approaches used in this study design were the semi structured interviews detailed in 3.2.3 and the analysis technique of data saturation and constant comparison detailed in 3.2.1. Data analysis techniques which were specific to the QD approach included inductive coding into categories and ensuring best fit with details provided in 3.2.1. Results of the data analysis were presented in Chapter 4 and discussed in relation to related literature in Chapter 5.

3.3.4 Research Participants: Inclusion and Exclusion Criteria

The key participants were clinical facilitators (CFs) who were recommended for employment at the university in NSW, Australia by the clinical coordinator at the School of Nursing. CFs were employed by the university and were responsible for facilitating students' learning and formal assessment on clinical practicum. This was considered important because it was an assurance that the participant had experience of facilitating CALD OSQ nurses for a full clinical practicum. Most CFs were usually expected to have a post graduate teaching qualification however clinical experience was taken into consideration due to shortages of RNs with appropriate qualifications. Eligible participants included CALD and non CALD CFs employed by the university. The decision to select from the two groups was initially based on findings of a study by Yoder (1996) which found that ethnic background of the CF was a major influence on the way CALD nurses' learning were facilitated. The CALD CFs included those who spoke another language or English as a second language with transcultural experience or education or have spent most of

their lives outside Australia. The CALD CFs' views could then supplement views of non CALD CFs who spoke English as a first language and had minimal transcultural education or experience. CFs were excluded if they were not employed by the university and did not have experience of formal assessment for at least one CALD OSQ nurse in the past 5 years. Inclusion criteria were important because CFs were asked their views of CALD OSQ nurses specifically and therefore needed to have had recent experience with facilitating them on clinical practicum as well as having been responsible for formal assessment. Participants were over 18 years of age and able to give informed consent. The inclusion and exclusion criteria were summarised on Table 3.

Table 3: Inclusion and exclusion criteria for Clinical Facilitators

	Inclusion criteria	
1.	CFs with CALD background defined as over 18 years and able to give informed consent.	CFs with non CALD background defined as over 18 years and able to give informed consent.
2.	Met requirements to be employed by a university in NSW as a Clinical Facilitator. These include current nurse registration and preferably > 5 years of experience, education qualifications.	Met requirements to be employed by a university in NSW as a Clinical Facilitator. These include current nurse registration and preferably > 5 years of experience, education qualifications.
3.	Have formally assessed and recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years	Have formally assessed and recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years
4.	Born in Australia or overseas, and speak English as second language (ESL and have spent most their lives outside Australia.	Born in Australia or have spent most of their adult lives in Australia, and speak English as first language.
	Exclusion criteria	
1.	Have not formally assessed and recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years	Have not formally assessed and recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years
2.	Are not employed by ACU as a CF	Are not employed by ACU as a CF.

3.3.5 Sampling approach

Purposive quota sampling was used to recruit four CFs with CALD background and four CFs with non CALD background. Quota sampling comes under the auspices of purposive sampling, though it differs because it had more specific sizes and proportions of the sub-samples for each prescribed quota (Lopez & Whitehead, 2013). This sampling approach enabled the capture of views of CALD and non CALD participants who could be confirmed to have experiences of facilitating CALD OSQ nurses. A quota sampling approach achieved this by enabling the selection of participants who represented appropriately

qualified and experienced CFs from different CALD and non CALD backgrounds who could provide the information needed to answer the research questions. As interviews progressed and data were analysed it became apparent that four CALD and four non-CALD CFs would provide sufficient data to reach saturation.

3.3.6 Selection and recruitment

After receiving a list of all CALD OSQ nurses enrolled in the BN from an administration officer, student files were checked to find the CF's name and signature on the students' clinical performance record. This was routinely filed in a locked cabinet in the School of Nursing, as a record of students' performance on clinical practicum. Participant CFs were selected according to the student researcher being able to match a CF with CALD OSQ nurses' student records as evidence of having had experienced formal assessment on clinical practicum with CALD OSQ nurses. Following this, an advance information letter (see APPENDIX B) to selected participants explained that they had been selected because they had facilitated CALD OSQ nurses. In addition participants would be able to provide an informed perspective on the challenges and strategies proposed to facilitate this group of students' clinical transition. Participants were informed that the researcher was seeking a wide variation and equal balance of views from participant clinical facilitators from CALD and non CALD backgrounds.

The information letter (see APPENDIX C) and consent form (see APPENDIX D) were attached to an email which gave a brief overview of the research aims and which advised that the researcher would contact them shortly. Another email was sent approximately a week after the first email to inquire if potential participants did or did not agree to participate. If the participant declined, the next eligible person on the list of CFs was selected. If the participant agreed to participate they were then contacted by the researcher to arrange a mutually suitable time for the interview. The consent form accompanied the information letter and was then brought to the interview and signed by the participant and the student researcher. Alternatively, participants who were interviewed by recorded teleconference sent the consent form by fax or email attachment.

E-mails inviting people to participate were sent, in a small group of ten then reducing to six then four. There was simultaneous collection and analysis of data so that the number of emails reduced as I came closer to reaching the quota sample. Several CFs who declined any alternative interview options, were given the choice of face to face or teleconference interviews due to distance from their homes and work. Finally out of the 22 emails sent there were 8 acceptances, 6 refusals and the remaining 8 did not respond

to the first or second email. This resulted in five face to face interviews and three participants being interviewed by teleconference.

Three participants commented that the reason they agreed to participate was they believed it was an important area to be researched while two others wanted to be involved in supporting research. The remaining three wanted to have a voice in developing strategies for future CFs. The most common reason for not accepting the invitation to participate was unsuitable timing. Examples of unsuitable timing included that one potential participant did not have time because he was completing a course of part time study and another was moving to facilitate students from a different university. Another participant did not wish to be interviewed by teleconference or to interrupt her workplace when I offered to travel to the health facility to conduct the interview. Several simply declined without giving a reason. The non-responders were not contacted again after the second email. Selection was completed when four CALD and four non-CALD CFs had agreed to participate and interviews had been recorded, data transcribed and was found to be sufficient for the study purpose. The 8 interviews were completed by the end of October, 2011.

3.3.7 Data collection: the semi-structured interviews

The interview guide was used to ensure that I covered key areas in the interview. It contained questions regarding demographic data and open ended questions regarding facilitation challenges that CFs experienced based on factors identified in the literature search. Questions were then included regarding strategies they proposed to address the challenges of facilitating clinical transition of CALD OSQ nurses specifically. The interview guide was piloted with a work colleague and minor revisions were made.

Prompts were used to encourage more detailed responses regarding CALD OSQ nurses and understanding of clinical transition. Interviews were conducted face to face and audiotaped or by recorded teleconference, using the interview guide (see Appendix E). The face-to-face interviews were conducted at a mutually suitable time in a vacant, private office. The recorded teleconferences were arranged in response to requests by participants who wanted to participate however were unable to travel to the university.

Three interviews were recorded by teleconference link and five interviews were recorded face to face. The duration of the interviews was from twenty to forty five minutes. There was simultaneous collection and analysis of data which was reflexive and responsive to change so that new data from each interview and insights were accommodated (Sandelowski, 2000). Data analysis was described in the following section.

3.4 Data analysis: coding, categorising and theme development

This section described how content analysis of the interviews was carried out. The first step advised by Patton (2002) was to read the transcripts at least twice and then develop a manageable way to classify the data obtained in the interview transcripts. Information from Neergaard et al. (2009) has been adapted to summarise descriptions of analytic strategies on Table 4. This provided an overview of analytic strategies that were used for the current study and which I discussed in detail below. Figure 3 illustrated Hahn's (2008) strategy of coding. Hahn's (2008) theme development followed level one and two coding. It involved further distillation of data, with frequent return to the original data, down to a few very significant points which clearly answered the research aims.

Table 4: Analytic Strategies (Adapted from Neergaard et al., 2009).

Analytic strategies in QD	Current study
Level 1 - Coding and recording data	Interviews coded into nodes in NVivo
Level 2 - coding: Sorting data	Similarities and differences, in vivo coding, category development. Sources were classified and attributes created in NVivo.
Looking for similarities and differences	Repetitions noted, data extracted from two groups of participants to compare differences in views of challenges and strategies proposed, in vivo coding.
Level 3 - Theme development: Deciding on generalizations	Development of open codes. Ensure final themes hold true to data.
Memos and reflexivity	Memos attached to data in NVivo
Enrichment of data analysis: Challenging generalizations	Examine themes in relation to previous research, respondent validation. Data reached saturation. Reduction of codes to categories and theme development.

3.4.1 Level 1 Coding and recording data

Searching for themes in audiotaped interviews began with transcribing and reading over transcripts at least twice (Ryan & Bernard, 2003). Since there was simultaneous collection and analysis of data which was reflexive and responsive to change, I recorded then read new data from each interview several times.

Following this I incorporated further insights as they were expanded. Open-ended responses were transcribed verbatim to produce narrative text.

Data were initially organised according to either 'challenges' or 'strategies'. Within these broad categories the data were thematically analysed to identify patterns, recurring and unique themes and categories. The qualitative software program NVivo 9.2 was used to enable data to be stored, coded, retrieved, compared and linked. Nodes, which were the folders where data segments were gathered together, could store any amount of coded data (NVivo 9, 2010). This expedited the process of locating coded themes, grouping data into categories and comparing passages in the transcripts referred to by Patton (2002) as inductive analysis.

As illustrated in Figure 3, Hahn (2008) demarcated codes in open coding as level one code which were all directly inspired by the data and provide the foundation for higher level analysis. For example, in my analysis this was achieved by firstly identifying communication as a challenge then finding similarities such as pronunciation, listening and comprehension which were then related to communication with patients, nurses or communication style. These groups of similar codes became categories. Similarities between some open codes, previously found, were fitted together naturally into groups.
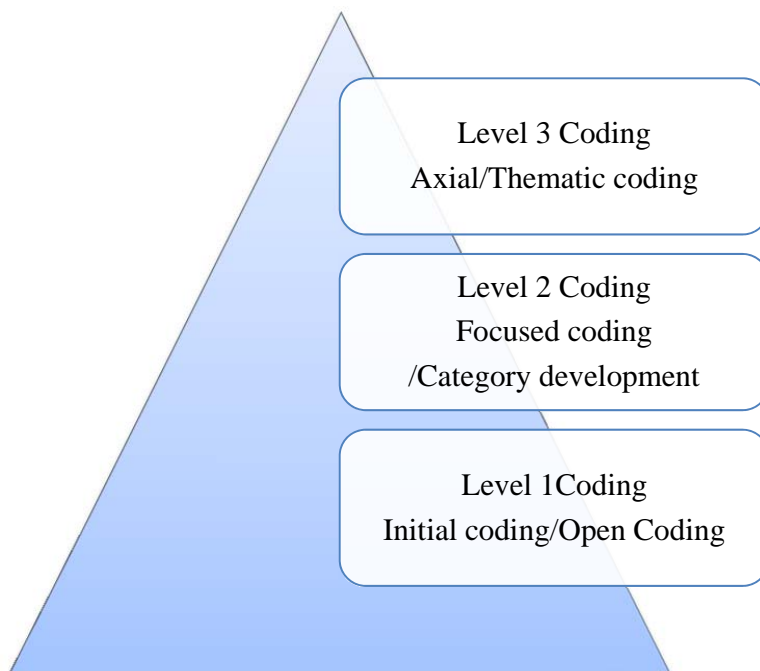
Figure 3: Illustration of coding and progressive refinement of data from level 1 to level 3 (adapted from Hahn, 2008, p. 6).

3.4.2 Level 2 coding: Category development

Developing categories at level two coding involved grouping of level one codes. This meant that multiple level one codes would be associated with almost all level two codes. This was assisted mechanically by NVivo9.2. Level two coding was considered a contemplative, creative phase as it was important to understand the meaning and relationship of each code phrase and associated data (Hahn, 2008). This level involved finding similarities and differences referred to as the constant comparison method by Glaser and Strauss (1967).

Level two coding entailed making systematic comparisons across units of data often with line by line analysis which ensured that the researcher was focused on the data (Ryan & Bernard, 2003). Kitto, Chesters & Grbich (2008) proposed that generation of profound insights could be achieved by revealing important though subtle differences through this use of similarities and differences of the experiences and responses of the participants against each other. In my analysis I identified how differences emerged in views of communication challenges and strategies between CALD and non CALD participants. These differences were compared and contrasted Patterns of difference between non CALD and CALD CFs were noted and the implications of the main differences were documented in Table 5 and explained in 4.3. While looking to describe the unique views of CFs I was looking for common themes between CALD and non CALD facilitators and within the two groups.

Since the current study was aimed at gaining an insider perspective of CFs' views, commencing inductive analysis with in vivo coding avoided labels being imposed by the researcher (Patton, 2002). Firstly, looking for repetitions were based on the concept that the more frequently a concept appeared the more likely it was to be a theme (Ryan and Bernard, 2003). One of the examples of a repetition that occurred in the current study was 'they don't understand' in relation to understanding professional language and communication.

Secondly, indigenous concepts were referred to by Patton (2002) as in vivo coding which was achieved by documenting key phrases that are specific to the participants. Ryan and Bernard (2003) recommended searching for indigenous concepts which enabled me to find themes by looking for local terms used in an unfamiliar way. An example of an indigenous concept in the current study was the use of the term "shower oriented". This term referred to CALD students being conditioned to only carry out task focused patient care such as showering instead of the more holistic approaches to patient care expected of RNs. Participants explained that this conditioning was thought to occur in relation to employment as assistants in nursing (AINs) in the aged care sector and enrolled nurses (ENs) also.

3.4.3 Level 3: Theme development:

Higher level three coding or development of themes in this study involved the use of the level one codes and categories of level two being used as building blocks (Hahn, 2008). Codes at this point were identified which could support a theme and helped achieve the research aims. Theme development was built from the categories which emerged within the interview schedule framework of challenges and strategies. For example, verbal and non-verbal communication style differences became one of the three key challenges which contained one theme and up to two sub themes organised around non-therapeutic relationships and non-assertive verbal and non-verbal communication style. Key associated strategies emerged from level two coding regarding verbal and non-verbal communication which resulted in one of the three key strategies which was represented by one theme and up to two subthemes.

Coding techniques began with open coding, followed by category development and finally axial or thematic coding (Hahn, 2008). Data were considered to have reached saturation as stated by Skeat (2013) when no new data were being generated and new data fitted into the categories which justified the number of participants. Although the number of participants was relatively small the rich descriptions from semi structured interviews provided sufficient data to reach saturation. In order for theoretical statements to be convincing they needed to be linked to adequate excerpts from data which were easily understood because they were related to recognizable life experiences (Seale, 1999). Data excerpts were provided in the Results Chapter 4.Themes were illustrated with examples from verbatim quotes and a narrative explanation given of the meaning of each theme.

3.4.4 Memos linked to implementation of reflexivity

During the data analysis I differentiated memos from codes as proposed by Hahn (2008). Memos provided an understanding of the context and framework of the study rather than the phrases comprising codes which were focused on the research question. Codes were later to be used as theme building. An example of a memo I referred to during analysis was the context of the interviews to remind me of the thoughts and interpretations I had made while talking to participants. These contextual features may have otherwise been forgotten or lost. Memos were also linked to the implementation of reflexivity. Reflexivity in social research such as the current study was the process involving the researcher reflecting on the effect they had on those they are studying which adds credibility to the research findings (Liamputtong, 2013b).

Documenting memos was important as it provided an understanding of the context, structure for the study and was also seen as the mechanizing of reflexivity (Hahn, 2008; Marshall, 2002). Addressing reflexivity involved showing an awareness of how my socio-cultural position of being non CALD and my current

role as academic international advisor, impacted on the results of the study. In addition, consideration was given to the profound effect of researcher values, such as those associated with being non CALD. These values may have affected all aspects of the research from selection of the problem to research design, collection and analysis of data. More broadly, Kitto et al., (2008) stipulated that reflexivity must also address the social setting of the research and the wider social context such as the health care team and the health care facility in this study.

In summary, memos were recorded from the beginning of level one coding in order to provide scaffolding for the study and to mechanise reflexivity. As advocated by Marshall (2002) memos were documented in NVivo during all stages of analysis as a means of filing insights providing a vital ingredient in the research process. Using memos to track my thoughts during coding and linking thoughts to data was imperative in order to enhance critical analytical creativity.

3.5 Research Quality safeguards

Research quality in this study was addressed by describing how the study operationalized the following processes: procedural rigour, representativeness and respondent validation; reflexivity and integrity; transferability; ethical considerations (Liamputtong, 2013a; Torrance, 2011; Neergaard et al.,2009; . Kitto et al.,2008). Below I have discussed each in turn, considering how these techniques assisted with enhancing research quality and how they were applied to this study.

3.5.1 Procedural rigour, representativeness and respondent validation.

Procedural rigour, representativeness and respondent validation were three of the processes incorporated in order to ensure research quality. Firstly, procedural rigour was supported by ensuring documentation of explicit descriptions of all aspects of how the research was conducted (Liamputtong, 2013a; Kitto et al, 2008). This included my reporting of how participants were accessed, how I developed rapport and trust. In addition, reporting of all processes was carried out including data collection, recording, coding, analysis and handling of errors and participant refusal. A clear document audit trail of the research process and analysis has also been provided to further ensure procedural rigour.

Secondly, representativeness also entailed my reporting in 3.3.5 of the use of purposeful quota sampling to capture a broader range and equal balance of views amongst CALD and non CALD participant CFs. A third process involved respondent validation whereby participants interviewed could be encouraged to view and amend their transcripts as a form of validity. This process has limitations due to the varying interpretations by the researcher and the participants (Kitto et al., 2008). As a form of respondent

validation the main themes that emerged from this analysis were fed back by e-mail to the participants who were asked if they felt that the main themes adequately represented their views. Two participants responded positively to this e-mail by confirming that they agreed with the themes and subthemes. .

3.5.2 Relevance and transferability

Additional criteria to strengthen rigour were relevance and transferability which was the desired outcome of qualitative research. Firstly, relevance was established by developing new knowledge to formulate innovative strategies to assist CFs facilitate CALD OSQ nurses' clinical transition. The section 1.5 discussed crucial HWA funding to expand clinical supervision capacity for health professionals to address health workforce shortages. Developing facilitation strategies for successful CALD OSQ nurses' clinical transition supports this focus within NSW Health. In addition, nursing and midwifery was one of the four core discipline modules which acted as a template for other health professions (NSW Health, 2012a). Secondly, transferability referred to having the capacity to make conceptual generalisations from the local context of this study to other settings (Liamputtong, 2013a; Kitto et al., 2008). Transferability was addressed by relating the study findings of the current study to other settings in current literature in Chapter 5.

3.5.3 Reflexivity and researcher background

As well as actually situating reflexivity in the research process through the use of memos described in 3.4.4, the use of reflexivity in the social sciences has also been described as 'benign introspection' or 'reflection' (Woolgar, 1988, p. 22). This encouraged me as the researcher to think about the 'inside story' of how my personal biases, experiences, values and beliefs affect how the research process was actually carried out. Consequently, I was mindful that it was likely that my experiences and relationships with CALD OSQ nurses and CFs may have influenced the way I conducted interviews and my interpretation of the phenomenon being studied. Below I have provided an outline of relevant features of my background.

My background has included more than 25 years of nursing, teaching and clinical facilitation experiences. I have been employed as a clinical nurse and a clinical educator across three Australian states including Western Australia (WA), Queensland (Qld.), NSW and in England. My educational and undergraduate experiences have been based in Australia and have been studied in English and focused on nursing and education. In the last 10 years, I have completed the degree of Masters in Clinical Education through an Australian university. I have had many cultural enrichment experiences through study, work and travel, however studying and working with CALD health professionals and students has had a major influence on

my worldview. Currently, as a university lecturer, I have taught and assessed undergraduate and post graduate students during their university based courses at a university in NSW.

Before studying nursing, I studied French formally as a second language for more than five years. I was intrigued at how difficult it was to speak very basic French coherently when visiting France. These experiences have provided some insight into the difficulties of applying a foreign language learnt in a classroom environment to actual, 'real life' communication with native speakers. More recently, I gained insights into the indigenous culture and language of people on the island of Tanna, Vanuatu while visiting and supporting a family member who was conducting research studies as a participant observer. These insights came from time spent on the island while participant observation and interview data were collected from indigenous participants. I also had privileged access to non-tourist villages and special culturally centred ceremonies.

Experiences as a CF have been transformative in my professional life. These experiences included facilitating diverse cultural groups including CALD OSQ nurses. During the years I was employed as a CF I looked for guidance and opportunities to share what I had learnt about clinical facilitation with other CFs and to learn from their experiences. Possibly ideas for the current study began during that time.

In my current role as Academic International Advisor, CALD students and CALD OSQ nurses who have been identified as having academic or clinical difficulties may be sent to me for support. This advisor role involves emails and possible interviews with the students. I have suggested referral to support services as well as to the Counselling service when necessary. I have taken a leading, consultative and collaborative role in conducting and researching a transition program and workshops aimed at remediating clinical communication and skills. The transition program and workshops were for identified and self-identified students before they attended or repeated clinical practicum. I have also conducted interactive education sessions during annual campus based CF workshops. These sessions provided an opportunity for CFs to share experiences of facilitating CALD students as well as reviewing and being updated on current practices.

In summary I view my work, study and family experiences to have provided me with insights into having a CALD background and gaining cultural awareness and hopefully a degree of cultural competence. I have CALD extended family members and continue to work in multiple roles with the whole student body and reflect on my dual perspectives as a researcher in this study. I have gained valuable knowledge about CFs and the diverse range of students and their transition to clinical practice. Hence, I am aware that my

views had potential to bias the findings in the study. Through the use of reflective practice, supervisor support and peer review of my findings, I have sought to minimise any researcher bias.

3.5.4 Ethical considerations

Ethical considerations have been incorporated in this study from its inception and have continued throughout. Ethics was defined as 'a set of moral principles that aim to prevent research participants from being harmed by the researcher and the research process' (Liamputtong, 2013a, p. 36). Addressing ethical issues in qualitative research was particularly essential because of the close interaction between the researcher and participant. In view of a history of unethical biomedical research practices recognised after World War II, the United Nations Educational, Scientific and Cultural Organisation (UNESCO) established mandatory high standards of integrity, responsibility and accountability in research. In addition, the most recent international declaration espoused by UNESCO in 2005 was the Universal Declaration on Bioethics and Human Rights. Core ethical principles were followed throughout the current study including: respect for autonomy requiring informed consent; respect for confidentiality and anonymity; respect for justice, beneficience; respect for human vulnerability and personal integrity; respect for cultural diversity (Woods and Schneider, 2013). Ethical considerations were identified in the current study and addressed below.

Potentially, the current study may have been seen to be associated with the clinical coordinator who was responsible for selection of CFs for employment by the university. I was aware that CFs might be concerned that their employment may be affected by participation in the research. In addition, employment interviews took place in the same building as the research interviews. Consequently, the participant information letter (see Appendix C) contained assurances that all information and recordings and documents would remain confidential then eventually destroyed. The letter was emailed by the investigator and the principal supervisor to all potential participants, to inform them about the study. These assurances included that the participants who agreed to participate and those who did not agree, will not be known by staff involved in recommending CFs for current or future employment by the university. In addition, the letter explained the research aims and the importance of the research, how and why they had been selected, what would be involved and the likely duration of the interviews. Assurances were also provided that ethical research principles would be applied throughout the study.

Ethics approval to conduct the proposed study was granted by the Australian Catholic University, Human Research Ethics Committee (see APPENDIX F). The following ethical considerations were included in the research proposal (see APPENDIX A) to the ethics committee: All study material will be disposed of

in a confidential manner by shredding all interview transcripts and audio recordings will be erased and electronic data will be deleted after 5 years. Also, all identifying information will be removed prior to data entry and only de-identified data will be analysed. No identified data will be published or released. All study material will be stored in a locked filing cabinet accessible only to the student researcher for five years following publication then destroyed. There are no particular risks envisaged to the confidentiality of personal information and only aggregated data will be reported.

3.6 Conclusion

This Chapter has discussed the selection of the qualitative research paradigm, features of QD research methodology, choice of qualitative methods and the justification for choice of the QD approach and methods. The study aims and research questions were presented. Alternative ways of collecting descriptive data were examined by considering quantitative surveys, participant observation and focus groups. The reasons for choosing to conduct semi structured interviews, the interview process and threats to validity were elucidated. Qualitative methods were related to the study by providing details of the study design, research participants, sampling approach, selection and recruitment procedures and data collection methods. This was followed by delineating data analysis processes and procedures and measures used to ensure research quality including ethical considerations throughout the study. The Chapter has expounded the design features of the QD approach using semi structured interviews to enable data collection and analysis for the development of codes, categories and themes. Chapter 4 presents the results of the thematic data analysis.

CHAPTER 4: RESULTS

4.0 Introduction and Overview

This Chapter has provided rich description of CFs' challenges and corresponding strategies of facilitating clinical practicum for CALD OSQ nurses. The clinical practicum journey began with the CFs' challenge of differentiating CALD OSQ nurses from other CALD students. Following this, interview data led to exploring challenges related to perceived changes in the CF role. Differences in verbal and non-verbal communication style then emerged as significant to experiences throughout clinical practicum. These differences could ultimately result in withdrawal of consent by patients, refusal to supervise by RNs and risk of clinical fail for CALD OSQ nurses. Underlying the corresponding strategies was the participant CFs development of CALD OSQ nurses' trust for reflective practice, addressing differences in verbal and non-verbal communication style and ensuring cultural empathy through transcultural education programs for CFs and RNs.

Challenges and strategies provided the organisation of categories around which themes emerged in accordance with the interview guide. Each challenge and corresponding strategy category had three themes each with up to two subthemes. Each of the challenge themes and subthemes was followed by corresponding strategy themes and subthemes which were substantiated with participants' verbatim quotes. These themes and subthemes have been included later in this Chapter. By presenting results of the analysis of collected data from participant interviews this chapter has addressed the research aim and answered the research questions displayed in 4.1 and 4.1.1.

Finally differences which were identified between CALD and non CALD CFs' views were summarised and found to provide a wide variation of views which enriched the research findings. Differences arose by clearly identifying CALD and non CALD participants' original transcripts and data extracts in this chapter. Some of the main differences in CFs' views of challenges and strategies between CALD and non CALD participants were integrated into the themes. Following below are participant demographics which were explained then detailed on Table Five. The Chapter concluded with a summary overview and conclusion of the key challenges and strategies.

4.1 Research Aim:

To describe CFs' views of the clinical transition challenges faced by CALD OSQ nurses during clinical practicum and their views on strategies to address these challenges.

4.1.1 Research Questions:

What are the challenges of clinical transition of CALD OSQ nurses during clinical practicum according to the views of the CFs who are facilitating their transition to clinical practice?

What strategies are proposed by CFs to address the challenges of facilitating clinical transition of CALD OSQ nurses during clinical practicum?

4.2 Participant Demographics

Data were collected at the beginning of each interview by using the interview guide to ask specific questions regarding length of nursing and CF experience, cultural background, educational preparation for the role of CF and nursing focus. The participant demographic data are summarised on Table 5. Ethical principles detailed in 3.5.4 were maintained by ensuring anonymity and confidentiality in the research process. Hence, pseudonyms were allocated to participants and one non CALD participant and the four CALD participants' cultural background were referred to in general terms. Purposive quota sampling as detailed in 3.3.5 was used to select 4 CALD and 4 non CALD participants. Shortages of appropriately qualified, experienced and available CFs across the many universities in NSW wanting to employ them may be one of the possible reasons for the low acceptance rate, refusals and non-responders. These shortages meant that CFs worked for multiple universities in order to meet the demand and obtain continuing employment between clinical placements. Participant CFs tended to respond to emails requesting participation in the study while they were employed by the participating site.

As shown on Table 5 the participants were all female with length of nursing experience as an RN ranged between 4 and 40 years. Participants had spent between 30% and 65% of that time working in the CF role. In addition, the four non CALD participants' main residence was in Australia, however one had spent more time in South East Asia where English was spoken as a first language. Three of the CALD participants' main residence was the Middle East, Africa and Europe. Another participant included as CALD had resided overseas, spoke English as a first language as well as speaking an Asian second language. This exemplified how learning a second language, temporarily residing overseas and seeking transcultural education and experiences enabled her to be included as a CALD participant. Educational preparation of participants ranged from post graduate Diploma courses to degree at Masters' level and Doctor of Philosophy (PhD). Nursing focus was distinguished because knowledge of nursing specialty areas could contribute to gaining insights into some of the different views as they emerged from collected data. It was found that four participants' nursing focus was medical surgical as well as aged care. Two

participants' nursing focus was medical surgical nursing only. Finally, two participants' nursing focus was mental health.

In summary use of purposive quota sampling ensured that collected data incorporated variation between participant demographics which contributed a more even balance and broad range of views to the study. Participant demographics have included non-identifying information regarding: length of nursing and CF experience, cultural background, nursing focus and educational preparation for the role of CF.

Table 5: Table of Participant Demographics

Participant Interviewed	Non CALD or CALD	Years of Experience	Credentials Nursing Focus	Main challenge	Main Strategy
Non CALD					
1st **Beccy**	Non CALD	7 as CF	Diploma Mental health.	Communication/non-assertive/Pronunciation/ task orientation	Collaboration with RNs,, Language practice, early IELTS testing
3rd **Pajlia**	Non CALD	>10 as CF	Masters Medical surgical	Communication pronunciation /task orientation	Language practice, listening exercises
6th **Hetty**	Non CALD	>7 as CF	Masters Medical surgical/ Aged Care.	Communication Pronunciation/ task orientation	Language practice, collaboration with RNs, develop assertiveness
8th **Sally**	Non CALD	>7 as CF	Diploma Medical surgical	Communication, pronunciation /task orientation/ role of CF, RN and student	Self-directed learning, language practice, role clarification
CALD					
2nd **Hazel**	CALD	7 as CF	PhD Mental health	Authoritarian communication/ task orientation	Language practice, role clarification
4th **Amber**	CALD	2 as CF	Diploma Medical Surgical/Aged Care	Non-assertive communication	Develop empathy, CF trust, reflective practice
5th **Pamela**	CALD	>20 as CF	BN Diploma medical surgical/aged care	Trust of CF and culture of fear/ role of CF, RN and student	Develop CF trust, therapeutic relationship, cultural awareness and empathy
7th **Gerda**	CALD	7 as CF	Masters Medical surgical/ aged care	Attitude toward CALD CF due to strong accent/role of CF, RN and student	Clarify CF/RN role, debrief and reflective practices, collaboration with RNs

4.3 Introducing the themes and sub themes

As shown on Table 6 below three key challenges and three key strategies emerged from the data. Each key challenge and each key strategy consisted of three themes and up to two subthemes. The themes and subthemes were organised around open ended questions from the interview guide about challenges and strategies. Each theme presented in 4.4 to 4.7.4 which identified challenges was followed by the corresponding strategy each represented by a theme and sub themes.

