# An exploration of the previous teaching and learning experiences of overseas educated nurses from China, Korea and India.

Submitted by

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## Statement of Authorship and Sources

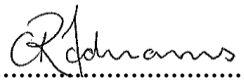
This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted toward the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgement in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees.

Authorship and sources

Signature: 

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## LIST OF ABBREVIATIONS AND ACRONYMS

**AHPRA** Australian Health Practitioner Regulation Agency

**ANMC** Australian Nursing and Midwifery Council

**ANMAC** Australian Nursing and Midwifery Accreditation Competencies

**CALD** Culturally and Linguistically Diverse

**DIAC** Department of Immigration & Citizenship

**EBP** Evidence Based Practice

**ESL** English as a Second Language

**HREC** Human Research Ethics Committee

**IBL** Inquiry Based Learning

**IELTS** International English Language Testing System

**ISNQ** International Student Nurse Questionnaire

**NESB** Non-English Speaking Background

**NMBA** Nursing and Midwifery Board of Australia

**OET** Occupational English Test

**SSS** Student Support Services

**PBL** Problem Based Learning

**SCL** Student Centered Learning

**SEAB** South East Asian Background

**SPSS©** Statistical Package for Social Sciences

**TCL** Teacher Centered Learning

**TEQSA** Tertiary Education Quality and Standards Agency

**QNC** Queensland Nursing Council

## ABSTRACT

The aim of this research was to identify and describe the teaching and learning strategies most commonly experienced by overseas educated nurses from China, Korea and India in their previous nursing courses in their homelands. A mixed methods approach utilised a specifically designed questionnaire and focus groups. Data collection took place over two years, with a sample of overseas educated nurses enrolled in a Bachelor of Nursing course with recognised prior learning (RPL). The questionnaire asked participants to describe their previous teaching and learning experiences and identified teaching and learning strategies experienced by the participants' in their homelands and focus groups explored these experiences in more depth. Three main themes emerged from the focus group data: *they will tell you definitely what you need to do; we hardly talk to each other*; and *no need to critical think* [*sic*].

Despite the wide range of previous learning experiences in their homelands, the participants had little educational preparation for professional accountability and autonomy resulting in their being unprepared to take an active part in their ongoing learning and thinking critically or independently. Findings also indicated that participants had little educational preparation in therapeutic and interpersonal professional communication. These research findings inform recommendations for support and meeting the academic and clinical teaching and learning needs of overseas educated student nurses in their transition to higher education and practice as Registered Nurses in Australia.

Key recommendations are that a tertiary preparation program for overseas educated nurses is implemented prior to the commencement of their Bachelor of Nursing course with RPL and includes the promotion of deep learning and critical thinking by providing students with strategies for self directed learning, independent inquiry, presentation skills and interpersonal communication. Nurses who have learnt and practiced in these countries also need to be prepared for the expectations of practice in an Australian healthcare system utilising evidence based practice and reflection and evaluation of care. In conjunction with these recommendations, academic staff need to be prepared for the range of student entry behaviours that arrive with overseas educated nurses in order to better support their transition to study and work in Australia.

# CHAPTER ONE

# INTRODUCTION

## 1.1 Introduction

This thesis demonstrates that overseas educated nurses from non English speaking Asian countries entering Australia for further study are not adequately prepared for the teaching and learning strategies commonly utilised in the Australian higher education setting. The research conducted identified and described the teaching and learning strategies commonly experienced by overseas educated nurses in their homelands of China, Korea and India. This information will inform strategies to better understand and support nurses from China, Korea and India as they study in Australia and assist their transition to nursing in the Australian context.

Nurse labour shortages over the past twenty years have resulted in an increase of overseas qualified nurses migrating to Australia to work and study (Hawthorne, 2001). As far back as 1991 the Australian Government, in a National Nurse Labour Market Study found that 'nothing is known as to how far [many nurses] qualifications fall short of the registrable standard' (Department of Employment, Education and Training (DEET), 1991, p. 6). The study defined a need for bridging programs, particularly for overseas educated nurses whose qualifications 'fall only a little way short of Australian registration standards' (DEET, 1991, p. 24). Although studies by the Australian Government and others found that nurses with more 'deficient' qualifications, require further study to assist them in achieving an Australian qualification (DEET, 1991, p. 24), the literature does little to identify the pedagogy that these nursing students have experienced nor does it address the differences in teaching and learning styles that they will experience when studying in Australia. More recent literature has also identified that while overseas educated nurses and international students in general present

with a qualification gained in their homeland, the teaching and learning processes involved in gaining that qualification are invisible (Dickson, Lock, & Carey, 2007; Lawson, Dalglish, Nelson, Reese, & Haker, 2006). These authors also suggest that overseas educated nurses are not always equipped with knowledge and skills comparable to those with whom they will be studying and working in Australia (Hoffmeyer & Cecchin, 2000; Lambert, Lambert, & Petrini, 2004; Yi & Jezewski, 2000). Many overseas educated nurses enter Australia aiming to raise their standard of education, therefore a thorough understanding of previous teaching and learning experiences including clinical scope of practice needs to be identified prior to granting recognised prior learning (RPL).

These studies conducted by the Australian Government and others, although now quite dated, highlight the need for Australian nurse educators to have a clear understanding of issues impacting the overseas educated nursing student, the teaching and learning styles that they have experienced and the strategies required to address any mismatch that overseas educated nurses may experience when studying in Australia. Research suggests that overseas educated students are constantly making comparisons with the familiar educational and clinical practises of their home country and expect that their Australian teaching and learning experiences will be similar (Sidoryn & Slade, 2008). Further findings indicate that prior teaching and learning strategies or clinical practises experienced by the overseas educated nurse do not prepare them for those utilised in the Australian higher education system, or for practising in Australian healthcare systems (Wang, Singh, Bird, & Ives, 2008). Therefore, the research question that focuses the conduct of this research is: *What were the teaching and learning strategies most commonly experienced by overseas educated nurses from China, Korea and India in their previous nursing courses in their homeland?*

The assumptions that underpin this study propose that overseas educated nurses from Asian cultures face significant challenges when arriving in Australia to study, such as differing learning styles and levels of learning, cultural barriers, and difficulties with Australian educational practices. It has been identified that international students particularly from Asian countries, struggle with independent critical thinking and problem-solving activities (Wang et al., 2008) and have difficulty participating in discussion and collaborative class work (Lawson et al., 2006). Critical thinking and problem-solving, discussion and collaboration are student centered teaching and learning strategies that are commonly utilised in Australian nurse education. Consequently, overseas educated nurses from Asian cultures have demonstrated a lack of experience with teaching and learning strategies utilised in Australia, thus indicating their unpreparedness for learning and practising in a Western education and healthcare system (Lawson et al., 2006; Wang et al., 2008).

This chapter outlines the background that led to this study and the significance of conducting the research. The objectives of the research and expected outcomes from the study are explained and the research design is introduced. The chapter concludes with an outline of the thesis structure, including a brief description of each chapter.

## 1.2 Background of the Study

Globalising processes have contributed to the movement of people around the world (Allen & Ogilvie, 2004; Hawthorne, 2001). Nurses are part of this movement as they strive for higher salaries, better career prospects, working conditions and environments. Part of the globalising process is the establishment of recruitment, placement and education agencies that contribute to the global migration of nurses (Jeon, 2007; Kline, 2003).

### 1.2.1 Global Migration of Nurses

In the past, the migration of nurses was opportunistic, based on individual motivation and personal contacts, whereas now large scale planning of international recruitment is utilised to meet the demand for labour in developed countries (Stalker, 2002). In 1995 to 2005, Australian nurse numbers were reduced by the permanent and long-term international movement of nurses from Australia to overseas countries. However since 2001, a turnaround in this trend began with more arrivals than departures on a permanent or long-term basis. In 2001 approximately 800 nurses arrived from overseas to work in Australia with the number rising to 1,900 nurses by 2004 and this trend has continued, including both those who have trained as nurses overseas and those who required further study after migrating to Australia (Australian Bureau of Statistics (ABS), 2006). At the 2006 census and just prior to the commencement of this study, 10,995 nurses had arrived in Australia (ABS, 2006).

This global freedom of movement has increased the number of overseas educated nurses with various levels of experience and education entering Australia to gain experience and establish careers. Importing 'ready-made' nurses from other countries is an attractive 'quick-fix' for countries facing political pressure to solve nursing staff shortages, a practise which has become accepted in Australia (Buchan, 2001b, p. 66). For example, international nursing student enrolments for 2005 in Australia increased by 42.3% (Department of Education Science and Training, as cited by Dickson et al., 2007). In this same period, the Queensland Nursing Council (QNC) also identified a 40% rise in registration applications from overseas nurses and midwives (Dickson et al., 2007).

The importing of overseas educated nurses presents an ethical dilemma for the global nursing community as the potential for a nursing 'brain drain' in those countries supplying

nurses impacts on quality of care in that country, losing not only human resources that are scarce, but also the future leaders in the profession (Buchan, 2001b, p. 65). Despite these effects on their home countries, nurses continue to seek career advancement abroad, often utilising higher education as the point of entry. Whilst these nurses assist in meeting Australia's skills shortage, nurses from Asian cultures not only often require further education to assist them in the transition to practice in Australia (Buchan, 2001a; Magnusdottir, 2005; Omeri & Atkins, 2002; Thomas, 2006), but also require assistance in their transition to study in Australia (Sidoryn & Slade, 2008; Wang et al., 2008). These findings can be applied to many international students in Australia, particularly those from Asia who are Australia's largest source of arrivals (ABS, 2006).

### 1.2.2 International Student Education in Australia

In 2004 and 2005, the main source countries of birth for all students contributing to migration in Australia were China (30%), India (20%) and South Korea (6%). Overall, the top ten source countries contributed 83% of student migration. All countries in the top ten source countries saw student arrivals exceed student departures (ABS, 2006). Between 2001 and 2009, overseas student enrolments had increased from 18.7% to 28.3% of all higher education students (ABS, 2011). In December 2010, the Australian Government commenced a review of the student visa program to help enhance the quality, integrity and competitiveness of international education. March 2012 saw an increase in student visa applications from students from China (0.8%) and India (16%) with a 7% drop in applications from Korea. These applications were from students enrolling in all sectors of higher education including vocational education and training (VET) and English language Intensive courses for overseas students (ELICOS) (Australian Government, 2012). In 2010, the higher education sector in Australia experienced a decline in enrolments due in part to the global economic downturn and changes

in immigration legislation (Ohr et al., 2010) affecting language requirements and subsequent visa requirements for international students. It appears that changes made by the Nursing and Midwifery Board of Australia (NMBA) that internationally qualified applicants must demonstrate evidence of completion of five (5) years (full-time equivalent) of education taught and assessed in English, or have achieved the required minimum academic level of 7 in each IELTS academic module, may have contributed to the decline in enrolments (Nursing and Midwifery Board of Australia (NMBA), 2011). Table 1.1 provides a snapshot of the 2012 year to date enrolments of international students and indicates that despite the decline in enrolments in recent years from countries of focus for this research, China, Korea and India still remain in the top five countries of Australian education export (Australian Government, 2011a).

| **Sector** | **YTD May 2011** | **YTD May 2012** | **% Growth on YTD May 2011** |
|---|---|---|---|
| Higher Education | 202,370 | 193,066 | -4.6% |
| VET | 120,312 | 102,990 | -14.4% |
| ELICOS | 56,102 | 52,131 | -7.1% |
| Other | 34,920 | 30,348 | -11.8% |
| Total | 556,704 | 504,868 | -8.5% |
| **Nationality** | **YTD May 2011** | **YTD May 2012** | **Growth on YTD May 2011** |
| China | 122,692 | 113,064 | -7.8% |
| Korea | 22,151 | 20,131 | -9.6% |
| India | 53,774 | 40,709 | -24.3% |
| Malaysia | 19,702 | 18,320 | -7.0% |
| Vietnam | 18,183 | 16,539 | -9.0% |
| Other Nationalities | 177,202 | 169,872 | -4.1% |
| **Total** | 413,704 | 378,535 | -8.5% |

Table 1.1: Overseas Student Enrolments including Top 5 Nationalities – May 2012.
Adapted from: Monthly Summary of International Student Enrolment Data, (Australian Government, 2011a).

Australia's success in the export trade of education is partly due to the increasing desire for higher education worldwide, and the desire among students to obtain a degree from an institution in an English speaking country (Ahern, 2008). As the enrolment of international students drives economic growth for both the university and the nation, Australian universities need to accept an ethical responsibility for the delivery of quality academic and clinical learning experiences, particularly if Australia is to maintain a position of influence in the global education export market (Australian Government, 2011a). The Australian Government has recognised the need to secure Australia's education market through the services provided to international students in Australia. The Department of Education, Employment and Workplace Relations (DEEWR) oversees the roles and responsibilities of education providers, migration and education agents, ensuring the quality and adequacy in information, advice, service delivery and support for international students. However universities are individually responsible for the quality of programs delivered, the experience that they are offering to international students, and the services available to assist these students to achieve optimal education outcomes when studying in Australia. Education Services for Overseas Students (ESOS) legislation ensures that both public and private institutions must meet high standards of quality and ethical practice that take into account such issues as curriculum, qualifications of teaching staff, and facilities (Australian Government, 2011a).

In addition to maintaining quality education, the Australian Government also accepts the responsibility of ensuring positive student experiences for all international students. In June 2009, Australia witnessed the tension experienced by Indian international students in the Australian community. The then Australian Prime Minister, Mr Kevin Rudd, announced an 'international student strategy' that would facilitate the enculturation of international students and develop a greater understanding of this group among the wider Australian community.

He stated, ‘helping international students engage with the community in which they live benefits the students and their communities’ (Rudd, 2009, p. 1). He also said the Government would work closely with the states and territories "as a matter of urgency" to work on ways to help international students feel safer (ABC, 2009). Findings from the 2009 Bradley Review reveal the Australian Government’s plans for comprehensive reform in the higher education sector and the impact these plans have on both international and domestic students. The Bradley Review supports increasing participation and diversity amongst the entire student cohort to the benefit of both (Australian Government, 2009).