There were a significantly larger proportion of data categorized into challenges however it was noted that strategies required less detail to explain. Reasons given for many of the facilitation challenges participants faced involved reference to international CALD students and local CALD students in general as opposed to CALD OSQ nurses. During the interviews, prompts included frequent reference and focus on CALD OSQ nurses. The acronym and word 'CALD OSQ nurses' was substituted when selecting participants' verbatim quotes instead of the following terms: 'overseas nurse', 'overseas RN', 'they' or 'the internationals' or simply 'students from overseas'.

Table 6: Summary of interview guide categories and corresponding themes and subthemes

Category	Challenges Themes and subthemes	Strategies Themes and subthemes
Knowledge and understanding	Challenge theme 1: Lack of knowledge and understanding. Subthemes: • Differentiating CALD OSQ nurses; • Perceptions and assumptions.	Strategy theme 1: Gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs.
CF autonomy CF expectations and ward priorities.	Challenge theme 2: Loss of CF role autonomy: Mismatch between CFs' expectations and ward priorities.	Strategy theme 2: Strengthening CF role autonomy: Aligning CF expectations with ward experiences.
Differences in verbal and non-verbal communication style.	Challenge theme 3: Differences in verbal and non-verbal communication styles; Subthemes • Non-assertive communication • Non-therapeutic communication	Strategy theme 3: Addressing differences in verbal and non-verbal communication styles; Subthemes: • Facilitating assertiveness. • Developing therapeutic relationships

Data about each category were collected separately and the 'strategy themes' were matched with challenges during the data analysis process as shown on Table 6. Differences in main challenges and strategies between CALD and non CALD participants shown on Table 5 were developed from comparing and contrasting responses. The main difference was the focus by non CALD participants on collaboration with supervising RNs and improving assertiveness, self-directed learning and pronunciation through language practice and earlier IELTS testing. On the other hand CALD participants focus was on addressing a culture of fear by developing strategies to engender trust, empathy and therapeutic relationships through reflective practice. Benefits of having multicultural participants therefore included that data from non CALD participants may provide views of challenges which data from CALD participants were able to address with strategies. For example 'challenge data' from 'Beccy' who was non CALD contributed to differences in verbal and non-verbal communication challenges which could be addressed by 'strategies data' regarding showing empathy and building trust from 'Amber' a CALD participant. Alternatively data from 'Gerda' a CALD participant contributed to a challenge regarding CF role conflict and loss of CF autonomy which was addressed with 'strategy data' which involved creating innovative RN connections from 'Hetty' a non CALD participant. The three key challenges each followed by key strategies were presented with my rich descriptions and participant verbatim quotes in the following.

4.4 Challenge theme 1 and its associated strategy:

Most participants described a lack of knowledge and understanding of CALD OSQ nurses. Participants were unable to differentiate CALD OSQ nurses from other CALD students on clinical practicum which led to imprecise perceptions and assumptions of the learning needs of CALD OSQ nurses. Two challenges and one strategy were described in this section.

4.4.1 Challenge theme 1: Lack of cultural knowledge and understanding; Differentiating CALD OSQ nurses'

The first challenge theme was entitled 'Lack of knowledge and understanding: Differentiating CALD OSQ nurses'. There was a great diversity of CALD local and international students including CALD OSQ nurses within student groups on clinical practicum. As described in chapter one CALD OSQ nurses were a relatively small subgroup of CALD international students who were enrolled in the BN. However Australian citizens or permanent residents who were CALD local BN students were another group who may have looked and sounded like international students. Participants described the challenges related to being unable to differentiate between different categories of CALD students. Participants often relied on information about their status being volunteered by CALD OSQ nurses, rather than being specifically

elicited by the participants early in the clinical practicum. These difficulties differentiating categories of CALD OSQ nurses often resulted in inaccurate perceptions by the CFs about CALD OSQ nurses' level of knowledge and understanding. Two challenge subthemes emerged from the parent data and were named: 'Differentiating CALD OSQ nurses' and 'perceptions and assumptions about CALD OSQ nurses'. These challenge subthemes will be presented below with data extracts substantiating them.

4.4.2 Challenge subtheme: 'Differentiating CALD OSQ nurses'.

Participants explained that they had been unable to identify CALD OSQ nurses and sometimes they relied on discerning differences as the clinical practicum progressed. According to participants it was not always feasible to seek information about the learning needs of individual CALD OSQ nurses at the beginning of clinical practicum. Participants' reasons for being unable to distinguish CALD OSQ nurses and the absence of orientation were ambiguous. However without introductions and orientation, the varying levels of knowledge and understanding between different categories of CALD students within the diverse student groups were either overlooked or discovered late in the three week clinical practicum. It appeared that identifying CALD OSQ nurse status was frequently not given priority. One participant made this very clear in the following verbatim quote:

I haven't noticed a difference between the international students [sic] or the CALD OSQ nurses, just say generally international students. That is I haven't noticed a difference between students who look international but they may be CALD local, international or CALD OSQ nurses (Amber 4 CALD CF).

The lack of communication about which students had nursing qualifications from overseas led participants to develop their own perceptions about the quality of clinical performance. However participants stated that assessing clinical performance was a complex process which required multiple assessment tools as well as input from the RNs who were supervising the students. It was not apparent from participant interviews exactly how judgements about clinical performance were made. For example, one participant said:

I can't get a group and after the first week see who the CALD OSQ nurses are and who aren't. At the moment, I have got two Nepalese students who I think are both CALD OSQ nurses. One I can see would be a CALD OSQ nurse. The other one is definitely like a regular three year CALD international student starting from scratch (Hetty 6 non CALD CF).

Even when a participant did inquire early in the clinical placement about a CALD OSQ nurse status, these nurses sometimes denied their status. CALD OSQ nurses were thought to deliberately conceal overseas qualifications by denying they had them if they were asked. This mystified one participant who assumed the denial to mean that CALD OSQ nurses were fearful that the participant CF would expect them to perform at a higher level. The following participant verbatim quote described this scenario:

I said are you a CALD OSQ nurse? They would initially say no until in the second or third week, they will say, "yes I am". They don't like to tell me in case they do something wrong. Maybe they think I will be harsher towards them because they already know what to do. They might be just scared (Gerda 7 CALD CF).

Participants described how there could be weeks before communicating to gain fragments of knowledge about the CALD OSQ nurses' status. This lack of communication resulted in participant CFs resorting to assumptions based on fragmented perceptions. The purpose of an interim progress report after one to two weeks was to provide students with adequate time to respond to formative feedback by strengthening any identified weaknesses in order to achieve a clinical pass. However participant CFs sometimes had not identified a CALD OSQ nurses' status until after the second week of clinical practicum. The following participant communicated with the CALD OSQ nurses after two weeks which was usually when the interim report was due:

I don't know on day one who is a CALD OSQ nurse and who isn't. Eventually, when I sit down and talk to students by the end of two weeks I get to know CALD OSQ nurses more and I ask them what their qualifications are and we communicate (Beccy 1 non CALD CF).

4.4.3 Challenge subtheme: 'perceptions and assumptions'.

Participants based their perceptions and assumptions about CALD OSQ nurses on appearance and fragmented communication gleaned over the first few weeks. For example several participants assumed that CALD OSQ nurses preferred to learn independently rather than in teams. Assumptions were formed about cultural influences on teamwork. Using team work on clinical practicum was considered to be extremely important when working to improve outcomes for patients and a crucial learning outcome for students. However, the following quote demonstrated how one participant assumed that preferring to work alone was a common cultural attribute of CALD OSQ nurses and CALD international students:

A lot of the wards now do team work. So they will be buddied up in pairs. Whereas I find the CALD OSQ nurses and CALD international students are more likely to work on their own (Hetty 6 non CALD CF).

Participants viewed another important attribute essential for all BN students was use of initiative rather than obediently waiting to follow instructions without question. In addition, use of initiative was a vital ingredient in the transition toward developing critical thinking skills. However another participant's assumption was that lack of use of initiative was a common cultural difference found in CALD OSQ nurses and other CALD international students but not found amongst non CALD students. This assumption was often based on previously formed perceptions or on deference shown by some CALD OSQ nurses to authority figures such as the CFs and RNs in the health facility. The assumption was exemplified in the following data excerpt:

What is more obvious is cultural difference as they don't tend to use their initiative. CALD OSQ nurses and [other] CALD international students do tend to run together (Pajlia, 3 non CALD CF).

The role of the RN in some other countries was perceived by participants to be extremely different from the RN role in Australia. For example, one participant assumed that the role of the RN was limited to medication administration in China. Further assumptions included an absence of holistic approaches to patient care, feeding patients and understanding nutrition. In addition, it was assumed that Australian university based theoretical and laboratory simulation preparation for clinical practicum had not transformed CALD OSQ nurses' culturally based difference in understanding clinical practice. The assumption that responsibilities and approaches to patient care were culturally different in different countries was often seen as an overwhelming hurdle for participants facilitating clinical transition. One participant stated the following:

Registered nurses in China for example only give medication. So they don't tend to do any of that sort of holistic care that we tend to do in Australia. CALD OSQ nurses don't even do things like feeding and understanding nutrition (Pajlia 3 non CALD CF).

Participants pointed out that part of preparation for clinical practicum for all students including CALD OSQ nurses routinely learnt about holistic care, interpersonal skills and therapeutic relationships in Australian clinical practice. Part of the participant CFs' role of facilitating clinical transition for all students including CALD OSQ nurses on clinical practicum was to consolidate understanding of the RN role and encourage the move away from technical, task oriented care. Participants perceived that

facilitating CALD OSQ nurses meant encountering previously entrenched and very different nursing experiences. Several participants had perceived that the role of the RN for Japanese CALD OSQ nurses, for example, was limited to technical responsibilities. Despite their preparation for clinical practicum it was assumed that CALD OSQ nurses who were Japanese RNs saw nursing as confined to technical, task oriented care. Assumptions about CALD OSQ nurses being restricted by having experienced these totally different RN role responsibilities were identified as challenges by participant CFs. In the following quote the participant proposed that overseas nursing qualifications made it challenging to facilitate clinical transition to the role of the RN in Australia:

..in terms of CALD OSQ nurses ... specifically one student that I know from Japan was talking about being qualified, it seemed to be very much a technical role. Difficulties that she had in actually moving into the role of RN here were that it required much more of the interpersonal skills and the therapeutic relationship (Sally 8 non CALD).

Participants pointed out that preparation for all students including CALD OSQ nurses incorporated developing appropriate nursing competencies associated with patients' personal care. These competencies involved assisting with clothing removal and supervising patients while in the shower and toilet. Participants reported that many students found carrying out responsibilities involving patients' personal care during the clinical transition period extremely confronting. However, when participants observed that CALD OSQ nurses initially found showering patients confronting, an assumption was that the reason for this was based upon cultural practices from overseas. These perceived cultural practices included patient's family members being expected to be responsible for personal care. Participants assumed this was preventing CALD OSQ nurses' successful clinical transition to easily carry out these practices. This was perceived as a facilitation challenge by participants:

... CALD OSQ nurses don't do personal care overseas, their families do that. When they are RNs overseas they are more responsible for medications and dressings and talking with the doctors. They find it quite confronting because they have to shower or sponge someone for the very first time (Hetty 3 non CALD).

Participants described how passing clinical practicum was dependant on completing documents following competency assessments carried out by the RN in the CF role. However it could be problematic locating the opportunity to assess appropriate clinical competencies. Sometimes the clinical practicum could be incomplete because all skills were not able to be assessed. Participants explained the worst case scenario

included an outstanding competency assessed on a later clinical practicum resulting in an overall clinical fail. This meant that the previous clinical would have to be repeated and passed or university enrolment could be terminated. Consequently students were encouraged to take responsibility for completing clinical competencies within the three week clinical practicum. However, participants often perceived that CALD OSQ nurses were 'assessment focused' which resulted in an assumed excessive urgency to have clinical report paperwork signed off without trying to improve clinical performance. As CFs the participants were made aware of the substantial financial and emotional cost of having to repeat clinical practicum as a result of possible clinical fail. The drive to focus on completing assessment forms was perceived by participants to cause a major distraction from learning. This concern with paperwork led participants to the assumption that CALD OSQ nurses were unwilling to focus on learning to apply holistic approaches to care and understanding RN role differences. One participant stated her concern in the following extract:

I find them [CALD OSQ nurses] very assessment focused. It's all about the paperwork and getting it signed off instead of looking at the holistic care and the role of the RN. They are really focussed on "Hetty, when can I do this assessment?" "When can I get this done and you know, if I don't get this signed off I don't pass and I have to reenrol and it's going to cost me $3,000" and so they are very assessment focused (Hetty 6 non CALD CF.)

Participants perceived that if they had cautioned against risk of clinical fail, attempts to support CALD OSQ nurse who were assessment focussed experienced even greater stress. Instead of attempting to respond to remediation advice it was assumed the majority would prefer to withdraw because the assessment was the major focus. Participants also perceived that singling CALD OSQ nurses out for testing knowledge and giving feedback could then be interpreted as bullying, particularly if knowledge questions were asked repeatedly. However as confidence dissipated many were perceived to feel they were being unfairly singled out by receiving the extra attention. Participants assumed that being assessment focused meant the emotional reaction to being at risk of clinical fail had overwhelmed any possibility of further learning. One participant described this scenario in the following data extract:

By Wednesday in the last week the CALD OSQ nurses were informed they were unsatisfactory. Every day they have every opportunity to provide evidence that they are satisfactory in certain areas. If they are focussed on the assessment and not responding to remediation advice you are 'flogging a dead horse' and putting the CALD OSQ nurse under stress. They see you as picking on them or being a bully because you are asking them the same questions. They usually decide to leave clinical practicum. It's too stressful for everyone (Hetty non CALD CF).

One participant perceived that the policy requiring all CFs to tell students they were at risk of clinical fail at the interim report could result in misunderstanding that clinical pass was no longer achievable. It was assumed that CALD OSQ nurses concluded immediately that they were being forewarned of an impending clinical fail. Reasons for this assumption were not clear. The following data extract depicts this scenario:

I say [at the interim report] 'you know [that] you need improvement' they [CALD OSQ nurses] think that I am going to fail them (Hazel CALD CF)

In summary, challenges which emerged for participants included a lack of knowledge and understanding which emanated from being unable to differentiate CALD OSQ nurses from other CALD students and understanding their learning needs. Reasons for not identifying CALD OSQ nurses were unclear however included being unable to create an opportunity to inquire at the outset of clinical practicum. In addition, the CALD OSQ nurses were perceived to be reluctant to volunteer information about their overseas qualifications leading participants to the assumption that their reluctance was fear based. Assumptions made about CALD OSQ nurses' learning difficulties were perceived to relate to: lack of understanding of team nursing; lack of initiative; unfamiliarity with holistic models of patient care. In addition assumptions were made by participants about CALD OSQ nurses': culturally entrenched nursing practices; understanding of the role of the RN in Australia; focus on assessments rather than learning holistic approaches to clinical care. Participants frequently viewed these perceived learning difficulties as CF role challenges to facilitate CALD OSQ nurses' clinical transition.

4.4.4 Strategy theme 1: 'Gaining cultural knowledge and understanding of CALD OSQ nurses learning needs.'

Strategy Theme 1 was entitled: 'Gaining cultural knowledge and understanding of CALD OSQ nurses learning needs'. Several participants conducted an orientation which employed facilitative, empathetic approaches to encourage sharing cultural backgrounds early in the clinical practicum. These facilitative approaches were aimed at creating a safe place and cultural empathy which was about enabling CALD OSQ nurses to feel supported.

Participants frequently viewed that the unpredictable nature of applying recently learnt skills to vulnerable patients can be extremely challenging for CALD OSQ nurses and all CFs and RNs responsible for facilitating and supervising the learning process. Consequently use of reflective practice involving regular

debriefing sessions during clinical transition became essential for all students including CALD OSQ nurses. Several participants proposed that orientation on the first day assisted with developing cultural empathy and incorporated preparation for reflective practice. This involved the development of trusting relationships to engender peer and participant CF trust and support. Participants described developing a climate of trust in order to learn from personal clinical experiences. This required assuring confidentiality about sharing negative feelings associated with those experiences. Ideally CALD OSQ nurses could then use collective verbal expression with the participant CF and peers to form new insights about what happened. This could then be followed by discussion about knowledge gained from the reflective process and application of this to new experiences.

Those participants who conducted orientation found out about what the CALD OSQ nurses had done in their country of origin in order to gain cultural knowledge and understanding. Participants identified that CALD OSQ nurses frequently needed support from them as CFs as well as from each other. So it was important for CALD OSQ nurses to develop sufficient trust to feel their confidentiality was respected. A technique adopted was encouraging groups to find something in common with peers and the participant CF so they would seek support and opportunities to reflect verbally. One participant articulated a three dimensional approach to creating trust.

Initially trust was developed at orientation then daily meetings were planned in order to provide opportunities to deal with positive and negative issues by reflecting and talking about them. Secondly, showing that being successful on clinical practicum was achievable. Thirdly, gaining knowledge and understanding about individual cultural attributes of the diverse groups of students as well as the participant CF was proposed to enable group members to trust each other to speak openly. One participant expressed this approach to cultivate cultural empathy to safely reflect feelings and be able to seek peer and CF support in the following verbatim quote:

I put great effort up front into orientation on day one to the clinical learning outcomes and preparing them for working with me and with that facility. Also creating a sense that this will be a safe place to talk openly at daily meetings, and deal with them. It's a three pronged thing to develop trust, get them on side and show that it's all going to be achievable. I need to understand who they are they need to understand each other because they are rarely a homogenous group. Some may be Nepalese CALD OSQ nurses or some Chinese CALD OSQ nurses and rarely Indian (Pamela 5 CALD).

Several orientation techniques or 'icebreakers' were used to gain cultural knowledge and understanding and to avoid imprecise participant CF and RN perceptions and assumptions about CALD OSQ nurses. Participants described how these techniques can be short and effective and take different forms from simple introductions with a brief background to organising students to find out culturally based information about each other and then introduce group members. Gaining deeper cultural knowledge and understanding was achieved if these activities continued to be threaded throughout clinical practicum. Participants described the need to place emphasis on valuing cultural diversity. One participant articulated that on the first day she was open about her own CALD background and encouraged CALD OSQ nurses to open up so that they felt empathy regarding cultural differences:

I make it a point at orientation on the first day to start to talk to them about my cultural background and experiences. I ask them to tell everyone about where they are from and why they chose nursing so that they get to know each other and have that support. If I have something in common with someone I will be more likely to go to them for help. They see a human side of me rather than 'this is our CF who is going to judge us on what we are doing' (Amber 2 CALD CF).

Several participants proposed that when they as CFs had a calm, open mind and empathetic approach it allowed CALD OSQ nurses to feel safe, supported and confident. Use of an empathetic approach was proposed to make the RN in the role of CF less intimidating for students and create trust in a supportive learning environment. Emphasis by the participant CF on empathy and being approachable was based on an underlying belief that CALD OSQ nurses needed to feel supported. Under these circumstances they were more likely to perform at a higher standard than if they felt threatened. It was essential to gain awareness of CALD OSQ nurses' personal, social and financial costs and benefits of coming to Australia. Travelling to upgrade qualifications in Australia was usually preceded by many years of study and experience in both the English language and nursing. Participants encouraged acknowledgement that CALD OSQ nurses have to adapt their skills to fit the new environment as well as having moved countries to come here. One participant expressed these sentiments in the following extract:

It's better if the CF goes in with an open mind and realises CALD OSQ nurses have moved countries to come here. The environment is different perhaps, the skills they have to learn to adapt to fit the situation means there is more empathy towards the CALD OSQ nurses who pick it up and feel more confident and comfortable around that CF. In that learning environment they feel supported and are more likely to perform better than if they feel threatened. CF's using a softer approach means the CALD OSQ nurses will feel more confident and able to do what they are supposed to do (Amber 2 CALD CF).

One participant recommended linking culture, trust and language by using informal conversations about travel to engender cultural empathy. While some participants could simply show interest and respect for cultural diversity others had actual experiences to share. One participant found her own experience of travel meant it was easier to empathise with CALD OSQ nurses' cultural background and relate this to personal, enjoyable cultural experiences. Key questions could also encourage the group to find something in common by relating positive experiences of different cultures. These experiences could be about holiday travel in culturally and linguistically diverse destinations which revealed insights into being interested and valuing different world views. In addition the value of cultural diversity in Australia can become more distinct. These questions about cultural experiences provided an opportunity for CALD OSQ nurses to gain the trust and confidence to speak about their culture in English in an unfamiliar environment without fear of humiliation. The following data excerpt described developing trust through finding common ground and hopefully improving language with more relaxed conversations:

But you can't separate culture, trust and language from each other. One of the early things that I do because I have travelled so extensively is I might ask [a key] question of the CALD OSQ nurse which country is their country of origin? It's likely that I have actually visited their country and I might talk with CALD OSQ nurses about it and say something I enjoyed about it (Pamela CALD CF)

Another technique involved openly acknowledging cultural difference by modifying the speed and type of language used compared to that used with non CALD students. In addition, time could be spent looking for signs of understanding specific instructions. Conversations regarding CALD OSQ nurses' background and experience were a more indirect, non-confrontational technique of checking understanding. These conversations also served to gain cultural knowledge and understanding. One non CALD participant tried to gain understanding of the CALD OSQ nurses by asking questions to gain knowledge and check their understanding:

I talk to them [CALD OSQ nurses]in a different way I probably don't recognise that I do talk to them a little bit differently than I talk to the Australian students. Finding out what they have done and if they actually do understand things (Beccy 1 non CALD CF).

Participants related some of their teaching style and successes with CALD OSQ nurses to their own experiences. Several participants emphasized that an understanding participant CF who gave plenty of

support to build confidence would make CALD OSQ nurses more empowered and therefore less at risk of failure. The following verbatim quote described how this would also build confidence:

When you are a student you feel a little bit disempowered, a bit more vulnerable and not sure what you are allowed to do. It helps a lot to have a CF who understands and can give you that leeway to become more confident. (Amber 2 CALD CF).

One participant explained that it was imperative to let CALD OSQ nurses know why CFs were there with the message of helping, supporting and motivating rather than examining and judging. One CALD participant CF described how she had learnt from personal experience of clinical fail and having to repeat a clinical practicum. From this experience the participant emphasized that decisions about pass and fail should be made after consultation with the CALD OSQ nurses. Any CALD OSQ nurse who was not complying then required the opportunity to both defend themselves and rectify the situation as described in the data extract below:

If I find that the student is not really complying, I just pull them aside. I give the student the chance to rectify the situation and to also defend themselves. I have had CFs who didn't do that for me and just listened to what the RNs were saying and I failed my course because of that. If the CALD OSQ nurse was not doing the right thing instead of me going and just failing them or taking the word of the RNs I say 'look, this is what I have heard and this is what I have noticed. What do you say?' I know how it feels and that helps because I come from another angle (Amber CALD CF).

Participants agreed that giving adequate notice and providing strategies to achieve a satisfactory result meant emphasising the facilitative role of helping CALD OSQ nurses was essential. One participant explained that part of preparation for the role of CF were discussions surrounding processes for reducing anxiety for CALD OSQ nurses who were unable to reach satisfactory standards of care. The main strategy to arise from these discussions was to provide remediation advice and adequate notice of risk of clinical fail. Keeping students informed also meant it was not a surprise if the final decision made by the clinical LIC was to fail the CALD OSQ nurses' clinical practicum as described below:

I will let the student know as early as possible that I need them to improve. I put my own strategies in place, 'you need to do this to look at getting a mark that's satisfactory for this clinical'. Even up until two or three days before their last day when they get their final assessment, I usually let them know what my

thoughts are on their assessment so far. It's not a surprise, we are always taught that it shouldn't be a surprise on the last day,bang, you have failed (Hetty non CALD).

Some participants proposed the need for cross cultural education for all CFs and RNs working with CALD OSQ nurses to avert fear reactions and further set the scene for positive feedback. Issues which emerged for participants were frequently based on witnessing reactions which were based on fear of the unknown practices of CALD OSQ nurses. These unknown practices could be religious as well as nursing. There were some strong negative reactions to CALD OSQ nurses wishing to avoid personal patient care such as showering patients or to interrupt their work to pray or to clarify or debrief in their home language. Several participants broached the issue of health facility staff receiving cross cultural education awareness programs to increase sensitivity and understanding of the multicultural workforce. One participant suggested that such programs would assist all CFs and RNs to deal with fear based reactions and feel more comfortable working with CALD OSQ nurses in the following verbatim quote:

Assessments depend largely on RN feedback and RN reactions to CALD OSQ nurses were often fear based. If we dealt with some of that we could help RNs to be more sensitive and more understanding of the richness and complexity of our multicultural society. I suggested at the education office that there was this element within their service that might respond positively to some cross cultural education awareness programs. These programs would enable RNs to feel more comfortable working alongside people from another culture (Pamela CALD CF).

Avoiding confrontation when faced with perceived cultural intolerance from RNs toward CALD OSQ nurses was recognised as an essential strategy. One participant recommended diplomatically approaching the health facility staff development services to utilise existing support structures. One participant felt placing recommendations with the education office for cultural awareness programs was an important way to avoid confrontation. Working within the structures and procedures that are already in place in health care facilities in this way was detailed below:

Suggesting transcultural education programs at the education office was how I dealt with fear based reactions to CALD OSQ nurses to avoid confrontation I think confrontation is not going to end happily and facilities do have their own structures and procedures in place to deal with these issues. I personally feel it's important for me not to cut across those but to work with them. (Pamela CALD CF).

An essential component of understanding learning needs of CALD OSQ nurses being placed in health facilities included the opportunity for clinical skills practice as part of experiential learning. Competency assessments of clinical skills are part of clinical preparation at the university in simulation laboratories. However performing these skills on patients in less controlled environments with real patients can be a great source of stress for CALD OSQ nurses. Examples of skills included administration of intravenous medication, complex wound dressings and management of chest drains. One participant pointed out practicing these skills as a supportive strategy to better prepare CALD OSQ nurses to carry out various competencies at a more satisfactory level on clinical practicum:

Getting the students to practice their skills more and getting the feel of what the assessment will be like helps make CALD OSQ nurses feel like they have taken something from the clinical practicum that they can implement (Hazel 3 CALD).

In summary, empathetic approaches, orientation and transcultural education programs for all CFs and RNs were the main strategies to arise from the data to facilitate gaining cultural knowledge and understanding of CALD OSQ nurses. Participants employed facilitative, empathetic approaches to encourage sharing cultural backgrounds early in the clinical practicum. This could be achieved by developing a climate of trust. Creating trusting relationships would incorporate orientation on the first day of clinical practicum so that daily reflection meetings could successfully run as a source of strength to gain knowledge from new experiences. Furthermore making success clearly achievable from the outset was accomplished by gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs at orientation.

Orientation could take several forms and incorporated techniques or icebreakers which acted as an introduction to develop cultural empathy and trust to facilitate reflective practice. This entailed CFs discerning empathetic ways to show students that they were there to facilitate their learning rather than be there to simply judge or examine them. Effective techniques included CF self-disclosure regarding cultural background and experiences, sharing pleasant multicultural experiences and having a calm approachable manner. In addition, conversations about different cultural experiences were beneficial. These conversations enabled CALD OSQ nurses to develop sufficient trust and confidence to practice having relaxed conversations in English. Consequently orientation and 'icebreaker' techniques helped to set a platform of cultural empathy and trust which could be threaded through clinical practicum to facilitate reflective practice.

The final strategy recommended by participants to gain cultural knowledge and understanding was transcultural education programs for all CFs and RNs which involved learning cultural awareness. These

programs were intended to modify some of the fear based reactions to CALD OSQ nurses. All CFs and RNs would then be able to offer culturally sensitive feedback which may avert clinical fail. A further strategy was working within the facilities' structures and procedures as an informed way to avoid confrontation and increase cultural knowledge and awareness. Further strategies to avert clinical fail included practice of competencies, early notification of the need for improvements, listening to CALD OSQ nurses' point of view and providing opportunities to strengthen their weaknesses. Participants recommended that all CFs and RNs incorporate culturally sensitive, facilitative approaches to empower the CALD OSQ nurses to gain the confidence to improve their clinical performance.

4.5 Challenge 2 and its related strategy

Loss of participant CF role autonomy was identified by most participants. They described a mismatch between ward staff's priorities for patient care in a busy setting and the expectations of participant CFs who needed to prioritise the educational needs of all students and CALD OSQs in particular. One challenge and one strategy are described in this section.

4.5.1 Challenge Theme 2: Loss of CF role autonomy: Mismatch between CFs' expectations and ward priorities.

The second challenge theme was titled: Loss of CF role autonomy: Mismatch between CF expectations and ward priorities. Participants described how the level of CF autonomy to facilitate the clinical learning environment for CALD OSQ nurses had reduced substantially which meant a mismatch of priorities could easily arise. Reasons for loss of autonomy were not explicitly specified. However, during the interviews participants described a drive from RNs and ward based educators to take control of CALD OSQ nurses. Furthermore participant CFs expressed a weakening of resolve to assert their role autonomy. Clinical placement agreements between university and health facility specified that all CFs and all students including CALD OSQ nurses were supernumerary on the wards. The students' supernumerary status at each clinical practicum meant that precedence could be given to prioritise educationally sound practices. This agreement meant that CALD OSQ nurses could learn to work more effectively and efficiently while making the transition to each new clinical area. However, since patient care has traditionally been a central tenet to nursing, participants found challenges in prioritising CALD OSQ nurses' learning needs instead of patient care needs. Learning need priorities for CALD OSQ nurses could be overlooked amidst the urgency of attending to patient needs.

Participants explained that CALD OSQ nurses brought clinical skills which could be used to reduce the workload of the supervising RNs by completing some of the RN tasks. There was active resistance by

RNs to orientation sessions and taking CALD OSQ nurses away from wards for reflection and debriefing throughout clinical practicum. This resulted in a mismatch of priorities when CALD OSQ nurses appeared to fill staff shortages and were not released for learning activities. One participant CF was required to document the CALD OSQ nurses' absence from the ward by completing a timesheet as stated below:

The ward based RN insisted that I had to sign a timesheet if I wanted to take a group of 10 third year students who included CALD OSQ nurses for a weekly, one and a half hour debriefing and reflection session. (Gerda, CALD CF).