In 2010, the survey of international student engagement with studying, international students reported being more engaged when learning in a study group or with students during class and were comfortable discussing ideas from classes with teachers, (Australasian Survey of Student Engagement, (AUSSE), 2010). Although this finding may give the appearance that international students are making the adjustment to a more active learning style, in the same survey international students reported higher levels of interaction with teaching staff but lower grades and lower overall satisfaction for their Australian university experience (AUSSE, 2010). Universities Australia, in working with the Australian Government submitted a proposal for an International Education Strategy which addressed seven key themes which included: expanding the Australian educational experience and enhancing the student experience (Universities Australia, 2012). In order to enhance the student experience the International Education Strategy for Australia outlines specific strategies for universities and government. These include ensuring safe and affordable accommodation for all international students, student transport concessions, adequate health care and particular emphasis on personal safety and provision of a safe environment for all international students (Universities Australia, 2012). However, despite the AUSSE findings that international

students are experiencing lower grades and the Australian governments' commitment to improving the student experience, it appears that little is being done to address the varied levels of preparedness with which overseas educated students present in order to improve academic outcomes.

### 1.2.3 Transition of International Students

Universities have long recognised the value of international students who enhance the quality of learning and the educational experience by contributing to understanding and tolerance throughout the entire student cohort (Universities Australia, 2012). Providing tertiary preparation and transition support will assist international students in their transition to study and work in Australia. However, despite achieving the prerequisite language scores and academic admission requirements for entry to Australian universities, IELTS academic level 7 (NMBA, 2011), international students continue to arrive with varying degrees of preparedness to study in Australia. In addition to the language difficulties that international students from non English speaking backgrounds (NESB) may experience when studying in English speaking countries, evidence from a study conducted by Evans and Green (2007) suggests that these difficulties arise from the contrast in educational preparation that international students experience. Lawson et al. (2006) identified issues raised by teachers of international students and those raised by international students themselves, and found that although international students from Asian cultures strive to achieve academically, they are not always familiar or comfortable with the teaching and learning processes used in the West. Table 1.2 on the following page compares summary points from the Australian Government expectations of international students entering Australia to study with those of Lawson et al. (2006) who have also identified that international students from Asian cultures are not familiar with Western teaching and learning processes and highlight the contrast in teaching

and learning strategies experienced, such as thinking critically and independently, participating in class interaction, collaborating, challenging information provided and using referencing to acknowledge the source of information.

| Australian Government Expectations | Teaching and Learning Strategy Contrasts |
|---|---|
| Conduct independent research, collect and analyse data individually and in teams | Unfamiliar with the expectations of critical analysis and team participation and debate |
| Raise questions, develop a logical argument and participate in discussions and debates with other students and teachers | Information given tends not to be challenged |
| Develop the ability to think critically and independently | Inability to work independently of teacher supervision |
| Read widely and critically, participate in debate, function in teams | Lack of student interaction, collaboration and discussion in class, unfamiliar with a self-directed learning regime |
| Attend lectures, seminars and tutorials, utilise libraries and laboratories conducting research | Unfamiliar with class participation, seminar presentations, referencing and preparation of academic papers |
| Take an active part in the learning process rather than engage in passive listening and rote learning | Expecting that the right answer will be given and requiring the use of 'templates' to prepare academic papers |

Table 1.2: *Contrasts in Teaching and Learning Strategies between Asian countries and the West.* Adapted from the 'Study in Australia' website (Australian Government, 2008) and Lawson, Dalglish, Nelson, Reese and Haker, (2006).

Note that these findings pertain to international students in general and are not aimed specifically at overseas educated nurses entering Australian to study, however many of the teaching and learning strategies listed are similar to those used in Australian nurse education (Chin & Kramer, 2008; Kilstoff & Baker, 2006; Parker & McMillian, 2007; Sherwood & Liu, 2005; Ungos & Thomas, 2008; Yu, 2008). The contrast in Western and Asian teaching and learning strategies highlights the importance of understanding the previous teaching and learning experiences of international students, in order to identify strategies to support and assist them to move from the style of teaching and learning with which they are familiar to the more active, independent style utilised in Australia with the added benefit of intercultural learning for all students.

Improving teaching and learning in higher education has become in important international endeavour since the 1960's and 1970's, in response to the influx of students from a broader range of backgrounds with diverse expectations. Higher education institutions in Australia have recognised the importance of ensuring consistently high quality learning experiences and support for all students (Lewis, 2010). From January 2012, the Tertiary Education Quality and Standards Agency (TEQSA) implemented performance evaluation of higher education providers against the new higher education standards framework. The standards framework comprises five domains: provider standards, qualification standards, teaching and learning standards, information standards and research standards. The provider standards and qualifications standards are collectively the standards which all education providers must meet within Australia's higher education system (TEQSA, 2011). In accordance with the Australian Government's expectations of international students, Australian teaching strategies aim to engage students as active participants and make appropriate use of information and communications technologies. The expectations and requirements for achieving each teaching and learning outcome are to be clearly communicated by teaching staff who are encouraged to develop critical, well-informed, up-to-date and innovative knowledge and research in their disciplines and in their teaching (Australian Government, 2011c). With most Australian nurse education programs now being conducted in the higher education sector, these framework principles for higher education are applied to teaching and learning strategies in Australian nursing.

### 1.2.4 International Student Nurse Education in Australia

The basic nursing educational preparation of Asian nurses is not immediately comparable with that of Western educated students (Lambert et al., 2004; Yi & Jezewski,

2000). These differences are now being recognised by the Australian Government, higher education providers and the registering body for the Australian nursing profession (Australian Government, 2011b; Australian Nursing and Midwifery Council (ANMC), 2006; NMBA, 2011). The development of educational programs which support the teaching and learning needs of overseas educated nurses are the result of this recognition and addresses the legislative responsibility of universities as determined by DEEWR and ESOS, and the responsibility which extends beyond the overseas students' education to the nursing profession in Australia and the safety of the Australian public (Australian Government, 2011a). Research suggests that university faculty do not fully appreciate overseas educated student needs and are inadequately prepared to provide a tailored, quality educational experience (Wang et al., 2008).

International students and particularly overseas educated nursing students arrive with varying educational experiences from their homelands. China, Korea and India conduct nursing courses at high school certificate and diploma levels from six months to three years and diploma and bachelor degrees from three, four, and five year duration at colleges and university (Abraham, 2007; Chan & Wong, 1999; Noh, Arthur, & Sohng, 2002; Sherwood & Liu, 2005; Ungos, & Thomas, 2008; Wong, Chan & Yeung, 2000; Xu, Xu, Sun, & Zhang, 2001). Many Australian universities offer Bachelor of Nursing with RPL courses which require that overseas educated nurses have completed a professional nurse education program in their homelands, must be eligible for registration as a nurse in the country in which they qualified and have an international English language test score (IELTS) of 7.0 overall. Although each applicant is assessed on an individual basis according to their education and experience (ANMC, 2006; NMBA, 2011), and Dooey (2010) found that readiness to study in a university in Australia goes beyond the achievement of an English language proficiency score for entry and university entry requirements. Receiving RPL to complete a shortened degree in Australia is an attractive

option for overseas educated nurses wishing to obtain Australian registration. The shorter study timeframe is more affordable and timelier registration can lead to work and residency in Australia, a very desirable option for experienced nurses coming from countries where their occupation is sometimes less valued and renumerated in comparison with their Australian colleagues (Abraham, 2007; Samuel, 2003; Thomas, 2006). However, choosing a shortened degree can challenge the students' transition to study and work in Australia and clear study pathways and bridging units are required to contribute to student success especially in light of the identified difficulties with differences in educational approaches.

### 1.2.5 Transition of International Student Nurses

The Australian higher education sector has implemented strategies to assist international students struggling with the transition to study and work in Australia. Transition to university pathways include general English language courses to develop language skills and meet IELTS requirements which also provide students with the opportunity to be immersed in the university environment whilst improving their English language proficiency and becoming familiar with Australian academic culture and academic skills. English language courses are also tailored to academic studies in health professions to enhance effective communication skills. All students undertaking pathway courses including nurses are introduced to critical thinking and problem solving with emphasis placed on working independently and as a team member (Australian Catholic University (ACU), 2012a; Queensland University of Technology (QUT), 2012). In the Vocational Education and Training (VET) sector, international students gain an initial qualification providing the basis to a nursing career, or assisting with further study at university. These training pathways to higher education provide credit and introduce practical skills towards a nursing degree (Future Unlimited, 2012).

In addition to the pathway programs offered at university and in the VET sector, bridging units within the Bachelor of Nursing with RPL are offered to eligible overseas educated nurses. These units introduce overseas educated nursing students to contemporary nursing practice in Australia and prepare them for clinical practice placements in Australian health care settings. Nursing students build on their clinical and communication skills to ensure safe and ethical practice, whilst recognising the importance of caring for people of different values, beliefs and cultures within the Australian health care system. Direct entry English programs (DEEP) and tertiary preparation programs (TPP) are designed to demonstrate academic competence and are available for nursing students who have completed a nursing qualification in their homeland which does not meet Australian university requirements, for example, a highschool certificate of nursing (ACU, 2012a; QUT, 2012; University of Technology Sydney (UTS), 2012). Units such as DEEP and TPP are intended to assist the overseas educated nurse to not only achieve language competence but also acquire useful academic study skills and meet the expectations of their study discipline, and ultimately the requirements for registration as a nurse in Australia (ACU, 2012a; ANMC, 2011; NMBA, 2011; QUT, 2012; UTS, 2012). In their national standards for the assessment of internationally qualified nurses and midwives, the NMBA provides a summary of criteria which requires that the applicants meet English language proficiency for the nursing and midwifery professions; meet current Australian nursing and midwifery education standards; and are fit to practise (NMBA, 2011). These criteria for assessment align internationally qualified nurses and midwives with the requirements for Australian qualified applicants for registration specified in the NMBA registration standards and the board-approved course accreditation standards (NMBA, 2011). Similarly, the ANMC competencies for the Registered Nurse utilise core competency standards to provide a framework for assessing competence as part of the annual renewal of license process and to assess nurses educated

overseas seeking to work in Australia. These competency standards also advise consumers of the standards that they can expect from nurses, and provide a guide for universities in the development of nursing curricula. The ANMC competencies for the Registered Nurse also provide a framework for student and new graduate performance in Bachelor of Nursing assessment including Bachelor of Nursing with RPL programs (ANMC, 2006).

Universities have a responsibility to ensure quality outcomes for all students and many institutions are designing and implementing comprehensive programs aimed at assisting international students and staff to function more effectively in the clinical environment and to become more confident in working together within the context of clinical education (QUT, 2012). One recently introduced program targets therapeutic communication, effective listening and questioning. Other aspects of the program cover culture in heath and cultural safety, building interdisciplinary relationships, and establishing a positive learning environment (QUT, 2012). Other Australian universities have developed similar programs to enhance the university experience of international students. These aim to provide students with guidance on various aspects of their learning including general English language skills and literacy required for study in particular discipline areas, and strategies for managing new expectations and workloads (University of South Australia (UTS), 2012). The teaching and learning strategies are provided in a variety of forms; both electronic and face-to-face and are aimed at establishing a positive learning environment which includes critical thinking and reflective practice (QUT, 2012; UTS, 2012) all of which have been identified in the literature as a challenge to the overseas educated nurse, an observation that I have made which has led me to this study. As overseas educated nurses continue to enter Australia to further their education, there needs to be an understanding of the teaching and learning strategies previously experienced by nurses in their nursing courses at home, to facilitate the

development of teaching and learning strategies that will support the overseas educated nurses' transition to university study in Australia.

### 1.2.6 Learning to Teach

I am a Registered Nurse working both in the higher education setting and the perioperative clinical setting. Combining clinical nursing and the education of undergraduate nursing students has exposed me to teaching overseas educated nurses both at university and in the perioperative clinical setting. Working in the higher education setting includes working on campus with a mix of overseas educated nursing students and domestic nursing students. I work in classrooms teaching theoretical nursing content and in the clinical laboratory teaching clinical nursing skills. I also facilitate nursing students during their clinical practice experiences in hospitals. In my work in the perioperative setting, many colleagues are overseas educated qualified nurses and I also have contact with overseas educated undergraduate nursing students. Although these settings are quite diverse, I have observed that in both the classroom and the clinical setting, many overseas educated nurses from varying countries who are studying and working in Australia have difficulty adapting to the teaching and learning strategies and clinical practices utilised in Australia.

Classroom difficulties experienced by overseas educated students that I have noticed appear to result from a lack of taught critical thinking skills and include: a reluctance to question or interrupt during class, resulting in the risk that questions remain unanswered; a reluctance to challenge information or ask "why"?, and difficulty participating in discussion or group work with students who are not immediately familiar to them. This in turn impacts on the development of their English language skills which then impacts on their ability to meet the language competency required for nursing. In the on campus clinical laboratories, I

have noticed that overseas educated nurses enrolled in the Bachelor of Nursing with RPL program often do not have the knowledge and skills that are assumed of students in this shortened study program. For example, students have difficulty with injectable medication calculations, a skill which needs to be mastered very early in an Australian Bachelor of Nursing and then reassessed regularly throughout the program. Many overseas educated nurses whom I have taught are not familiar with medication calculations or administering the correct dose of medication from a prescribed order, which are nursing practices introduced early in the Australian Bachelor of Nursing curriculum.

In the hospital setting, I have noticed a mismatch of qualification expectations and skill expectations between nursing staff. In some cases, the skill level from a Registered Nurse who has qualified in Australia does differ from the skill level of an overseas educated qualified nurse, despite the expectation that both are at a comparable level. Due to the differences in scope of practice expectations, the overseas educated qualified nurse struggles with role expectations and independent decision making, preferring to report changes immediately to the medical officer rather than implement nursing interventions and evaluation of care prior to notifying the medical officer. In light of this situation, one major hospital has now instructed that all patient queries are directed to the nursing team leader who will then advise on appropriate nursing interventions or decide if the attending medical officer needs to be contacted. For the overseas educated nurse enrolled in the Bachelor of Nursing with RPL, these differences in curriculum content and scope of practice expectations impacts on their level of success in their Australian higher education experience and transition to the role of Registered Nurse in Australia.

Overseas educated nurses who are qualified in their homeland and now studying in Australia as undergraduate nursing students can also be challenged by their Australian nursing student role and the influences of their past experiences. This challenge has been witnessed at times by their struggle to work within their scope of practice as an Australian student nurse. Some overseas educated nurses in their student role in Australia feel that they are capable of working as they may have done as a student nurse in their homeland, and then find that they are performing duties not expected of a student nurse in Australia. An example of this was when an overseas educated nursing student was found injecting a patient with their morning insulin dose without having it checked with her supervising nurse prior to administration. Despite the Australian expectation that all student nurses are supervised at all times during drug administration and the requirement that insulin is checked by two registered nurses, when asked why the insulin was given without checks being carried out, the student explained that in her homeland she would have been allowed to do this.

In the higher education setting, I found myself asking questions of the overseas educated student nurses' experiences in classrooms in their homeland and how that impacted on their role as a student nurse in Australia, inquiring about teaching and learning strategies, and comparing clinical practice experiences from their homeland to those they have experienced in Australia. In the workplace, I found myself inquiring about operating room practices abroad and the experiences of those colleagues. From these questions and the responses I received, I realised that there were differences in the students' expectations of teaching and learning in Australia in comparison to those that they were accustomed to in their homeland and that clinical practices also varied. These are some of the initial factors which led me to explore the teaching and learning experiences of overseas educated nurses in order to assist them to adjust to their new learning and practice environments.

I chose to investigate students from China, Korea and India because at the time that this study was proposed, the majority of international nurses in my work in higher education and in the clinical area originated from these countries. My interest in this study is to understand the previous overseas teaching and learning experiences of nurses educated in China, Korea and India in order to make recommendations which may contribute to the development of strategies for both the higher education and clinical settings aimed at assisting overseas educated nurses in their transition to practice as Registered Nurses in Australia.

## 1.3 Significance of the Study

The background information for this study has outlined the effect of globalisation on the nursing profession and the subsequent ethical considerations this creates for Australia's increasingly multicultural nursing workforce and the countries from which nurses are migrating. The increase in higher education enrolments and the resulting benefits to both university funds and the contribution to Australia's economy from international student spending serves to strengthen the need to ensure a positive student experience were also outlined. The globalisation of nursing and the impact of Australian education exports are also significant to this study due to the opportunity this provides for intercultural learning and sharing of knowledge and perspectives which benefits all students by adding a depth of cultural understanding which will assist them further in Australia's multicultural healthcare settings.

Globalisation and multiculturalism are having a direct impact on Australian universities and funding. With the Australian Government's decreased funding of higher education, a new market emerged for Australian universities – full fee paying international students (Kilstoff & Baker, 2006; Su, 2006). The 2012 (May) 'year to date' figures from

Australian Education International (AEI), indicate that 378, 535 students have enrolled in all sectors of higher education. From those figures Chinese students made up 30% of enrolments, Korean students made up 5% and Indian students made up 11% of all international student higher education enrolments, and a total of 46% of all international student education enrolments in Australia (AEI, 2012). The strong growth in international student numbers and increasing revenue from international education services have received increasing publicity over the last decade, with less attention being given to the quality of programs delivered or the international reputation of institutions and the Australian higher education industry (National Tertiary Education Union, 2007).

Reforms proposed by the 2009 Bradley Review conducted by the Australian Government recognise Australia's need to 'participate fully in' and 'benefit from' the global knowledge economy in order to meet Australia's own knowledge and skills challenges. The report describes measures that will 'transform the scale, potential and quality of the nation's universities and open the doors of higher education to a new generation of Australians' (Australian Government, 2009, p. 5) and 'sustain the international education industry which is Australia's third largest export' (Australian Government, 2009, pp. 5-6). Key requirements listed in the 2009 Bradley review include, the preparation of 'graduates with the knowledge, skills and understandings for full participation in society and the economy', and the provision of 'opportunities for all capable people from all backgrounds to participate to their full potential and be supported to do so' (Australian Government, 2009, pp. 7-8). Further requirements listed call for the creation of a 'framework that supports student choice and access to learning, encourages flexibility in teaching, learning, and research', and engaging the 'global community through student and staff mobility with the exchange of knowledge and ideas' (Australian Government, 2009, pp. 7-8). In order to achieve these reforms,

maintaining and improving the quality of teaching and learning and the student experience is a critical factor in the success of universities, both for the domestic and the international market (Australian Government, 2009). These Bradley review requirements add strength to the significance of this study to ensure overseas educated nurses are offered university programs that meet their teaching and learning so that they can make a successful transition to the role of the Registered Nurse in Australia.

In conjunction with reforms to support the teaching and learning experiences of international students, the healthcare sector needs competent healthcare workers. The Australian Health Workforce Institute (AHWI) has identified the need to address the increasingly complex needs of the multicultural healthcare setting (AHWI, 2012). In 2012, the AHWI held a clinical training and workforce planning summit which covered issues such as: National accreditation requirements, assessing regulatory and employer competencies in pre-registration programs, developing and managing a strong and capable multigenerational workforce, and nurses as the key to health workforce reform. This summit focused on ensuring that Australia's future nursing workforce has the capacity and experience to provide high quality care for Australia's increasing healthcare needs. The AHWI has recognised the multicultural population and that a multicultural health workforce will be needed to meet the demand with changes in the way healthcare is delivered in the future. The National Health and Medical Research Council (NHMRC) also recognises health as influenced by culture and increasing multiculturalism in the healthcare workforce will improve equity and access for all healthcare consumers resulting in better use of health resources (NHMRC, 2011). To address the international education market and meet the Australian Government reforms and multicultural workforce strategies for the future, it is important that the prior teaching and learning experiences of international students are considered and appropriate strategies

developed and implemented to assist these students in their transition to university study in Australia and practice in Australian health care settings. This study utilised a mixed method of data collection which provided participants the opportunity to describe how they were taught in their previous nursing courses and how they experienced that learning.

## 1.4 Objectives of the Research

The objectives of this study of overseas educated nurses from China, Korea and India are to describe:

- the academic (classroom) teaching and learning strategies experienced in previous nursing courses in their homeland;
- the clinical learning strategies experienced in previous nursing courses in their homeland.

## 1.5 Expected Outcomes of the Research

The findings of this study will contribute to recommendations for teaching and learning strategies to better support overseas educated nurses in the classroom and during clinical practice. These recommendations will inform the future development of guidelines for:

- the development and implementation of appropriate academic teaching and learning strategies to facilitate transition to university study in Australia for overseas educated nurses;
- the implementation of clinical placement, facilitation and support processes to better prepare overseas educated nurses in transition to practice in Australian healthcare settings;
- the implementation of strategies to improve academic and clinical staff awareness of the range of student entry behaviours.

## 1.6 Research Method

This research employs a mixed methods research design, with the use of the International Student Nurse Questionnaire (ISNQ) which was specifically designed for this research project. Initially, the research design planned to use the questionnaire as the primary method of data collection. However, following analysis of the initial questionnaire data, very little narrative data was provided in the responses, resulting in a focus group data collection method being added to the design. The focus group data collection method provided an added advantage of clarifying data provided from the ISNQ whilst simultaneously providing data to answer the research question more comprehensively.

## 1.7 Location of the Study

This study was undertaken at a university suburban campus in a metropolitan city of Australia where I was employed as a clinical teacher. At the time of the study proposal, this campus was experiencing increasing numbers of overseas educated nursing student enrolments from China, Korea and India. All aspects of the study including the initial recruitment of participants for pilot testing of the questionnaire, and the recruitment of participants for both the questionnaire and focus group data collections were completed at this campus.

## 1.8 Overview of the Thesis

This thesis is presented in six chapters. In Chapter one, I introduced myself and my teaching and learning experiences with overseas educated nurses. The background and significance of the study highlights the challenges that overseas educated nurses may experience when they arrive in Australia, believing that they are prepared for study, only to

face teaching and learning strategies with which they are unfamiliar and challenged. Chapter one also explains the significance of the role that international education plays in the Australian economy and the contribution made to education outcomes. The literature review in chapter two examines key themes of the research; the teaching and learning strategies and the teaching and learning environment that overseas educated nurses from China, Korea and India have experienced, and the Australian teaching and learning practices for student nurses in higher education. A table at the beginning of the chapter summaries key literature used. Chapter three describes and justifies the research design and methods of data collection along with ethical considerations for this study. Chapter four presents the questionnaire data findings whilst chapter five provides an analysis of data obtained from the focus groups along with analysis of the findings in relation to the questionnaire findings and relevant literature. The final chapter, chapter six, presents a discussion of the findings, the strengths and limitations of the study, recommendations for the future, and directions for future research.

## 1.9 Conclusion

This chapter has highlighted the need to provide a positive student experience and successful academic outcomes in order to contribute to Australia's higher education system and health care system. The chapter has identified that overseas educated nurses from China, Korea and India are unprepared for study in Australia when they are accepted into Australian university nurse education programs. The chapter also challenges the preparedness of overseas educated nurses from Asian cultures for study in Australia. It identifies teaching and learning strategies utilised in the Australian higher education system and the challenges they face in the context of previous teaching and learning experiences which have not prepared them for teaching and learning in Australia. This chapter also describes Australia's expectations of international students entering Australia for further study. Research is needed

to investigate the previous teaching and learning experiences of overseas educated nurses from China, Korea and India in order to meet the needs of these students to prepare them for nursing in the Australian context.

The next chapter will present a review of the literature to identify what is known on this topic, outlining key issues and the gaps in research relating to the teaching and learning experiences of overseas educated nurses from China, Korea and India which will justify the conduct of this research study.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Introduction

The purpose of this literature review was to investigate the body of literature pertaining to the teaching and learning strategies utilised for the academic education and clinical preparation of nurses from China, Korea and India in their homeland. Although the review focuses on the countries of interest in this study, a broader review of teaching and learning in Asia was also conducted. The teaching and learning strategies currently used in Australia and in Australian nursing were also reviewed along with strategies currently being used to support international nursing students in Australia. Where appropriate, the Australian Nursing and Midwifery Council Standards and Criteria for Accreditation of Nursing and Midwifery in Australia - 2006, and the Australian Nursing and Midwifery Council Competency Standards for the Registered Nurse - 2006 were referred to in relation to the teaching and learning approaches utilised in Australian nurse education.

## 2.2 Literature Search Strategies

A manual search for research articles and eJournals was performed using electronic databases: CINAHL, Medline with Full Text, Academic Search Complete, Health Source – Nursing/Academic Edition, Ebscohost, Journals@ovid, ERIC Plus Text, Informit Complete, the Nursing and Allied Health Collection, Wiley Blackwell, Wiley Interscience and Wiley Online Direct. Keywords included were: *second language nurses, international nursing students in Australia, international nursing students studying overseas, academic nurse education in China/Korea/India, clinical nurse education/practice in China/Korea/India, nursing schools in Asia/India and teaching and learning in higher education.* Automatic

alerts via email were also received from the Wiley online library and Sage journals online. Articles were limited to those which were available in English and published within ten years of commencement of the study. Papers which provided descriptive information related to the development of the nursing profession and nurse education in China were abundant with less information available for Korea and India. In order to identify the learning strategies experienced by overseas educated nursing students from China, Korea and India, separate literature searches were conducted for academic teaching and learning experiences and clinical teaching and learning experiences.

## 2.3 Review of Literature

Literature available on the teaching and learning strategies experienced by nursing students in China, Korea and India was scarce and largely reflected curriculum content and development, and faculty resources rather than the actual teaching and learning strategies being utilised in those countries. Before presenting the available literature on these specific countries, I will review the literature on preparation of Asian students for study in Australia followed by the review of literature available pertaining to China, Korea and India. I will then provide a review of teaching and learning strategies utilised in Australia.

### 2.3.1 Preparation of Asian Students for Study in Australia

Literature from Asia identifies a number of obstacles to learning encountered by all international students, not specifically nursing students. These studies (Clark & Baker, 2006; Clark, Baker & Mingshen, 2007; Lawson et al., 2006; Wang et al., 2008) cited language barriers, social and cultural differences and social isolation impacting on the international students' ability to adapt to the academic environment in Australia. More specifically, research has found that international students generally struggle due to their unfamiliarity

with teaching strategies such as independent research, essay writing with grammar and expression difficulties, critical argument, group work and presentations(Lawson et al., 2006; Wang et al., 2008). These studies highlight faculty responsibility to address pedagogical and socio-cultural needs of international students (Lawson et al., 2006; Wang et al., 2008). The study by Wang et al. (2008) focused on a sample of only 21 Taiwanese participants' learning experiences in Australia, and is not representative of overseas educated nurse from China, Korea and India and the study by Lawson et al. (2006) refers to all international students.

Australian research conducted by Seibold, Rolls and Campbell (2007), was specifically directed at international nurses teaching and learning experiences in Australia and cited problems with specific strategies used in Australian nurse education such as reflective journaling and communication both in the classroom and during clinical experience. Communication was also cited as the main contribution to stress and isolation experienced by overseas educated nurses in Australia (Konno, 2006). In a review of literature on the experiences of international students and their teachers in Australia, Omeri, Malcolm, Ahern and Wellington (2003) found that students struggled in areas such as analysis and critique, computing, oral discussions, asking questions and concepts of plagiarism. This research also found that the lack of written material (textbook or lecture notes) due to online and blended learning, added further obstacles to the international students' ability to adjust to teaching and learning styles in Australia. It is important to note that these studies were not focused on the previous teaching and learning experiences of nurses prior to their coming to Australia but they do allude to the impact of those experiences on their Australian experience. For example, the study by Omeri et al. (2003) appears to indicate that those students had an expectation that familiar teaching and learning practices of their homeland would be continued in Australia, with written materials and lecture notes provided to students.

The Australian literature available described the development of a student centred teaching and learning approach emphasising the use of problem-based learning (PBL) and more recently, inquiry-based learning (IBL) utilising case studies and scenarios, self-directed learning, collaborative learning with traditional teaching strategies such as didactic lectures being used less frequently where the aim is purely to transmit information. These teaching and learning strategies are established in some Asian schools of nursing (Thompson, 2004) but less literature is available describing the development and utilisation of these student centered teaching and learning approaches in China, Korea and India. Further findings from the review of broader Asian literature found that international students coming to Australia to study and the teachers of international students recognise faculty responsibility to address pedagogical and socio-cultural needs of international students (Clark & Baker, 2006; Clark et al., 2007; Lawson et al., 2006; Wang et al., 2008).