Participant CFs expressed conflicted feelings about allegiances developed from acting in the role of RN previously and those from being in the role of CF currently. These feelings may have been linked to the fact that all CFs had worked as a RN to be eligible to qualify for the CF role. Participant CFs were frequently challenged by the ensuing mismatch of their current priorities and those of the supervising RNs. The mismatch resulted in differences in what CALD OSQ nurses were required to do by the RNs. Differences ranged from filling staff shortages to reflecting on issues related to course learning outcome requirements. Participant CFs' expectations to prioritise facilitation of CALD OSQ nurses' learning were perceived to be subsumed by the RNs' ward priorities.

Some participants acknowledged having been personally challenged especially when alternating the role of CF and RN at the same facility. Weakening of resolve to assert CF role autonomy emerged as one participant found it difficult to act in the role of CF and prioritise CALD OSQ nurses' learning needs. Periodically alternating CF and supervising RN roles could afford advantages however it could also be viewed as a challenge due to feelings of divided loyalty when the clinical practice environment was complex and unpredictable. The following data extract exemplifies this:

Well as a CF I am between the university and working as a RN at the hospital. It is hard to prioritise CALD OSQ nurses when the hospital is very busy and short staffed (Beccy 1 non CALD CF).

Priorities set by supervising RNs frequently did not match with participant CFs' expectations. The CALD OSQ nurses who were there to learn could be perceived to add to the workload of the supervising RNs. Important participant CF expectations for CALD OSQ nurses included encouraging application of theory taught at university to the real clinical environment as a form of experiential learning to meet specific learning outcomes. These participant CF expectations comprised having the autonomy to facilitate orientation and group debriefing and reflection. Conversely, participants described the priorities for ward

based RNs included responsibility for managing and performing patient care, associated reporting and documentation. Supervising CALD OSQ nurses during clinical practicum became an additional, difficult and often frustrating responsibility for the RNs who sometimes actively resisted supervising CALD OSQ nurses. Participants described challenges when arguments between supervising RNs sometimes ensued because the frustration would spill over to anger:

Two RNs were arguing about who wants to take the CALD OSQ nurse and sometimes in front of the student they will say 'I don't want her, I had her yesterday'. (Hetty 6 non CALD CF).

Participants explained that practicing less complex competencies was most suited to first year BN students who were new to the health care system. Conversely, CALD OSQ nurses entered at second year level and required practice in more complex holistic nursing care. However unlike other second year students, CALD OSQ nurses were making their initial clinical transition to the Australian health care system from entry at second year level. Transition for CALD OSQ nurses was complicated because while they did not require practice in performing less challenging tasks they needed close supervision with complex patient care because of lack of competence and confidence. Lamentably CALD OSQ nurses were often delegated to tasks in which they were previously competent and did not require close supervision such as taking vital signs. Several participant CFs interpreted this delegation of tasks to mean RNs were using the CALD OSQ nurses to fill staff shortages by completing labour intensive, repetitive tasks. The following verbatim quote was an example of participants expressing these concerns:

CALD OSQ nurses would not change to holistic care here [from task oriented care] because the RNs give them basic tasks, you know, you have to check up observations of BP and pulse and ask .."Where is the medication?" (Hetty 3 non CALD).

Participants described what they perceived as an explicit shift in control over the past few years which had resulted in CFs losing autonomy over CALD OSQ nurses learning activities. It was noted that in recent years the CF role had changed so they were no longer able to allocate the students according to their learning needs. Instead of CFs, the RNs who are hospital based educators have mostly taken over the allocation role and are seen by CFs to take responsibility for CALD OSQ activities on clinical practicum. Ultimately the apparent loss of CF role autonomy exacerbated the mismatch of priorities. One participant relayed how loss of autonomy meant that the CF was left with the role of monitoring students instead of planning their learning experiences:

We can't allocate CALD OSQ nurses the educator at the hospital allocates the students to the ward. CFs used to be able to change the students if they have a second time on a medical ward I would put them on surgical. For several years we have not been allowed to do that, we don't have the power. The hospital educator has actually taken responsibility for the students and allocates ward placements. I monitor what the CALD OSQ nurses are doing and how they are doing (Gerda 7 CALD CF).

This perceived lack of autonomy interfered with early maintenance of trust between participant CFs and CALD OSQs. For those participants who were able to establish a platform of trust and cultural empathy at orientation, new challenges emerged from the data. Some participants supported the RNs' view that CALD OSQ nurses needed to practice being 'at the bedside'. Alternatively others described how there were strong forces preventing reflective practice taking place away from 'the bedside'. Several participants were prevented from facilitating group reflections. Perceived loss of CF role autonomy meant it became difficult to conduct orientation or follow up with debriefing sessions for reflective practice. The mismatch of priorities sometimes caused misunderstanding with supervising RNs regarding CFs taking CALD OSQ nurses away from patient tasks for debriefing sessions. One participant sought assistance from the Director of Nursing (DoN) and was supported by him/her. The DoN reminded the RN that CALD OSQ nurses were at the facility to learn. The following data extract details this scenario:

…the RN complained to the ward based nurse educator that the CALD OSQ nurses were taken away for too long and they are supposed to be on the ward. We are actually debriefing and reflecting and that's part of this clinical and the curriculum. You have to have the briefing and reflection with the CALD OSQ nurses. She just would like to give them more RNs' work, to check on blood pressures and observations after surgery. I spoke to the DoN who went to the ward and told the RN she doesn't have a clue why the students are there and actually said "they come here to learn." (Gerda, CALD CF).

In summary, participants were challenged by the mismatch between ward based RNs' priorities toward patient care and participant CF expectations of facilitating educationally sound practices for CALD OSQ nurses. Participant CFs explained the extreme frustration experienced at being unable to retain autonomy over CALD OSQ nurses' learning activities even though they were supernumerary. In addition, participants outlined active resistance to releasing students for learning activities by supervising RNs which added to challenges of perceived loss of CF role autonomy. At times participant CFs expressed divided allegiances when working as a RN in a facility where they were periodically employed as a CFs by the university. In these circumstances CALD OSQ nurses' learning became their primary focus. On the other hand when working as an RN, patients were their primary focus. Overall, the challenge to CFs' role

autonomy to facilitate CALD OSQ nurses' learning, active RN resistance and divided allegiances resulted in a mismatch of ward priorities and CFs being unable to fulfil expectations to prioritise CALD OSQ nurses' learning needs.

4.5.2 Strategy theme 2: Strengthening CF role autonomy: Aligning CF expectations with ward experiences:

Strategy theme two was titled 'Strengthening CF role autonomy: Aligning CF expectations with ward experiences.' To avoid the challenge of a mismatch occurring between participant CFs' expectations and ward priorities participants emphasised the critical role of forming clinical connections particularly with supervising RNs. It was extremely difficult to address CALD OSQ nurses' learning needs without strengthening participant CF role autonomy by collaborating with RNs and being familiar with the clinical environment. This theme was developed from the data to describe ways that CFs found of aligning their expectations with ward experiences for CALD OSQ nurses. The main approaches used to achieve this comprised assertively developing collaborative relationships, becoming familiar with the health facility and use of role modelling.

Although some participants experienced challenges with divided allegiances and with prioritising CALD OSQ nurses learning needs, returning to the same health facility in the role of CF or RN also meant that CFs could strengthen autonomy within their role. Strengthening role autonomy was achieved by improving collaboration with health facility personnel by a process of familiarisation with the health care team and the clinical practice environment. An advantage of familiarisation and developing mutually beneficial relationships was that participant CFs had the flexibility to move CALD OSQ nurses around as needed. This could be achieved in several ways including ensuring adequate RN professional development training for the change in priorities to be employed periodically as CFs in the same health care facility. Participants viewed several advantages for CFs to have been periodically employed by the university as well as by the same health facility as a RN. These advantages included formation of clinical alliances which allowed the CF more autonomy with organizing the CALD OSQ nurses' learning experiences. One participant stated quite succinctly that staying at the same facility as a CF meant RNs and other staff could become familiar with the CF which made it easier to facilitate CALD OSQ nurses learning:

I like to move around, don't get me wrong. But if you know the hospital, the RNs know you, it's always heaps easier to prioritise CALD OSQ nurses (Hetty non CALD).

CF collaboration with the RNs was essential for CALD OSQ nurses when caring for patients as they spent the most time acting as supervisors and role models. Although participant CFs were employed by the university, with students as their primary focus, participants said that they found it necessary to also make clinical connections and communicate assertively with RNs. Several participants identified that the CFs' role in planning strategies to meet learning needs of CALD OSQ nurses was preferably preceded by working out how the ward operates. This could be managed by meeting during clinical practicum or preferably visiting the health facility before commencement to meet the Nursing Unit Manager (NUM) and supervising RNs. The following data extract was an example of how participants described this part of their role:

So you really need to wait until you are on the ward to see how the RNs run it. As a CF you sort of have to collaborate from that day one, or that first week, you see how the NUM and RNs operate the ward before you can put in your own strategies for the CALD OSQ nurses (Hetty 6 non CALD CF).

When facilitating third year students particularly, some participants had a clear aim to settle CALD OSQ nurses into their role and to align participant CF expectations with ward experiences. Several CFs were able to use RNs or CALD OSQ nurses' peers as role models. This was achieved by forming an appropriate relationship to enable CALD OSQ nurses to shadow the RN. Sometimes a more advanced student was chosen as a role model for the first week. After this, CALD OSQ nurses were usually able to take two patients who were considered half a 'patient load'. As they became more confident this was increased to the full RN patient load of three to four patients to look after every aspect of their care. The process of building CALD OSQ nurses' confidence beginning with participant CFs collaborating assertively with the RN was described by the following participant:

We usually collaborate for CALD OSQ nurses to be allowed a week to shadow the RN and then they have to take two patients so they are allocated half a patient load. Then we negotiate with RNs for them to take three to four patients. So they have to do everything for those first two patients from start of shift to finish. (Hetty non CALD CF).

Placing CALD OSQ nurses with peers who were capable student buddies was a strategy that provided a strong role model for less confident students to understand their scope of practice. Role modelling has been found to be a very effective educational strategy particularly if good rapport has been formed. One participant commented that this worked best when CALD OSQ nurses were challenged by a capable student:

Strategies can be just the clinical environment which is the ward, even who they are buddied up with day to day, such as the other student on the ward. Because at the moment I have got a local student with an international student, I think she is a CALD OSQ nurse, but the local student is setting a very high bar. She has done a lot of objectives and is just setting a very good example. Alternatively, CALD OSQ nurses could be put with another poor student and it doesn't challenge them (Hetty non CALD CF).

In summary, strategies participants proposed to strengthen CF role autonomy and align priorities were built upon forming relationships with the NUM and ward based RNs preferably prior to commencement of clinical practicum. In addition, some participants recommended that RNs are prepared with professional development to work as a CF in the same facility to develop these connections and gain insights into the CF role. Professional development may assist with ensuring allegiance to CALD OSQ nurses' learning needs after being focused on patient care needs as an RN. Returning to the same health facility repeatedly according to one participant can assist CF familiarisation with wards and particularly understanding how RNs and NUMs operate wards. Another strategy involved ensuring adequate rapport has developed so that RNs and peers can act as role models for CALD OSQ nurses at the beginning of clinical practicum. With strengthened CF autonomy participants can assertively communicate to ensure CF expectations to address CALD OSQ nurses' learning needs are aligned with appropriate supervision by RNs which is then recognised as a ward priority.

4.6 Challenge 3 and its related strategies

Problems stemming from verbal and non-verbal communication differences were pointed out by most participants. During interviews it emerged that problems arose from differences in CALD OSQ nurses' non-assertive verbal and non-verbal communication style and the use of the English language when compared to other nurses. Participants explained that RNs could refuse to supervise CALD OSQ nurses and patients could withdraw consent to be treated when communication had seriously broken down. Two challenges and two strategies are described in this section.

4.6.1 Challenge theme 3: Differences in verbal and non-verbal communication styles

Participants reported challenges emanating from differences between CALD OSQ nurses, participant CFs, staff and patients' verbal and non-verbal communication styles. Consequently participants pointed out that these differences could easily result in CALD OSQ nurses having problems communicating assertively with staff and therapeutically with patients. The ultimate outcome as articulated by participants was

rejection of CALD OSQ nurses by RNs and withdrawal of consent by patients which meant that participant CFs could not facilitate adequate clinical experience for the CALD OSQ nurses.

Participants explained that problems CALD OSQ nurses have actually applying assertiveness techniques during hurried or angry exchanges from staff and patients were easily mistaken for poor English. The third challenge theme was 'Differences in verbal and non-verbal communication styles'. Two subthemes emerged from the data to explain the elements of this theme: 'non-assertive communication style' and 'non-therapeutic communication'.

4.6.2 Challenge subtheme: Non-assertive communication style.

Participants described non-assertive communication style as a cultural attribute of many CALD OSQ nurses which could lead to lack of understanding, lack of patient advocacy and treatment errors. However participants explained that although everyone was using the English language, their verbal and non-verbal communication styles could be vastly different. CALD OSQ nurses' non-assertive communication style was usually based on hierarchical compliance, with deference to authority figures and older people. Consequently silent or passive agreement in response to unclear instructions could be culturally acceptable. Conversely, in Australia, assertive interactive forms of communication based on critical thinking were advocated for nurses. Participants proposed that verbal and non-verbal communication problems may stem from all staff and patients' different use of English language and styles of communication. These differences included expression, jargon, abbreviations, acronyms, new terminology and pronunciation. Participants described how these differences may result in problems for CALD OSQ nurses embracing culturally acceptable techniques to respond assertively to unclear or aggressive communication.

One participant described the lack of understanding that arose when a CALD OSQ nurse appeared reluctant to ask for clarification. In this example the CALD OSQ nurse seemed to guess the question rather than ask for it to be repeated. Remaining silent was culturally acceptable behaviour when a question or instruction was unclear. The participant explained that CALD OSQ nurses were unable to understand questions because they were focused on what they should reply in English:

I don't think CALD OSQ nurses have good listening skills. Their active listening skills can be poor because they are concentrating on what they are going to say back to you in English. They pre-empt how they are going to answer the question. I ask them a question and they will answer something totally different. First greeting might be to just say hi, how are you? They will say "oh yes, I am on PM shift and

I have patients 16, 17 and 18". I have actually asked them 'hi, how are you?' They are pre-empting what the expectations are without actually listening to what you are asking them. (Hetty non CALD CF).

Misunderstandings could be exacerbated when non assertiveness was combined with CALD OSQ nurses having difficulty with pronouncing certain words. Challenges emerged for participant CFs when the RNs made judgements about CALD OSQ nurses' intelligence because they were hesitant over English language pronunciation. According to the participants some accents were harder to understand. RNs could then begin to treat the CALD OSQ nurses as incompetent and lacking in intelligence. Participants explained that this misunderstanding came from non CALD RNs who then appeared to make it more difficult for CALD OSQ nurses as described by a participant below:

Sometimes it's an issue for the Anglo Australian staff [RNs] for a number of reasons and they may give the CALD OSQ nurses' a harder time than they need to. Some staff assumed that because their language has an accent or doesn't come as easily to them as it does to the RNs, they assumed that means that they were not all that bright. This was often very far from the truth. (Pamela CALD CF)

Another participant observed that CALD OSQ nurses did not assertively challenge the CF and ask questions. The participant did not express a preference however acknowledged that CALD OSQ nurses would not question an instruction from the CF. Asking questions seemed to be an expectation of 'Australian' BN students' to clarify their understanding. The participants made a comparison with 'Australian BN students' who were considered more likely to challenge the CF:

If I say to be somewhere or do something [CALD OSQ nurses] never challenge me in asking questions that sometimes the Australian students do (Beccy 2 non CALD).

The lack of understanding which emerged from the interview data resulted in the possibility of CALD OSQ nurses being left unsupervised. Participants described strong resistance from the RNs to supervising the CALD OSQ nurses in particular. This was a major challenge because CALD OSQ nurses were not permitted to care for patients without RN or CF supervision. It was expected that rapport between the RN and the CALD OSQ nurse would be strengthened over time which would improve confidence with communication. Sometimes instead of time spent with the RN strengthening rapport it appeared to create tension and RNs refused to supervise CALD OSQ nurses. Reasons why RNs were speaking out against having to supervise CALD OSQ nurses were not clearly stated. However some of the verbal and non-verbal communication differences relating to non-assertiveness were described leading up to the

arguments between RNs. These problems included CALD OSQ nurses holding back and refusing to make eye contact as well as an apparent lack of understanding of instructions without asking for clarification. The following extract from a participant described the times when frustrations were expressed in front of the CALD OSQ nurses. Consequently RNs may have simply refused to work with them:

RNs get extremely frustrated, because they are working with CALD OSQ nurses for eight hours straight whereas CFs can come and go in half hour blocks. In the last four weeks there were at least five RN's who refused to work with two of our CALD OSQ nurses (Hetty 6 non CALD CF).

Participants acknowledged that they understood that lack of assertiveness was a cultural tradition as in some cultures it was simply inappropriate to make eye contact and initiate conversations. However participants acknowledged that changing cultural practices can be extremely difficult. Making eye contact can be particularly hard to adapt. In some countries there may have been a strongly held belief that it was extremely disrespectful. The following participant transcript explained how this created a challenge for the participant CF as the CALD OSQ nurses were unable to act as patient advocate:

A cultural limitation for them [CALD OSQ nurses], is they really hold back and they don't like making eye contact with people. They come across as either being shy or disinterested or some people might think that they don't know what they are doing. In fact it's their culture not to speak unless they are spoken to, so they find it hard to be the patient advocate (Hetty 6 non CALD CF).

Non-assertive communication style was observed by participant CFs as a precursor for making errors when there was an unwillingness to question people in authority and older patients or staff. Consequently during the interviews participants recounted the challenges associated with CALD OSQ nurses responding to instructions with a blank look, pretending to understand and then doing the wrong thing rather than assertively seeking clarification. It was acknowledged by participants that cultural differences meant that if CALD OSQ nurses did not understand an instruction then they may consider it culturally inappropriate to ask to have it repeated. One participant pointed out that this lack of willingness to clarify requests or instructions can often result in mistakes. Furthermore CALD OSQ nurses would not disagree with a participant CF, RN or patient even when it was the wrong course of action:

Mistakes can happen anytime everywhere. Rather than clarify and say 'excuse me, what do you mean?' especially with the Asian people who respect older people the cultural practice [will mean they] say 'you are my teacher and I will respect everything you say is right'. They may think 'that's not right', but they

wouldn't say. CALD OSQ nurses will obey everything. They should really say 'no I am not supposed to do that due to the policy or something'. Mostly they would do what the RN asked them to do or they would say 'I did it because she asked me' (Gerda 7 CALD CF).

In summary the first challenge subtheme was 'non-assertive communication style'. Participants observed that a major challenge to facilitation was that CALD OSQ nurses' non-assertive communication style toward authority figures can result in lack of understanding, lack of patient advocacy and clinical errors. However participants stated that RNs who supervised CALD OSQ nurses were often unable to identify that communication problems were related to non-assertiveness. In its place non-assertiveness often appeared to RNs to be a problem of CALD OSQ nurses' English language ability. Regrettably non-assertive communication style could be confused with silent, hesitant responses due to poor English. Associated problems included RN frustration due to communication breakdown expressed as aggressive, rejecting comments and refusal to supervise CALD OSQ nurses. These communication problems related to CALD OSQ nurses' non-assertiveness were reported during the interviews as a relatively common occurrence in the workplace.

4.6.3 Challenge subtheme: Non-therapeutic communication

Participants described how non-assertive verbal and non-verbal communication can be non-therapeutic to patient care as well as presenting a challenge to the work of all CFs. This challenge sub-theme focusses on non-assertive forms of verbal and non-verbal communication and its place in non-therapeutic communication. Several participants explained that nursing communication with patients is referred to as therapeutic communication which is built on a therapeutic relationship based on mutual trust and respect. In addition, selected assertive communication techniques are used as a form of healing therapy. These therapeutic assertive communication techniques based on a therapeutic relationship have a positive effect on the patient. These techniques may be used to inform and advocate for the patient or encourage the patient to express emotions and help them to find ways to resolve their own problems. Participants pointed out that CALD OSQ nurses' non-assertive communication style could make therapeutic communication extremely difficult. Sufficient confidence and ability are needed to be able to use the unique assertive communication techniques comprising verbal and non-verbal skills with patients. Participants observed that patients needed to trust that CALD OSQ nurses could respond therapeutically or they could withdraw consent to treatment.

Participants explained that despite building CALD OSQ nurses' confidence, patients were often quite demanding, impatient to have their needs met, intolerant of non-assertiveness and diverse linguistic

abilities. Non-assertiveness could result in non-therapeutic communication with patients, triggering anxious frustration as manifested in aggression and possible insults. To prepare CALD OSQ nurses, participants described demonstrating assertive communication skills to facilitate a mutually respectful attitude and a friendly encouraging approach to guide slower, clearer expression. Using a more facilitative approach was based on the premise that more cultural awareness and support during the clinical transition period would build confidence. One participant proposed that a facilitative approach required greater acceptance to understand diverse linguistic abilities. In the following data extract one participant challenge was that unlike patients, the participant CFs' understanding of CALD OSQ nurses' language came from an accepting relationship and being accustomed to understanding strong accents. However patients may become frustrated and aggressive:

[As a CF]I think I am probably more accepting [of strong accents]but some of the patients that I have looked after with some of the CALD OSQ nurses have been frustrated which then manifests itself in aggression at not being able to understand what they are saying. (Pajlia, 3 non CALD CF).

An important aspect of the participant CF role was student advocacy which included ensuring both CALD OSQ nurses and patients were adequately prepared for experiential learning encounters. Participants explained that it was customary to inform the patient that the CALD OSQ nurses were new to the ward and in their transition to clinical practice in Australia. Since the CALD OSQ nurses are supernumerary, appropriate patients can be selected who are more tolerant of nurses who speak English as a second language. However participants described numerous challenges of being allocated very unwell patients who cannot understand the CALD OSQ nurses. Confused frustration from non-therapeutic communication was clearly expressed in the following excerpt from participant transcripts:

They are not feeling terribly well, they are lying in hospital, someone is telling them something. They don't really know what's being said and I am standing next to them and they look at me and go what the hell are they saying to me? (Pajlia, 3 non CALD CF).

Participants proposed that communication difficulties between patients and CALD OSQ nurses escalated to the point where patients refused treatment. However the main participant challenge was that non-therapeutic communication difficulties can mean the patient doesn't trust the CALD OSQ nurses' ability and will not consent to being treated*:*

The patient sometimes feels frustrated and they obviously don't trust that the CALD OSQ nurse knows what they are doing. At times patients will refuse and ask me to do a sub cut injection. They will ask, 'how many have you done before? Is this your first one?' Whereas the student might have done a load of them, but because their communication skills aren't great the patient doesn't trust that they know what they are doing and if they have done the skill before, so they will refuse (Hetty 6 non CALD CF).

One participant gave a compelling account of the challenge of having a CALD OSQ nurse who appeared unable to communicate understanding that a patient was in pain. When in pain, patients' tolerance for all aspects of their care was generally diminished. The following participant verbatim quote described the patient in pain having an aggressive response to non-therapeutic communication causing sufficient frustration to send the CALD OSQ nurse away. This was a major participant CF challenge as it acted as withdrawal of patient consent to be treated:

I had a CALD OSQ nurse who was doing a complex dressing which was quite painful for the patient. Even lifting up his leg caused screaming and the student was up quite close trying to talk and speaking so fast and the accent was so thick that he said "look, I have got no idea what you are saying". In the worst case scenario they will get to a point, they will just look at you for confirmation and they will just tell the student. 'Go away I have got no idea what you are saying'. (Hetty 6 non CALD CF)

In summary there were two critical challenges which emerged within the challenge theme 3 'differences in verbal and non-verbal communication style'. Participants reported that CALD OSQ nurses had problems that led to an apparent non-assertive communication style and non-therapeutic patient communication. Differences between CALD OSQ nurses, RNs, CFs and patients stemmed from the use of English language in terms of assertiveness and new terminologies embedded in acronyms, abbreviations and jargon for example. Participants also reported CALD OSQ nurses' differences in non-verbal communication styles including lack of eye contact and other non-assertive body language. Participants explained the challenges emanating from CALD OSQ nurses inability to adapt non-assertive communication practices. Consequently CALD OSQ nurses had difficulty applying assertive techniques to respond to unclear, angry or aggressive RNs and therapeutically to emotional patients. These challenges appeared to be overwhelming at times when CALD OSQ nurses resorted to pretending to understand while patients and RNs reactions varied between frustration, anger, fear and refusal to supervise. Ultimately refusal to supervise or participate by any RN or patient was a major facilitation challenge for participants who relied on supervision of CALD OSQ nurses by RNs and on patients consenting to treatment by CALD OSQ nurses.

4.6.4 Strategy theme 3 Addressing differences in CALD OSQ nurses' verbal and non-verbal communication styles

Participants addressed the critical challenges of differences in CALD OSQ nurses' verbal and non-verbal communication styles by facilitating the development of assertiveness and therapeutic relationships. Participants advocated development of trust in a participatory environment, assertiveness and exploring culturally appropriate assertive forms of professional communication with RNs and therapeutic patient communication. Participants also addressed some of the underlying cultural beliefs and attitudes constraining the development of assertiveness and therapeutic relationships. The main differences in verbal and non-verbal communication styles could then be addressed. Strategy Theme 3 was titled 'Addressing differences in CALD OSQ nurses' verbal and non-verbal communication styles' and comprises two subthemes: 'CFs facilitating CALD OSQ nurses' assertive communication style' and 'Developing therapeutic relationships.'

4.6.5 Strategy subtheme: 'CFs facilitating CALD OSQ nurses' assertive communication style'

Several participants identified that underlying CALD OSQ nurses' non-assertive verbal and non-verbal communication differences was uncertainty about reactions to becoming assertive. Participant CFs initiated strategies that would form the basis of assertiveness training. Strategies included development of trust within participant CF and peer group relationships. Consequently learning assertiveness meant firstly building a foundation of trust so that CALD OSQ nurses could practice assertive communication techniques with a trusted CF and peer group before actual clinical practice with RNs and patients. Participants proposed that strategies to facilitate assertive verbal and non-verbal communication style would help to avoid RNs refusal to supervise and patients withdrawal of consent. Assertive verbal and non-verbal communication style would enable CALD OSQ nurses to become more self-confident to form direct statements of positive and negative feelings and beliefs. Use of these statements would mean that CALD OSQ nurses could respond to unclear communication and aggressive comments appropriately.

Initially participants recommended using their role as CF to provide an open friendly approach to enable CALD OSQ nurses to be able to assertively disagree or ask questions when in doubt. Furthermore participants explained that the fundamentals of all CFs facilitating assertiveness training included that the group environment has established trusting relationships. Strategies to achieve this were aimed at enabling CALD OSQ nurses to talk about culturally sensitive issues. Second, time away from the ward was advocated for debriefing, reflection about positive and negative verbal and non-verbal communication experiences. Third individual exercises to help CALD OSQ nurses communicate assertively in difficult circumstances. An example was managing words that have not been understood within a sentence as well

as telephone conversations. Participants found that assertive verbal and non-verbal communication style could be built by showing cultural sensitivity in a trusting participatory group environment.

Participants said they wanted to find ways to make CALD OSQ nurses comfortable with assertively disagreeing with the CF or their supervising RN. One participant CF's view was that unless they can change the passive or non-assertive way they relate to the CF or the RN they will find it difficult to overcome the lack of assertiveness and to be critical thinkers in terms of examining and debating certain issues. The following participant wanted to find ways to make it acceptable for CALD OSQ nurses to assertively disagree and ask questions:

CALD OSQ nurses bring with them a way of relating to the CF and to the RN which is a little bit distant [passive or non-assertive]. They are not going to [be assertive] question you too much if they are in disagreement with you. So in order to foster debate or drilling down and examining issues you have to find a way to make it [assertiveness] okay for them. (Pamela 5 CALD CF)

Participants' strategies encouraged peer and CF trust and participation in reflective practice and debriefing activities to further address critical, non-assertive verbal and non-verbal communication styles differences. Participants explained that these strategies required building of trust particularly from debriefing and reflecting. In addition it was essential to make assertive, democratic, participatory processes more acceptable. One strategy involved development of peer and CF trust and enabling students to participate in more friendly, egalitarian processes. These processes were aimed at breaking down communication barriers particularly toward authority figures. The process of building trust also involved showing sensitivity to differences in the ways that the world is perceived according to cultural background. One participant explained how having a trusting friendly experience during clinical practicum gave CALD OSQ nurses the confidence to talk about sensitive issues:

I do debriefing and reflecting with student groups because it also builds trust [and assertiveness]. CALD OSQ nurses get to a point where they get to trust that even if I don't know the specific issue, they could trust me to talk about it. [This is because] I already have shown some sensitivity to culturally different world views. CALD OSQ nurses have trouble with participatory [assertive techniques] more egalitarian democratic process. Therefore I don't think it hurts them to have a friendly experience of it [clinical practicum] (Pamela 5 CALD CF).

One participant explained that CALD OSQ nurses' debriefing and reflective education sessions should be carried out away from the stresses of a busy ward. Separating student groups from patients and RNs for debriefing sessions enabled sharing of some of the bewildering clinical experiences. In addition participants wanted to ensure that CALD OSQ nurses did not feel alone and unsupported. It was expected that peer support and reflective exercises in a trusted group could build CALD OSQ nurses' confidence to practice communicating assertively with their peers as expressed in the following data extract:

I like to do the debriefing sessions because I think it's important for CALD OSQ nurses to come off the ward, away from the staff because a lot of times it can be quite stressful. I include [assertiveness] education sessions within those debriefing times. Coming away from the staff and amongst each other means they can trust the group to tell each other what they have experienced. This includes the challenges they have had and it helps everyone to feel like they are not alone and supported [to communicate assertively] (Hazel 2 CALD).

Participants recommended that assertiveness techniques would empower CALD OSQ nurses to gain the confidence to initiate conversations and to respond assertively to variations in ability to hear and comprehend patients and RNs. During the interviews participants suggested specific strategies to improve CALD OSQ nurses' listening and comprehension based on personal experiences with understanding another language. The reality of having to assertively ask for words to be repeated can be too intimidating for CALD OSQ nurses. Focusing on a lost word meant it was possible to miss the meaning of the whole sentence. It was recognised that early in the clinical transition period was a particularly difficult time to assertively ask for clarification. Several practical, supportive strategies were described to help CALD OSQ nurses manage the barrage of new terminologies frequently embedded in abbreviations and acronyms. This strategy included managing sentences when word meaning is missing by letting words go when they can't be understood and allowing the context to give them meaning. CALD OSQ nurses were given the opportunity to practice this strategy with their peers. The participant explained this strategy in the following way:

To deal with CALD OSQ nurses' [non-assertive] listening comprehension communication problems I draw a strategy from my personal experience. When I am listening to someone speaking in another language I may get stuck on a word and stay with that word to try to figure it out instead of letting it go. I then miss out on all of the next words. I check that to make sure that's what CALD OSQ nurses do too and I'm not just making an assumption. Then I offer them the strategy and some practice in letting that word go with the expectation that the context will give them the meaning (Hazel CALD CF).

One participant emphasized that keeping a reflective journal encouraged CALD OSQ nurses to enhance reflective practice which was aimed at improving all aspects of assertive verbal and non-verbal communication. This participant elaborated that this meant CALD OSQ nurses were able to look back and reflect on how they could improve by finding assertive ways to communicate and carry out clinical activities more effectively. Reflective journals were encouraged to supplement debriefing and reflective group sessions as they provide a record of thoughts associated with clinical activities. The following data extract articulated that journaling was particularly relevant to the increasing complexity of clinical transition experienced by final year CALD OSQ nurses:

During teaching as a CF here, I always tell the CALD OSQ nurses in third year to keep a reflective journal because it is important to be able to put those thoughts down and go back to them to understand and talk about what you could have done better. Because it helps improve your [clinical] practice (Beccy non CALD CF).

Participants described use of role plays as a strategy used by participant CFs to build assertiveness with inter-professional communication so it was less threatening for CALD OSQ nurses. Most participants saw practice with telephone calls as a chance to build confidence with professional communication particularly speaking assertively to different members of the health care team. Placing or receiving telephone calls were generally known as a source of great consternation for CALD OSQ nurses who would avoid them where possible. One participant CF described devising strategies using mock phone calls between a second CF who would role play a medical officer:

I like to see them [practice] having [assertive] telephone conversations, paging doctors and allied health, to take down mock orders. It's not for a real medication order for a patient but we get a medication chart and a real scenario. If we are facilitating and there are other CFs, I will tell them, 'I am going to get the student to ring the ward, can you role play that you are the doctor?' and they handover a new admission that's under their care. They call the 'doctor' to get say a medication order or something (Hetty 6 non CALD).

Participants also suggested one way to help with the knowledge component of communicating assertively for CALD OSQ nurses was to introduce an Inquiry Based Learning (IBL) approach, which was currently in use in the BN curriculum. IBL has been described as encompassing the construction of new knowledge through active engagement with content. The patients on clinical practicum also provide the context. This

approach has a particular focus on students asking questions and finding ways to search for answers through discussion, internet searches and appraising the evidence. One participant described this as a strategy to empower CALD OSQ nurses to be able to learn to understand and communicate information assertively on particularly difficult placements. This involved searching for information in response to clinical questions they have raised about patients and practice presenting it as a case study to the group during debriefing sessions. Having more complete knowledge of nursing in relation to pathophysiological aspects of patients in their care allowed CALD OSQ nurses to gain confidence to present to peers. This activity would be expected to enable them to assertively provide information to patients and participate in active listening. This learning process was described in the following verbatim quote:

A strategy for a particularly difficult placement was to empower students to learn to communicate [assertively] using the IBL process rather than me finding information where they are not going to learn. Therefore, they take a portion of information such as common diseases [relating to a patient] and go and research that. If they [gain confidence to] go out with those questions and find out information and then they stand and present to the group. They research [about patients] what they are curious about and everyone present to the debrief session (Amber 2 CALD).

In summary there were three main strategies participants used to facilitate CALD OSQ nurses' assertiveness which included: use of the CF role to develop a platform of group trust; debriefing and reflecting away from the ward to talk about positive and negative communication experiences; individual exercises for difficult circumstances such as missing single word meaning and telephone calls. First participants explained that underlying the development of assertiveness techniques required participant CFs to facilitate a platform of CF and group trust to overcome CALD OSQ nurses uncertainties regarding cultural appropriateness of being assertive. Participants encouraged peer and CF trust and participation in reflective practice and debriefing activities. This was achieved by use of the CF role to develop a friendly, participatory approach to engender trust to talk about positive and negative communication experiences. Second participants recommended time away from wards for group reflection and practice to gain confidence with assertive communication techniques. Finally individual exercises entailed: practice with adjusting to missing single word meanings by understanding words in context; assertive technique practice with telephone calls; use of IBL to build knowledge.

4.6.6 Strategy subtheme: Developing therapeutic relationships.

Several participants recognized that being unfamiliar with the Australian health care environment and being CALD OSQ nurses meant there may be discomfort with holistic, relationship oriented care and

actually developing a therapeutic relationship. Some participants devised strategies to address the CALD OSQ nurses' underlying cultural values, beliefs and attitudes about patients in order to enable formation of therapeutic relationships.

One participant highlighted that it was critical to find ways to convince CALD OSQ nurses to assertively ask questions if they didn't understand. This was to be achieved by simply recommending reminders to be assertive and open about not understanding patients and ask questions. Without these prompts it was assumed that non-assertive communication would be resumed as this was a more familiar practice. However patient safety was brought into profile as a major challenge when participants reported that they also needed to remind CALD OSQ nurses that pretending to understand an instruction or request from patients or staff was an extremely dangerous practice. It was assumed that the reason for this pretence was that CALD OSQ nurses wanted to avoid asking questions for clarification. Several participants simply encouraged the CALD OSQ nurses to speak more assertively with the patients and staff and to give clear answers and ask when in doubt without addressing the underlying cultural beliefs. This approach was detailed in the following data extract:

I recommend more [assertive] communication with the patient and more [assertive] communication with the nursing staff. You have to be more assertive and open, to everything you are doing. You have to give clear answers. If you did not understand sometimes that the patient told you [then you] would clarify. CALD OSQ nurses need to understand that pretending you know is a 'no no'. Rather clarify and say 'excuse me, [I did not understand] do you mean that and that?' (Gerda 7 CALD).

One participant explained that it was vital to encourage CALD OSQ nurses to develop a therapeutic relationship by enabling them to feel comfortable talking with patients about personal issues. Clinical practicum is designed to provide the opportunity for students to respond to issues in clinical context which meant that learning was deeper and more meaningful. A participant CF devised a strategy using this educational principle of experiential learning or learning by doing in context. The strategy involved interviewing patients without asking about their illness.

Establishing a therapeutic relationship with a patient means doing that in a gentle and authentic way. CALD OSQ nurses choose a patient [to ask them] to tell their story which is not about their diagnosis. [Their story] is only about their life such as where they were born, what they did or anything, except their illness. This means they have got to sit down, talk to them and ask questions (Pamela CALD CF).

Some participants recognised that changing from culturally appropriate non-assertive, objectified and distant forms of communication was difficult for CALD OSQ nurses. A powerful strategy described by one participant addressed the culturally embedded values and beliefs underlying the non-assertive communication. These values and beliefs included that it was forbidden to broach personal issues with patients and inquire about their private lives. To overcome the cultural restraints of these strongly held beliefs a strategy was implemented by one participant who asked CALD OSQ nurses to have authentic conversations with patients. The reason for these conversations was to familiarise CALD OSQ nurses with ways to de-objectify the patient so that they are seen in the context of their whole lives and their family. Furthermore building their life story involved transforming the concept of the patient with physical ailments into a whole person in the process. Patients could then enjoy the benefits of therapeutic communication as CALD OSQ nurses were then able to listen actively and provide assertive responses. The following data extract expresses the change in approach for the CALD OSQ nurse:

Responses vary between exhilaration and pleasant surprise about the 'okayness' of talking to patients about their personal issues without feeling like they are probing. The patient transforms before their eyes from a body in a bed with a health event going on, to a person that they develop some kind of a bond with that is therapeutic which means it de-objectifies the patient (Pamela CALD CF).

The same participants' rationale for a conversational, non-medical approach was to support CALD OSQ nurses to overcome the hurdle of feeling culturally inappropriate by asking personal questions and developing a therapeutic relationship. It became clear to several participants that CALD OSQ nurses were having difficulty with many aspects of assertive communication at a more therapeutic level. The participant explained this in the following data extract:

Inevitably, CALD OSQ nurses develop the beginnings of a therapeutic relationship with patients. It makes them formulate questions and jump over what they may experience as probing from their cultural perspective. Asking about their personal and private lives or their story is usually seen as being rude in their own culture because anyone who is older than them CALD OSQ nurses defer to and show respect in different ways (Pamela 5 CALD CF).

Several participants proposed that one strategy to address difficulties for CALD OSQ nurses coping with communicating therapeutically across cultures was to have discussions about issues such as attitudes toward mental health patients. Cultural attitudes to patients are known to include authoritarianism in different cultures throughout the world which can be disempowering. Several participants understood that

CALD OSQ nurses believed mental health patients particularly should be treated with aggressive forms of communication. This reflected an authoritarian approach in certain cultures. These discussions acted as a catalyst to raise issues such as ethics, human rights and helped to address the challenge of communicating cross-culturally not only with mental health patients but medical surgical patients as well. One participant addressed these broader issues by talking to CALD OSQ nurses about ethical systems, including secular, human rights and coping with communicating across cultures. These conversations were designed to enable CALD OSQ nurses to communicate assertively when working in a third culture which is outside their own culture as well as the majority Australian culture as stated below:

I talk about different ethical systems, including secular, human rights, especially in mental health because that's the best place to talk about both those things. They come into fairly high profile and acknowledging that there are different ethical systems then I ask them 'how do you cope working and communicating across cultures where you have got to do a triple shuffle?' Not this culture and not their own. (Pamela CALD CF).

In summary participants facilitated assertive techniques and therapeutic communication to avert withdrawal of consent by patients and refusal to supervise CALD OSQ nurses by RNs. Advocating development of a platform of trust partially achieved this so that CALD OSQ nurses could overcome uncertainties about the cultural appropriateness of becoming assertive. Participants recommended that with peer group trust and practice CALD OSQ nurses could then practice assertive techniques to develop more self-confidence. Direct statements of positive and negative feelings and beliefs could then be formed. Participants proposed that trust could be built by showing cultural sensitivity in a friendly participatory group environment. Strategies were aimed at enabling CALD OSQ nurses to talk through culturally sensitive issues and ask questions when in doubt. Further strategies to facilitate peer and participant CF trust encouraged involvement in reflective practice and debriefing activities to address non-assertive verbal and non-verbal communication challenges. Practice of assertive techniques in peer groups enabled assertive RN communication as well as formation of therapeutic relationships with patients by exploring culturally appropriate patient communication. Participants advocated use of an IBL approach to build confidence with knowledge and assertive, therapeutic communication techniques. Strategies to address underlying cultural beliefs and attitudes restricting the formation of therapeutic relationships included enabling CALD OSQ nurses to practice having appropriate personal conversations with patients.

4.7 Summary of Results and Conclusion

A summary of the results of this study shown on Table 6 comprised three challenge themes with up to two subthemes and associated strategy themes and subthemes which arose from analysing participant transcripts. Table 7 illustrated how the collected data and analysis answered the first research question regarding CF challenges of facilitating CALD OSQ nurses' clinical transition during clinical practicum. In addition data analysis answered the second research question regarding strategies to address these challenges also shown on Table 7. Many culturally sensitive facilitation challenges were addressed from the wider range of views from data collected from purposive quota sampling of CALD and non CALD participants. When combined these views provided facilitation challenges and strategies from both non CALD and CALD participant CFs.

Table 7: Summary of research questions and corresponding themes and subthemes

Research Questions	Research Question 1: What are the challenges of clinical transition of CALD OSQ nurses during clinical practicum according to the views of the CFs who are facilitating their transition to clinical practice?	Research Question 2: What strategies are proposed by CFs to address the challenges of facilitating clinical transition of CALD OSQ nurses during clinical practicum?
Category	**Themes and subthemes:** **Challenges**	**Themes and subthemes:** **Strategies**
Knowledge and understanding	Challenge theme 1: Lack of knowledge and understanding. Subthemes • Differentiating CALD OSQ nurses; • Perceptions and assumptions	Strategy theme 1: Gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs
CF autonomy, CF expectations and ward priorities	Challenge theme 2: Loss of CF role autonomy - mismatch between CFs' expectations and ward priorities	Strategy theme 2: Strengthening CF role autonomy - aligning CF expectations with ward experiences
Differences in verbal and non-verbal communication style.	Challenge theme 3: Differences in verbal and non-verbal communication styles; Subthemes • Non-assertive communication • Non-therapeutic relationships	Strategy theme 3: Addressing differences in verbal and non-verbal communication styles; Subthemes • CF facilitating CALD OSQ nurses' assertiveness. • Developing therapeutic relationships

A brief summary of themes and subthemes begins with the first challenge which was lack of cultural knowledge and understanding: differentiating CALD OSQ nurses and perceptions and assumptions. Associated strategies included: orientation techniques to gain cultural knowledge and understanding: differentiate CALD OSQ nurses' learning needs through icebreaker techniques; minimising the CF assessment role through culturally empathetic feedback. The second challenge theme was 'loss of CF autonomy: Mismatch between CFs expectations and ward priorities'. Associated strategies incorporated aligning CF expectations by strengthening CF autonomy through innovative clinical connections. The third challenge theme and subtheme was 'verbal and non-verbal communication style differences: non-assertive communication and non-therapeutic relationships.' Associated strategies began by participant CFs addressing the underlying cultural differences in CALD OSQ nurses being able to accept the need for assertive verbal and non-verbal communication. This strategy involved building peer group trust for reflective practice where positive and negative experiences can be discussed within the safety of a confidential participatory group process. Consequently CALD OSQ nurses could also practice using assertive techniques including statements expressing positive and negative feelings and beliefs for later use with patients and RNs. Participant CFs then facilitated therapeutic relationships by providing CALD OSQ nurses with opportunities to practice assertive techniques and then have inquiring, non-medical conversations with patients.

In conclusion, the journey of CFs supporting CALD OSQ nurses on clinical practicum began with participants needing knowledge and understanding of CALD OSQ nurses. Instead participant CFs reported relying on perceptions and assumptions about cultural differences in clinical practice. Assumptions were made about CALD OSQ nurses' culturally different interpretations of the role of the RN. Strategies to address these challenges included participants focusing on the use of orientation to create a supportive environment. This environment was based on CF and peer group trust to talk about difficult issues as they arose. Within this supportive environment participants and CALD OSQ nurses were enabled to interact freely around exploring and sharing cultural knowledge and understanding.

There was a strong view from participants that challenges of gaining knowledge and understanding of CALD OSQ nurses were part of a larger problem regarding the CF role. Participant CFs frequently viewed that they had minimal autonomy to manage the facilitation of CALD OSQ nurses' learning. This loss of autonomy was viewed as resulting in a mismatch between participant CF expectations and ward priorities. Strategies to keep everyone on the same track devised by participants included innovative clinical connections with ward based RNs. In addition, participant CFs often switched allegiances from CALD OSQ nurses' learning needs to patient care needs to establish periodic employment in the same facility in

the role of RN. If divided allegiances were averted through professional development this could potentially act to reinforce these connections and strengthen Ethnographic participant CF role autonomy.

Assessment was a vital thread running through the clinical practicum journey. Participants found ways to provide culturally sensitive feedback regarding assessments to CALD OSQ nurses which required cultural knowledge and understanding. This feedback involved minimising stresses related to assessment by encouraging empathetic approaches from participant CFs and RNs. Recommending transcultural education programs within health care facilities for all CFs and RNs was a recommended strategy to avert formation of allegiances and confrontation regarding culturally sensitive challenges. These programs were to assist RNs and CFs to gain cultural knowledge and understanding and value diversity while facilitating learning, assessing, supervising and working alongside another culture including CALD OSQ nurses.

One of the major features highlighted by participants throughout the clinical practicum journey was CALD OSQ nurses' verbal and non-verbal communication style differences. Critical challenges were by RNs and patients as a result of CALD OSQ nurses' non-assertive communication style and non-therapeutic communication. Participants approached these differences by addressing cultural issues regarding assertive forms of communication with authority figures and formation of therapeutic relationships. This was achieved by engendering participant CF and peer group trust and empathy to enable CALD OSQ nurses to address uncertainties regarding the cultural appropriateness of being assertive and forming therapeutic relationships. Opportunities for debriefing and reflective practice based on a platform of peer group trust could then lead to practicing assertive techniques. These techniques could then be applied to forming therapeutic patient relationships as well as forming assertive statements in response to unclear or aggressive communication with RNs or patients.

Ultimately the clinical practicum journey required participant CF autonomy to gain cultural knowledge and understanding of CALD OSQ nurses in order to facilitate assertive communication techniques and formation of therapeutic patient relationships. These strategies provided the foundations for participant CFs to facilitate CALD OSQ nurses to gain acceptance to be supervised by RNs and to gain experience with clinical practice in treating patients. Moreover participant CFs expected to have enabled CALD OSQ nurses to become self-directed, critical thinkers when faced with their own challenges such as verbal and non-verbal communication differences.

Chapter 5 discussed these findings with reference to the literature. The themes and subthemes were distilled into three key interpretations which were: 'Gaining cultural knowledge and understanding of

CALD OSQ nurses' learning needs'; 'Aligning participant CF expectations: CF role autonomy to facilitate CALD OSQ nurses' learning'; 'Participant CFs enabling the formation of therapeutic relationships and assertive verbal and non-verbal communication styles'.

CHAPTER 5: DISCUSSION AND CONCLUSION

5.0 Introduction

This chapter discussed the results of the study with reference to the literature. Two important concepts helped to provide an explanation of participant CFs' struggle to facilitate CALD OSQ nurses on clinical practicum and answer the research questions. One of these concepts was experiential learning theory (ELT). Participants' strategies were interpreted in the context of a cycle of learning based on ELT which was introduced in the next section. This interpretation of CFs facilitating CALD OSQ nurses' learning explained where CFs' challenges and associated strategies were located and how they operated within the phases of the ELT cycle.

A second concept was the environmental model of influence introduced in Chapter Two and presented in Figure Two. Centrally located on this multilayered circular model was the clinical learning environment of clinical practicum surrounded by multiple influences impacting on the CF role. My reworking of Kolb and Kolb's (2009) adaptation of Bronfenbrenner's (1994) ecological model introduced in chapter two has depicted these influences on the clinical learning environment and included: overarching international, national and local cultural patterns; university and health facility policies and procedures; formal and informal structures of the clinical practice environment. The clinical practice environment could contain competing or complementary goals which strongly influenced the CF role. Therefore the ELT cycle and the environmental model of influence enabled discussion in relation to the literature of the key study interpretations which have been distilled from the main themes and subthemes.

Although up to two subthemes were identified within each main theme, rather than separate entities, each theme and the subthemes should not be seen in isolation, instead they were a combination of intersecting challenges and strategies. The key study interpretations represented these intersecting challenges and strategies to create an understanding of the vulnerability of the whole CF facilitation of CALD OSQ nurses' experience.

Purposive quota sampling from participating CALD and non CALD CFs meant that it was possible to form a rich understanding from different cultural perspectives of participant CFs' views of facilitating CALD OSQ nurses. In addition, categorizing the data into challenges and strategies enabled the development of related themes and subthemes within each category. From these themes and subthemes the three key interpretations were discussed in relation to existing literature. These key interpretations comprised: 1. 'Gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs'; 2. 'Aligning CF expectations: CF role autonomy to facilitate CALD OSQ nurses' learning'; 3. 'Participant

CFs enabling the formation of therapeutic relationships and assertive verbal and non-verbal communication styles'. The next section introduced how participant CFs attempted facilitation strategies in relation to the ELT cycle with examples from findings of the study supported by the literature. Following this the focus of this chapter comprised discussion of the three key interpretations also with reference to the literature. Finally the strengths and limitations of the study, implications of the findings for clinical practice, recommendations for further research and the thesis conclusion have been presented.

5.1 CFs' struggle to facilitate CALD OSQ nurses

Contextualizing and preceding a discussion of the key interpretations, the concept of the ELT cycle has been presented and discussed in relation to the literature in order to explain participant CF's struggle to facilitate CALD OSQ nurses. This section used the environmental model of influence introduced in chapter two and presented in Figure 2 to discuss influences on CFs facilitating in the clinical learning environment. The environmental model of influence introduced the concept of clinical practicum as a central clinical learning environment with a participant CF and a CALD OSQ nurse. Therefore the next section integrated the ELT cycle and my reworking of Kolb and Kolb's (2009) adapted ecological model by Bronfenbrenner (1994). These two concepts portrayed participant CFs efforts to enable CALD OSQ nurses' to make the transitional journey to experiential learning on clinical practicum.

5.1.1 Participant CFs facilitating experiential learning amidst multiple cultural influences

Learning and teaching as a partnership in creating knowledge from clinical experience for CALD OSQ nurses was found amongst the more holistic participant CF facilitation processes on clinical practicum. These holistic facilitation processes were explained by examining the key findings in terms of the ELT cycle. My adaptation of Kolb's (1984) ELT cycle and Kolb and Kolb's (2009) connection of this cycle with learning styles have been represented on Figure 4 as a cyclical process with four phases shown below. The first phase involved acquiring concrete experience by actually carrying out an activity and then abstract conceptualization. The second phase involving abstract conceptualization encouraged deeper learning by examining the activity and what it meant. This was followed by transformative reflective observation which took place with reflective journaling or reflection in a trusted group to discuss how it felt to carry out the activity and how it could be improved. Confidentiality was an important aspect of this phase to ensure disclosure of negative experiences could be expressed without fear of repercussions. Finally active experimentation meant applying new knowledge gained from the previous three phases of the experience to a different situation for deeper learning.
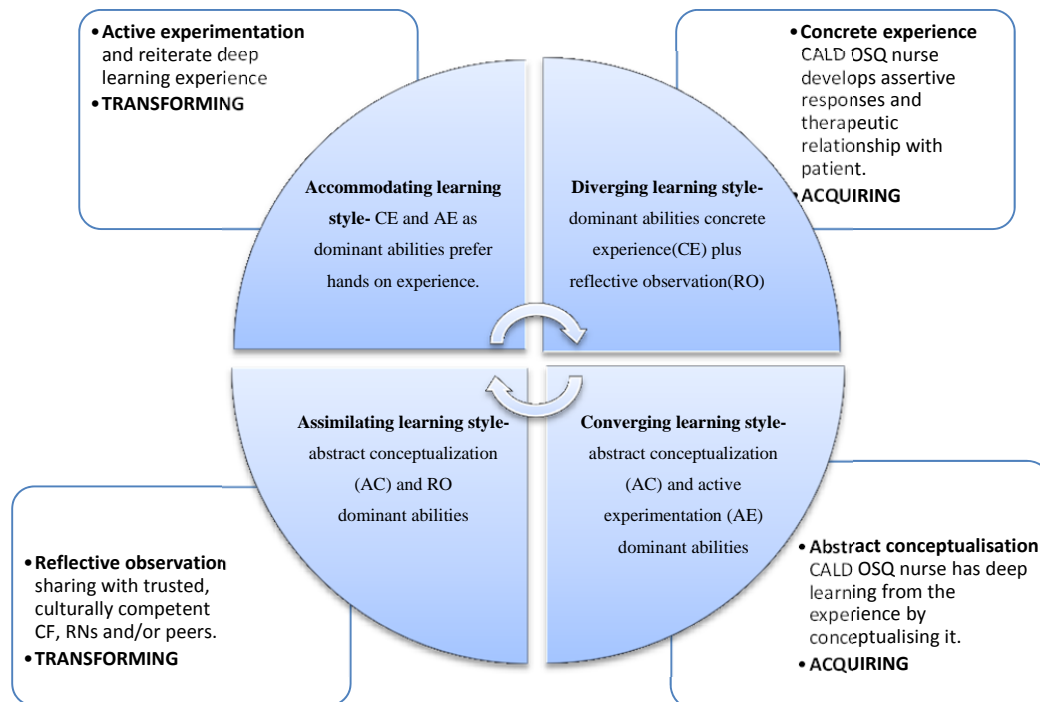
Figure 4: The experiential learning cycle linked to learning styles (Adapted from Kolb & Kolb, 2009; Kolb, 1984).

An example of CFs applying the four phases of the ELT cycle was when a CF asked CALD OSQ nurses to have a concrete experience of developing a therapeutic relationship. This incorporated devising culturally different ways of conversing with patients about non-medical aspects of their lives while still maintaining professional boundaries. Abstract conceptualization involved recognition that this was a new acceptable way of communicating with patients in order to form appropriate patient relations. The CALD OSQ nurses were then encouraged to engage in transformative participant CF and peer group reflective observation about how it felt to communicate this way with a patient. During these reflections the patient was then seen to transform into a whole person instead of a patient with a medical condition or 'a body in a bed'. Following this, reflective observational discussion may have entailed discussion of difficulties CALD OSQ nurses experienced in relation to previous cultural practices of communication with patients. It may have arisen for example that in China it was not the role of the nurse to communicate with patients. The participant CF could then provide additional support depending on the CALD OSQ nurse's particular learning style which has been explained in the following.

Learning styles which were linked to the phases of the ELT cycle on Figure 4 referred to possible differences in CALD OSQ nurses' learning which stemmed from preferring different phases of the learning cycle. The matching of dominant learning ability to each learning style included: diverging which combined concrete experience (CE) with reflective observation (RO) as dominant abilities; converging

which combined abstract conceptualization (AC) and active experimentation (AE); assimilating which combined abstract conceptualization and reflective observation ; and accommodating combined concrete experience and active experimentation as dominant abilities (Kolb & Kolb, 2009). Learning styles explained the influence of diverse cultures and language on CALD students' learning which formed the course of their personal and professional development. Learning styles were proposed to be related to culture, hereditary factors, and environment (Yamazaki, 2005; Kolb & Kolb, 2009).

The four empirically developed learning styles were based on the Clinical Learning Environment Inventory (Kolb, 1984) which was introduced in Chapter Two. Cavanagh, Hogan, & Ramgopal (1995) applied learning styles to nursing by assessing learning styles of 192 RNs who were post graduate students using Kolb's Learning Styles Inventory. It was found that 53.7% of participant RNs were predominantly concrete learners and 46.3% were predominantly reflective learners (Cavanagh et al., 1995). Further analysis resulted in finding no relationship between entry to nursing qualifications, age, sex or previous employment. A possible relationship between learning styles, culture and language was not studied. The study recommended that all CFs re-examine perceptions and assumptions of student learning needs (Cavanagh et al., 1995).

A central concept to emerge from the current study was that ELT principles linked to learning styles helped to explain participant CFs' challenges of many attempts at facilitation of deep learning to learn strategies for CALD OSQ nurse. Learning to learn strategies according to Kolb & Kolb (2005) involved learners becoming empowered to take responsibility to continue clinical learning in difficult circumstances. Consequently participants mostly preferred that facilitating deep learning involved integrating CALD OSQ nurses' cultural beliefs with new ideas such as forming therapeutic relationships. Several participants attempted to implement all four phases of the experiential learning cycle linked to CALD OSQ nurses' learning styles to facilitate deep rather than superficial learning As advocated by Kolb (1984) and Kolb and Kolb (2009) implementing all four phases of the ELT cycle was aimed toward combining emotional, perceptual, intellectual and interactive processes holistically. All four phases were considered essential to facilitate deep learning processes. Conducting reflective practice helped to resolve conflicts between different choices of action after reflective observation as well as addressing issues regarding thoughts and feelings about clinical experiences with patients and staff. Finally consistent facilitation patterns within the ELT cycle provided peer and participant CF support for CALD OSQ nurses' to have successful clinical transition experiences.

A crucial phase of the ELT cycle in the context of this study comprised the combining of meaningful experiences with reflection in a confidential participant CF and peer group environment. However the

effectiveness of participant CFs facilitating experiential learning for CALD OSQ nurses was influenced by the more robust environmental systems (presented in Figure 2) in which clinical practicum was embedded. These more robust systems projecting into the fragile learning environment of clinical practicum meant it was difficult to preserve the dynamic, holistic nature of the ELT cycle. An example of this is the way RN influences coming from the clinical practice environment can prevent participant CFs from following the full ELT cycle by omitting transformative reflective observation. Participant CFs were challenged to be able to implement all four phases of the ELT cycle for CALD OSQ nurses. Superficial learning was more likely when concrete experiences were acquired without reflective observation and active experimentation. A negative consequence was that participant CFs could be relegated to supporting RNs in the clinical practice environment rather than facilitating deep learning processes in the clinical learning environment for CALD OSQ nurses.

Particularly relevant to the findings of this study was a concept analysis of the ELT cycle linked to learning styles by English nurse academic Fowler (2008) which confirmed that experiential learning depended upon reflecting on experiences. The quality and extent of overall learning for CALD OSQ nurses relied on participant CFs' strategies to facilitate learning through reflective practice and ensure clinical experiences were meaningful. Benefits from experiential learning for CALD OSQ nurses depended upon participant CFs' challenges and strategies within the cyclical process. In addition these benefits varied from acquisition of skills such as complex clinical procedures to forming therapeutic relationships and personal development.

Similar to all students new to the Australian clinical learning environment, participants found that CALD OSQ nurses had to spend time practicing without fully understanding what to do and how to put theory taught at university into clinical practice. Hallett (1997) pointed out that reflection after a concrete action helped to make sense of the experience because confusion was to be expected when learning from experience. Thomas, Bertram and Allen (2012) studied the transition from student to new RN in clinical practice and found feelings of frustration and being overwhelmed were one of the four themes. These feelings of frustration and being overwhelmed during clinical transition could be linked to confusion which was based on the view that there was not a well-ordered match between theory and practice (Hallett, 1997).

Participants at times recognized that experiential learning meant that the basis of learning depended on the way experience was processed. This was explained by Fowler (2008) who contended that the work of John Dewey in 1938 acted as a foundation for the experiential learning movement which was based on the concept that experience with reflection leads to learning. Additionally reflection on experience as a crucial

element for learning has formed the foundation of the work of Kolb (1984) and Schön (1983). Fowler (2008) concluded that nurses actively learnt in a holistic way and that learning was socially and culturally constructed and influenced by the socio-emotional context in which it occurred. Participating CFs faced challenges when CALD OSQ nurses carried out tasks without fully understanding this context and were unable to follow all four phases of the ELT cycle.

Fowler (2008) explained that the internal dynamics of the ELT cycle contained a framework that implies that only certain ways of reflecting on experience enhanced learning. Participants in this study described how CALD OSQ nurses were allocated tasks instead of holistic care of patients. Task allocation affected the quality of learning in several ways including: degree of involvement, relevance and the fact that the subject was task and not patient based. Meaningfulness depended on participant CF autonomy to assist the reflection phase. Adequate planning of the activity was essential. Finally the behavior of the CALD OSQ nurse as learner in the reflective process also affected the quality of learning. However participant CFs' lack of autonomy meant they were often unable to facilitate reflective observation debriefing sessions so that the internal dynamics of the ELT cycle were omitted from the experiential learning process.

Within the clinical learning environment influences on the ELT cycle may have included: the external intervention of a CF; internal motivation of the CALD OSQ nurse; random act of a third party such as patients asking questions. Another dimension of this framework was the reflection of the experience being dependent upon higher level influences in the clinical practice environment. Individuals in the clinical practice environment who were encouraging such as supportive supervising RNs could enhance meaningfulness in the reflective phase of CALD OSQ nurses' learning.