Tables 2.1 and 2.2 on the following pages provide a summary of research papers used in this literature review. The articles are entered chronologically by year of publication starting with the most recent. Note that most of the articles reviewed investigated curriculum content and education outcomes but none of the articles reviewed the teaching and learning strategies utilised to achieve those outcomes. The scant availability of research relating to the teaching and learning strategies and processes experienced by overseas educated nurses from China, Korea and India in their previous overseas nursing programs highlights the need for further research in this area in order to facilitate transition to university study and nursing practice in Australia. Following the summary tables, a more specific review of literature relating to each of the countries of origin will continue.

| Authors | Title & Publication | Research Design | Key Findings | Limitations |
|---|---|---|---|---|
| **Lee, H.**<br>**Kim, Y.**<br>**Kang, A.**<br>College of Nursing, Kyung Hee University, Seoul, Korea.<br>**Fan, X.**<br>**Ling, M.**<br>**Yuan, Q.**<br>School of Nursing, San Dong University, San Dong, China.<br>**Lee, J.**<br>College of Nursing, Kyung Hee University, Seoul, Korea. | An international comparison of Korean and Chinese nursing students with nursing curricula and educational outcomes.<br><br>Nurse Education Today. (2011). | Survey - sampling 355 Korean nurses and 407 Chinese nurses using four survey instruments measuring critical thinking, professionalism, leadership and supportive communication. | Korean nursing courses were more focused on specific nursing which was reflected in critical thinking ability.<br><br>The Chinese nurses reflected higher scores in professionalism and communication. There was no difference in scores on leadership or nursing practice. | The study compared nursing curricula and education outcomes without consideration for the teaching and learning strategies used.<br><br>The study did not reflect the differences in the nursing school systems between the two countries.<br><br>Because the study questionnaires were self reporting of ability, they reflect the student's perception of their ability rather than their actual ability to practice. |
| **Oh, K.**<br>School of Nursing, Ulaanbaartar University, Mongolia.<br>**Ahn, Y.**<br>Department of Nursing, Yonsei University Wonju College of Medicine, Wonju, Korea.<br>**Lee, H.**<br>**Lee, S.**<br>College of Nursing, Korea University, Seoul, Korea.<br>**Kim, I.**<br>Department of Nursing, Daejeon University, Daejeon, Korea.<br>**Choi, K.**<br>Department of Nursing, Chung-Ang University, Seoul, Korea.<br>**Ko, M.**<br>Christian College of Nursing, Gwangju, Korea. | A study on Korean nursing students' educational outcomes. Journal of Educational<br><br>Evaluation for Health Professionals. (2011). | Survey - sampling 454 Korean Nurses in Bachelor of Nursing (246) and Associate Degree (208) programs.<br><br>Used four survey instruments measuring critical thinking, professionalism, leadership and supportive communication. | Critical thinking, professionalism, leadership and communication scores were higher for students who had completed more years of education.<br><br>Critical thinking scores score slightly higher in the Bachelor of Nursing than the Associate Degree program. | The study is unclear as to whether curriculum content is having an impact on critical thinking, professionalism, leadership and communication abilities in students.<br><br>The study did not explore the teaching and learning strategies used to achieve the Korean nursing educational outcomes. |

Table 2.1: *Summary of Research Papers.*

| Authors | Title & Publication | Research Design | Key Findings | Limitations |
|---|---|---|---|---|
| **Sheer, B.**<br>DNSc, FNP-C, FAANP, Associate Professor (Ret), University of Delaware, Newark, USA.<br>**Wong, F.**<br>Associate Professor, Department of Nursing and Health Sciences, Hong Kong Polytechnic University, Hong Kong. | The development of advanced nursing practice globally.<br>Journal of Nursing Scholarship. (2008). | Survey of literature on advanced nursing practice. Two members of the International Nurse Practitioner (INP)/Advanced Practice Network (APN) who have experience in global advanced nursing development analysed the data. 14 countries were included. | The development of advanced nursing practice in those 14 countries reflects a global trend for enhanced education in nursing and regulation of practice.<br>Korea, Singapore, Thailand and Australia are well into development but China is deterred by the abolition of nursing education (Cultural Revolution) and the physician/nurse ratio. | Only sources of information available at the INP/APNN and documents that were available in Chinese or English were used.<br>The article does not provide details of teaching and learning strategies or curriculum content in the development of advanced nursing practice programs. |
| **Ungos, C.**<br>Graduate student, School of Nursing, University of New Mexico. USA.<br>**Thomas, E.**<br>Assistant Professor, School of Nursing, University of Colorado, Denver. USA. | Lessons learned from China's health care system and nursing profession.<br>Journal of Nursing Scholarship. (2008). | Content analysis of China's healthcare policy and its impact on the Chinese nursing profession. | Describes a mix of traditional and Western nursing concepts currently included in Chinese nurse education. | Refers to the absence of the nurses' voice in issues related to nurse education and health reform in China.<br>Few articles analysed are of primary research conducted by nurses.<br>Teaching and learning strategies in nurse education are not addressed. |
| **Wang. C.**<br>MSN, Registered Nurse.<br>**Singh, C.**<br>MMH, Registered Nurse, FRACMHN.<br>**Bird, B.**<br>MSN, MPH, Registered Nurse, FRCNA<br>**Ives, G.**<br>PhD, Registered Nurse. | The learning experiences of Taiwanese nursing students studying in Australia.<br>Journal of Transcultural Nursing. (2008). | Focus groups using semi-structured, individual interviews. A snowball sampling method with 21 Taiwanese postgraduate nursing students studying in Australia in 1999 - 2000. | Identifies obstacles to learning, citing language barriers, social and cultural differences and social isolation, affecting the students' ability to adapt to the academic environment in Australia.<br>Unfamiliarity with teaching strategies independent research, essay writing grammar and expression, critical argument, group work, presentations.<br>Highlights faculty responsibility to address pedagogical and socio-cultural needs of international students. | Small convenience sample of only 21 participants not representative of overseas educated nurse from China, Korea and India.<br>Research focused on the participants' learning experiences in Australia, but not while in their homeland in Taiwan. |

Table 2.1: *Summary of Research Papers, continued.*

| Authors | Title & Publication | Research Design | Key Findings | Limitations |
|---|---|---|---|---|
| **Clark, J.**<br>Faculty of Business and Information Technology, Whitireia Community Polytechnic, Porirua, New Zealand.<br>**Baker, T.**<br>School of Business, Wellington Institute of Business Technology, Wellington, New Zealand.<br>**Mingsheng, L.**<br>College of Business, Massey University Wellington, New Zealand. | Student Success: Bridging the gap for Chinese students in collaborative learning.<br>Paper presented at the 18th ISANA International Education Conference. (2007). | Focus groups with Chinese international students and New Zealand tertiary lecturers who use collaborative learning techniques in their teaching. | Findings indicate that there is strong cultural conflict in the conceptualisation of collaborative learning between Chinese students with little prior experience of collaborative learning and lecturers who are often not fully prepared to help Chinese students to bridge the gaps. | Research focused on the participants' collaborative learning experiences when in Australia but does not describe their previous teaching and learning experience.<br>Neither the researchers nor the research participants were nurses. |
| **Seibold, C.**<br>**Rolls, C.**<br>**Campbell, M.**<br>School of Nursing and Midwifery, Australian Catholic University, Victoria, Australia. | Nurses on the Move: Evaluation of a program to assist international students undertaking an accelerated Bachelor of Nursing Program.<br>Contemporary Nurse. (2007). | Survey, Focus groups and individual interviews - sampling a cohort of 20 participants but reduced to nine participants. | Identification of key barriers to overseas educated nurses learning experiences in Australia as strategies introduced such as reflective journaling, communication and clinical nursing in Australia. | Limited numbers with only 20 commencing participants from six Asian countries - majority from Japan.<br>No reference is made to ethical considerations however the study was supported with the aid of an ACU National Teaching and Learning Enhancement Scheme grant.<br>The study did not explore previous teaching and learning experiences from the homelands of the participants. |
| **Clark, J.**<br>Faculty of Business and Information Technology, Whitireia Community Polytechnic, Porirua, New Zealand.<br>**Baker, T.**<br>School of Business, Wellington Institute of Business Technology, Wellington, New Zealand. | Collaborative learning in diverse groups: A new Zealand experience.<br>Paper presented at the 17th ISANA International Education Conference. (2006). | Survey of staff and students in two tertiary facilities investigating how students are prepared for collaborative learning. | Results indicate that students were often inadequately prepared for working in groups and they did not achieve the desired outcome of learning to work together constructively for assessed collaborative assignments. | Research focused on the participants' collaborative learning experiences when in Australia but does not describe their previous teaching and learning experience.<br>The research does not reflect collaborative learning in nurse education and neither the researchers nor research participants were nurses. |

Table 2.1: *Summary of Research Papers, continued.*

| Authors | Title & Publication | Research Design | Key Findings | Limitations |
|---|---|---|---|---|
| **Konno, R.**<br>Discipline of Nursing, School of Population Health and Clinical Practice, Faculty of Health Sciences, University of Adelaide, Adelaide, South Australia. | Support for overseas qualified nurses in adjusting to Australian nursing practice: A systematic review.<br>International Journal of Evidence Based Healthcare. (2006). | Literature review of the best available evidence supporting overseas nurses' adjustment to Australian nursing practice. A total of 12 articles - qualitative, quantitative and textural in nature.<br>The review question was: What supportive interventions assist overseas nurses to adjust to Australian nursing practice. | The amount of published research focusing on the experiences of overseas qualified nurses is very limited.<br>Program evaluation studies involved a single program from a single institution and were around 10 years old. No course evaluation studies were found in more recent years.<br>Findings reflected problems with ESL contributing to workplace stress and isolation due to being in a new country and difficulties in forming relationships. | The articles which addressed overseas qualified nurses were not research based.<br>The articles reviewed focused on experiences in Australia and did not refer to previous teaching and learning experiences prior to working in Australia. |
| **Thomas, P.**<br>BSc (Nursing), Master of Nursing | The international migration of Indian nurses.<br>International Nursing Review. (2006). | Survey - sampling 453Indian nurses - 448 response rate. | 63% of Indian nurses expressed their intention to migrate with 81% in the 20-29 year age group.<br>Migration affects those at the base level of nursing, particularly those in private employment.<br>Incentives were: income, neglect/respect living conditions, professional ideals. | Half of the participants in the study said that it was not possible to fulfil the ideals of the nursing profession while working in India and 81% stated that they were unhappy working in India, the study does not indicate factors contributing to these findings. The sample cross-section also included those who had established careers in India and were not likely to migrate. |
| **Omeri, A.**<br>Registered Nurse, PhD. CTN. FRCNA. Senior Lecturer, Dept. of Family and Community nursing, Faculty of Nursing, University of Sydney, NSW, Australia.<br>**Malcolm, P.**<br>Registered Nurse, BA. BEd. MNA. MPH. Former Lecturer, University of Sydney, NSW, Australia.<br>**Ahern, M.**<br>Registered Nurse, BA, MPH, Lecturer, University of Sydney, NSW, Australia.<br>**Wellington, B.**<br>Registered Nurse, BEd (Nursing), MAS (Nursing), Former Lecturer, University of Sydney, NSW, Australia. | Meeting the challenges of cultural diversity in the academic setting.<br>Nurse Education in Practice. (2003). | A systematic review of research studies from literature to identify tertiary education experiences and approaches of students and academics. The focus was on local Non-English Speaking Background (NESB) students including English Second Language (ESL) students and international students.<br>A cross-section of literature and disciplines: medicine and nursing and countries to capture the rang of information. 34 articles were reviewed, 22 -Australia, 7 -USA 3 -UK and 1- NZ. | South East Asian Background (SEAB) students felt that they lacked support in their tertiary education experiences and had greater difficulties adjusting to teaching and learning styles.<br>Students cited problem areas as those requiring analysis and critique, computing skills, oral discussions, reluctance to ask questions and concepts of plagiarism.<br>Other problems cited lack of written material (textbook or lecture notes); difficulties understanding concepts and unfamiliar cultural references. | Many of the studies within individual literature reviewed were of small sample sizes.<br>Results related to many disciplines and the authors note that generalisations cannot be made across disciplines. E.g. medical students and nursing students. |

Table 2.1: *Summary of Research Papers, continued.*

| Authors | Title & Publication | Research Design | Key Findings | Limitations |
|---|---|---|---|---|
| **Noh, C.**<br>Associate Professor, School of Nursing, Hallym University, South Korea.<br>**Arthur, D.**<br>Associate Professor, Department of Nursing and Health Sciences, The Hong Kong Polytechnic University, Hong Kong.<br>**Sohng, K.**<br>Associate Professor, College of Nursing, The Catholic University of Korea, South Korea. | Relationship between technological influences and caring attributes of Korean nurses.<br>International Journal of Nursing Practice. (2002). | Survey - sampling 560 Korean Nurses.<br>Instrument previously used in an international sample - reports comparative and contrasting data. | Identifies that 80% of the nurses sampled were aged less than 30, 70% had less than six years experience, 60% were diploma level.<br>Lack of experienced role models and senior professional nurses in the Korean workforce. | No reference is made to ethical considerations however the study was supported with a research grant from the Hallym Academy of Sciences, Hallym University, South Korea.<br>Limited focus on teaching and learning strategies employed in Korea.<br>Provided limited information regarding actual teaching and learning strategies used in Korean schools of nursing. |
| **Sun, J.**<br>Registered Nurse, Xinyang People's Hospital, Xinyang, China.<br>**Xu, Y.**<br>Registered Nurse, College of Nursing, University of South Alabama, USA.<br>**Xu, Z.**<br>Registered Nurse, Second teaching hospital, Henan Medical University, Zhengzhou, China.<br>**Zhang, J.**<br>Registered Nurse, College of Nursing, University of South Alabama, USA. | Baccalaureate nursing education curricula in the People's Republic of China.<br>Nursing and Health Sciences. (2001). | Content analysis of Bachelor Nursing education curricula in China. All Bachelor of Nursing programs were targeted = 22 with 18% return. (N=4). | Bachelor of Nursing programs are identified as the pinnacle of nurse education in China.<br>Three traditional five year curricula were compared and contrasted with the four year curriculum.<br>Identifies the dominance of the medical model in the five year curricula and the effort toward the differentiation of nursing from the medical model. | Determination of course content was based on the title of the unit rather than on an examination of the content or consideration for the teaching and learning strategies used. |
| **Xu, Z.**<br>Registered Nurse, Second teaching hospital, Henan Medical University, Zhengzhou, China.<br>**Xu, Y.**<br>Registered Nurse, College of Nursing, University of South Alabama, USA.<br>**Sun, J.**<br>Registered Nurse, Xinyang People's Hospital, Xinyang, China.<br>**Zhang, J.**<br>Registered Nurse, College of Nursing, University of South Alabama, USA. | Globalisation of tertiary nursing education in post-Mao China: A preliminary qualitative assessment. Nursing and Health Sciences. (2001). | A qualitative assessment of a systematic review of published and unpublished studies of Chinese nursing education.<br>Case studies of nursing programs training graduate nurses to advanced clinicians and faculty. | Highlights recognition by the Chinese nursing profession that nursing education must become integrated with the global nursing community.<br>Recognises the shift from a teacher centered approach to a student centered approach in nurse education and the change from an illness to health orientated framework with the role of nurses in health promotion.<br>An increase in collaboration of nurse educators and academics from other countries are contributing to Chinese nursing education. | The study compared nursing curricula and education outcomes without consideration for the teaching and learning strategies used. |