Participating CFs who were able to use all four phases of the ELT cycle were able to encourage CALD OSQ nurses to practice developing a therapeutic relationship with patients for example by talking to them about non health related issues. In addition, CALD OSQ nurses who trusted the CF and peers to talk about negative as well as positive experiences were then able to reflect on the concrete experience and learn by conceptualizing the patient holistically as a whole person. Practice with particularly stressful forms of communication such as using the telephone could then take place in an informal learning environment. Moreover CALD OSQ nurses were also able to easily ask questions to clarify rather than pretending to know what was said to be culturally respectful and avoid conflict.

Alternatively, CALD OSQ nurses may have encountered nursing experiences such as racism, death and dying affecting cultural and spiritual beliefs as discussed in CALD OSQ nurses' experience of transition in Chapter Two. Participant CF challenges to the ELT cycle could have emanated from these overarching

cultural contexts outside the clinical learning environment and included: competing priorities for the CALD OSQ nurse such as inability to attend a session with the CF; personal or social problems such as language barriers or family issues; active reluctance to reflect on practice as many nursing subjects were not emotionally neutral. Difficulties may have been incurred if a CALD OSQ nurse held strong beliefs which prevented reflection on subjects outside their belief structure.

5.1.2 CALD OSQ nurses' preferred learning styles

Studies providing insights into CALD OSQ nurses' preferred learning styles were limited. However, Yamazaki (2005) studied relationships between cultural difference and preferred learning styles. The study concluded that learning styles were produced as an interplay between people and their environment. Yamazaki emphasized that understanding culture was imperative to recognize individual learning styles. Attempts to develop richer multicultural teaching and learning approaches in Western institutes of higher education were reviewed by Valiente (2008). Cultural issues were associated with learning styles in this review. According to Valiente's (2008) analysis of learning processes in different cultures, the learner's previous experience and the learning context significantly influenced the preferred learning style as long term behavior. An essential insight for the current study was that recognizing the value of culturally diverse learning styles, may have conflicted with the ideas of those who lacked cultural competence. However attempts to modify CALD OSQ nurses' culture and behavior by imposing generally accepted Western standards of learning may be found to be ineffective.

Most participants were concerned about CALD OSQ nurses' personal, family and financial pressures which could have led to higher levels of anxiety regarding risk of clinical failure. This was often linked to family expectations. Valiente (2008) found that CALD students outside the main Western countries including East Asia, the Middle East and Africa had greater expectations from families As well as this personal, professional and social identity has been linked to university degrees gained in specific institutions and countries such as Australia (Valiente, 2008). Similarly, many of the CALD OSQ nurses being facilitated in the current study were from these regions and were anticipated to have similar concerns about family expectations.

Participants described their perception that CALD OSQ nurses were 'assessment focused' so that they were assumed to develop inappropriate coping strategies. These coping strategies appeared to be focused more on passing clinical competencies and less about deeper experiential learning. According to Valiente (2008) coping strategies could cause serious learning delays. In addition, fear of clinical fail for any student could also lead to an inability to incorporate deep learning strategies (Valiente, 2008). Under these circumstances, some of the superficial learning styles such as memorization can be a useful learning tool

and external motivation, communication and collaborative patterns could work differently with CALD OSQ nurses.

The clinical competency tool used by participant CFs for student assessment on clinical practicum incorporated the Western, Socratic style of learning. This tool used Western style learning focusing on four traits: critical thinking as opposed to memorization; internal instead of external motivation; active instead of passive involvement and individual rather than group learning. However, this Western style of learning may be inappropriate for multicultural groups and CALD OSQ nurses (Valiente, 2008). Alternatively, CALD OSQ nurses who used memorization, external motivation, passive involvement and collaborative learning were not necessarily using a less effective approach to learning. Participant CFs in the current study frequently viewed CF and peer group collaborative learning as essential on clinical practicum. In addition transcultural communication theories were recommended to complement the Western models of learning styles (Valiente, 2008). Moreover insights from transcultural theories could have brought new meanings to observed practices of CALD OSQ nurses in this study. The value of learning in groups, identifying unique learning styles and using all phases of the ELT cycle was highlighted for participating CFs facilitating learning on clinical practicum.

In summary, the ELT cycle linked to learning styles has been introduced to explain participant CF's struggle to facilitate CALD OSQ nurses' learning. It was argued that all four phases of the ELT cycle were essential to facilitate deep rather than superficial learning. Learning styles have been differentiated in relation to phases of the ELT cycle with some examples of preferred learning styles in nursing. Review of literature results indicated that the learning processes in different cultures, the learner's previous experience and the learning context significantly influenced CALD OSQ nurses' preferred learning style. This highlighted that gaining knowledge and understanding of CALD OSQ nurses' unique learning needs meant being able to identify and build on dominant learning abilities to facilitate deeper transformative learning experiences. In addition concepts introduced in chapter two regarding situating the fragile clinical practicum learning environment within multiple robust external influences illustratet the basis of multiple CF facilitation challenges found in this study. The clinical practice environment has been designated to contain patients and RNs with varying levels of cultural competence which was discussed in chapter two. Organizational influences of the university and health facility policies and procedures also have a commanding position. Frequently underestimated is the omnipresence of overarching international, national and local cultural patterns which influence the clinical learning environment. This cultural context contained a graphic picture painted in chapter two of unsupportive clinical transition experiences of CALD OSQ nurses internationally, nationally and locally.

5.2 Discussion of the three key study interpretations

This section discussed the three key study interpretations listed in 5.1 in relation to the literature. The environmental model of social influences introduced in chapter two (Figure 2) and the ELT cycle discussed in 5.2.2 which was linked to learning styles were integrated into discussion of the key findings.

5.2.1 Gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs

The first key finding was 'Gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs'. It became evident that it was essential for participants to identify CALD OSQ nurses' unique learning styles and previous overseas nursing experiences. As discussed in chapter two, Hawthorne (2002b) supported the view that CALD OSQ nurses brought knowledge, experience and skills to fill workforce shortages in Australia. However CALD OSQ nurses had unique needs which required targeted strategies to successfully make the transition to clinical practice. Two main strategies were examined in relation to overcoming participant CF difficulties of differentiating CALD OSQ nurses. These strategies assisted with avoiding imprecise participant CF perceptions and assumptions about CALD OSQ nurses. The two main techniques to achieve this were orientation on the first day and stress reduction 'icebreaker' techniques to set up a platform of trust and an empathetic CF and peer support group. These techniques provided opportunities for sharing of cultural and professional experiences and enabled CFs to identify different learning needs.

Participants explained that it was extremely unlikely they would differentiate between local students who 'looked international' as they may be CALD local or international students or CALD OSQ nurses. In addition, research studies into understanding and enhancing the learning experiences CALD BN students in Australian programs did not necessarily focus on the learning needs of CALD OSQ nurses separately from all CALD students (Yeun-Sim Jeong, Levett Jones, Pitt, Hoffman, Norton & Ok Ohr, 2011; Sawir et al., 2008; Saunders et al. 2006). However, the learning needs of people who looked like international students in this study could be anticipated to vary depending on related university entry requirements. Nevertheless if students 'looked and sounded international' they may have actually been long term Australian citizens. These students would have completely different needs to the CALD OSQ nurses. Lamentably the tendency to make assumptions about students who 'looked international' left a gap in understanding of CALD OSQ nurses and knowledge of their learning needs. Allan (2010) studied mentoring of CALD OSQ nurses in the United Kingdom from the perspective of 93 participant CALD OSQ nurses, 23 managers and 13 mentors. Although mentors in Allan's study were described as taking a similar role as CFs it was unclear if they were employed by the health facility or the university. Nonetheless Allan's was an ethnographic interpretive study which supported the view that: 'Overseas-

trained nurses in supervised practice need to be recognized as trained nurses and be called 'overseas-trained nurses' rather than 'students' or 'learners' (Allan 2010, p. 610).

Participants who discerned CALD OSQ nurses' unique learning needs were able to adapt peer supported ELT cycle phases to individual learning needs and learning styles. Secomb (2008) produced a systematic review which focused on learning using peer group reflective practice in clinical education. The findings included that peer supported learning increased CALD students' confidence in clinical practice and improved learning in the psychomotor and cognitive domains (Secomb, 2008). In addition Secomb (2008) found that it was important that personalities and learning styles were compatible as incompatibility could result in poor CALD students' learning. Gaining cultural knowledge and understanding of CALD OSQ nurses in the current study enabled participant CFs to identify learning style compatibility. Individual needs could then be matched during CF and peer group teaching and learning using the ELT cycle particularly during the reflective observation phase. This identification of learning needs was considered crucial to facilitating learning. However peer supported learning was often not possible to implement because of active resistance emanating from the clinical practice environment.

Ultimately icebreaker techniques were aimed to reduce stress and establish ongoing CF and peer group support through the sharing of professional information. As reviewed in chapter two previous research has shown that CALD students as a group commonly experienced stress and anxiety (Thompson, Rosenthal & Russell, 2006). Stress reduction techniques and sharing of cultural knowledge were appropriate to counteract CALD OSQ nurses' cultural stress and feelings that the knowledge and skills they brought from their home country were not valued. In addition to cultural stress reported by Thompson et al. (2006) Gerrish and Griffith (2004) pointed out that CALD OSQ nurses have been found to experience feelings that their qualifications were undervalued.

Participants viewed that improving cultural competence of supervising RNs and CFs enabled them to feel comfortable working alongside another culture. According to Eyre (2010) supportive CFs could help floundering CALD students build confidence. Alternatively, critical CFs could cause stress, self-doubt and withdrawal (Eyre, 2010). Several participants described that all CFs and RNs required cultural competence in order to circumvent potential clinical fail for CALD OSQ nurses. Hewitt and Lewallen (2010) supported that participant CFs benefitted from transcultural education programs to help them cope with the challenges of facilitating the learning of groups of culturally diverse students. In response, several participant CFs proposed transcultural education as part of professional development for RNs and other CFs.

Participants proposed that strategies to gain cultural knowledge and understanding of CALD OSQ nurses were developed by demonstrating a high degree of cultural competence as discussed in chapter two. In addition participant CFs recognized the fragile nature of the clinical practicum learning environment in relation to the powerful surrounding influences. Creating a safe supportive clinical learning environment enabled CALD OSQ nurses to envisage that the goal of attaining clinical pass was achievable. In addition participant CF and peer group support was to be trusted and available throughout clinical practicum. Gaining knowledge and understanding of CALD OSQ nurses' learning needs was described by participants as a strategy used on the first day, to set the tone of the clinical practicum. Setting the tone meant using icebreaker techniques and friendly conversations at orientation aimed at showing interest in the CALD OSQ nurses' cultural and nursing background.

Several reflective observation exercises were used to encourage CALD OSQ nurses to feel comfortable to turn to the participant CF and peer group to discuss their learning needs and any negative experiences as they arose. Participants described how they would then talk about personal knowledge of different cultures to show understanding of different world views. The CALD OSQ nurses amongst the group of six to eight culturally diverse students would then share their goals for the practicum and begin to see the participant CF as empathetic and other students as a form of peer support. This was part of enabling all students to feel culturally competent and supported by the CF and peer group through creating a safe place, achievable goals and group cohesion.

Many participants could focus on the appropriate phase of the ELT cycle using CALD OSQ nurses' dominant learning abilities to strengthen weaker abilities. For example a CF described a CALD OSQ nurse who had an accommodating learning style who preferred hands on experiences as a stronger ability. An accommodating learning style meant the nurse were more willing to engage in active experimentation of new transformed approaches to skills such as communicating therapeutically. However to develop transformed approaches the CF focused on strengthening abstract conceptualization and reflective observation in order to facilitate recognition of how to improve their practice. In addition practices which may appear as weaker abilities may be identified as strongly influenced by entrenched nursing practices from overseas or cultural beliefs and values. Inaction to gain knowledge and understanding of CALD OSQ nurses' communication style could therefore lead to faulty perceptions and assumptions about individual learning styles and abilities.

In summary, the first key interpretation was participant CFs gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs to identify their unique learning styles. However the powerful influences from outside the clinical learning environment acted as major challenges. These challenges

could result in CFs having minimal contact so that lack of knowledge and understanding of CALD OSQ nurses meant that learning styles were not discerned. Supporting research regarding the overarching cultural influences has provided a broader view of how CALD OSQ nurses potentially experienced negative feelings of not belonging and cultural stress. In addition the literature revealed CALD OSQ nurses had negative feelings that knowledge and skills from their overseas qualifications were not valued. Consequently CALD OSQ nurses' unique learning needs were not evident however required identification of targeted strategies to facilitate optimal learning.

5.2.2 'Aligning CF expectations: Gaining CF role autonomy to facilitate CALD OSQ nurses' learning'

The second key interpretation was 'Aligning CF expectations: Gaining CF role autonomy to facilitate CALD OSQ nurses' learning'. Strategies included strengthening CF role autonomy through collaborative partnerships with RNs in the clinical practice environment. This collaboration was aimed at enabling alignment of CF expectations with ward experiences in the clinical practice environment for CALD OSQ nurses. Participants recognized challenges at the higher more robust levels outside the clinical learning environment. Most participants described loss of CF role autonomy regarding facilitation of CALD OSQ nurses' learning. In addition, if the CF was new or the RN was a work colleague then it became difficult to assert the authority needed to fulfill their role. Outcomes varied for CFs who were employed at a facility as a RN as well as by the university as a CF. Overall it was considered advantageous for participant CFs to cultivate professional relationships with both RNs and health facility based educators. These positive relationships were viewed as necessary in order to organize activities considered beneficial to CALD OSQ nurses' deep learning processes.

There is evidence in the literature that origins of the CF role are related to improving health service delivery by providing greater support for BN undergraduates' clinical transition on clinical practicum. Recently a need has been identified to strengthen the CF role in Australia due to role inconsistencies. As reviewed in chapter two introducing the role of CF in Australia can be traced to an initiative at national level to address unsupportive attitudes on clinical practicum (Dickson et al., 2006; Rowan & Barber, 2000). Focus was particularly placed on CFs to provide the support that CALD BN students needed for successful clinical transition from university studies (Yeun-Sim Jeong et al., 2011; Dickson et al., 2006 Rowan & Barber, 2000). Also reviewed in chapter two was Australian research by Saunders, White, Davis, Gavin, Hill, and Sarich (2006) into clinical practicum experiences of BN students. This study identified difficulties with the CF role arising from perceived performance inconsistencies. These inconsistencies were between hospital employed RNs in current practice and university employed CFs who were observed to have inconsistent skill sets (Saunders, et al., 2006). In addition, CFs in the

Saunders' et al. (2006) study were found to have particular difficulty with regard to assisting and assessing students at risk of clinical fail who were performing below expected standards of patient care. Similar to the current study identified needs to strengthen the CF role included on-going education and training for CFs and RNs (Saunders et al., 2006).

However, relying totally on participant CFs in the clinical learning environment to address unsupportive attitudes to students on clinical practicum was shown to be an inadequate response to a major issue in this study. As a result the CF role has been vulnerable to the powerful environmental influences of the clinical practice environment, hospital and health facility organizational influences and the overarching international, national and local cultural contexts described in Chapter 2. However significant initiatives that may assist CFs at local level have been implemented by NSW Health (2012a) which have been to 'teach the teacher' and prepare RNs for their major supervising role in the clinical transition of BN students described in Chapter One 1.5. As discussed in Chapter One the CF role was included in a quick reference guide called The Superguide: A supervision continuum for nurses and midwives (NSW Health HETI, 2013).

This Superguide (2013) provided information regarding the NSW Government funded activity aimed at preventing poor patient outcomes due to inadequate supervision of all nursing staff requiring professional development. The guide was proposed to be used throughout the career of nurses, midwives and healthcare workers. Furthermore the Superguide aimed to embed a culture of lifelong learning and reflection for nurses and midwives (NSW Health HETI, 2013). However this guide omitted strategies for facilitating particular groups of students' unique learning needs such as CALD OSQ nurses. In addition RNs were guided in the practice of clinical teaching using knowledge transfer instead of facilitation techniques. Clinical teaching was defined in the Superguide as experienced clinicians transferring knowledge and skills to the learners who have less understanding such as students on clinical placement (NSW Health HETI, 2013). However Chapter Two reviewed literature which found instruction from an expert for knowledge transfer has been superseded particularly as an effective form of experiential learning. Instead transferring knowledge by instruction from an expert was concluded to result in superficial task oriented approaches to nursing.

Instructional approaches to teaching have been superseded in nursing by facilitative approaches that support holistic models of nursing care. However the Superguide inferred that supervision in the clinical practice environment remained focused on instruction of task oriented care. Instructional task oriented approaches could result in surface task oriented learning instead of life long, reflective, holistic, self-directed deep learning to learn approaches. Facilitative approaches have been proposed to develop

learning abilities that sustain learning particularly for CALD OSQ nurses under difficult circumstances. These circumstances included during CALD OSQ nurses' clinical transition to practice from university to the health facility.

Alternatively the CF role was proposed in the Superguide to make things easier for others (NSW Health HETI, 2013). Outcomes of the CF role included that students became active, enthusiastic self-directed learners, the CF became a co learner and all CFs and students collaborated as equals (NSW Health HETI, 2013). A clear distinction has been drawn between holistic facilitation in the clinical learning environment and goals of clinical teaching in the clinical practice environment. The Superguide and its accompanying policies and procedures were proposed to act as a powerful influence at local level on RNs who spent the most time supervising CALD OSQ nurses. Furthermore RNs were encouraged to use instructional, knowledge transfer approaches instead of facilitative learning to learn approaches. Similar to the findings of this study this could result in a further mismatch of CF expectations for CALD OSQ nurses on clinical practicum.

Several participants emphasized the significance of combining education courses for acquisition of facilitation skills for periodic employment as both supervising RN and CF. This was because participants who were seeking to provide CALD OSQ nurses with much needed support often viewed important benefits of acting in RN and CF roles. Previously discussed in Chapter Two was research related to the overarching international, national and local cultural contexts partially contained in an integrative review of earlier studies by Kawi & Xu (2009). This review found that CALD OSQ nurses received inadequate support in their adjustment to new work environments in health facilities. Experience of participants in both RN and CF roles enabled role clarification as well as extension of learning and teaching skills and updating clinical skills in clinical practice environments.

In the current study the participating CF role in the clinical learning environment often depended on participant CF autonomy to carry out facilitation activities such as briefing and group reflection. Participant CFs mostly described feeling powerless to intervene when CALD OSQ nurses were asked to carry out previously learned tasks, instead of learning holistic approaches to the RN role in its entirety. Results from Kawi and Xu's (2009) integrative review supported findings that perceived lack of autonomy in the current study resulted in role inconsistencies for participants. Further inconsistencies in understandings of the role of CF were identified in the literature which was reviewed in Chapter Two.

In summary, the second key interpretation of the study was 'aligning CF expectations and gaining autonomy over the CALD OSQ nurses' learning' which has been discussed in relation to the literature. The significance of the origins of the CF role was articulated and current role inconsistencies were found

to be evident in previous studies. Furthermore it has been identified in this study and supported by the literature that part of aligning CF expectations to facilitate deep learning experiences involved ensuring that CFs had clear autonomous role responsibilities. The Superguide from NSW Health HETI (2013) partially explained the conspicuous contrast between the RNs' role in clinical teaching and CFs' role in clinical facilitation. Contrasting RNs' transfer of knowledge and skills approach with CFs' approach to clinical facilitation highlighted important differences. Ultimately these differences meant superficial task centred approaches with the former and the more beneficial holistic person centred, deep experiential learning to learn approaches for the latter. Participant CFs enabling CALD OSQ nurses to use the ELT cycle to learn in difficult circumstances potentially ensured continuing lifelong learning and improved retention in nursing.

5.2.3 'Participant CFs enabling the formation of therapeutic relationships and assertive verbal and non-verbal communication styles'

The third key interpretation of the study was 'Participant CFs enabling the formation of therapeutic relationships and assertive verbal and non-verbal communication styles'. Participant CF strategies to facilitate assertiveness with verbal and non-verbal communication style required that those people in relationships essential to the clinical learning environment valued diversity. This was achieved through tolerance and empathy with CALD OSQ nurses. Addressing communication differences and therapeutic relationships as well as encouraging different forms of assertive communication styles incorporated the socio emotional context of the ELT cycle. In addition the ELT cycle explained the CF strategies which supported the belief that the main foundation of learning was dependent on the way that information was processed. An essential ingredient of making experiential learning transformative was recognizing the quality of experiences and the type of reflection on those experiences. In order to illustrate strategies to enhance these aspects of communication the ELT cycle was adapted in Figure 4. Finally, it was pointed out that there were numerous challenges to effective experiential learning of verbal and non-verbal communication. These challenges included influences from the overarching international, national and local context, the university and health facility policies and procedures as well as the clinical practice environment.

The reported negative impact of CALD OSQ nurses' non-therapeutic patient communication and non-assertive verbal and non-verbal communication upon patients, RNs, and CFs was described by participants as a major challenge. The CF strategies were developed to prevent refusal to supervise CALD OSQ nurses by RNs and withdrawal of consent by patients and possible clinical fail for CALD OSQ nurses. When analyzing the data initially verbal and non-verbal communication style differences appeared to mostly present as CALD OSQ nurses' culturally bound non-assertiveness. Broader insights were gained

from findings from an integrative review by Kawi and Xu (2009) who developed facilitators and barriers to CALD OSQ nurses' clinical transition. Similar to the current study one of the barriers included differences in culture based life ways such as avoidance of conflict and lack of assertiveness which if not addressed was a hindrance to transition. Kawi and Xu's (2009) findings suggested that when CALD OSQ nurses remained silent and nodded agreement they would be following cultural practices by being non-assertive and avoiding conflict. However in a robust clinical practice environment which relied upon assertiveness and critical thinking such non-assertive responses could endanger patients. This finding was supported by Magnusdottir (2005) particularly with regards the possibility of CALD OSQ nurses endangering patients due to verbal and non-verbal communication differences. Reasons non-assertiveness could be unsafe included that CALD OSQ nurses would not ask for clarification regarding patient treatments or disagree with an authority figure who may be seeking verification.

Further to this Sherman and Eggenberger (2008) supported the view that building a clinical learning environment which respected and valued the diversity of all staff was an imperative step toward building confidence with CALD OSQ nurses' verbal and non-verbal communication. Within the clinical learning environment of clinical practicum several participants devised assertiveness strategies with verbal and non-verbal communication which were aimed at improving the whole experience for CALD OSQ nurses. These strategies were aimed at cultivating communication with the participant CF and encouraging peer supported learning using reflective activities based on the reflective observation phase of the ELT cycle. Appropriate assertive responses could then be developed to aggressive forms of communication frequently experienced by CALD OSQ nurses in the clinical practice environment.

A confidence building strategy used by participants was to have a tolerant attitude and establish empathetic relationships with the CALD OSQ nurses. In addition, participants conferred that appropriate CF self-disclosure was also part of helping students to feel more confident. The importance of tolerance and empathetic approaches were emphasized by Sherman and Eggenberger (2008) who employed qualitative methodology to investigate the educational and support needs of CALD OSQ nurses from students and their managers' perspective. Similar to participants in the current study Sherman and Eggenberger (2008); Amaro,D., Abriam-Yago & Yoder (2006); Yoder (2001) support the view that tolerance and empathy were enhanced if CFs were culturally competent or have insights from previous experience of being a CALD OSQ nurse.

Participants explained that risk of clinical fail became unavoidable when non-therapeutic verbal and non-verbal communication resulted in withdrawal of patient consent to be treated. Furthermore non-assertive

verbal and non-verbal communication differences could result in rejection by supervising RNs. Participants often described CALD OSQ nurses anxiety regarding potential clinical fail as a major challenge during their clinical practicum. This finding was supported by Brown (2005) who also noted that persistent fear of clinical fail was a characteristic of CALD students. Regrettably, the implications on patient safety of CALD OSQ nurses' verbal and non-verbal communication differences often meant the ensuing potential fail situation became culturally sensitive. Recommended strategies included cultural awareness or transcultural education programs for all RNs and CFs. These strategies enabled culturally sensitive feedback and understanding about the RNs' and CFs' role in facilitating the development of assertiveness and formation of therapeutic relationships which could circumvent a clinical fail for CALD OSQ nurses. As a result connections within and between the clinical learning environment and the clinical practice environment were potentially strengthened by building cultural competence for both CFs and RNs.

Most CALD OSQ nurses were described by participants as having their own cultural understanding of the role of the RN from their home country which was significantly different. An example several participants pointed out was that aggressive or authoritarian forms of communication were often used with mental health patients by RNs in certain cultures. As supported by Kawi & Xu (2009) participants discerned that CALD OSQ nurses had recently come from more traditional models of learning whereby the CF role was seen as a didactic teacher who had authority and should be respected and obeyed. Providing CALD OSQ nurses with opportunities to understand different ways of relating to authority figures and to patients therapeutically between cultures was supported in the literature. Takeno (2010) emphasized that in nursing, different cultures have varied priorities for psychological support and levels of physical care. Understanding and addressing these varied priorities included addressing non-assertiveness as a cultural hurdle to therapeutic patient communication. Participants pointed out that this required focused activities aimed firstly at making experiences with patients more meaningful. In addition, these meaningful experiences were to help CALD OSQ nurses to understand the beginnings of a therapeutic relationship.

Several participants used all four phases of the ELT cycle to facilitate transformative, deep learning of assertive verbal and non-verbal communication styles and formation of therapeutic relationships with patients. Facilitation began by providing concrete experiences with patients within the clinical learning environment. This was followed by conceptualizing or thinking about what they had done and how it could be improved. Sharing reflective observation of positive and negative feelings was then followed by actively experimenting with the new knowledge. The activity involved asking patients a range of questions which were unrelated to their health. By doing this, several cultural hurdles were addressed.

Consequently, CALD OSQ nurses had transformative, deep learning experiences and were beginning to understand holistic approaches to care as well as the therapeutic relationship.

Participants sometimes set about trying to assist development of English language skills by giving CALD OSQ nurses listening and writing exercises. Several participants said they had tried but couldn't improve CALD OSQ nurses' English on a three to four week clinical practicum. This experience concurred with challenges identified by meta-syntheses by Xu (2007). One of the four themes outlined the unique communication challenges identified for CALD nurses. This theme was communication as a daunting challenge, in terms of accents, informal use of language and most feared was telecommunication which was also pointed out in the current study. With focus placed on correcting language a vicious cycle of communication deficiency resulted in language proficiency being delayed, due to fear of making mistakes (Xu, 2007). Similar findings during the current study culminated in participant CFs finding it frustrating when CALD OSQ nurses resorted to giving a blank look and then pretending to know what was said rather than ask for clarification. These CALD OSQ nurses' responses could result in withdrawal of consent to be treated by patients and refusals from RNs supervising who became concerned with possible mistakes.

Part of the ELT strategy used by several participants was to use reflection and briefing sessions to build higher levels of knowledge and understanding. However approaches to briefing students included informal group discussions as well as exercises to aid cultural understanding of patients and each other as peer support. In addition, these briefing and reflection sessions included opportunities for CALD OSQ nurses to share their previous clinical experiences. However, debrief and reflection sessions were not always possible as they were contingent upon the CALD OSQ nurse's release by the supervising RN. Implications of omitting reflection can result in superficial understanding instead of deep learning.

In summary environmental challenges were addressed by participant CFs implementing all four phases of the ELT cycle. Participant CFs facilitated the development of assertiveness and the formation of therapeutic relationships by addressing culturally different forms of verbal and non-verbal communication styles. This began with recognition of environmental influences including understanding that authoritarian approaches to patients and non-assertiveness with authority figures were encouraged in certain cultures. This study identified that these attributes in CALD OSQ nurses could present a danger to patient outcomes on clinical practicum where assertiveness and therapeutic patient relationships are expected. Failure to recognize these communication differences could significantly impede participant CFs efforts on clinical practicum because of rejection of CALD OSQ nurses by RNs and patients. A strategy to avoid this outcome was transformative experiential learning of communication which required assurances of the

quality of reflection of the active experimentation stage. Finally effective reflection required growth of trust in the participant CF and peer group to bring about transformative experiential learning in the formation of assertive RN and therapeutic patient relationships.

5.3 Strengths and Limitations

The strengths of this study included that the principles of qualitative research methodology have been used to systematically approach the research questions. Despite conducting eight one-off interviews lasting from 20 to 45 minutes with three via teleconference participants were able to provide the depth and frankness which enabled data to be sufficiently in-depth to develop rich descriptions of participants' views. A reassuring conversational style seemed to encourage participant CFs to respond honestly and to expand on questions when prompted with further questions. An unexpected outcome of the teleconference interviews was the quality and depth of collected data. This may be explained partly by the increased sense of anonymity allowed without facial recognition. Researcher bias has been minimized by using a reflexive approach and responding to supervisor feedback throughout the research process. The results of the study have been discussed and strengthened by reference to previous research which was related to the topic. New local knowledge has come from describing the participating CFs' views of challenges and strategies proposed for facilitating CALD OSQ nurses' clinical transition. Previously, studies have focused on CALD OSQ nurses' perspective on transition and adjustment to working in Australia. There has been minimal research with reference to clinical practicum experiences from the CFs' perspective. This study has significance to the nursing profession in view of planned changes by the HETI. The current study could potentially inform changes which were planned to the proposed model of preparation of clinical supervisors and facilitators of future CALD student nurses and CALD OSQ nurses.

Limitations of this study included that it was a small qualitative descriptive study which was exploratory. In addition, the findings provided sufficient depth of information to develop rich descriptions of participants' views however they apply to a specific group of people and circumstances and therefore cannot be generalized. If a different selection of CFs had volunteered to participate in the study the data analysis could have resulted in emphasis on completely different views of challenges and strategies. Data collected via teleconference may have lacked elements provided by non-verbal communication in face to face interviews however those participants and their valuable data would not have been accessible otherwise. The experience and educational background of the CALD and non CALD CFs was not homogenous within the two groups of participants. Any differences may be related to other variables which were unrelated to having a CALD or non CALD background. Findings were not confirmed with observational data or other perspectives which were outside the scope of this small study.

5.3.1 Clinical Practice Implications

Clinical practice implications of this study included the need to use research evidence to support change to educational practices applied to the whole body of culturally diverse nursing students. This study affirmed that clinical facilitation strategies needed to be strengthened to empower CALD OSQ nurses with lifelong learning skills for transformative, deep learning rather than surface learning. Implications for clinical practice to be described from the current study included: informing models of clinical facilitation; highlighting the need to create cultural competence in all clinical environments; accentuating the role of the CF in reducing the theory practice gap for CALD OSQ nurses for improved readiness for health service delivery.

First the study has informed holistic models of clinical facilitation to improve patient care by applying all phases of the ELT cycle linked to CALD OSQ nurses' learning styles. This was particularly significant in view of the changes in NSW by the HETI transforming models of applying clinical education to improve patient care (outlined in Chapter One). These changes were aligned with the WHO's newly updated strategic directions for strengthening nursing and midwifery 2011-2015 and included the Clinical Supervision Support Project (CSSP). Importantly the main aim was to expand clinical supervision/facilitation capacity and competency for all health professionals. Changes included a recently completed Superguide from NSW Health HETI (2013) which provided insights into expected CF and RN role responsibilities. The Superguide partially explained the conspicuous contrast between the RNs' role in clinical teaching and the CFs' role in clinical facilitation. Perplexing differences were revealed from the Superguide by contrasting the supervising RNs' transfer of knowledge and skills approach with CFs' as partners in learning approach. Clinical implications of these differences meant didactic, superficial task centred approaches with the former and holistic person centred deep approaches to experiential learning for the latter. Similarly participant CFs struggled to enable CALD OSQ nurses' clinical facilitation using holistic approaches to facilitation against a tide of challenges beginning with supervising RNs in the clinical practice environment.

Second this study supported research in the literature which highlighted that there was a lag in incorporating cultural competence in nursing which could be incorporated in future university based research. It has been recommended that all nurses in clinical practice and clinical learning environments maintained an awareness of lack of cultural competence. This placed all CFs and RNs in the position of seeking knowledge and trying to gain insight about the CALD OSQ nurses' learning needs. In addition, this reflected the approach of several participants in this study who acknowledged their own cultural competence which incorporated knowledge, understanding, sensitivity and skill. It was a phenomenon which was evolving and changing and cultural competence which was not ever fully achieved. Valuable

lessons learnt from interviewing participant CFs and previous research included the imperative to respect everyone's views so that the general welfare of the whole body of culturally diverse nursing students was prioritized.

Third, a need has been identified for evidence of positive, culturally competent clinical practice and clinical learning environments where deep learning to learn strategies contribute to reducing the theory practice gap (CNR of ICN, 2009). Participant CFs frequently described their concern that patients may be at risk because of CALD OSQ nurses' clinical transition challenges such as verbal and non-verbal communication differences. This reflected concerns acknowledged by regulatory frameworks including the ICN and AHPRA to protect the public by being able to ensure CALD OSQ nurses' educational standards were sufficient to make the clinical transition to practice (CNR of ICN, 2009). At the same time international and national organizations urged that efforts needed to be accelerated to ensure equitable treatment of CALD OSQ nurses as they migrated globally (Xu, 2008). However, in Australia, there was a continued reliance on OSQ nurses to fill workforce shortages without necessarily seeking to address the increase of superficial task oriented learning processes possibly leading to poor retention rates (ABS, 2006). This underscores the urgency of implementing participant CFs' holistic facilitation strategies. These strategies could enable CALD OSQ nurses to make the clinical transition to evidence based practice, critical thinking skills, and holistic approaches toward therapeutic patient care. However with minimal participant CF role autonomy the theory practice gap for CALD OSQ nurses could widen further.

Clinical practice implications included agreed strategies which must be based on balancing all levels of social environmental influence on the clinical learning environment to enhance learning opportunities. These influences included the omnipresent international, national and local macrosystem, the university and health facility exosystem, the clinical practice environment mesosystem and the clinical learning environment microsystem. Finally, strengthening CF role autonomy to facilitate all phases of the ELT cycle linked to learning styles will potentially support CALD OSQ nurses' successful clinical transition on clinical practicum in the clinical learning environment. The effectiveness of these strategies could be tested in future larger quantitative research studies to develop results that could be generalized.

5.3.2 Research Recommendations

Considering the overarching aim of the HETI to expand clinical facilitation capacity and competency there was an urgent need for future research to focus on a wider, national study. Results of this research could potentially act as a valuable resource to inform the tailoring and incorporation of transcultural education programs. These programs could include instruction on facilitating the four phases of the ELT cycle to be part of transforming the preparation of current and future CFs and RNs. It is recommended that

larger quantitative studies are carried out to test the effectiveness of these transcultural education learning packages. Focus should be on developing cultural competence and capability using the principles of experiential learning. Therefore, it is recommended that effectiveness could be measured quantitatively and understood using CF, RN and CALD OSQ nurses' evaluations and assessment results combined with content analysis of interviews and focus groups. Changes to processes in a future study to recruit a larger number of participants are recommended. This could be achieved by allowing a longer timeframe and including multiple participating sites across NSW. This could potentially enable confirmation and transferability of strategies developed from this study.

Further evaluation studies to be conducted after strategies have been implemented will assist the program to evolve according to CF and CALD OSQ nurses' feedback. However it was acknowledged that it has been very difficult to change people even when they supported multicultural education (King, Nielsen and Colby, 2004). Previous research has shown that difficulties were evident during the evaluation process of a multicultural initiative; it was found that there are inherent challenges of culturally competent evaluation (King et al., 2004). According to SenGupta, Hobson and Thompson-Robinson (2004) evaluation was an attempt to measure values, merit and worth. Consequently, the link between cultural competence and evaluation is posited to be values and since culture strongly influences values, beliefs and worldviews, it was argued to be present in all aspects of evaluation (SenGupta et al., 2004).

Culture was anticipated to influence the design, approach, stance and methods as well as the contexts of implementation of evaluations for future research (SenGupta et al., 2004). Surface and hidden issues pertaining to cultural competence and evaluation needed to be differentiated. Therefore, surface issues involving contextual diversity include CFs' social, cultural, historical, economic and political contexts. Likewise, these issues point to the more obvious dimensions of evaluation such as the CFs' race, ethnicity, gender, and age. Alternatively, hidden issues that lie below the surface were proposed to be the contextual dimensions of the clinical learning environment of CF autonomy as well as dimensions of culture (Sen Gupta et al. 2004). These inherent challenges of evaluating cultural competence must be addressed in future research designed to evaluate CF facilitation strategies for CALD OSQ nurses' clinical transition. Research recommendations also include that further research is required to examine attitudes of CFs and hospital staff towards CALD OSQ nurses.

5.4 Thesis conclusion

To conclude this thesis I have argued the significance and contribution to nursing knowledge of this study. This began with a summary of the three key interpretations of the study results which were a distillation of the challenge themes and strategy themes and subthemes. The key interpretations were related to the

literature to reveal that CFs facilitating CALD OSQ nurses on clinical practicum were at the intersection of challenging, powerful, inescapable social and structural environmental influences. The participating CFs' revealed a patchwork of understanding of ELT and the accompanying learning cycle arising from the data which has been pieced together to form a whole. It then became clear that strong environmental influences regularly impacted on the clinical learning environment. Therefore unless holistic participating CF facilitation strategies were firmly defended, clinical practicum became one of the supporting pieces of the clinical practice environment. Instead of CFs facilitating CALD OSQ nurses deep, self -directed approaches to learning, potentially fragmented and superficial learning occurred so that task oriented models of nursing care were sustained.

The three key interpretations of the study comprised: *Gaining cultural knowledge and understanding of CALD OSQ nurses' learning need; Aligning CF expectations: Gaining CF autonomy over CALD OSQ nurses' learning; 'CFs facilitating therapeutic relationships and assertive communication styles'*. Firstly gaining cultural knowledge and understanding of CALD OSQ nurses' learning needs entailed orientation and icebreaker techniques to establish trust and empathetic, participatory CF and peergroup support. Participant CFs reported that this provided sustained support in a trusting, confidential environment for reflective practice so that learning occurred from reflecting on both positive and negative experiences. The second key finding which was gaining participant CF autonomy to enable CALD OSQ nurses' learning mainly focused on developing collaborative relationships with the RNs who supervised the CALD OSQ nurses. Participant CFs conferred that these relationships with the RNs and NUMs enabled familiarity with the clinical practice environment leading to greater CF role autonomy to initiate clinical facilitation strategies. Finally the third key interpretation of the study was forming therapeutic relationships and developing assertive verbal and non-verbal communication styles. This required the participant CFs to address cultural barriers. These cultural barriers to forming therapeutic relationships and assertiveness impacted on patient safety and resulted in CALD OSQ nurses facing possible refusals to be supervised by RNs and withdrawal of consent by patients. Participating CFs needed the role autonomy to facilitate appropriate assertive patient communication to overcome cultural hurdles to forming therapeutic relationships.

As well as the study results being discussed in relation to the literature, participating CFs facilitating CALD OSQ nurses in the clinical practicum learning environment fitted well as a microsystem within an environmental model of powerful influences. This clinical learning environment microsystem was set at the centre of a multilayered circular model of surrounding social influences. The next most observable layer of influence contained the robust clinical practice environment mesosystem. Following this was the commanding university and health facility policies exosystem. The outer skin macrosystem contained the

omnipresent overarching cultural international, national and local influences on what became the fragile clinical learning environment of clinical practicum. This model enabled discussion of how powerful influences impacted on the fragile clinical learning environment of clinical practicum. Evidence was provided from the literature to support discussion of these influences. Literature review findings ranged from alarming global, national and local cultural contexts to the relatively unfamiliar unpredictable territory of the RNs and patients in the clinical practice environment. There was evidence of perpetuation of task oriented nursing approaches leading to superficial learning in the clinical practice environment.

Behind the key strategies it became evident that participant CFs were using a patchwork of understanding of the ELT cycle which they linked to CALD OSQ nurses' learning styles. Participants overriding aim was to empower CALD OSQ nurses to take responsibility for their own learning. This meant acquiring the necessary skills to be able to learn in situations that were uncomfortable and problematic. The discussion was centred on participant CFs' views of facilitating deep transformative learning strategies using the four phases of the ELT cycle linked to CALD OSQ nurses' learning styles. Cultural competence was a particularly vital social influence at all environmental levels which impacted on the success of the facilitation of learning process. In addition the significance of all four phases of the ELT cycle has been linked to facilitation of successful clinical transition of CALD OSQ nurses on clinical practicum.

The findings reflected some of the research results in the literature on changes taking place in holistic models of nursing. Participating CFs' challenges were articulated particularly with fragmentary attempts to facilitate ELT approaches to enable deep CALD OSQ nurses' learning in health facilities. Moreover changes in models of nursing included reversion to superficial rather than deep transformative learning reflected in task oriented approaches to skill acquisition. Finally, ascertaining participant CFs' views on unique learning needs necessitated focus on identifying CALD OSQ nurses as a unique subgroup of CALD students. This was difficult at times when participants referred to international students as a single group. Research supports that CALD OSQ nurses have highly valued strengths which included that overseas qualifications have taken many years to achieve and are a scarce resource in terms of the diminishing global pool of nurses. Utilizing these strengths required participating CFs to use targeted strategies to enable clinical transition while CALD OSQ nurses were feeling cultural stress and professionally devalued.

This study contributed new knowledge as there were no previous studies found which focused on describing CFs' views of challenges and associated strategies of facilitating clinical transition of CALD OSQ nurses on clinical practicum from a local context. This study has articulated the views of participant CFs on facilitation of CALD OSQ nurses based on the ELT cycle linked to learning styles which has also

not been done before. Social and structural influences on the learning process have been discussed as an environmental model which highlighted the fragile nature of participant CFs facilitating CALD OSQ nurses in the clinical practicum learning environment. In addition, the significance of the study was discussed in Chapter One which highlighted the reliance on the relatively new role of the CF in narrowing the theory practice gap for CALD OSQ nurses to improve health service delivery. Therefore, this study achieved its aim and answered the research questions by developing rich descriptions of key facilitation challenges and associated strategies currently being implemented by participating CFs facilitating CALD OSQ nurses on clinical practicum.

Glossary

Constructivism	Constructivism refers to an epistemology which challenges the concept of a single truth. Instead reality is constructed by multiple truths which are shaped by social factors such as gender, culture and age.
Facilitation	Facilitation in nursing refers to a process of making things easier and entails aspects of building relationships including communication, continuous monitoring and evaluation. Respect and the development of trust are essential. This enables learning as a self-directed process and the practice of critical reflection.
Holism	Holism refers to understanding a human as a whole person which means acquiring knowledge of a person's whole life and history to understand their present state and behaviour.
Task orientation model of nursing	Task orientation model of nursing refers to an approach which focuses on developing competence in a hierarchy of clinical tasks and applying them to patients. This was considered an expedient form of patient care that did not require critical thinking and reflective analysis. Task orientation affects the quality of learning in several ways including: degree of involvement, relevance and the fact that the subject may be task and not patient based.
Theory-practice gap/divide in nursing	The theory-practice divide refers to the gap between nursing theory taught at university and applying this theoretical knowledge to clinical practice. This gap was manifested when RNs in health facilities found BN university graduates unprepared for work as RNs for health service delivery
Transition in nursing	Transition in nursing refers to a journey which is not linear, prescriptive or progressive instead it is evolutionary and transformative. It is a continuing process which moves in many directions.

References

Adeniran, R., Rich, V., Gonzalez, E., Peterson, C., Jost, S. & Gabriel, M.(2008). Transitioning internationally educated nurses for success: A model program. *OJIN*: *The Online Journal of Issues in Nursing*, 13 (2), pp. 39-52, Manuscript 3. DOI: 10.3912/OJIN.Vol13No02Man03**.**

Allan, H (2010). Mentoring overseas nurses: barriers to effective and non-discriminatory mentoring practices*. In: Nursing Ethics, Vol. 17, No. 5, 2010, p. 603-13;*
DOI: 10.1177/0969733010368747 Retrieved from: http://nej.sagepub.com/content/17/5/603

Amaro,D., Abriam-Yago, K. & Yoder, M.(2006). Perceived barriers for ethnically diverse students in nursing programs. *Journal of Nursing Education,*45 (7), p. 251. Retrieved from
http://www.ncbi.nlm.nih.gov/pubmed/16863104

Australian Bureau of Statistics (ABS) (2006), Cultural Diversity Overview, pp. 38-156. Retrieved from
http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/2070.0Publication29.01.0910/$File/20700_Cultural_overview.pdf

Australian Education International (AEI), Australian Government, (2013). *International student data.* International summaries of international student enrolment data. Retrieved from
https://aei.gov.au/research/International-Student-Data/Pages/default.aspx

Australian Health Professional Regulation Authority (AHPRA) (2010-2014). Nursing and Midwifery Board (NMB), Retrieved from General FAQ on English language skills registration standard

http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/faq-internationally-qualified-applicants-english-language-skills.aspx

Australian Nursing and Midwifery Accreditation Council (2014). National Competency Standards for the Registered Nurse. Retrieved from http://www.anmac.org.au/standards-review

Australian Nursing and Midwifery Council (2005). National Competency Standards for the Registered Nurse. Retrieved from
http://theses.flinders.edu.au/uploads/approved/adt-SFU20100708.110421/public/09Appendix7.pdf

Baker, C., Wuest, J., & Stern, P. (1992). Methods slurring: The grounded theory / phenomenology example. *Journal of Advanced Nursing*, 17, pp. 1355 – 1360. DOI: 10.1111/j.1365-2934.2006.00620.x

Beckett, D. & Hager, P. (2002). Describing the richness of practice. In Beckett, D. & Hager, P., *Life Work and Learning: Practice in Post Modernity*. pp. 22-28. Madison Ave, New York: Routledge. Retrieved from: http://books.google.com.au/books?hl=en&lr=&id=PriZz383wgoC&oi=fnd&pg=PP2&dq=nursing+holism +and+lifelong+learning&ots=EeRL9EzSDG&sig=OuiyX0CVDGDtM-JhV1wnpoU-DB8#v=onepage&q=nursing%20holism%20and%20lifelong%20learning&f=false

Bernard, R. (2006). Research Methods in Anthropology: Qualitative and Quantitative Approaches (4th ed.).pp. 463-521. Oxford, UK: Alta Mira Press.

Bondas, T. (2006). Paths to nursing leadership. *Journal of Nursing Management* 14 (5) pp. 332-339. Retrieved from Blackwell Synergy database 10/12/2006. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2934.2006.00620.x/

Boychuk-Duchscher, J. (2008). A process of becoming: The stages of new nursing graduate professional role transition. *The Journal of Continuing Education in Nursing* 39, 10 pp. 451-450. Retrieved from http://nursingthefuture.ca/assets/Documents/Stages2008.pdf

Bronfrenbrenner, U. (1994). Ecological models of human development. In International Encyclopaedia of Education, Vol. 3, 2nd. Ed. Oxford: Elsevier. Reprinted in: Guavin, M. & Cole, M. (Eds.), Readings on the development of children, 2nd ed. (1993, pp. 37-43). NY: Freeman.

Brown, V. (2005). Culturally and linguistically diverse nursing student education: A grounded theory study. Thesis presented for the Degree of Doctor of Philosophy of Curtin University, School of Nursing and Midwifery, Western Australia.

Bryman, A. (2012). Social research methods, (4th ed.) New York: Oxford University Press.

Buhler, C. (1971). Basic theoretical concepts of humanistic psychology. *American Psychologist*, 26, 378-386.

Burrows, D. E. (1997). Facilitation: a concept analysis. Journal of Advanced Nursing, 25, pp. 396-404. Retrieved from http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1997.1997025396.x/pdf

Cangelosi, P. R., Crocker, S. & Sorrell J. M., (2009): Expert to novice: clinicians learning new roles as clinical nurse educators. *Nursing Education Perspectives* 30 (6) pp. 367-371. Retrieved from http://go.galegroup.com/ps/i.do?id=GALE%7CA213601862&v=2.1&u=acuni&it=r&p=AONE&sw=w&asid=8aaf9a516b43fd7ff5a4f647ef7e91e9

Caelli, K., Ray, L. & Mill, J., (2003). Clear as mud: Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methodology,* 2 (2), pp.1-13. Retrieved from https://ejournals.library.ualberta.ca/index.php/IJQM/article/viewArticle/4521

Carpenter,C. (2013). Phenomenology and rehabilitation research. In Liamputtong, P. (Ed.) *Research methods in health: foundations for evidence based practice* (2nd ed.). Australia & New Zealand: Oxford University Press pp. 115-131.

Cavanagh, S., Hogan, K. & Ramgopal, T. (1995). The assessment of student nurse learning styles using Kolb Learning styles inventory. *Nurse Education Today* 15 (3) pp.177-183. http://dx.doi.org/10.1016/S0260-6917(95)80103-0 Retrieved from: http://www.sciencedirect.com/science/article/pii/S0260691795801030

Charmaz, K. (2011). Grounded theory methods in social justice research. In Denzin, N. & Lincoln, Y., (Eds.) *The Sage Handbook of Qualitative Research*. (4th ed.) Sage Publications: Thousand Oaks, California pp. 359-380.

Clark, C. L., Gibb, C. E., & Romprogus, V. (2003). Clinical learning environments: an evaluation of an innovative role to support pre registration nursing placements. *Learning in Health and Social Care* 2 (2) pp. 105-115. Retrieved from http://onlinelibrary.wiley.com/doi/10.1046/j.1473-6861.2003.00044.x/full

Cowan, D. & Norman, I. (2006). Cultural competence in nursing: new meanings. *Journal of Transcultural Nursing,* 17, (1), pp. 82-86. doi: 10.1177/1043659605281976 Retrieved from http://tcn.sagepub.com/content/17/1/82.short

Creswell, J. (2011), Controversies in mixed methods research. In Denzin, N. & Lincoln, Y., (Eds.) *The Sage Handbook of Qualitative Research*. (4th ed.) Sage Publications: Thousand Oaks, California, pp. 269-284.

Cubit, K. & Lopez, V., (2011). Qualitative study of enrolled nurses transition to registered nurses. *Journal of Advanced Nursing*. 68 (1), pp. 206-211. DOI: 10.1111/j.1365-2648.2011.05729.x

Cuellar, N., Brennan, A., Vito, K. & De Leon Siantz, M. (2008). Cultural competence in the undergraduate nursing curriculum. *Journal of Professional Nursing,* 24, (3), pp 143-149. http://dx.doi.org/10.1016/j.profnurs.2008.01.004 Retrieved from http://www.sciencedirect.com/science/article/pii/S8755722308000185

Denzin, N. & Lincoln, Y., (2011). Introduction: The discipline and practice of qualitative research. In Denzin, N. & Lincoln, Y., (Eds.) *The Sage Handbook of Qualitative Research*. (4th ed.) Sage Publications: Thousand Oaks, California pp. 1-19.

Denzin, N. & Lincoln, Y., (2005), (Eds.) *The Sage Handbook of Qualitative Research*. (3rd ed.) Sage Publications: Thousand Oaks, California.

Department of Education, Employment and Workplace Relations (DEEWR). (2013). Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) Australian Government. Retrieved from http://cricos.deewr.gov.au/Contacts/CRICOSContacts.aspx

Dickson, C., Walker, J. & Bourgeois, S. (2006). Facilitating undergraduate nurses' clinical practicum: The lived experience of clinical facilitators. *Nurse Education Today*. 26, (5), pp. 416-422. Retrieved from http://www.sciencedirect.com/science/article/pii/S0260691705002388

Dogherty, E., Harrison, M. & Graham, I. (2010). Facilitation as a role and process in achieving evidence-based practice in nursing: A focused review of concept and meaning. Worldviews on Evidence-Based Nursing: Second Quarter. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1741-6787.2010.00186.x/full

Ellis, R. & Hogard, E. (2003). Two deficits and a solution? Explicating and evaluating clinical facilitation using consultative methods and multiple stakeholder perspectives. *Learning in Health and Social Care,* 2, (1), pp. 18-27. Retrieved from
http://web.ebscohost.com/ehost/detail?sid=7b95ebe0-20a2-44d5-93d9-df95fbb541fb%40sessionmgr14&vid=3&hid=12&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=rzh&AN=2009340472

Erickson, F., (2011). A history of qualitative inquiry in social and educational research. In Denzin, N. & Lincoln, Y., (2005), (Eds.) *The Sage Handbook of Qualitative Research*. (3rd ed.) Sage Publications: Thousand Oaks, California pp. 43-59.

Eyre, J. (2010). *Communication in Clinical Practice: Critical success factors for ESL students*. A thesis completed in fulfillment of the requirements for the Degree of Master of Philosophy at Massey University, Palmerston North, New Zealand.

Fleming, J. (2008). Health care workforce. In Taylor, S., Foster, M. & Fleming, J. (Eds.), *Health Care Practices in Australia*, (pp. 103-130). South Melbourne, Victoria: Oxford University Press.

Fleming, J. Foster, M. & Taylor, S., (2008). Contemporary health care practice. In Taylor, S., Foster, M. & Fleming, J. (Eds.), *Health Care Practices in Australia*, (p.169). South Melbourne, Victoria: Oxford University Press.

Fowler, J. (2008). Experiential learning and its facilitation. *Nurse Education Today*. 28, (4), pp. 427-433. Retrieved from http://www.sciencedirect.com/science/article/pii/S0260691707001165

Gerrish, K. & Griffith, V. (2004). Integration of overseas registered nurses: evaluation of an integration program. Journal of Advanced Nursing, 45 (6) pp. 579-587. DOI: 10.1046/j.1365-2648.2003.02949.x Retrieved from http://europepmc.org/abstract/MED/15012635

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York: Aldine.

Grant, L., & Letzring,T. (2003) Status of cultural competence in nursing education: a literature review. *Journal of Multicultural Nursing and Health.* Chautauqua. 9, (2), pp. 6-14.

Grbich, C. (2013). Integrated methods in health research. In P.Liamputtong (Ed.) *Research methods in health: foundations for evidence based practice* (2nd ed.). Australia & New Zealand: Oxford University Press.

Greene, J. (2006). Towards a methodology of mixed method social inquiry. *Research in the Schools*, 13 (1), pp.93-98.

Hahn, C. (2008). *Doing qualitative research using your computer: A practical guide*. Los Angeles: Sage.

Hallett, C.E. (1997). Learning through reflection in the community: the relevance of Schon's theories of coaching to nursing education. *International Journal of Nursing Studies* 34 (2), pp.103-110 http://dx.doi.org/10.1016/S0020-7489(97)00001-1 Retrieved from http://www.sciencedirect.com.ezproxy1.acu.edu.au/science/article/pii/S0020748997000011

Harding, T. & Whitehead, D. (2013). Analysing data in qualitative research. In Schneider, Z., Whitehead, D., LoBiondo, G. & Haber, J. (Eds.) *Nursing and Midwifery Research: Methods and Appraisal for Evidence Based Practice.* (4th ed.) pp. 35-53. Chatswood, NSW: Mosby Elsevier.

Hardy, M. & Bryman, A. (2004). Introduction: Common threads among techniques of data analysis. In Hardy, M. & Bryman, A. (Eds.). *Handbook of Data Analysis*. Sage Publications: Thousand Oaks, California pp. 1-13.

Hawthorne , L. (2005). "Picking Winners": The recent transformation of Australia's skilled migration policy pp. 663-696. *International Migration Review*, Volume 39, Issue 3 Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1747-7379.2005.tb00284.x/abstract

Hawthorne, L. (2002a). The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia. *Nursing Inquiry* 8 (4), 213 – 229. DOI: 10.1046/j.1320-7881.2001.00115.x

Hawthorne, L. (2002b). Qualification recognition reform for skilled migrants in Australia: applying competency – based assessment to overseas qualified nurses. *International Migration*, 40 (6) 55-91. Retrieved from http://faculty.ksu.edu.sa/hisham/Documents/Medical%20Education/English/Nursing%20Education/127.pdf

Heale, R., Mossey, S., Lafoley, B. & Gorham, R. (2009). Identification of facilitators and barriers to the role of mentor in clinical settings. *Journal of Interprofessional Care*, 23 (4), pp. 369-379. Retrieved from http://informahealthcare.com/doi/abs/10.1080/13561820902892871

Health Education and Training Institute (HETI) (2013).*The Superguide: A supervision continuum for nurses and midwives*, HETI, Sydney. Retrieved from: www.heti.nsw.gov.au

Health Education and Training Institute (HETI) (2012). *Clinical Supervision Support Project*, New South Wales Centre for Learning and Teaching. Retrieved from http://www.heti.nsw.gov.au/programs/cssp/

Henderson, A. & Tyler, S. (2011). Facilitating learning in clinical practice: Evaluation of a trial of a supervisor of clinical education role. *Nurse Education in Practice.* 11, (5), pp. 288-292. Retrieved from http://www98.griffith.edu.au/dspace/bitstream/handle/10072/45852/78416_1.pdf?sequence=1

Henderson, A., Twentyman, M., Heel, A., &Lloyd, B., (2006). Students' perception of the psychosocial clinical learning environment: An evaluation of placement models. Nurse Education Today, 26 (7) pp. 564-571. Retrieved from http://dx.doi.org/10.1016/j.nedt.2006.01.012

Hewitt, P. & Lewallen, L. (2010). Ready, set, teach! How to transform the clinical nurse expert into the part-time clinical nurse instructor. The Journal of Continuing Education in Nursing 41 (9). pp.403-407. DOI: 10.3928/00220124-20100503-10 Retrieved from http://europepmc.org/abstract/MED/20506923

Higgins, P. (2009), *Review of Current Cultural and Linguistic Diversity and Cultural Competence Reporting Requirements, Minimum Standards and Benchmarks for Victoria Health Services Project: literature review*. Melbourne Victoria: Statewide Quality Branch, Victorian Government Department of Health.

Hogard, E. & Ellis, R. (2006). Evaluation and communication: Using a communication audit to evaluate organizational communication. Evaluation Review 30 pp.171-187. DOI: 10.1177/0193841X05278789 Retrieved from http://erx.sagepub.com/content/30/2/171

International Council of Nurses (ICN) (2009). *Positive practice environments: key considerations for the development of a framework to support the integration of international nurses*. Council of National Representatives.

Imms, C. & Greaves, S. (2013). Measure twice, cut once: Understanding the reliability and validity of the clinical measurement tools used in health research. In P. Liamputtong (Ed.) *Research methods in health: foundations for evidence based practice* (2nd ed.). Australia & New Zealand: Oxford University Press.

Johnstone, M., Kanitsaki, O. & Currie, T. (2008). The nature and implications of support in graduate nurse transition programs: An Australian study. *Journal of Professional Nursing*, 24 (1), pp. 46-53. Retrieved from http://www.sciencedirect.com/science/article/pii/S8755722307001408

Kai, J., Spencer, J. & Woodward, N. (2001). Wrestling with ethnic diversity: toward empowering health educators *Medical Education.* 35 (3) pp. 262-271. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2001.00880.x/full

Kawi, J. & Xu, Y. (2009). Facilitators and barriers to adjustment of international nurses: an integrative review. International Nursing Review 56, pp. 174-183. doi: 10.1111/j.1466-7657.2008.00705.x Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19646166

King, J., Nielsen, J. & Colby, J. (2004). Lessons for culturally competent evaluation from the study of a multicultural initiative. *New Directions for Evaluation.* 102, pp. 67- 87 DOI: 10.1002/ev.116 Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/ev.116/abstract

Kitto, S., Chesters, J. & Grbich, C. (2008). Quality in qualitative research: Criteria for authors and assessors in the submission and assessment of qualitative research articles for the Medical Journal of Australia. *Medical Journal of Australia* 188 (4) pp. 243-246. Retrieved from https://www.mja.com.au/journal/2008/188/4/quality-qualitative-research

Kline, D. (2003). Push and pull factors in international nurse migration. *Journal of Nursing Scholarship* 35 (2), 107 – 111. Retrieved from http://www.uregina.ca/gspp/marchildon/WRTCfiles/Farag_Reading3.pdf

Kolb, A. & Kolb, D. (2009). Experiential learning theory: A dynamic, holistic approach to management learning, education and development. In Armstrong, S. J. & Fukami, C. (Eds.) *Handbook of Management Learning, Edication and Development.* London: Sage Publications. Ch. 3, pp. 42-68.

Kolb, A. & Kolb, D., (2005). Learning styles and learning spaces: Enhancing experiential learning in higher education. *Academy of Management Learning and Education.* 4 (2) pp. 193-212. doi: 10.5465/AMLE.2005.17268566 Retrieved from http://www.jstor.org/stable/40214287

Kolb, D. (1984) Experiential learning: Experience as the source of learning and development. Englewood Cliffs, NJ: Prentice Hall.

Konno, R. (2006), Support for overseas qualified nurses in adjusting to Australian nursing practice: a systematic review. *International Journal of Evidence Based Healthcare,* 4 (2), pp. 83-100. DOI: 10.1111/j.1479-6988.2006.00037.x Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1479-6988.2006.00037.x/

Konno, R. (2008), *Lived experience of overseas qualified nurses from non-English speaking backgrounds in Australia.* A thesis submitted to the University of Adelaide for fulfilment of the requirements for the degree of PhD.