Table 2.1: *Summary of Research Papers, continued.*

| Authors | Title & Publication | Article | Key Findings | Limitations |
|---|---|---|---|---|
| **Wong, F.**<br>Associate Professor, Department of Nursing and Health Sciences, The Hong Kong Polytechnic University, Hong Kong.<br>**Chan, S.**<br>Assistant Professor, Department of Nursing, Chinese University of Hong Kong.<br>**Yeung, S.**<br>Registered Nurse, Hong Kong | Trends in Nursing Education in China.<br>Journal of Nursing Scholarship. (2000). | An exploratory descriptive content analysis of 345 manuscript abstracts presented at the Hong Kong nurse education conference describing trends in the development of Chinese nursing education.<br>The research was funded by the Hong Kong Nurses Training and Education Foundation. | Chinese nursing education development appeared in line with global trends. In 1996, Chinese nurse educators identified the importance of communication, total patient care and continuing nurse education and research and moving toward student centered learning. | The countries of origin of the 345 manuscripts or their authors are not identified.<br>Focus is on trends in Chinese nursing education development, with little emphasis on teaching and learning strategies.<br>Little emphasis on teaching and learning strategies reflecting student centered learning (SCL) with most approaches to learning centered on teachers. Methods of problem-based learning such as reflective learning seldom addressed. |
| **Yi, M.**<br>Assistant Professor, College of Nursing, Seoul National University, Seoul, Korea.<br>**Jezewski, M.**<br>Associate Professor, School of Nursing, State University of New York, Buffalo, New York. USA. | Korean Nurses' adjustment to hospitals in the United States of America.<br>Journal of Advanced Nursing. (2000). | Grounded theory research describing the Korean nurses' experiences of adjustment when working in USA health care settings. Constant comparison of semi-structured formal interviews. | The participants identified five key categories in the process of adjustment to working in the USA. Accepting USA nursing practice, relieving psychological stress, overcoming language barriers, adopting problem solving strategies and adopting styles of interpersonal communication.<br>Study comprised of two stages with the first stage lasting 2-3 years and the later stage taking an additional 5-10 years. | Small purposive sample of only12 nurses.<br>All of the participants had resided in the USA on average for 15 years, ranging from 1 to 23 which may have affected recall.<br>The study did not explore participants' previous learning and teaching experiences in Korea before their move to the USA. |
| **Shin, K.**<br>Associate Professor, Ewha Woman's University, College of Nursing Science, Seoul, Korea. | Critical thinking ability and clinical decision-making skills among senior nursing students in associate and baccalaureate programmes in Korea.<br>Journal of Advanced Nursing. (1998). | Comparison of senior nursing students enrolled in Associate Degree programs (n=119) and Bachelor programs (n=115) on measures of critical thinking and clinical decision-making skills. | The Bachelor of Nursing (BN) group scored significantly higher than the Associate Degree group in both critical thinking and clinical decision-making.<br>Critical thinking appraisal scale of 80 items with 5 sub scales measuring skills (1)inference, (2)recognition of assumptions, (3)deductions, (4)interpretations, (5)evaluation of arguments. Tested for internal consistency. | Although the results demonstrate a higher outcome for the BN group, the author notes that this may be due to differences in program selection and recruitment, rather than nurse education.<br>Further research is required to determine whether course work in the Bachelor program improved critical thinking skills or clinical decision-making skills. The article did not describe the teaching and learning strategies utilised in the Associate Degree programs or the Bachelor programs. |

Table 2.1: *Summary of Research Papers, continued.*

| Authors | Title & Publication | Article | Key Findings | Limitations |
|---|---|---|---|---|
| **Attard, A.**<br>Assistant Private Secretary at Ministry of Education, Employment and the Family.<br>University of Oxford, Collegio Europeo di Parma, L-Università ta' Malta.<br>**Di Ioio, E.**<br>**Geven, K.**<br>**Santa, R.**<br>Education International, European Student Union. | Student centered learning. An insight into theory and practice. (2010). | Advisory Committee Report based on an analysis of SCL literature including publications from European government and non-government institutions and other published and electronic materials particularly from academic journals. | This article discusses the definition of SCL and the conditions that need to be in place in order for implementation of a SCL approach.<br>Examines the professional development and training that is required for academic staff implementing a SCL approach to teaching and learning and provides an analysis of student experiences, perceptions and attitudes to the learner centered approach. | The authors are not nurses and the article does not relate to nurse education.<br>The article does not provide details of the critique of literature used.<br>The article refers to the use of SCL teaching and learning styles but does not consider the application of these strategies to students of Asian origin. |
| **Thompson, D.**<br>Registered Nurse, PhD, FRCN, FESC. Professor of Nursing and Director, Nethersole School of Nursing, Chinese University of Hong Kong, Hong Kong, China. | Evidence-based nursing in Asia: Enter the tiger.<br>Worldviews on Evidence-based Nursing. (2004). | Commentary on the issues and challenges involve with establishing Evidence-based learning (EBL) in some Asian countries. | Hong Kong and Thailand have embraced EBL with China just starting to do so.<br>In Hong Kong much of the effort of EBL is being focused on research, on the dissemination and implementation of evidence.<br>The author recognises the strong tradition of scholarship in China and sees this as strength for Chinese nurses to view EBL in a global context and make the paradigm shift to research to support EBL. | The article does not describe the teaching and learning strategies used to deliver EBL. |
| **Abraham, E.**<br>Principle of the PSG College of Nursing, India. | Pulse on health and nursing in India.<br>Nursing and Health Sciences. (2007). | Journal editorial. | Description of three major nurse education programs in India.<br>Describes the shortage of funding for Indian schools of nursing and the impact that this has on the development of Indian nursing programs.<br>Describes the impact of Western migration on nurse education in India. | Limited information regarding curriculum content or actual teaching and learning strategies used in Indian schools of nursing. |

Table 2.2: *Summary of N0n- Research Papers.*

| Authors | Title & Publication | Article | Key Findings | Limitations |
|---|---|---|---|---|
| **Lawson, L.**<br>**Dalglish, C.**<br>**Nelson, P.**<br>**Reese, M.**<br>Queensland University of Technology, Queensland, Australia.<br>**Haker, C.**<br>University of Applied Sciences, Berlin, Germany. | Student Voice: A powerful and realistic way to prepare students for study in Australia.<br>Paper presented at the 17th ISANA International Education Conference. (2006). | Primary research was not carried out for this paper however one of the authors was involved in the initial research identifying the different educational backgrounds that international students have experienced. | The introduction describes culturally diverse classroom behaviours and implications for transition to Australian higher education.<br>Lists viewpoints from both international students and teachers of international students.<br>The article recognises that Australian institutions need to be absolutely clear about the nature of the learning experience that they are offering students, not just in content, but the learning processes, and challenges of daily life. | The authors are not nurses and the article does not relate to nurse education.<br>The article is focused on the production of a DVD capturing a student perspective on life and study in Brisbane. |
| **Smith, D.**<br>National Institute of Industrial Health.<br>**Tang, S.**<br>University of Yamanashi. | Nursing in China: Historical development, current issues and future challenges.<br>Oita Nursing Science Research. (2004). | Expert opinion/commentary. | The early influence of Western nurse education in China.<br>Outline of the curriculum content in Chinese nurse education and the influence on cultural understandings of health.<br>Occupational health issues for Chinese nurses; burnout related to age, gender, and specialty area of work.<br>The future challenge for the Chinese health profession related to low nurse numbers and the reforms beginning to occur in Chinese nurse education to address the shortfall.<br>The strengthening the professional identity of nurses in contemporary China as a method of reducing low self esteem and increasing public respect for the profession. | The article does not provide details of the methods undertaken to compile the article or the critique of literature taken to support the claims in this report.<br>Much of the discussion in this article regarding curriculum content repeats already published findings without providing new or extended information.<br>The article does not provide details or critique of the research undertaken to identify the occupational health issues in the Chinese nursing profession. The educational programs being trialled to address the health issues, stating that they are beginning to show results but does not provide a critique of those results and the research undertaken to measure them. |
| **Samuel, S.**<br>Registered Nurse, Trained Nurses Association of India. | Today's nursing education: Vision for the future.<br>Nursing Journal of India. (2003). | Expert opinion/commentary. Keynote address. | Issues concerning the quality of Indian nurse education citing poor teaching infrastructure, poor clinical experiences, a lack of autonomy for both teachers and students, poor information technology. | The author does not cite the source of her comments but states that these have been her experiences. |

Table 2.2: *Summary of N0n- Research Papers, continued*

| Authors | Title & Publication | Article | Key Findings | Limitations |
|---|---|---|---|---|
| **Xu, Y.**<br>Registered Nurse, Second teaching hospital, Henan Medical University, Zhengzhou, China.<br>**Xu, Z.**<br>**Zhang, J.**<br>Registered Nurse, College of Nursing, University of South Alabama, USA. | The nursing education system in the People's Republic of China: evolution, structure and reform.<br>International Nursing Review. (2000). | Expert opinion and account of the nursing education system in China. | A description of Chinese nurse education programs available leading to the title of Registered Nurse and their equivalency to programs in the USA.<br>This article cites (as an advantage) that five year nursing curriculums are equal in duration to medical education programs in China, all bachelor nursing programs are physically located within major medical colleges and universities, physicians rather than nurse educators teach most of the courses and the resulting influence of the medical model assists nursing students to pursue economic and social mobility through the transfer to medicine in the last two years of study. | The article does not provide details of the critique of literature taken to support the claims in this report.<br>Describes a biomedical model of nurse education where physicians led technical care with little emphasis on caring in nurse education.<br>This article focuses on nursing education programs in China, with little emphasis placed on teaching and learning strategies. |
| **Creedy, D.**<br>Registered Nurse. BA(Hons) (Psychology), Grad. Dip. Ed., Lecturer, Department of Nursing Studies, Queensland University of Technology, Queensland, Australia.<br>**Horsfall, J.**<br>Registered Nurse. BA(Hons), MA(Hons), Senior Lecturer, Department of Nursing Studies, Faculty of Health Sciences.<br>**Hand, B.**<br>BSc, Grad. Dip. Ed., Grad. Dip. Science Ed. MApp SC (Science Ed), Lecturer, Faculty of Education, La Trobe University of Northern Victoria, Victoria, Australia. | Problem-based learning in nurse education: an Australian view.<br>Journal of Advanced Nursing. (1992). | Commentary on the issues and challenges in the conceptual change to Problem-based learning (PBL) in the transfer of nursing education from hospitals and the tertiary sector in Australia. | The article describes PBL principles used in teaching and learning practices that develop links between theory and clinical practice.<br>The pedagogy required for PBL particularly in relation to the role of the educator to empower students to take control of their own learning, create equality in the classroom and encourage positive student behaviours.<br>The article challenges beliefs about how students learn and identifies strategies for conceptual changes in teaching such as focusing on student ideas, creating cognitive dissonance and assisting the student to recognise their knowledge gaps.<br>The article identifies programs to assist faculty in making changes in their teaching styles. | The article does not provide details of the critique of literature used.<br>The article refers to Australian teaching and learning styles but does not consider the effectiveness of the strategies suggested if applied to international students. |

Table 2.2: *Summary of N0n- Research Papers, continued*

Following is a review of literature organised in sections reflecting nurse education in each of the countries of origin, followed by current teaching and learning practices in Australian nurse education.

### 2.3.2 China

As evidenced in the literature tables provided, available literature related to nursing education in China mostly focused on the development of the nursing profession and the content of nurse education curricula. Much of the research is based on secondary analysis and none of the studies found provided data on the teaching and learning strategies used in Chinese nursing education. More recent literature beginning to emerge does reflect the influence of the global nursing community in the recognition of the need to achieve education outcomes such as critical thinking ability, autonomy, professionalism, leadership, and therapeutic communication (Lee et al., 2011; Oh et al., 2011). However, to date only a few articles reflect this emerging trend.

In order to understand the present state of nurse education in China, it is important to understand China's history of episodic nursing education, the underlying cultural values that are inherent in the teaching and learning styles of Chinese nursing education, the influence of medicine on nurse education and the progress made to integrate Chinese nurse education with the global nursing community. Sheer and Wong (2008) have recognised the impact of the cultural revolution on the development of the nursing profession in China. Table 2.1 on the following page summarises the development of nurse education in China.

| | |
|---|---|
| **1999-2000** | Bachelor of Nursing programs start to recognise nurse education and research |
| **1998-1999** | Bachelor of Nursing programs increase from 18 to 67 but with limited admissions keeping graduate nurses at less than 1% of the 1.2 million Chinese nurse population |
| **1993** | A nursing framework is established to introduce exams and licensing |
| **1992** | First Master of Science in Nursing program commenced |
| **1983** | First Bachelor of Nursing program commenced as a four to five year program |
| **1980** | Nursing education recommenced |
| **1979** | Ministry of Public Health affirms significance of nursing creating a Nursing Services Division |
| **1966-1976** | Cultural revolution - all nursing education abandoned |
| **1961** | Postsecondary nursing education commenced, nurses able to enrol for further education |
| **1953** | Total abolition of all tertiary nursing education |
| **1952** | Peking Union Medical College reduced to a vocational institution |
| **1943** | WW2 - nursing schools closed down or occupied |
| **1930** | Secondary school nursing increased with hospital based programs of three / four years |
| **1920** | Nursing education influenced by Western curricula with first nursing program of five years at Peking Union Medical College |

Table 2.3: *Development of the Nursing Profession in China.*
Adapted from: Chan & Wong (1999), Sherwood & Liu, (2005), Shin, Shin & Li, (2002), Xiang-Dong & Acorn, (1999), Xu, Xu & Zhang, (2000).

In contemporary China, there are three levels of basic nursing education; health schools, college and university diploma and the more recent introduction of the Bachelor of Nursing degree also available at college or university (Sherwood & Liu, 2005; Ungos & Thomas, 2008; Wong, Chan & Yeung, 2000; Sun, Xu, Xu, & Zhang, 2001; Xu, Xu, Sun, & Zhang, 2001). Bachelor of Nursing education is perceived as the pinnacle of the system; however health school nursing, which is part of the traditional high school system, is the first certificate level in nursing and most dominant in China. Health schools train 95% of nurses

who are then provided with a licence to practice (Wong et al., 2000). The Diploma is the next level nursing program in China, offered to senior high school graduates as a three year course at college or university (Chan & Wong, 1999).