Kralik, D., Visentin, K. & van Loon, A. (2006) Transition: a literature review. *Journal of Advanced Nursing* 55 (3) 320-329. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2006.03899.x/

Lee, W., Cholowski, K., & Williams, A. (2002). Nursing students' and clinical educators' perceptions of characteristics of effective clinical educators in an Australian university school of nursing. *Journal of Advanced Nursing*, *39*(5), 412-420. doi:10.1046/j.1365-2648.2002.02306.x

Lambert, V. & Glacken, M. (2005). Clinical education facilitators: a literature review. *Journal of Clinical Education*, 14, (6), pp. 664-673. http://www.uregina.ca/gspp/marchildon/WRTCfiles/Farag_Reading3.pdf http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2006.01608.x/abstract

Levett-Jones, T. & Fizgerald, M. (2005). A review of graduate nurse transition programs in Australia. Australian *Journal of Advanced Nursing*, (23), 2, pp. 40-45. Retrieved from http://www.ajan.com.au/Vol23/Vol23.2-6.pdf

Liamputtong, P. (2013a). *Qualitative research methods.* (4[th]ed.) South Melbourne, Victoria: Oxford University Press.

Liamputtong, P. (2013b). The science of words and the science of numbers: Research methods as foundations for evidence-based practice in health care. In P.Liamputtong (Ed.) *Research methods in health: foundations for evidence based practice* (2nd ed.). Australia & New Zealand: Oxford University Press.

Liamputtong, P. Shields, N. & Nevill, A. (2013). Writing and critically appraising published research reports. In Liamputtong, P. (Ed.) *Qualitative Research methods* (4th ed.). Australia & New Zealand: Oxford University Press.

Lincoln, Y., Lyneham, S. & Guba, E. (2011). Paradigmatic controversies, contradictions and emerging confluences, revisited. In Denzin, N. & Lincoln, Y., (Eds.) *The Sage Handbook of Qualitative Research*. (4th ed.) Sage Publications: Thousand Oaks, California.

Lopez, V. & Whitehead, D. (2013). Sampling data and data collection in qualitative research. In Schneider, Z., Whitehead, D., LoBiondo, G. & Haber, J. (Eds.) *Nursing and Midwifery Research: Methods and Appraisal for Evidence Based Practice.* (4th ed. pp. 35-53) Chatswood, NSW: Mosby Elsevier.

Magnusdottir, H. (2005). Overcoming strangeness and communication barriers: A phenomenological study of becoming a foreign nurse. *International Nursing Review*, 52, pp. 263-269. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1466-7657.2005.00421.x/full

Marshall, H. (2002). What do we do when we code data? *Qualitative Research Journal*, 2 (1) pp. 56-70. Retrieved from http://www.stiy.com/qualitative/1AQR2002.pdf#page=56

Maynard, M. (2004). Feminist issues in data analysis. In Hardy, M. & Bryman, A. (Eds.). *Handbook of Data Analysis*. Sage Publications: Thousand Oaks, California pp. 131-145.

Milne, J. & Oberle, K. (2005). Enhancing rigor in qualitative description: a case study. *Journal of Wound Ostomy Continence Nursing*, 32 (6) pp. 413-420. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16301909

Milner, M., Estabrook, C. & Humphrey, C. (2005). Clinical nurse educators as agents for change: increasing research utilisation. *International Journal of Nursing Studies*, 42, (8), pp. 899-914. Retrieved from http://www.sciencedirect.com/science/article/pii/S0020748904002238

Momeni, P., Jirwe, M., & Emami, A. (2008). Enabling nursing students to become culturally competent – a documentary analysis of curricula in all Swedish nursing programs. *Scandinavian Journal of Caring Science*, 22, pp. 499-506. DOI: 10.1111/j.1471-6712.2007.00554.x Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1471-6712.2007.00554.x/full

Morse, J. M. (2005). Evolving trends in qualitative research: Advances in mixed methods designs. *Qualitative Health Research*, 15, pp. 583-585. doi: 10.1177/1049732305275169 Retrieved from http://qhr.sagepub.com/content/15/5/583.extract

National Health and Medical Research Council (2005). *Cultural competency in health. A guide for policy partnerships and participation.* Retrieved from http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/hp19.pdf

Neergaard, M., Oleson, F. Sand Anderson, R. & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *Biomedical Central Medical Research Methodology*, (9), 52 doi: 10.1186/1471-2288-9-52 Retrieved from http://www.biomedcentral.com/1471-2288/9/52/

New South Wales Health (2012a). ClinConnect, Partnering for clinical placements. Retrieved from http://www.health.nsw.gov.au/clinconnect/pages/default.aspx

New South Wales Health (2012b). *NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities* 2012-2016. http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_020.pdf

NVivo 9 Basics, 2010. QSR International. Retrieved from www.qsrinternational.com

Omeri, A. & Atkins, K. (2002). Lived experience of immigrant nurses in New South Wales, Australia: searching for meaning. *International Journal of Nursing Studies*, 39 (5) pp. 495-505.http://dx.doi.org/10.1016/S0020-7489(01) Retrieved from http://www.sciencedirect.com/science/article/pii/S0020748901000542

Organisation for Economic Cooperation and Development (OECD) (2011a), OECD Health Statistics, OECD Publishing. DOI:10.1787/factbook-2011-en Retrieved from OECD Factbook 2011-2012: Economic, Environmental and Social Statistics

Organisation for Economic Cooperation and Development (2011b), Health at a Glance OECD Indicators Retrieved from http://www.oecd.org/els/health-systems/49105858.pdf

O'Toole, G. (2012). *Communication: Core interpersonal skills for health professionals.* (2nd ed.). Chatswood, NSW: Elsevier.

Parahoo, K. (2006). *Nursing Research: Principles, Processes and Issues*. (2nd ed.). Palgrave Macmillan: Basingstoke, Hampshire, UK.

Paton, B. L. (2007). Knowing within: practice wisdom of clinical nurse educators. *Journal of Nursing Education*, 46 (11), pp. 488-495. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18019106

Patton, M. Q. (2002), Qualitative Research & Evaluation Methods (3rd ed.).Thousand Oaks: Sage Publications.

Pidgeon, N. & Henwood, K. (2004). Grounded theory. In Hardy, M. & Bryman, A. (Eds.). *Handbook of Data Analysis*. Sage Publications: Thousand Oaks, California pp. 624-648.

Pierson, J. (2013). Data analysis in quantitative research. In P.Liamputtong (Ed.) *Research methods in health: foundations for evidence based practice* (2nd ed.). Australia & New Zealand: Oxford University Press.

Rogers, C., (1985). Towards a more human science of the person. *Journal of Humanistic Psychology* 25 (4), p. 7-24. doi: 10.1177/0022167885254002

Rowan, P. & Barber, P., (2000). Clinical facilitators: a new way of working. *Nursing Standard*, 14 (52), pp. 35-38.

Rush, K., Adamack, M., Gordon, J., Lilly, M. & Janke, R., (2013). Best practices of formal new graduate nurse transition programs: An integrative review. *International Journal of Nursing Studies*,50 (3), pp. 345-356. Retrieved from http://dx.doi.org/10.1016/j.ijnurstu.2012.06.009

Ryan, G. & Russell Bernard, H. (2003). Techniques to identify themes. *Field Methods*, 15 (1) pp. 85-109.DOI: 10.1177/1525822X022395659 Sage Publications. doi: 10.1177/1525822X02239569 Retrieved from http://fmx.sagepub.com/content/15/1/85.short

Sandelowski, M. (2001), Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and Health*, 23, p. 334-340. DOI: 10.1002/nur.20362

Sandelowski, M. (2010), What's in a name? Qualitative description revisited. *Research in Health and Nursing*.33, (1), pp. 77-84. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/nur.20362/abstract

San Miguel, C. & Rogan, F. (2012). Clinical expectations: What facilitators expect from ESL students on clinical placements. Nurse Education in Practice. 12 (2) pp. 115-119, DOI: 10.1016/j.nepr.2011.10.008) Retrieved from http://www.nurseeducationinpractice.com/article/S1471-5953(11)00157-0/abstract

San Miguel, C., Rogan, F., Kilstoff, K. & Brown, D. (2006). Clinically speaking: A communication skills program for students from non-English speaking backgrounds. *Nurse Education in Practice,* 6, pp. 268-274. Retrieved from http://www.sciencedirect.com/science/article/pii/S1471595306000266

Saunders, R., White, K., Davis, S., Leslie, G., Hill, O. & Sarich, K. (2006). Clinical placement of nurses in Western Australia (WA): A project to assess and improve the quality and scope of clinical education. A collaborative project: Edith Cowan University; Sir Charles Gairdner Hospital; Royal Perth Hospital.

Sawir, E., Marginson, S., Deumert, A., Nyland, C. & Ramia, G., (2008). Loneliness and international students in Australia. *Journal of Studies in International Education*, *vol. 12,* (2), 148-180. Retrieved from http://jsi.sagepub.com/content/12/2/148.short

Schön, D. A. (1983) *The Reflective Practitioner: How Professionals Think in Action*. Temple Smith, London.

Seale, C. (2002). Quality issues in qualitative inquiry. *Qualitative Social Work*.1 (1), p. 97-110 doi: 10.1177/147332500200100107 Retrieved from http://qsw.sagepub.com/content/1/1/97.short

Seale, C. (1999). Quality issues in qualitative inquiry. *Qualitative Social Work,* 1 (1), p. 97-110. doi: 10.1177/107780049900500402 Retrieved from http://qix.sagepub.com/content/5/4/465.short

Secomb, J., (2008). A systematic review of peer teaching and learning in clinical education. *Journal of Clinical Education*. 17, (6) pp. 703-716. Retrieved from http://www.ncbi.nlm.nih.gov/m/pubmed/18047577/

Seibold, C. Rolls, C. & Campbell, M.(2007). Nurses on the move: Evaluation of a program to assist international students undertaking an accelerated Bachelor of Nursing program. *Contemporary Nurse,* 25 (1-2), p. 63-71. Retrieved from http://pubs.e-contentmanagement.com/doi/abs/10.5172/conu.2007.25.1-2.63

SenGupta, S., Hobson, R. & Thompson-Robinson, M. (2004). Cultural competence in evaluation: an overview. *New Directions for Evaluation*. No.102, p. 5-19.

Sherman, R. & Eggenberger, T., (2008). Transitioning internationally recruited nurses into clinical settings. *The Journal of Continuing Education in Nursing.* 39, (12), pp. 535-544. http://dx.doi.org/10.3928/00220124-20081201-03 Retrieved from http://web.b.ebscohost.com/ehost/detail?sid=093f95f8-f711-4604-a706-305654439ab4%40sessionmgr112&vid=1&hid=117&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=ccm&AN=2010128946

Shields, L. & Watson, R. (2013. Common quantitative methods. In Schneider, Z., Whitehead, D., LoBiondo, G. & Haber, J. (Eds.) *Nursing and Midwifery Research: Methods and Appraisal for Evidence Based Practice.* (4th ed.) Chatswood, NSW: Mosby Elsevier.

Skeat, J. (2013). Using grounded theory in health research. In P.Liamputtong (Ed.) *Research methods in health: foundations for evidence based practice* (2nd ed.). Australia & New Zealand: Oxford University Press.

Takeno, Y. (2010). Facilitating the transition of Asian nurses to work in Australia. *Journal of Nursing Management* 18**,** 215–224. DOI: 10.1111/j.1365-2834.2009.01041.x Retrieved from http://europepmc.org/abstract/MED/20465749

Taylor, B., Kermoda, S. & Roberts, K. (2011). *Research in nursing: Evidence for best practice* (4th ed.). South Melbourne, Victoria, Australia: Cengage Learning.

Tertiary Education Quality and Standards Agency (TEQSA) (2011), Australian Government. *International higher education providers seeking to offer higher education in Australia: TEQSA Act.* Retrieved from http://www.teqsa.gov.au/for-providers/frequently-asked-questions-providers

Thomas, C. M., Bertram, E. & Allen, R. L. (2012).The transition from student to new registered nurse in professional practice. *Journal of Nurses' Staff Development*, 28 (5) pp. 243-249. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22992640

Thomas, E.& Magilvy, J. (2011). Qualitative rigor or research validity in qualitative research. Journal for Specialists in Pediatric Nursing, 16, pp. 151-155. Doi: 10.1111/j.1744-6155.2011.00283.x

Thompson, G., Rosenthal. D. & Russel, J. (2006). *Cultural stress among international students at an Australian university*. Australian International Education Conference. Retrieved from http://trove.nla.gov.au/version/166825713

Thorne, S., Kirkham, S. & Flynn-Magee, K. (2004).The analytic challenge in interpretive description. *International Journal of Qualitative Methodology.* 3(1), pp. 1-11. Retrieved from http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=93848cc1-650f-4ed4-82e4-b01af00a1e1f%40sessionmgr4004&vid=1&hid=4109

Tollefson, J. (2010). *Clinical psychomotor skills: Assessment tools for nursing students* (4th ed.). Australia: Cengage.

Torrance, H. (2011). Qualitative research, science, and government: Evidence, criteria, policy and politics. In Denzin, N. & Lincoln, Y., (Eds.) *The Sage Handbook of Qualitative Research.* (4th ed.) Sage Publications: Thousand Oaks, California pp. 1-19.

Tregunno, D., Peters, S., Campbell, H., & Gordon, S. (2009). International nurse migration: U-turn for safe workplace transition. *Nursing Inquiry*, *16*(3), 182-190. doi:10.1111/j.1440-1800.2009.00448.x

Valiente (2008). Are students using the 'wrong' style of learning? A multicultural scrutiny for helping teachers to appreciate difference. Active Learning in Higher Education, 9 (1) pp. 73-91. doi: 10.1177/1469787407086746 Retrieved from http://alh.sagepub.com/content/9/1/73.short

Watson, R., Stimpson, A., Topping, A. & Porock, D. (2002). Clinical competence assessment in nursing: a systematic review of the literature. *Journal of Advanced Nursing*, 39 (5), pp. 421-431. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12175351

Webster, S., Harding, T., **Robinson, J.,** Yeboah, C., Hutchison, C. & Mountain,D., (2014).Improving academic success: Evaluation of the BN transition to clinical practice module (TCPM). *Journal of Nursing Education and Practice* 4 (5), pp. 95-106. DOI: 10.5430/jnep.v4n5p95 Retrieved from: www.sciedu.ca/jnep

Whitehead, D. (2013). Searching and reviewing the research literature. In Schneider, Z., Whitehead, D., LoBiondo, G. & Haber, J. (Eds.) *Nursing and Midwifery Research: Methods and Appraisal for Evidence Based Practice.* (4th ed. pp. 35-53) Chatswood, NSW: Mosby Elsevier.

Williams, R.& Calvillo, E. (2002). Maximizing learning among students from culturally diverse backgrounds. Nurse Educator, 27 (5), pp. 222-226. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12355048

Willis, J. & Anderson, K. (2010). Ethnography as health research. In Liamputtong, P. Research Methods in Health: Foundations for Evidence Based Practice. Australia and New Zealand: Oxford University Press. Ch. 6, p. 92.

Woods, M & Schneider, Z. (2013). Ethical and legal issues in research. In Schneider, Z., Whitehead, D., LoBiondo, G. & Haber, J. (Eds.) *Nursing and Midwifery Research: Methods and Appraisal for Evidence Based Practice.* (4th ed. pp. 35-53) Chatswood, NSW: Mosby Elsevier.

Woolgar, S. (1988). Reflexivity is the ethnographer of the text. In Woolgar, S. (Ed.) *Knowledge and Reflexivity: New Frontiers in the Sociology of Knowledge*. London: Sage Publications.

World Health Organization (WHO). (2011). *Transformative Scale Up of Health Professional Education.* Retrieved from http://whqlibdoc.who.int/hq/2011/WHO_HSS_HRH_HEP2011.01_eng.pdf

World Health Organization (WHO). (2010). *Strategic Directions for Strengthening Nursing and Midwifery Services 2011-2015*, p. 4-10. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.1_eng.pdf

World Health Organization (WHO). (2009), *The World Health Report 2006: Working together for Health*. Retrieved from http://www.who.int/whr/2006/whr06_en.pdf

Wright, J. & Gollan, M. (2008). A research report on the psychosocial needs of international students enrolled in degree and diploma courses at ACU National, Mackillop Campus, North Sydney.

Xu, Y. (2007) Strangers in strange lands: a meta-synthesis of lived experiences of immigrant nurses working in western countries. *Advances in Nursing Science*, 30 (3), pp. 246-265. DOI: 10.1097/01.ANS.0000286623.84763.e0

Xu, Y. (2008), Facilitating adaptation of international nurses: need for an evidence-based transition and integration program. *Home Health Care Management and Practice.* 20 (2) p. 199-202. doi:10.1177/1084822307309064 Retrieved from http://hhc.sagepub.com/content/20/2/199

Yamazaki, Y. (2005). Learning styles and typologies of cultural differences: A theoretical and empirical comparison. *International Journal of Intercultural Relations.* 29 (5), pp. 521-548. http://dx.doi.org/10.1016/j.ijintrel.2005.07.006 Retrieved from http://www.sciencedirect.com/science/article/pii/S0147176705001021

Yates, S. (2004). Doing Social Science Research. Trowbridge, Wiltshire, Great Britain: Cromwell Press Limited.

Yeun-Sim Jeong, S., Levett Jones, T., Pitt, V. Hoffman, K., Norton, C. & Ok Ohr, Se. (2011). Understanding and enhancing the learning experiences of culturally and linguistically diverse nursing students in an Australian bachelor of nursing program *Nurse Education Today*, 31 (3), pp. 238-244. doi:10.1016/j.nedt.2010.10.016 Retrieved from http://www.nurseeducationtoday.com/article/S0260-6917(10)00199-1/abstract

Yoder, M. (2001). The Bridging Approach: Effective Strategies for Teaching Ethnically Diverse Nursing Students *Journal of Transcultural Nursing*. 12 (4) p. 319-325. doi: 10.1177/104365960101200407 Retrieved from http://tcn.sagepub.com/content/12/4/319.short

Yoder, M. (1996).Instructional responses to ethnically diverse nursing students. *Journal of Nursing Education*, 35(7), 315-321. Retrieved from http://europepmc.org/abstract/MED/8892119

Zizzo, K. & Xu, Y. (2009). Post-hire transitional programs for international nurses: A systematic review. *Journal of Nurse Education*, 40, (2). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19263926

APPENDICES

APPENDIX A – RESEARCH PROPOSAL

Aim: To describe clinical facilitators' views on the:

Challenges and strategies to address the challenges of facilitating the clinical transition of culturally and linguistically diverse overseas qualified nurses during clinical practicum.

Research Design:

This study will employ a qualitative descriptive approach whereby in-depth, face- to-face, semi-structured, audio-taped interviews will be undertaken. The aim will be to elicit the views of clinical facilitators (CFs) on the challenges and strategies to address these challenges of facilitating clinical transition of culturally and linguistically diverse (CALD) overseas qualified (OSQ) nurses during clinical practicum. Two groups, CALD and non CALD CFs' views will be sought to gain understanding of a wider range of views (Patton, 2002).

Eligible Participants:

To capture this wide range of views, eligible participants will include CALD and non CALD CFs. The reason for selecting from the two groups is based on a previous Californian study by Yoder (2001). This study found that ethnic background of the clinical educator was a major influence on the way CALD nurses were facilitated. The rationale for this is therefore that the views of the non CALD group will represent the cultural and linguistic majority and the CALD group will represent the views of the cultural and linguistic minorities in Australia who speak English as a second language. Eligible participants include CFs employed by the ACU who meet the inclusion criteria shown in Box 1. Participants will be over 18 years of age and able to give informed consent. Exclusion criteria are also shown in Box 1.

Box 1: Inclusion and exclusion criteria

Inclusion criteria		
	CFs with CALD background over 18 years and able to give informed consent.	CFs with non CALD background over 18 years and able to give informed consent.
1.	Meet requirements to be employed by a university in NSW as a Clinical Facilitator. These include current nurse registration and preferably > 5 years experience, education qualifications.	Meet requirements to be employed by a university in NSW as a Clinical Facilitator. These include current nurse registration and preferably > 5 years experience, education qualifications.
2.	Have recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years	Have recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years
3.	CFs who were born in Australia or overseas, and speak English as second language (ESL and have spent most their lives outside Australia.	CFs who were born in Australia or have spent most of their adult lives in Australia, and speak English as first language.

Exclusion criteria		
1.	Have not recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years	Have not recommended clinical pass or fail of at least one CALD OSQ nurse in last 5 years
2.	Are not employed by ACU as a CF	Are not employed by ACU as a CF.

Sampling Approach:

Based on these findings, a maximum variation, purposive sampling approach will be used for recruitment of 4 to 5 CFs with CALD background and 4 to 5 CFs who speak English as a first language, have spent most of their lives in Australia and meet the inclusion criteria shown in Box1.

Procedure:

CFs will be selected from a list of eligible participants provided by an administration officer. The advance letter to participants (see Appendix B) will invite CFs to participate after explaining the significance of the research and what will be involved and seek agreement to send further information. The advance letter will also contain reassurances that participation is voluntary and will not affect their relationship with staff at ACU or the researcher if they do or do not agree to participate. In particular, they will be assured that the members of staff, who are responsible for recommending CFs to be employed by ACU, will not be involved in any way in the research process.

The CFs who are in agreement in response to the advance letter will receive the information letter to participants (see Appendix C) which will contain similar assurances as well as explain the research aims and the importance of the research. It will also outline how and why they have been selected, what is involved, the likely duration of the interviews and assurances regarding confidentiality and adherence to ethical research practices. If the participant declines then the next eligible person on the list of facilitators will be selected. If agreeable, an appointment will be made at a time suitable to the participant.

Data Collection:

The ACU consent form (see Appendix D1 and D2) will be used to obtain consent to interview the selected participants. In order to ensure there is adequate privacy and minimal noise the semi-structured interviews will be held in a private, vacant office at ACU, North Sydney. They will be face to face, audiotaped, de-identified and will be conducted by the researcher. It is envisaged the interviews will be of 30-45 minutes duration. An interview guide will be used as a framework for the interview (see Appendix E).

Data Analysis:

Open-ended responses will be transcribed verbatim to produce narrative text. This data will be thematically analysed to identify common, recurring and unique themes related to views on the challenges and strategies employed to address the challenges of clinical transition for CALD OSQ nurses.

Any convergences and divergences that emerge between non CALD and CALD CFs will be explored and reported, the implications of any differences found will be discussed. This analysis will be reflexive and

responsive to change so that new data from each interview and insights can be accommodated (Sandelowski, 2000). Themes will be illustrated with examples from verbatim quotes and a narrative explanation given of the meaning of each theme.

As a form of respondent validation the main themes that emerge from the analysis will be fed back by email to the participants who will be asked if they feel the themes adequately represent their views and if there is any key points missing. A clear document, audit trail of the research process and analysis will be provided.

Significance of Study:

By developing rich descriptions of the views of CFs this research has the potential of identifying critical challenges and strategies to address the challenges faced by CFs as they guide CALD OSQ nurses through clinical practicum. This knowledge can be used to develop strategies to assist future CFs to meet these clinical transition challenges.

Dissemination of Results:

This research is being carried out as part of the requirement for the Master of Philosophy at the, Australian Catholic University, North Sydney. The results of the study of facilitators will be disseminated through publication in a peer-reviewed journal and presentation at conferences.

References

Kitto, S., Chesters, J. & Grbich, C. (2008). Quality in qualitative research: Criteria for authors and assessors in the submission and assessment of qualitative research articles for the Medical Journal of Australia. *Medical Journal of Australia* 188 (4) pp. 243-246.

Patton, M. Q. (2002), Qualitative Research & Evaluation Methods (3rd ed.).Thousand Oaks: Sage Publications.

Ryan, G. & Russell Bernard, H. (2003). Techniques to identify themes. *Field Methods*, 15 (1) pp. 85-109.DOI: 10.1177/1525822X022395659 Sage Publications.

Sandelowski, M. (2000), Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and Health*, 23, p. 334-340.

Seale, C. (2002). Quality issues in qualitative inquiry. *Qualitative Social Work.*1 (1), p. 97-110

Yoder, M. (2001). The Bridging Approach: Effective Strategies for Teaching Ethnically Diverse Nursing Students. *Journal of Transcultural Nursing*. 12 (4) p. 319-325.

APPENDIX B – ADVANCE INFORMATION LETTER TO PARTICIPANTS

Advance information letter to participants

Dear Colleague,

Project title: Clinical facilitators' views on challenges and strategies to address the challenges of facilitating the clinical transition of culturally and linguistically diverse, overseas qualified nurses.

As a research student at the Australian Catholic University (ACU) I am undertaking a qualitative study of clinical facilitators' views of the challenges and strategies to address the challenges of facilitating transition of culturally and linguistically diverse (CALD) overseas qualified (OSQ) nurses on clinical practicum. This is a significant project as the findings from the study will be used to gain insights into developing strategies to meet the challenges of facilitating CALD OSQ nurses for future clinical facilitators. In addition, there is very little published research available about clinical facilitators' views about these challenges and strategies.

You have been identified as a key participant in this research and your participation would be highly valued. As such, this letter is to ask that you agree to receive further information. If you are willing, I will send you an information letter and request your consent to participate. The research is designed around interviews of 30 to 45 minutes using mainly open ended question. The interview can be arranged at a time suitable to you from June to October, 2011. During the research process, your identity will remain anonymous. Staff and particularly those involved in staff recruitment at ACU will not know who agreed to participate and who chose not to.

While the research is intended to advance the understanding of the challenges facing clinical facilitators and strategies they use to address the clinical transition of CALD OSQ nurses during clinical practicum, it may not be of direct benefit to you. Participation in this study is entirely voluntary. You are in no way obliged to participate and you can withdraw at any time without giving a reason. Whatever you decide, please be assured that it will not affect your relationship with me or staff at ACU. All aspects of the study, including the results, will be strictly confidential. A report of the study will be submitted for publication but individuals will not be identified in such a report.

This research is part of the requirements for me to complete the Master of Philosophy under the supervision of A/ Professor Elizabeth McInnes and co supervision of Professor Kim Walker. Please do not hesitate to telephone me on (02)9739 2391 or email jennie.robinson@acu.edu.au if you have any questions.

Thank you in anticipation for your valued assistance.

Yours sincerely,

Jennie Robinson
Student researcher

APPENDIX C – INFORMATION LETTER TO PARTICIPANTS

INFORMATION   LETTER TO

PARTICIPANTS

TITLE OF PROJECT: **Clinical facilitators' views on challenges and strategies to address the challenges of facilitating the clinical transition of culturally and linguistically diverse, overseas qualified nurses.**

SUPERVISOR: Associate Professor Elizabeth McInnes

STUDENT RESEARCHER: Jennie Robinson

PROGRAMME IN WHICH ENROLLED: Master of Philosophy

Dear Participant,

You are invited to participate in the above study which has been approved by the Australian Catholic University, Human Research Ethics Committee. You have been selected as being able to provide an informed perspective on the challenges and strategies to address the challenges of facilitating the clinical transition for culturally and linguistically diverse (CALD), overseas qualified (OSQ) nurses.

This qualitative descriptive research study is being conducted as part of my Master of Philosophy studies at the School of Nursing (SON), Australian Catholic University (ACU). The findings from the study will be used to gain insights into developing strategies for future clinical facilitators to address the challenges of facilitating CALD OSQ nurses.

If you agree to participate, I will conduct a face to face interview which will be audiotaped for ease of transcription. The interview will take 30 to 45 minutes. I will be asking for your views on aspects of your experiences of clinical facilitation; your views of the challenges of clinical transition for CALD OSQ nurses, and how these challenges might be addressed. There are no anticipated risks associated with this study.

Interviews will be anonymous and confidentiality will be ensured by allocation of a unique identifier that will be used to transcribe what has been said. All information will be stored in accordance with National Health and Medical Research Council recommendations. This means that any potentially identifying information will not be linked with research data. Individual responses will not be provided to the SON, ACU or any other organisation.

Participation in this study is entirely voluntary. You are in no way obliged to participate and you can withdraw your consent at any time without giving a reason. Whatever you decide, please be assured that it will not affect your relationship with the researcher or ACU staff including those involved with staff recruitment at ACU. All aspects of the study, including the results, will be strictly confidential and individuals will not be identified in any reports, articles or documents. While the research is intended to advance the understanding of the challenges facing clinical facilitators transitioning CALD OSQ nurses to clinical

practice, it may not be of direct benefit to you. You will be informed of the findings of the study by being provided with a copy of the final publication of the results.

Please do not hesitate to contact me by phone (02) 9739 2391 or by email jennie.robinson@.acu.edu.au or email my supervisor Associate Professor Elizabeth McInnes liz.mcinnes@acu.edu.au if you have any questions.

In the event that you have any concerns, or any inquiry that I or Associate Professor McInnes have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee care of the nearest branch of the Research Services Office at the address below:

NSW and ACT: Chair, HREC, C/- Research Services,
 Australian Catholic University,
North Sydney Campus
PO Box 968
North Sydney. NSW 2059
Telephone: (02) 9739 2105 Fax: (02) 9739 2870

Any concern will be treated in confidence and fully investigated and you will be informed of the outcome.

Thank you in anticipation for considering this and I hope you will agree to participate.

Yours sincerely,

Jennie Robinson
Student Researcher

APPENDIX D – CONSENT FORMS: RESEARCHER AND PARTICIPANTS

ACU
AUSTRALIAN CATHOLIC UNIVERSITY

TITLE OF PROJECT: Clinical facilitators' views on challenges and strategies to address the challenges of facilitating the clinical transition of culturally and linguistically diverse, overseas qualified nurses.

PRINCIPAL SUPERVISOR: Associate Professor Elizabeth McInnes

STUDENT RESEARCHER: Jennie Robinson

I .... have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this semi-structured, face-to-face interview of 30 to 45 minutes duration which will be audio-taped, realising that I can withdraw my consent at any time without adverse consequences. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: ....

SIGNATURE:... DATE ....

SIGNATURE OF PRINCIPAL SUPERVISOR: DATE:

SIGNATURE OF STUDENT RESEARCHER: DATE:

TITLE OF PROJECT: Clinical facilitators' views on challenges and strategies to address the challenges of facilitating the clinical transition of culturally and linguistically diverse, overseas qualified nurses.

PRINCIPAL SUPERVISOR: Associate Professor Elizabeth McInnes

STUDENT RESEARCHER: Jennie Robinson

I .... have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this semi-structured, face-to-face interview of 30 to 45 minutes duration which will be audio-taped, realising that I can withdraw my consent at any time without adverse consequences. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: ....

SIGNATURE:...   DATE ....