Chinese Bachelor of Nursing degrees at university level were divided into two basic programs: four year programs and five year programs incorporating required subjects and electives (Sun et al., 2001). Both programs included general education subjects such as English, mathematics, biology, computing, English language and some science, which were intended to lay a common foundation for all students regardless of academic majors. Professional foundation subjects included anatomy, physiology and pharmacology; and nursing subjects, for example, practice theory and clinical practice in the final year of the five year program. The professional foundation category was found to mirror the content for clinical medicine rather than nursing, with emphases on aetiology, pathology, diagnosis and treatment of disease processes and cure rather than on care (Smith & Tang, 2004; Sun et al., 2001).

Reliance on the medical model originates from a nursing faculty whose staff were initially trained as doctors and reassigned to teach nursing (Sun et al., 2001). After the 32-year cessation of higher nursing education, the retirement of these original teachers weakened the infrastructure even as programs were expanding. At the onset of the 1990's, most Chinese nurses had technical education but undergraduate bachelor education was sparse and further advancement of the profession was limited (Sherwood & Liu, 2005; Shin et al., 2002; Smith & Tang, 2004). The medical influence remained evident and nursing subjects were arranged according to specialties in clinical medicine with the subject titles remaining the same but prefixed and suffixed with 'nursing'. Sun et al. (2001, p. 232) describe this as 'watered down

doctoring' as it lacked the psychosocial and humanities base of nursing practice. The principles of Traditional Chinese Medicine and related knowledge and skills were also incorporated (Sun et al., 2001). The Chinese cultural understanding of health heavily influenced Chinese contemporary nursing practice with the premise that illness occurs when there is disharmony between the patient and their environment. As such, a large component of traditional Chinese medicine focuses on restoring this overall balance, rather than treating the symptoms, in some cases at the expense of Western pharmacology and science (Smith & Tang, 2004). In addition to pharmacology and science, content areas missing are: management and leadership; nursing research; and professional role development, each of which dominate significantly in Western curricula (Sun et al., 2001).

Traditional Chinese nursing education was characterized by conventional didactic or rote learning, with learners being the quiet and passive recipients of imparted knowledge with little interaction between the learner and the teacher. This situation was further reinforced by the examination-oriented approach to education in China, where students engaged in passive learning characterized by memorization, regurgitation of facts, and little encouragement to ask questions (Sun et al., 2001) or engage in discussion. Conformity was preferred over deviation from the norm, thus inhibiting the development of critical thinking, which is a hallmark of Western professional nursing practice (Xu et al., 2001). As a result, the Peking Union Medical College's recently launched quality education movement from teacher centered learning (TCL) to student centered learning (SCL) has been targeting these passive teaching modes (Chan & Wong, 1999; Shin et al., 2002; Sun et al., 2001; Wong et al., 2000). Methods of learning, such as problem-based learning, reflective learning, experiential learning and the process of problem solving were seldom utilised (Wong et al., 2000). However, it has been found that students entering Australia to study in Australian universities are immediately

confronted with these teaching and learning strategies which are in contrast with the Chinese students' past experiences (Australian Government, 2008; Lawson et al., 2006).

Subsequently, the Bachelor of Nursing curriculum in China has been altered to more closely meet nursing needs and objectives thus reflecting the professional role of the nurse. The goal was to make the Bachelor of Nursing degree globally compatible and more importantly, to build a model promoting nursing as an autonomous discipline within which critical thinking and problem solving were highly valued (Sun et al., 2001). This program structured nursing content according to six broad categories of human needs and functions: social interaction, reproduction, nutrition-elimination, oxygenation, activity-rest, and cognition-perception, rather than body systems and life stages which were dominant frameworks in the medical curriculum (Sun et al., 2001). In addition, new content areas were community health, professional development, nursing education, and nursing research (Sun et al., 2001). This content is more closely aligned with the curriculum content outlined in the Australian Nursing and Midwifery Council (ANMC) National Accreditation Standards and Criteria which has determined that the central focus of the course is to be nursing and contemporary nursing practice addressing foundation professional and contemporary nursing knowledge and skills, which emphasise health promotion, illness prevention and care of individuals, sick or well (Ryan, 2008).

In 2001, clinical practice in China comprised approximately 35% of the entire degree and was offered in blocks of clinical experience including clinical laboratories and observation only experiences on external placements under the direct supervision of a designated nurse preceptor-mentor. Initially, external clinical practice was only available in the final year of the five year degree, however in conjunction with on campus clinical

experience, external clinical practice became available as part of the four year degree also (Sun et al., 2001). However, Chinese clinical practice programs had minimal integration with academic curriculum content, further increasing the theory to practice gap. Allocating clinical placements towards the completion of the degree compromises the integration of theory to practice (Sun et al., 2001) a practice which is still evident today.

The integration of the Chinese nursing profession into the global nursing community is just beginning to create a shift from the traditional illness-orientated framework to the health-orientated framework with integrated categories of human needs and functions resembling Western nursing frameworks, and changes from the teacher-centered approach to the student-centered approach (Xu et al., 2001). Separate courses on psychiatric nursing, community nursing, geriatric nursing, nursing research, nursing ethics, nursing management and leadership have also been incorporated into the curricula to reflect global nursing education (Xu et al., 2001). As far back as 2000, Chinese nurse educators were preparing for a new generation of nurses, particularly in providing total patient care, but still with less emphasis placed on advanced nursing practice and the improvement of outcomes based on clinical practice (Wong et al., 2000). More recently, the China Nursing Development and Strategic Planning (2010) document has supported the development of advanced nursing practice, but development is still deterred by the late re-establishment of tertiary level nursing education and the high physician to nurse ratio (Sheer & Wong, 2008). However, this article does not provide details of the teaching and learning or curriculum content intended for use in this development.

Although the literature reviewed provides a comprehensive description of the development of nurse education programs and Bachelor of Nursing curricula in China with its

history of content focusing on disease and cure rather than the more Westernised health promotion and prevention and care, there was little information available in English about the actual teaching and learning strategies utilised in Chinese nurse education (see Summary of Literature at the beginning of this review) and many of the articles available on this topic appear to be descriptive discussions papers of the state of nurse education in China without sound critiques of the sources of information. There appears to be few studies focusing on the strategies utilised to deliver information to nursing students in China and what affect this has on the more recent focus on nurse education and research for the professional development of Chinese nurses and the profession.

### 2.3.3 Korea

As was the case for China, the initial literature available for Korea largely described courses and facilities available for nurse education, with little information available on the teaching and learning processes that Korean nursing students encounter in achieving nursing qualifications in Bachelor of Nursing or Diploma programs or the impact of these programs on graduate outcomes. The development of Korean nursing programs more closely reflected concepts from modern Western nursing which were introduced after the Korean War in 1953 and assisted in the independence of nursing education from a medically dominated model where directors of nurse education centres were Doctors (Lee, 2000) similar to the situation in Chinese nursing development, and the content of nurse education was low in quality (Lee, 1991).

The independence of Korean nursing resulted in an expansion of nursing education which set the pace for the growth of nursing and called for an increasing number of skilled practitioners (Lee, 2000). In 2002, a two-tiered nursing program was established with 48

universities providing Bachelor of Nursing education for intakes of about 2,325 students per year, ultimately providing administrative, education and research qualifications. In conjunction with those universities, in 2005, there were 65 junior colleges providing diploma qualifications for a further 8,661 students per year (Lee, 2005). Licensing, regulated by the Ministry of Health has been required since 1962 which is obtained through successful completion of a licensing exam after graduating from the four year Bachelor of Nursing program or a three year Diploma program (Lee, 2005) also similar to other Asian countries.

The educational goals of Korean universities aim to cultivate the nursing student's critical thinking ability and the promotion of continuous self-development by combining theoretical education and clinical education (Kang, Choi, & Ryu, 2009). However, the majority of Korean nurses working in the clinical area did not have university level preparation. The National League for Nurses in 1989 stated that the Bachelor of Nursing curriculum must reflect critical thinking and synthesis of learning in order for nurses to become decision-makers, and that this skill can only be improved by the completion of a Bachelor's degree (Shin, 1998; Shin et al., 2002). In 1998, Shin compared Korean nurses enrolled in associate degree programs and bachelor programs on measures of critical thinking ability and clinical decision making skills. Two hundred and thirty four nurses were sampled and findings indicated that nurses enrolled in the bachelor programs demonstrated more advanced critical thinking ability and clinical decision making skills. The author of this study did acknowledge however, that the results may have reflected the initial differences in intelligence and resulting program selectivity rather than critical thinking skills being encompassed in Korean nurse education (Shin, 1998).

In 1998 Shin found that critical thinking and decision making ability in clinical practice were a concern for Korean nurses and research to measure critical thinking was undertaken. This same research found that nursing education has focused solely on providing facts and rote memorization instead of providing students with opportunities to think critically with flexibility in dynamic situations, and on knowledge-based evaluations based on stereotypical answers for given questions instead of providing an education that enables nurses to make accurate decisions based on critical thinking in clinical situations (Shin, 1998). However, this dated literature reflected the differences of participants' critical thinking and decision making ability in Associate Degree programs and Bachelor programs. The study does not clarify whether teaching and learning strategies used in each of the programs influenced critical thinking and decision making ability or whether different student entry behaviours reflected the higher scores in the Bachelor of Nursing (Shin,1998).

In their study describing the Korean nurses' experiences of adjustment when working in the United States of America (USA) health care settings, Yi and Jezewski (2000) findings supported those previously observed by Shin, that Korean nurses entering the USA experienced problems with differences in decision-making styles, teaching and learning strategies and expectations of the professional role. This study sampled 12 nurses who had resided in the USA on average for 15 years but did not explore participants' previous learning and teaching experiences in Korea before their move to the USA.

More recent literature has explored Korean nursing education outcomes in terms of critical thinking ability, knowledge integration, curative nursing interventions, human caring relationships, professionalism, management and leadership and communication in undergraduate nursing students (Lee et al., 2011; Oh et al., 2011). The studies recognise the

importance of these competencies in the clinical workplace and both make a comparison of the nursing student's level of competency on completion of three year Associate Degree and Bachelor programs but do not describe the teaching and learning approaches used to achieve the measured outcomes. These studies mark the Korean nursing professions move into the global nursing community with the direction of research being undertaken, however these studies of the critical thinking, professionalism, leadership and communication in Korean nurses do not identify the teaching and learning strategies utilised to achieve these educational outcomes.

### 2.3.4 India

As with the Chinese and Korean literature above, the literature describing the teaching and learning strategies experienced by Indian nursing students was scarce. The available literature highlighted the limited facilities available to support nurse education and the improvements being made by the Indian Nursing Council (Samuel, 2003). Nursing education in India is regulated by the Indian Nursing Council which safeguards the quality of nursing education in the country through the administration of syllabi, inspection, examination, certification and registration (Samuel, 2003). Current courses in nursing are both at Diploma and Degree levels. Diploma courses include the auxiliary health worker course of six to twelve months duration; and the General Nursing and Midwifery Diploma of three years (Samuel, 2003). Students new to higher education complete a Bachelor of Science – Nursing, of four years duration and the Post Basic Bachelor of Science – Nursing, is offered to practising Diploma nurses who wish to continue their education (Samuel, 2003).

In 2007, the Indian Nursing Council had in excess of 2,100 schools offering auxiliary courses such as, the General Nursing and Midwifery Diploma; and the Bachelor of Nursing

(Abraham, 2007). Despite the large numbers of colleges, universities and students, Samuel (2003) described the facilities for nursing students in India as consisting of poor classrooms and laboratories with limited teaching manpower and poor resources such as library facilities, books, journals and internet access. Additionally, students struggled with inadequate clinical opportunities which resulted from an over weighted curriculum in course content and hours, and a lack of support for student status resulting in external pressures that sacrificed students for service. Additionally, nursing faculty lacked not only opportunities to attend conferences or workshops for further development of teaching and learning strategies, but also autonomy in enrolment procedures which resulted in poor selection of students and poor academic outcomes (Samuel, 2003).

In 2002, Indian National Health Policy recognised the need to improve the education and skill level of nurses as well as improve facilities for university preparation and placement of nurses in primary health centres. In line with this policy, major developments implemented changes to improve nurse training. Changes which were introduced saw the curriculum revised for nursing courses: nurses being trained within clinical specialities; the preparation of additional specialty courses administered through the Indian Nursing Council such as the provision of post graduate courses for nurses; improved staffing for nurse education; the strengthening of regulatory mechanisms and improved funding of nursing services (Samuel, 2003).

The clinical nurse education situation in India is similar to the academic situation in the nursing schools. Health workers, who are the least qualified of the profession, remain in the clinical area to provide clinical education to those nursing students fortunate enough to have the opportunity to experience clinical practice. In a survey of government and private

hospitals, and schools and colleges of nursing, Thomas (2006) found that despite improvement in the Indian National Health Policy, better-educated nurses were particularly prone to migration, citing higher income, improved living conditions and job prospects abroad. Of all the categories of nurses, only the community health worker (who has a lower level of education than the General Nurse Midwife or the Bachelor of Nursing – trained nurse) is allowed to administer medications or provide treatment to patients (Thomas, 2006). This leaves graduating nurses, with a higher-level qualification but with a limited scope of practice seeking to practise abroad. If these nurses with higher-level qualifications were able to practise, improved supervision would be available for student nurses and the clinical education of nurses would improve with a positive effect on the entire nursing community in India (Thomas, 2006).

As was the case with China and Korea, much of the available literature pertaining to Indian nurse education is descriptive and centered on curriculum and nurse education policy. There appears to be no research literature available on the teaching and learning strategies employed to prepare nurses.

## 2.4 Teaching and Learning in Australian Nursing

Over the last twenty years, Australian nurse education has undergone major changes which impact on the teaching and learning experiences of all students. By 1993, pre-registration nursing programs in Australia had transferred from hospitals to the higher education sector. The transfer aimed to produce skilled, educated and proactive professional nursing graduates eligible for registration, and to foster the development and practice of nursing through graduate studies where the student was regarded as a student rather than a

trainee, where an atmosphere of learning prevailed, and learning could occur more readily (Creedy, Horsfall & Hand, 1992).

With these changes in Australian nurse education, a teaching and learning approach to facilitate education guided by real-life problems addressing cognitive, pedagogic and practical aspects of implementing SCL was being embraced (Attard, Di Ioio, Geven & Santa, 2010). SCL approaches place the student at the heart of the learning process, replacing lectures with active learning, integrating self-directed learning and collaborative group work, ultimately holding the student responsible for their own education whereas TCL approaches describe the student as passive receptors of information not needing to actively participate in the learning process (Attard, 2010). Within the classroom, the practical implementation of a SCL approach included components; such as group project work, student centred active learning, problem-based learning, resource-based learning, use of the case methods and analyses, role plays, classroom workshops, group presentations, use of web-conferencing environments to enhance student discourse and interaction in distance education, and the use of learning logs for students to record their educational experience (Attard et al., 2010).

This study on SCL strategies and approaches was conducted to increase the capacity of student and staff organisations to be active partners in these changes. The project aimed to provide a comprehensive insight into the necessary tools and already-encountered challenges and success in SCL (Attard et al., 2010) but the study did not explore the changes which need to be considered to address the needs of Australia's cohort of international students. There is little available literature addressing the impact of SCL on the overseas educated nurse and their previous experiences in this approach or its impact on their experiences as students in Australia.

Wang et al., (2008) explored the learning experiences of Taiwanese nursing students in Australia, and identifies a number of obstacles to learning encountered by these students when studying in Australia. Participants in this study cited difficulties due to unfamiliarity with teaching strategies and styles such as independent research and engaging in critical argument, presentations and group work (Wang et al., 2008). Overseas educated nurses with English Second Language (ESL) often have slower reading skills and difficulties with grammar and expression, all of which contribute to their difficulty adapting to Australian teaching and learning strategies (Wang et al., 2008). The previous teaching and learning approaches experienced by overseas educated nurses in their homeland had an influence on those nurses' expectations when studying in Australia, including their expectations of teachers and fellow students and they struggled with the collaborative learning environment promoted in Australia (Wang et al., 2008). However, the snowball sampling technique in this qualitative study with a sample of only 21 participants from Taiwan, means that the results cannot be generalised to Taiwanese students and are not applicable to overseas educated nurses from China, Korea and India as in the focus of my study.

The SCL approach in Australian nurse education is based on inquiry and questioning and requires teaching and learning processes that assist individual learners to reflect critically on the validity of their assumptions and engage in discussions with others (Kiely, Sandmann & Truluck, 2004). This inquiry based reflective approach can leave the overseas educated nurse who has not experienced a student centred teaching and learning environment, struggling when required to engage in independent critical thinking and problem-solving activities (Wang et al., 2008), as they make comparisons with the familiar educational practices of their home country (Sidoryn & Slade, 2008) resulting in a loss of confidence and

failure to achieve. This situation highlights the need for a clear understanding of the issues impacting the overseas educated nursing student, the learning styles that they have experienced and the strategies required to address any mismatch in teaching and learning approaches when studying in Australia.

## 2.5 Summary of Literature

As reflected in the background of this thesis, higher education students in Australia are expected to engage in independent active learning for which overseas educated nurses may not be prepared (Australian Government, 2008; Lawson et al., 2006). Learning is influenced from past experiences which make up personal perspectives that assist in guiding observations, interpretations, and actions. Different learning environments impacts on student patterns of classroom behaviour and students with little prior experience of SCL were often inadequately prepared for Australian classrooms resulting in poorer outcomes where group interaction and collaboration is an expectation (Clark & Baker 2006; Clark et al., 2007; Lawson et al., 2006).

Clearly, overseas educated students will have differing past experiences from Australian domestic students, both from their experience of teaching and learning and from a socio-cultural context. In the attempt to address the differences, the overseas educated student enters the Australian higher education system which values questioning of current knowledge, questioning the beliefs of others and forming one's own opinion, all of which can be uncomfortable and confronting for overseas educated students (Seibold et al., 2007). In their study evaluating a program to support international nursing students undertaking an accelerated Bachelor of nursing, Seibold et al. (2007) identified key barriers to learning confronting Asian nursing students in Australia. The key barriers were that the overseas

educated nurses were not familiar with teaching and learning strategies used in Australian Bachelor of Nursing programs such as reflective journaling, therapeutic communication, information technology and clinical nursing skills, and included general issues such as communication difficulties, cultural differences and unfamiliarity with the healthcare environment.

As outlined in the Bradley Review, in the global education community, Australian higher education needs to improve opportunities for those from all backgrounds to participate to their full with access to flexible teaching and learning (Australian Government, 2009). However, it cannot be assumed that overseas educated nurses who have attained the title of 'Registered Nurse' in their homeland have had the equivalent preparation of their colleagues in Australia. In order to facilitate the overseas educated students' transition to Western teaching and learning styles, and to address the gaps in the available literature, the following research question has been developed: *What were the teaching and learning strategies most commonly experienced by overseas educated nurses from China, Korea and India in their previous nursing courses in their homeland?*

## 2.6 Conclusion

The review of literature provided in chapter two has outlined relevant key issues including significant gaps in research relating to the teaching and learning strategies utilised by nursing students in higher education in China, Korea and India. Very little research was found that provided insight into the academic teaching and learning processes or the clinical preparation that overseas educated nurses experience, particularly for those who originate from China, Korea or India. Recent research surrounding nurse education in China and Korea does indicate a movement from teacher centered teaching and learning strategies to more

student centered teaching and learning practices, however the strategies being utilised in this move are not yet visible in the English-language literature which appears to be directed towards identifying outcomes rather than the processes involved in generating those outcomes. Literature gaps of this nature have contributed to the necessity of this research study.

The following chapter will discuss the methodological approach taken in this research study along with the sampling method for participant selection, the method and instruments used for data collection and the data analysis methods that were utilised. Chapter three will also provide an explanation of the measures taken to ensure validity of the study and the ethical considerations for participants taking part in the study.

# CHAPTER THREE

# RESEARCH DESIGN

## 3.1 Introduction

The previous chapter examined the literature that relates to and underpins the research topic. The research design addresses the research question: *What were the teaching and learning strategies most commonly experienced by overseas educated nurses from China, Korea and India in their previous nursing courses in their homeland?* This chapter presents the methodological approach used to guide the research study, the research methods used for data collection and analysis, and the rationale for the approach and methods. The methods for participant selection and the ethical considerations and processes of data analysis are also explained.

## 3.2 Research Design

An exploratory descriptive design was chosen for this study because the research question asks 'what?', and there is limited literature available about the topic (Taylor et al., 2006; Wood & Ross-Kerr, 2011). Exploratory studies are the initial step in the development of new knowledge based on the assumptions that the sample participants have personal experience of, or knowledge about, the topic. Descriptive designs examine characteristics of a specific population to build knowledge about the topic in order to answer a research question and require self-reporting directly from research participants when the variables cannot be measured by instruments, or observed (Taylor et al., 2006; Wood & Ross-Kerr, 2011). This study aimed to develop new knowledge about the topic from participants who have the characteristics and personal experience/knowledge of the topic, therefore the study fits within exploratory descriptive design parameters.

The research methodology chosen initially to answer the research question aimed to measure the frequencies of selected objective variables identified in the literature (Polit & Beck, 2012) using a quantitative questionnaire only. The questionnaire also invited participants to provide qualitative comments to supplement the quantitative data. However, few participants responded to this invitation, so, following additional ethics approval, further data collection was undertaken using focus group interviews.

As this was an exploratory descriptive study with limited literature available on the topic, there were no existing instruments that could be used to gather the data required. A specifically designed questionnaire (the International Student Nurse Questionnaire (ISNQ)) was developed to gather a wide range of data from as many participants as possible in order to answer the research question. At the time of its design the questionnaire was not intended to be used for any other study; therefore the instrument was not tested for reliability and validity.

### 3.3 Research Methods

The use of the two research methods outlined above provides strength in this study because a single method can never adequately shed light on a phenomenon and using multiple methods can help facilitate deeper understanding (Denzin & Lincoln, 2005; Grbich, 2007; Taylor et al., 2006). Multiple methods provide the benefit of triangulation which is a validation or verification technique for corroborating findings and ensuring validity, and assumes that a weakness in one method will be compensated by the other/s (Denzin & Lincoln, 2005; Grbich, 2007; Taylor et al., 2006). Focus group interviews were conducted to compensate for the lack of participant comments on the completed questionnaires. Although

the questionnaire provided data confirming available literature with some new knowledge, the focus groups allowed the participants the opportunity to further describe their personal experiences adding rich and deep context to the questionnaire data. The processes of data collection for both methods are explained in further detail including questionnaire development and focus group design.

### 3.3.1 Questionnaire Development

The ISNQ was designed to meet the objectives of the study (see Appendix D to view the ISNQ). Questions included in the ISNQ arose from the literature and from my experience in teaching overseas educated nurses. The literature that led to the question formation is identified in the following paragraph. The questions elicited demographic information and teaching and learning strategies experienced as student nurses and qualified nurses in their homeland. The questionnaire was structured in four sections and comprised of a mix of 'tick the box' questions using a five point Likert scale with an invitation for comment at the end of each section.

The first section gathered demographic data, including the participant's country of birth, the country in which they had lived the longest and completed their previous nursing education and education in Australia. This section provided data on the location of the student's prior teaching and learning experience. Sections two and three examined the academic and clinical experiences of the participants as student nurses in their homeland using a similar format. Many of the questions in this section were informed by literature describing the learning environment of Asian students in general, i.e. references to rote learning and memorisation and the role of the Asian student as a passive recipient (Watkins & Biggs, 1996; Wong, 2004). Literature pertaining specifically to nursing students mirrored

some of the above findings confirming a teacher centered surface approach to learning but also described the teaching and learning environments for nursing students in each of the countries of origin (Chan, & Wong, 1999; Lee, 2005; Lee, 2000; Lee, 1996; Smith & Tang, 2004; Sun, Xu, Xu, & Zhang, 2001; Ungos & Thomas, 2008; Wong, 2004; Wong, Chan, & Yeung, 2000; Xu, Xu, Sun, & Zhang, 2001; Xu, Xu, & Zhang, 2000; Yi & Jezewski, 2000; Yu, 2008). Literature pertaining to the teaching and learning expectations in the Australian nursing environment also assisted with the development of questions for the questionnaire (Australian Nursing and Midwifery Council, 2006; Australian Government, 2011b; Hawthorne, 2001; Magnusdottir, 2005; Magnussen & Amundson, 2003; Parker & McMillan, 2007; Ryan, 2008). Those participants who had not worked in their homeland as a qualified nurse had completed the questionnaire at this point as section four examined the participants' clinical experiences in their homeland since gaining their qualification and followed a format similar to section three.

Following ethics approval (see Appendix A), the ISNQ was piloted to ensure that differences in the participants' education experiences and cultural backgrounds would not result in misinterpretation of the questions. Nine overseas qualified nursing students representing the three countries in the study and who had almost completed the Bachelor of Nursing with recognised prior learning consented to pilot the questionnaire. The pilot identified minor issues with interpretation of some terms and these were amended. Overall feedback from the students demonstrated that the questionnaire was relatively easy to understand and could be completed within the anticipated timeframe of thirty minutes. The data obtained from this cohort were not included in the final study as the length of time that these students had been attending university in Australia was outside the criteria used for selection.

### 3.3.2 Focus Group Design

Focus groups are useful in exploratory research for creating new ideas, collecting unique thoughts and identifying needs, expectations and issues with which theoretical constructs and theories can be generated (Fern, 2001; Grbich, 2007; Taylor et al., 2006). The findings of the ISNQ guided development of the focus group trigger questions to address gaps in the data. For example, focus group trigger questions asked "What were the most helpful teaching and learning experiences that you had in (homeland)?" and; "How are clinical practice experiences for students provided in (homeland)?" The ISNQ provided a list of teaching and learning strategies designed to describe the experiences that the participants may have had. The participants could indicate the frequency of their experience of these strategies but the ISNQ did not indicate whether the participants found these strategies of benefit or value. Since the expected outcomes of this study include facilitating transition to university study and practice in Australia for overseas educated nurses and the preparation of academic staff for the range of entry behaviours with which these students may present, it was important to explore the participants' experiences of teaching and learning in their homelands. The lack of ISNQ narrative data limited the richness and depth of findings resulting in the need for focus groups.

## 3.4 Research Participants

Purposive sampling was used in this study with participants intentionally selected because they had knowledge which would address the research question (Cresswell & Plano Clark, 2011; Morse, 1994). The inclusion criteria for the questionnaire required that participants:

- were overseas educated student nurses who completed their initial nursing qualification in China, Korea or India, and
- enrolled in the Bachelor of Nursing with recognised prior learning, and
- had completed no more than three months of study in the Bachelor of Nursing.

Participants from China, Korea and India were selected as there was an increase in the number of overseas educated nurses from these countries entering Australia to study at the time the research was proposed, as explained in Chapter one. The time limit of three months was determined to ensure that all participants had less than one semester of exposure to Australian university nurse education in order to maximise recall of their teaching and learning experiences in their homeland. The time limit also allowed for the participants to settle into the university environment, overcome initial feelings of homesickness and develop language skills which would assist in their comprehension of the ISNQ. Participant recruitment required access to the university enrolment database and timetable to identify students who met the inclusion criteria and when they would be on campus.

### 3.4.1 Questionnaire Participants

Originally, it was predicted that two intakes of students would provide a total population of 139 students from the three countries who would meet the inclusion criteria. Although the proportion of Korean students who accepted offers and enrolled was less than expected from previous years and much lower than the other two countries, Korean students were nevertheless included to enrich the data.

The February intake provided 22 participants from 58 enrolments however the July intake resulted in lower than expected enrolment numbers with only 28 of the projected 81 enrolments. For this reason, a third intake of students was included in the population to be sampled. Ethics approval was obtained to extend the data collection period to Semester 1, 2010. As before, to ensure consistency between the groups of participants, data collection was not carried out until all students had been on campus for three months. From the additional 40 students enrolled and who met the inclusion criteria, a further 18 participants were recruited to participate in 2010. This final stage of the ISNQ data collection was completed in May 2010 with 50 participants in total as summarised in Table 3.1 below.

| Country | Group A - February 2009 | | | Group B - July 2009 | | | Group C- May 2010 | | | Participant Response Rate | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Population | Participants | | Population | Participants | | Population | Participants | | | |
| China | 37 | 15 | | 6 | 6 | | 30 | 13 | | 34 | 46.5% |
| Korea | 6 | 3 | | 1 | 1 | | 2 | 2 | | 6 | 66.6% |
| India | 15 | 4 | | 21 | 3 | | 8 | 3 | | 10 | 27.7% |
| Total | 58 | 22 | 38% | 28 | 10 | 36% | 40 | 18 | 45% | 50 | 39.7% |

Table 3.1: *Population and Participant Totals – May 2010.*

Potential participants for the questionnaire were contacted in their classrooms. A suitable time to complete the questionnaire at the end of a class was determined through consultation with relevant staff. At the commencement of the selected class, the teacher informed the students that a student researcher would visit at the end of the class and all students in the class were invited to stay to hear about the research.