SIGNATURE OF PRINCIPAL SUPERVISOR: DATE:

SIGNATURE OF STUDENT RESEARCHER: DATE:

APPENDIX E – INTERVIEW GUIDE

Interviewer to complete	
Id No:	**Date of interview:**
Recording Number:	
	Position:
Place of Birth:	**Main language spoken at home:**
Information letter has been given to participant by interviewer	☐ Yes ☐ No
Consent to Participate has been signed by participant and researcher	☐ Yes ☐ No
Interviewee understands and consents to recording of interview:	☐ Yes ☐ No

PREAMBLE:

The purpose of this interview is to understand what your views are on the challenges and strategies used to address these challenges of clinical transition of CALD, OSQ nurses, during clinical practicum. Also, I am interested in the challenges that you find difficult to meet. In addition, I want to know what strategies that you think are generally important to assist CALD OSQ nurses and not just the strategies you have been able to implement.

This information will be used to help develop strategies based on your views, to assist future clinical facilitators transition CALD OSQ nurses on clinical practicum.

Throughout the interview, researcher to note language/descriptors used by participant in relation to the questions below.

OPENING BACKGROUND QUESTIONS:

First of all, I would like to start by clarifying how you prepared for clinical facilitation by asking you some background questions:

How long you have been employed in the role of clinical facilitator?

What has been your main focus? (may give more than one – also note length of time since nurse graduation)

What have been your experiences and/or education to prepare for the role?

How long in facilitation:	Main focus:
Experience and /or education to prepare for the role :	

1. <u>Tell me something about your experiences of/views of clinical facilitation of CALD OSQ nurses in general.</u>

Keywords, descriptors etc.

Additional notes:

2. Drawing from these experiences of clinical facilitation, what do you view as the particular challenges encountered while facilitating clinical transition of CALD OSQ nurses during clinical practicum?

PROBES:

In your view, what is involved in the process of clinical transition for CALD OSQ nurses?

Note keywords below

Keywords, descriptors etc.

Additional notes:

Participant comments:

PART B CFs' views of strategies to address the challenges of clinical transition for CALD OSQ nurses

I would now like to hear about what you think are, or could be, useful strategies for addressing some of the challenges you have mentioned

Record responses noting keywords below

Keywords

3. <u>Have you any comments or anything you would like to add about anything you have said?</u>

Participant comments:

Thank-you for your time and contribution

APPENDIX F: HUMAN RESEARCH ETHICS COMMITTEE APPROVAL FORM

Human Research Ethics Committee
Committee Approval Form

Principal Investigator/Supervisor: Dr Liz McInnes   Nth Sydney Campus

Co-Investigators: Professor Kim Walker

Student Researcher: Ms Jennie Robinson   Nth Sydney Campus

Ethics approval has been granted for the following project:
The challenges and strategies for addressing the challenges of facilitating clinical transition of culturally and linguistically diverse, overseas qualified nurses during clinical practicum: A qualitative descriptive study of clinical facilitators' views.   (Clinical facilitators' views on challenges and strategies to address the challenges of facilitating the clinical transition of culturally and linguistically diverse, overseas qualified nurses.)

for the period: 4 August 2011 to 31 December 2011

Human Research Ethics Committee (HREC) Register Number: N2011 34

Special Condition/s of Approval

Prior to commencement of your research, the following permissions are required to be submitted to the ACU HREC:

N/A

The following <u>standard</u> conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (2007) apply:

(i)   that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
- security of records
- compliance with approved consent procedures and documentation
- compliance with special conditions, and

(ii)   that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
- proposed changes to the protocol
- unforeseen circumstances or events
- adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

APPENDIX G: FACILITATION AND THE ROLE OF THE CF

Author/ Year (least to most recent)	Aim/ Method	Participants/ Place/Search Strategies	Results	Study critique
Yoder, 1996.	To identify the process that CFs/nurse educators teach CALD nursing students. To formulate a substantive theory that explains the process of responding and potential consequences of CFs actions for students. Naturalistic research using grounded theory methodology. Constant comparative analysis. Data collected using intensive, in-depth interviews.	26 CFs from 9 nursing programs 17 CALD graduate nurse participants. USA	Overall, five patterns of teaching emerged from the data including: generic pattern, culturally non tolerant pattern; mainstreaming pattern; struggling pattern; bridging pattern. A figure was developed showing the central organizing concept as the interactive process of responding to CALD nursing graduates in culturally sensitive ways.	Formative article leading to further studies. Data were triangulated by interviewing both CFs and CALD students to establish more credible findings and interpretations.
Burrows (1997).	To clarify the meaning of facilitation and differentiate between facilitation in counseling and in education.	Concept analysis using Walker and Avant's framework. 18 nursing and non-nursing peers asked to define facilitation. Information from thesauruses and different dictionaries compiled with responses to produce dendrogram. Reliability test involved two peers to check responses and	Critical attributes: genuine mutual respect, the development of a partnership in learning, a dynamic goal oriented process and the practice of critical reflection. Antecedents of facilitation: involved a self-aware teacher with effective interpersonal skills and both students and teacher understood how it was implemented. Consequences of facilitation: that students became motivated self-directed learners along with the teacher as co-learner which results in control moving away from the CF towards being student centred.	Formative concept analysis. Useful model of facilitation; critical attributes; Antecedents and consequences developed. Concepts not tested for effectiveness.

		repeat of the procedure after a period of reflection.		
Yoder (2001).	To describe one of the 5 patterns of teaching CALD students, the bridging pattern. Bridging patterns of teaching were identified by the author in a previous qualitative study.	27 CFs and 17 CALD graduate nurse participants. USA	Cultural awareness of the bridging faculty; Faculty interactions with diverse students; identifying barriers students face; effective strategies of bridging educators; incorporating students' cultural knowledge; preserving ethnic identity; role models; facilitating negotiating barriers; consequences of bridging pattern.	Use of data from previous study. Confirming previous study.
Kai, Spencer & Woodward (2001).	To identify current experience and challenges perceived by educators of different (CALD) health professionals, and to facilitate and debate the development of teaching in this field.	61 participant educators including CFs. Qualitative data generated from facilitated workshops in 3 different settings in UK.	Themes represented by common issues included: current experience of training in ethnic diversity in health care; challenges of developing and delivering training: institutional responses; personal challenges to understanding ethnic diversity. Guiding philosophy of training; Practical challenges for educators.	Exploratory study on significant issues of need for CF training in ethnic diversity across disciplines. Focus on stimulating debate.
Watson, Stimpson, Topping & Porock (2002).	To investigate the evidence for the use of clinical competence assessment in nursing.	Literature review using defined dates, databases and search terms.	Clinical competence assessment remains almost universally accepted in the nurse education literature as a laudable pursuit yet there are aspects of it that remain at odds with the higher education of nurses.	Review process clearly outlined.
Williams & Calvillo (2002).	To address diversity in the classroom and propose a model for viewing diversity and ways to maximize learning among students from CALD backgrounds.	Learning Model of maximizing learning for CALD students. Discussion paper. LA, California.	Model proposed to conceptualise diversity and its effect on learning containing 3 main components: input meaning students' background; process referred to learning environment or educational setting; output referred to the interaction of input and process measured by student success.	Expert opinion and discussion of proposed model. Could have strengthened the paper with research study.
Ellis & Hogard (2003).	To describe an evaluation of an 18 month pilot scheme for CFs in the acute medical and surgical wards of a	16 participants CFs with 14 female and 2 male between 28 and 47 years old.	Multi-method approach with 3 components: 1)Outcome measurements of competency assessments between students with a CF and without a CF. 2)Process	Statistical power weak due to low numbers and lack of

	consortium's hospital trusts. Evaluation strategy used a novel multi-method approach: outcome measurement, process analysis and multiple stakeholder perspectives. Quantitative data collected using questionnaires, focus groups and interviews (CFs only).	57 students with group sizes 30 CF and 27 non-CF examined. Multiple stakeholders were 12 CFs, 16 university staff link tutors, 150 ward staff, 7 education managers 2 consortium managers and 600 students with CFs. United Kingdom.	analysis of what CFs actually did in practice. 3) Multiple stakeholder perspectives between students, ward and university staff. Critical incident analysis. Resulted in strong consensus regarding CF utility for student learning on clinical placement. All unanimously agreed that CFs had met 4/5 key objectives. Doubts expressed about communication objective which may reflect imprecise nature of objective.	randomisation.
Lambert & Glacken (2005).	To present a broad overview of former and existing clinical support personnel, explore the concept of facilitation and examine what is known about the role of the CF. Literature review.	Databases searched included CINAHL, Medline and Synergy with key terms: clinical, facilitation, practice, education and teacher. 6 research papers and 7 non empirical articles.	Further research needed as there is lack of role clarity. CFs promote recruitment and retention of nurses, expected to embrace self-directed, lifelong learning, critical reflection and research Strategies to orchestrate the clinical environment so that it provides an effective learning environment. These strategies included preparing the clinical environment, facilitating student transition into the clinical learning environment, maximizing learning opportunities and providing support.	High quality review. Referred to frequently by others. Extensive review of the literature at that time. Review approach of 6 research and 7 non empirical papers not clearly outlined. Descriptive results from review provide a rich resource.
Saunders, White, Davis, Gavin, Hill, & Sarich, (2006).	To describe the quality and scope of clinical placements of undergraduate nursing students and to explore the perspectives of key participants in clinical placements. Critical hermeneutics and focus groups	14 focus group interviews containing: clinical coordinators from 8 different health facilities; CFs, mentors, nurse unit managers and clinical	14 statements of key findings and Relevant to aims of this review: problems with CF performance inconsistencies, communication lacking. CF has role inconsistencies seen as valuable to reduce demands on clinical staff and increased support for students. 12 recommendation statements with several relevant to this	Large qualitative study. Critical hermeneutics not explained. Collaborative project across multiple

		nurse specialists. 20 RNs in supervisory roles as participants for individual interviews.	study: all groups need education on how to support assessment of struggling students.	health facilities. Unpublished qualitative study.
Henderson, Twentyman, Heel & Loyd (2006).	To assess undergraduate nurses' perception of the psychosocial characteristics of of clinical learning environments within 3 different placement models.	Participants: 16 preceptor model; 269 Facilitation model; 116 clinical education unit (CEU). 25 clinical areas in one tertiary facility. A survey design using Clinical Learning Environment Inventory to collect data.	Most positive social climate was Preceptor model category highest median score. Significant difference(using p= 0.008), n=16 means limit conclusions. CEU s had higher median scores however using p= 0.008 this only significant for the case for personalization sub scale. CF model and CEU model accommodate larger student numbers. CF model is disadvantaged by having different RNs as CFs for students to adjust to. Sustained relationships proposed to correlate positively with improving learning opportunities.	Variables too numerous to reliably compare models. Non experimental design with disproportionate numbers of respondents between models. Many extraneous variables leading to biased results. Useful for differentiating models.
Dickson, Walker & Bourgeois (2006).	To reveal dimensions of the lived experience of being a CF. Heideggerian phenomenology using purposive sampling with semi structured in-depth interviews and theme development.	10 eligible participant CFs and 6 responses returned with data saturation determining the final number of participants. Sydney, Australia.	Study highlights how CFs facilitate learning with 5 themes: employing the notion of stepping in or stepping back; Developing alliances; Acknowledging the reciprocity of the learning experience; Identifying appropriate clinical buddies. Recommends CF be placed in same facility and RNs need to be upskilled in clinical teaching. Basic premise that facilitation is dynamic and involves mutual respect to enable learning.	Good quality study. Study conducted according to requirements of Master of Clinical Nursing study. Interviews were taped and transcribed verbatim to ensure an audit trail. Verbatim quotes used to depict

				themes.
Amaro, Abriam-Yago & Yoder (2006).	To examine the perceived barriers for CALD students completing their nurse education. Builds on Yoder, (1996) study. Grounded theory methodology for data analysis.	17 CALD RN graduates. 14 female and 3 male. San Jose, California.	Four categories of student needs confirmed Yoder's (1996) findings: personal needs; cultural needs: communication needs verbal communication, reading and writing; encountering barriers; coping with barriers; self-motivation and determination, teachers important(bridging), peer support, ethnic associations.	Clear links with Yoder's study in 1996. Provides a strong statement about CALD student needs.
Hogard and Ellis, (2006).	To evaluate the effectiveness of a CF objective of improving communication between university and hospital. To describe the method of inquiry known as communication audit and to argue for its place in evaluation studies. Study reinforced by a case study using a communication audit in evaluating aspects of the CF role. Case study and survey.	One of two case studies using a communication audit was evaluating aspects of the role of the CF. Four groups: ward staff, link tutors, ward managers and student nurses completed the questionnaire tool. United Kingdom.	All groups reported not enough information communicated to allow roles to be carried out effectively. Result of focus on CF objective of improving communication between university and hospital was a survey which revealed significant loss of information between being sent and received. There was generally however a positive level of trust between RN, student and CF identified. Provided a baseline for CF to make communication improvements.	Limitations of study not clearly explained. The customised questionnaire tool effectively enhanced face validity and utility though was long and complex and took up to 40 minutes to complete. These factors may eliminate CALD student nurses who are slowed down by language issues.
Paton, B. (2007).	To explore the knowing within the subjective and contextual experiences of CFs within particularly unexpected situations. Interpretive phenomenological inquiry.	32 interviews conducted with 9 CF participants. Calgary, Alberta, Canada.	Overall metaphor of Unready to Hand as Adventure exposed the challenging life world of CFs teaching students in clinical practice. Commitment, vibrancy and confidence while feeling alone and uncertain. Three domains of practice within unready to hand immersions: Preserving the ideal; salvaging	Article follows interpretive phenomenol ogical inquiry closely to provide excellent in depth

			learning; Sustaining self.	detailed insights into actual CF experiences.
Cangelosi, Crocker & Sorrell, (2009).	To enhance understanding of the unique perspectives of nurses enrolled in a Clinical Nurse Educator Academy through written narratives as they prepare for roles as CFs. Interpretive phenomenological approach using Van Manen's analysis approach to analyse data holistically.	9 students from 1st academy and 36 from 2nd academy. Each wrote three reflective papers for a total of 135 papers in sample. Fairfax, Virginia.	One overarching pattern of 'The phenomenon of learning to teach'. Three themes: Buckle your seatbelt; embracing the novice; mentoring in the dark.	Very good quality which closely follows phenomenol ogical methods.
Heale, Mossey, Lafoley & Graham (2009).	To investigate the needs and barriers of clinical mentors (including CFs) in a variety of health education programs. Descriptive design using survey with qualitative data for some responses based on Bandura's self efficacy theory.	119 respondents from multiple health disciplines 19.5% RNs. Ontario, Canada.	CFs as clinical mentors are only moderately confident in their roles of introducing and interpreting current protocols and procedures, communicating philosophy of clinical environment. Few had confidence to understand: expectations of clinical education program and practice environment, student learning needs, facilitating EBP and assessing students' performance, resolve challenges in student learning. Barriers: lack of resources ,time, orientation, contact with education program and balancing multiple roles.	Good quality study providing broad sweeping interprofessi onal descriptive data.
Dogherty, Harrison, & Graham (2010).	To examine the current state of knowledge surrounding the concept of facilitation as a role and process in the implementation of research findings within the nursing context.	Literature review. Using a multistep approach, identified literature focused on facilitating research utilisation (RU) in nursing in	What facilitators or individuals engaging in facilitation are doing to enable changes in nursing practice. Specific strategies involved in facilitation of RU in nursing: Increasing awareness of a need for change. Leadership and project management. Relationship-building and communication. Importance of the local context. Ongoing	Systematic search of databases clearly detailed. Aims and objectives specific and clear. (Dogherty supported by

		three bibliographic databases (CINAHL, MEDLINE, and EMBASE). Included studies:research studies (17), frameworks (4), reviews (4), project descriptions (6), and discussion or commentary pieces (8)	monitoring and evaluation. A taxonomy constructed to synthesize review findings, which outlines activities involved in facilitation of RU in nursing. Organized in specific stages related to the process of carrying out evidence implementation: planning for change, leading and managing change, monitoring progress and ongoing implementation and evaluating change. Synthesis of findings coherent, resulting in organized taxonomy of facilitation activities to bring about evidence implementation.	Ontario Graduate Scholarship)
San Miguel & Rogan (2011).	To explore areas of clinical performance CFs focus on when assessing CALD students. CFs' expectation of CALD students on clinical placement. Descriptive Interpretive design CFs written assessments from Facilitating CALD students during clinical placements.	CFs written clinical assessments over 2.5 years of 12 CALD students previously involved in clinical language support program. Australia	1st Category 'good students'with 4 themes: communication; learning style; bedside manner; personality factors. 2nd category 'improvements required' same themes except personality factors not mentioned. CFs focused on students' personalities at times.	Describes CFs expectation. CALD students' language and clinical communication performance

APPENDIX H: TRANSITION, TRANSITION PROGRAMS AND EXPERIENCES OF CLINICAL TRANSITION

Author/ Year	Aim/ Method	Participants /Place/Search strategy	Results	Study Quality
TRANSITION				
Kralik, Visentin & van Loon, (2006).	To explore how the term 'transition' has been used in the health literature. Integrative literature review and meta-analysis of qualitative studies.	45 papers located and 23 primary qualitative studies were appraised and analysed. Data bases searched include CINAHL, Socioprofile, Psychlit using keyword 'transition'. Limits were dates 1994-2004, transition as a central concept, health or social focus.	Lack of consensus as to whether transition process has a beginning and end or if it is linear or cyclical. Transition is a concept central to nursing and involves movement and adaptation to change. Transitional processes require time to change from previous behaviours and ways of defining self. The authors acknowledged the tension that exists between the analytical approach and the systematic approach required for a systematic review.	All studies reviewed used qualitative methods with small non random sampling. There was a vast array of analytical approaches as well as participants in different situations.
Konno, (2006).	To summarise the best available evidence supporting CALD OSQ nurses' transition/adjustment to clinical practice in Australia. Systematic Review. Two qualitative studies extracted and meta synthesised using Joanna Briggs Institute(JBI)- Qualitative Assessment and Review Instrument (QARI).	Sixty four papers about CALD OSQ RNs transition were identified and 52 papers excluded, 12 included studies.	Two synthesis derived: CALD OSQ RNs find entry into Australian culture very difficult; CALD OSQ RNs who feel lonely or isolated experience difficulty settling into nursing in Australia. Summary of examples of key findings and recommendations: loneliness at work; major language issues; lack of support; informal networks can help; collegial relationships difficult due to attitudes at work; Being inferior and no effort to understand; conflict and tension between expected work roles. The review found mainly barriers to transition and made recommendations, listed as implications for practice.	Two reviewers used for methodologic al quality. Use of critical appraisal instrument JBI-QARI. Search strategy included international websites. Supportive interventions to assist CALD OSQ nurses adjustment not clear.
TRANSITION PROGRAMS				
Levett-Jones & Fitzgerald, (2005).	To explore the theory practice conundrum. To challenge the status quo and question whether priority should be given to formal transition programs or to the	Mapping of current transition programs and exploration of arguments regarding preparation for	25% of graduates experience lack of support from clinicians; conflict and bullying of graduates in the workplace is a national problem. The efficacy of formal transition programs is not clear so that focus may need to shift to alternatives such	Systematic process of reviewing the literature not explained.

	development of educationally supportive clinical learning environments. Literature review.	practice and the dissonance between views held by universities and health sector organisations.	as the development of a supportive practice culture which is more conducive to learning.	
San Miguel, Rogan, Kilstoff & Brown (2006).	To report on the design, delivery and evaluation of an innovativeoral communication skills program for first year CALD students in a BN degree at a university in NSW, Australia. Some use of verbatim quotes strengthened study.	CF evaluations and 5 CALD students for focus group and 15 students in clinically speaking program. 15 students who had failed clinical placement assessments.	Strong support for the program and CALD student communication and confidence improved resulting in a more positive experience for students.	Small qualitative descriptive study so that results cannot be generalized. Research design not clearly explained.
Seibold, Rolls & Campbell (2007).	To evaluate a Teaching and Learning Enhancement Scheme (TALES) program designed for CALD OSQ nurses/ questionnaire and focus groups resulted in descriptive statistics.	20 CALD OSQ nurses studying at an Australian university to upgrade to Australian registration completed entry questionnaire, 7 completed the 3 month post course completion questionnaire. 14 completing CALD OSQ nurses filled in the course completion questionnaire and participated in the focus group interview. Victoria, Australia.	Confirmed findings from other studies that challenges included English proficiency; communication; cultural differences. Evaluations predominantly positive highlighted need for transition TALES program to continue.	Use of descriptive statistics with very small sample of 20 participants. Only 7 students completed the post course completion questionnaire.
Johnstone, Kanitsaki, & Currie (2008).	To explore and describe the nature and implications of support for new grads in first year; development of a supportive environment to facilitate a safe environment and practice among new grads; safe transition of new grad from novice to advanced beginner. Exploratory-descriptive case study approach incorporating	3 purposeful samples: 1. n=11 newly graduated nurses in transition program; 2. 34 key stakeholders, Nurse unit managers, CFs, quality manager, senior RN administrators.3. research and discussion papers	Support identified by key stakeholders participants as including: CFs making time to be available; approachable; being enabled to ask questions without feeling put down; prompts to engage in best practice; benevolent surveillance so support could be provided if observed to be needed; timely feedback; providing reassurance; having backup; being debriefed after dealing with a difficult situation.	Case study using mixed methods so that results are limited to study participants.

	qualitative and quantitative data collection and analysis.	addressing key graduate nurse transition issues. Rural Victoria, Australia.		
Zizzo & Xu (2009).	To evaluate the status of post-hire transitional programs for CALD OSQ nurses available in the literature. Systematic review.	24 articles on transitional programs for CALD OSQ nurses. 20 programs exclusively designed for post hire CALD OSQ graduates. 13 focused on multifaceted transitional issues. 10 research based articles	Results: Data indicate that most programs were not evidence-based. In addition, there is minimal research on effectiveness of transitional programs particularly.	
Rush, Adamack, Gordon, Lilly & Janke (2012).	To examine transition program literature using 4 themes: Education; support/ satisfaction; competency critical thinking; and workplace environment. Integrative review of new graduate transition programs. Integrative review using Cooper's five-stage approach.	From 695 relevant citations 163 papers (included hand searching) evaluated by two researchers. Final number 47 included studies. Identify best practices of formal new graduate nurse transition programs / Studies included mainly descriptive designs (n=27), then quasi experimental (n=8), longitudinal (n=7) and qualitative (n= 5). MEDLINE, CINAHL, Embase	Few rigourously designed studies on best practice for new grad transition programs. Strong theme was formal transition programs improved retention; new grads benefit from mentors and peer support opportunities. Preceptors require formal training and work environment requires improvement.	At least two researchers checked inclusion and exclusion criteria. Table provided summary of studies including level of evidence. No reference to workforce diversity in results.
INTERNATIONAL RESEARCH **TRANSITION EXPERIENCE CALD OSQ nurses.**				
Xu (2007).	To synthesise the lived experience of Asian CALD OSQ nurses working in Western countries.Metasynthesis	14 studies that met preset selection criteria. using Noblit and Hare's (*Meta-ethnography: Synthesizing*	Four overarching themes emerged: communication as a daunting challenge; differences in nursing practice; marginalization, discrimination, and exploitation; and cultural differences.	

		Qualitative Studies.)		
Sherman & Eggenberger (2008).	To investigate the educational and support needs of CALD OSQ RNs. CALD OSQ RNs and supervisor perspective of transition to working in USA. Qualitative descriptive methods.	21 CALD OSQ RNs with average of 10 years of nursing experience. 10 nurse leaders with experience of supervising 2 to 40 nurses. USA.	Themes from the nurse leaders : Cultural challenges during transition include non- assertiveness, role and technical differences; Significance of leadership support key to success; contributions of CALD OSQ RNs make to nursing units overwhelmingly positive. Themes from CALD OSQ RNs: differences in nursing practice; challenges transitioning to a different culture and educational need during orientation.	Small descriptive study. Strengthened by interviews with CALD OSQ RNs and nurse leaders.
Kawi & Xu (2009).	To synthesise what is known about the specific facilitators and barriers when CALD OSQ RNs adjust to foreign health-care environments. Meta-synthesis of publications about the adjustment period for CALD OSQ RNs in foreign environments.	29 of 42 publications of empirical studies including dissertations and thesis, published in English which describe adjustment issues of CALD OSQ RNs.	Facilitators and barriers co-exist during the adjustment period for CALD OSQ nurses. These are grouped into two categories of internal (CALD OSQ nurses controlled eg. Continuing education) and external factors (CALD OSQ nurses unable to control eg. Orientation programs). Facilitators include: +ve work environment, persistence and logistical support; assertiveness training; continuous learning. Barriers include: language and communication difficulties; cultural differences; lack of support; inadequate orientation; differences in nursing practice.	Review protocols clearly followed. Authors have multiple publications on the topic. Categories provide readily usable information.
Tregunno, Peters, Campbell & Gordon (2009).	To examine the barriers and challenges CALD OSQ nurses experience transitioning into the workforce after initial registration in adopted country. Semi structured interviews.	30 CALD OSQ RNs Ontario, Canada.	CALD OSQ RNs change from Clinical expert to cultural novice. 5 themes: 1. expectations of practice (eg. More involvement, patient responsibility, more assertive, less hierarchy). 2. Nurse-client relationship (eg. Patients more knowledgeable, culturally diverse and have more rights. Consent required). 3. Resource utilization: (eg. Disposable products, advanced technology, religious beliefs and treatment decisions.) 4. Language: (eg. Stress related to understanding difficulties, constant vigilance required, work slower and use of humor). 5. Being the outsider: (eg. Racism, aggression, lack of trust, resentment and unequal workload assignments.)	Small qualitative study provides rich descriptions.
Allan, H.	To find the main barriers	93 CALD OSQ	Main barrier was lack of preparation	Large

(2010)	to effective and non-discriminatory mentoring practices. Ethnographic interpretive study using mixed data collection methods.	nurses in the UK and 24 national and 13 local managers and mentors from 6 research sites in the UK.	caused by: lack of awareness of cultural differences; concern that overseas skills not up to British standards; The need to nurse the British way; bullying and discriminatory practices in the workplace. Recommended better preparation of mentors and to treat CALD OSQ nurses respectfully as RNs rather than students.	qualitative study by experienced researcher provides rich description from several perspectives.
Eyre (2010).	To provide greater understanding of factors that influence CALD students' ability to communicate effectively in clinical settings. Grounded theory using interviews and focus groups.	7 final placement CALD student nurses (1 CALD OSQ nurse), 2 preceptors and 4 lecturers for focus groups. NZ	Factors that facilitate effective communication include extrinsic factors such as quality of CF, attitude, training and tone of placement. Intrinsic factors include proficiency with English language, socio-pragmatic language skills and proactive learning strategies. Informative focus on communication issues. Extrinsic and intrinsic facilitators of effective communication from student and preceptor/lecturer perspective.	Quality evident due to supervisor review. Masters dissertation.
Thomas, Bertram, Allen, (2012).	To understand the lived experience of the 1st year of clinical practice. Qualitative, phenomenological design.	10 female RNs and 1 male RN making transition from Graduate to RN. Indiana, USA.	Lived experience of new grad year in USA four themes: feelings of frustration and being overwhelmed, ongoing support of preceptors, identified fears and ongoing feedback during orientation.	Small qualitative study provides rich descriptions. No cultural issues addressed.

NATIONAL RESEARCH				
CALD OSQ RNs				
Konno, (2008).	To examine the lived experience of CALD OSQ RNs working in Australia. Hermeneutic phenomenology. Australia	24 CALD OSQ RNs from 11 different countries.	4 themes: 1. From the past to the future; 2. new environment; 3. living in the English language; 4. Shared world. Core essence of phenomena: Process of obtaining a new identity in the English language, while actively formulating reality through interplay with new surroundings. Recommended improved support for OQNs.	Doctoral dissertation. Informative though participants already registered in Australia and working as RNs.
Takeno (2010)	To intensively explore experiences of CALD OSQ RNs working in Australia, to uncover meanings not previously described in detail. Qualitative exploratory research framework.	5 East Asian CALD OSQ RNs Australia	Five themes: work conditions; support system; nursing values; language difficulties and cultural differences. Potential for misunderstanding included English language deficits, differences in culture and beliefs about the nurses' role; too much help may be a form of covert discrimination.	Small exploratory study. Follows qualitative research framework.

NATIONAL RESEARCH Cont. CALD & CALD OSQ nurses / Lecturers.				
Brown (2005).	To examine and describe experiences of CALD BN students across 3 Australian states. Qualitative interviews using grounded theory method of constant comparison to analyse data.	40 CALD BN students and 32 nurse teachers. Data source includes field observation notes and memos CALD students on clinical practicum and classroom.	Developed a substantive theory explaining experience of CALD BN students. Overview of substantive theory was set in a context of disharmony: The basic social psychological problem was sociocultural discord: Being different and not fitting in eg. Different communication, culture, race, clothing and facial expressions. The basic social ongoing process was seeking concord to get in the right track eg. Suppressing discord; avoiding interaction. Developed schema to represent theory as an ongoing process of students trying to overcome the context of disharmony which was clearly itemized into easily understandable subheadings.	Doctoral thesis. Teacher and student perspective across 3 states with extremely large sample size.
NATIONAL RESEARCH Cont. NON CALD GRADUATE RNs				
Cubit & Lopez (2011).	To explore the transition experience of new graduate RNs from having been EN. Qualitative descriptive design using focus group interviews.	8 Graduate RNs Previously ENs in ACT, Australia.	Stepping out of their comfort zone, Being taken advantage of & needing support like any other RN. Concerns about unrealistic expectations after revealing EN status. Informs understanding of experience of graduate ENs converting to RN status.	Small qualitative descriptive study so that results cannot be generalized.
LOCAL RESEARCH CALD OSQ RNs				
Omeri & Atkins (2001).	To understand CALD OSQ RNs' lived experiences in order to throw some light on their under representation in the workforce. NSW, Australia. Heidegarian phenomenological approach with open ended interviews.	5 CALD OSQ RNs. Study location NSW, Australia.	Lived experience and meaning from analysis included: professional negation; experienced in lack of support; otherness, experienced in cultural seperateness; silencing, experienced in language and communication difficulties and other related experiences.	Phenomenological process of data collection and analysis clearly relayed with verbatim quotes.
LOCAL RESEARCH cont.. CALD students and CALD BN students				
Wright and Gollan (2008).	To report on the psychosocial needs of international CALD students enrolled at a university in NSW. >50% from the School of Nursing, NSW, Australia. Grounded theory methodology.	48CALD students, mainly female from 17 countries.>50% CALD BN students. 23 key stakeholders at study campus.	Five core themes: personal and interpersonal issues; meeting basic needs; risks to psychological and physical well - being; organizational and campus issues; stories of resilience.	Data collection focus groups not recorded.

This Page has been intentionally left blank.