### 3.4.2 Focus Group Participants

The focus group participants included students who took part in the ISNQ questionnaire and more recently arrived students who met the inclusion criteria. The participants were invited through their student email with information about the research and the level of involvement required. The email included examples of trigger questions planned (see Appendix E) so that participants were aware of topics for discussion. Five focus groups were conducted between June and September, 2010 with a total of 22 participants. Each group was comprised of students from one ethnic origin with up to six participants per group (see Table 3.2) to facilitate understanding and discussion and capitalise on their shared experiences, with minimal discomfort from language and cultural differences (Polit & Beck, 2012).

| Focus Group | Country of Initial Qualification | Total |
|---|---|---|
| **1** | China | 6 |
| **2** | Korea | 3 |
| **3** | China | 5 |
| **4** | China | 5 |
| **5** | India | 3 |
| **Total Participants** | | **22** |

Table 3.2: *Focus Group Participants – September 2010.*

## 3.5 Ethical Considerations

Ethics approval was obtained prior to all stages of data collection. The key ethical issues for this study were: vulnerability of a minority group; fully informed consent for English Second Language (ESL) students and; confidentiality. Storage of data is also discussed.

### 3.5.1 Vulnerability of a Minority Group

As the participants in this study are a vulnerable minority group, consideration was given to language difficulties and cultural and environmental differences (Hoffmeyer & Cecchin, 2001; Magnussen & Amundson, 2003) in recruitment of participants, obtaining informed consent and individual responses to the study. As I was a tutor and clinical teacher in several units of study for this cohort of students, I was aware during recruitment processes that the students may feel coerced into participating in the study due particularly to their cultural beliefs and respect for teachers (Lee, 1996). Coercion, a sense of coercion, or a feeling of alienation was avoided by reassuring all students that they were not obliged to participate, and that questionnaire completion or focus group participation were in no way linked to their studies, academic performance or personal standing with myself as a teacher or within the university. When introducing the research to potential participants, each student was given the opportunity to decline to participate or later withdraw. To further eliminate any feeling of coercion, after introducing the research, students were left to peruse the information letter provided, and decide whether they wished to participate in the study prior to commencing data collection.

Although this study was of negligible to low risk to the participants, student support was available and students could withdraw without reason. If completing the questionnaire or participating in focus group discussions invoked any anxiety or discomfort for the participants, counselling was made available through the university student services. Information on counselling services was included in the information letters (see Appendix C & F).

### 3.5.2 Informed Consent

In ensuring informed consent was given by this vulnerable group of students who have English as a second language, information on the study was provided in the information letters and reiterated verbally prior to each stage of data collection. I carefully explained and answered questions to clarify the purpose of the study and process of data collection. Completing the questionnaire was considered inferred consent to participate in the study.

Prior to commencement of focus group discussions, I introduced the study and the focus group process to the participants to ensure that they were fully informed. To respect the participants' autonomy, I left the room to allow them time to consider and complete the written consent form (see Appendix G). A copy of the consent was retained by both the participant and the student researcher.

### 3.5.3 Confidentiality

The completed questionnaires were identifiable only by the participants should they have wished to withdraw from the study. Each participant assigned a code which only the individual student would know: their mother's date of birth in a six (6) digit format (dd/mm/yy), on the front page. The completed questionnaires were collected and secured confidentially by the research assistant, who then returned them to me, as the student researcher. Only my immediate research supervisors and I had access to the questionnaires during the study. Prior to commencement of the focus group interviews all participants were reminded of the confidentiality of the discussions which should not be discussed outside the focus group. All identifying information in the focus group data transcripts was excluded and participants' names were replaced by pseudonyms.

### 3.5.4 Storage of Data

All paper copies of questionnaires, consent forms and transcripts gathered for the project were securely stored in a locked filing cabinet in a locked office on the university campus. Electronic copies of data including recordings and transcripts have been stored on a password protected external hard drive and stored in the locked office. On completion of the study, the data will be stored in the research supervisor's office on the campus for a period of five years. Following the five year period all data will be destroyed by deletion of electronic copies and shredding of questionnaires.

## 3.6 Data Collection

Two methods of data collection took place within an eighteen month period using questionnaires and focus groups.

### 3.6.1 Questionnaire Data Collection

Questionnaire data was collected over three semesters using the same process each time. Following introduction of the research by the researcher who then left the room, a research assistant who had no involvement in teaching the participants distributed the questionnaires and stayed to assist the participants with interpretation, if required, during completion of the questionnaire. The personal contact with the research assistant and the allocated timeframe aimed to provide a high return rate by reducing the risk of the questionnaire being abandoned (Taylor et al., 2006). The research assistant collected the completed questionnaires and returned them to me in a sealed envelope. Refreshments were provided in consideration of interrupted meal or break times.

### 3.6.2 Focus Group Data Collection

Five focus groups were conducted following analysis of the questionnaire data. Each focus group was held in a small private conference room, with the furniture arranged to facilitate conversation (Polit & Beck, 2012). During introductions refreshments were provided to create an informal, relaxed atmosphere. Two tape recorders were used to ensure accuracy when transcribing data from the focus group discussions. The recording devices were in open view and the participants were aware when recording commenced.

Trigger questions (see Table 3.3) generated from the questionnaire data and the literature were tailored to each focus group depending on the country of origin to ensure that the participants felt that the questions pertained to them, and their homeland experiences were the primary focus (Borbasi, Jackson & Langford, 2008). Additional questions were used when required to refocus the discussion however it was not necessary to use all the pre-planned questions. Table 3.3 provides examples of trigger questions used to initiate focus group discussions.

| **Examples of guided questions used during Chinese focus group discussions.** |
|---|
| What were the most helpful teaching and learning experiences that you had in China? |
| Could you please provide an example of how a formal lecture was conducted in China? |
| What strategies did you use if you had a question during the lecture? |
| How are clinical practice experiences for students provided in China? |
| How did the on-campus clinical experience prepare you for your off-campus clinical experience? |

Table 3.3: *Focus Group Trigger Questions.*

## 3.7 Data Analysis

In keeping with the sequential mixed methods approach that evolved for this study, data analysis was conducted in two stages. Analysis of the ISNQ data used SPSS© software to assist with the descriptive statistical analyses required. The focus group data analysis followed Braun and Clarke's six phases of thematic analysis (2006).

### 3.7.1 Questionnaire Data Analysis

This exploratory descriptive study sought to identify the frequency of particular independent variables (teaching and learning strategies, resources or interactions) from the experience of nurses educated in three different countries of origin. Prior to analysis the data were screened. This included checking for maximum and minimum values, out of range values and the number of valid and missing cases to ensure that the data set was as error-free as possible (Pallant, 2007).

The Chi-square test for goodness of fit was used to measure the proportion of cases that fitted into a single variable and so also assisted with the identification of missing data (Pallant, 2007). To ensure accuracy of categories, data were regularly audited for categorical errors, for instance, checking for values which fell outside the possible range. Frequency distribution was used to identify the number and percentage of responses for each variable. Descriptive statistics were used to analyse the questionnaire data (Polit & Beck, 2012) and make comparisons of the findings. Crosstabulation was used to make comparisons between each of the countries of origin (Pallant, 2007).

### 3.7.2 Focus Group Data Analysis

Thematic analysis was used to analyse and synthesize the focus group data as it is a theoretically flexible approach detecting patterns and regularities as well as inconsistencies in qualitative data (Polit & Beck, 2012). Qualitative enquiry can utilise various means to achieve its aims and methods. The practical activities of generating and interpreting data to answer questions about the meaning of what others are doing and saying and then using that information requires a continuous process of critical reflection and analysis (Schwandt, 2000). For this analysis the Braun and Clarke method of data analysis provided clear guidelines to start thematic analysis and conduct it in a deliberate and rigorous way (Braun & Clarke, 2006). Braun and Clarke argue that their widely-used qualitative analytic method offers an accessible and theoretically-flexible approach to analysing qualitative data (2000). Six phases of thematic analysis as described by Braun and Clarke (2006) were used for guidance and support in the analysis of the emerging themes. These were:

1. Researcher becomes familiar with the data.
2. Initial codes are generated.
3. Potential themes are identified.
4. Themes are reviewed to ensure they reflect the coded extracts and data set.
5. Themes are defined and named.
6. The report is produced with a selection of vivid compelling extract examples relating back to the research question and literature.

The first phase of becoming familiar with the data was achieved by conducting all five of the focus groups and subsequent transcription of the data myself. This familiarity with the data was achieved by constantly reviewing the transcripts for accuracy against the original recordings, both during transcription and the following phases of analysis.

In phase two, initial codes were generated by reviewing the transcripts word by word and line by line to ascribe meanings to the data. Initially numerous codes were generated. Data were coded with clear definitions to reflect the research question through a continuous back and forth process of searching for relationships between the data, including literature reviewed and the questionnaire data (Braun & Clarke, 2006). Many notes were made as I attempted to identify patterns of interest in the data which would then help me to identify themes as they emerged. As part of the analysis, I had to determine which patterns of interest were of greatest relevance to the research question (Polit & Beck, 2012). A code book was used to record the definitions of each code and ideas and continually referred to throughout the analysis to ensure consistency.

In the third phase, potential themes emerged as links were identified between the codes and patterns of meaning (see Table 3.4). The themes captured important aspects of the data in relation to the research question, without inferring that they contained the most frequently occurring data (Braun & Clarke, 2006) but that they best conveyed the messages of the participants. As the data were coded, contextual data were included which were not necessarily required in the themes but ensured that the context and rich meaning of the emerging story would not be lost. For example, although the focus of the study is the participants overseas nurse education experiences, data on their Australian nurse education experiences were included where they support the context of the findings. Table 3.4 on the following page illustrates the initial in-vivo codes collapsed into sub-themes and themes in accordance with phases two and three of Braun and Clarke's thematic analysis. Note that the in-vivo codes are derived directly from the language of the focus group participants in the transcript and have been condensed into broader sub-themes and themes to reflect the objectives of the study (Polit & Beck, 2012).

| Phase 2 | Phase 3 | |
|---|---|---|
| **Codes** | **Sub-themes** | **Themes** |
| Chapter 1, chapter 2 | Follow the textbook | They will tell you definitely what you need to do |
| Hold your hand | | |
| We just write | Copy and learn | |
| It's about the memorise | | |
| Just follow the nurse | Just follow orders | |
| What the doctor said | | |
| It's about the score | Listen and keep silent | We hardly talk to each other |
| Listen, listen, listen | | |
| Don't hands up | Not in front of them all | |
| We will not ask questions | | |
| We never explain | You do not need to say something | |
| You don't have to tell anyone | | |
| The teacher gives everything to us | Finding resources | Everything is prepared for us |
| They have prepared notes | | |
| They say the definite answers | The teacher must push us | |
| Teachers have the pressure | | |
| It's already compared | The doctor has prepared it | |
| It's easy for us | | |
| Demonstrations in detail | You have to do this, then do that - perfect | Follow the strict procedure |
| Watch and then do | | |
| Focus on the strict procedure | This is a rule – just follow it | |
| They don't allow us to be individual | | |
| Disadvantages | It's not real | |
| I belong to her | | |
| Practise on mum | You needed to do it | It's just a task |
| They need to know | | |
| Beds and vital signs | If you don't know, just do it | |
| So just do it | | |
| It's not really written | Just grab the paper | |
| They need to draw the lines | | |

Table 3.4: *Theme Development.*

Phase four required that the themes and transcripts were repeatedly reviewed to ensure that the participant's story was being reflected accurately. Returning to re-read the transcripts and re-listen to the recordings whilst writing the report ensured that the original meanings and inferences were not lost. The deeper analysis ensured the data were coded accurately into sub-themes and themes. Table 3.5 illustrates further analysis to the final themes.

| **Phase 4** | | **Phase 5** |
|---|---|---|
| **Re-coding** | **Sub-themes** | **Final Themes** |
| The text book covers all | Follow the textbook | They will tell you definitely what you need to do |
| Remember all the notes | Copy and learn | |
| Teacher has the pressure | The teachers must push us | |
| Follow the strict procedure | Do this, then do that - perfect | |
| I am worker - I belong to her | Just follow orders | |
| Listen, listen, listen | Listen and keep silent | We hardly talk to each other |
| It's about the score | | |
| We won't ask a question | Not in front of them all | |
| Just in front of the teacher | | |
| We never explain | You do not need to say something | |
| You don't have to tell anyone | | |
| The teacher gives everything to us | You don't find other resources | No need to critical think |
| They say the definite answers | | |
| The doctor has prepared it | It's just a task | |
| You needed to do it - just do it | | |
| It's not written | Not perfectly prepared | |
| They need to draw the lines | | |

Table 3.5: *Further Theme Development.*

Phase five resulted in three final themes and three sub-themes which were named verbatim from the data transcript. These were; *they will tell you definitely what you need to do, we hardly talk to each other,* and *no need to critical think* [*sic*]. Clear definitions were again provided for each theme and sub-theme to ensure that data extracts were correctly assigned to their theme and that the ensuing discussion related to the theme. Table 3.6 illustrates the themes and their sub-themes.

| 1 | 2 | 3 |
|---|---|---|
| **They will tell you definitely what you need to do** | **We hardly talk to each other** | **No need to critical think** |
| Follow the textbook | Listen and keep silent | You don't find other resources |
| The teachers must push us | Not in front of them all | It's just a task |
| Just follow orders | You do not need to say something | Not perfectly prepared |

Table 3.6: *Final Themes and Sub-themes.*

The final phase of Braun and Clarke's thematic analysis is the production of a report with verbatim excerpts taken directly from the transcripts relating back to the research question and the literature. The excerpts chosen provide rich insights into the participants' experiences resulting in data triangulation by providing multiple perspectives (Polit & Beck, 2012). The full report is provided in Chapter five however the overarching theme which clearly emerged from the data was that overseas educated nurses from China, Korea and India *had little expectation to take an active part in independent learning or critical thinking.* An example of the first theme and some supporting excerpts follows.

**Theme 1 - *They will tell you definitely what you need to do***

This theme reflects the participants' experiences of the teacher's role in their homelands. The theme also explains how the expectation of being told exactly what needed to be done in class carried through to expectations during clinical practice where the nursing student also expected their supervising nurse to tell them exactly what needed to be done. Again the idea of being told exactly what needed to be done transferred to practice in the workplace where the doctor then told the nurse what they needed to do. The following data excerpts support this theme:

> All of us had the textbook for our self so you can write on the textbook, whatever the teacher says is the main point. We don't have outline but you have own textbook so write in textbook. The text book all cover all the knowledge (FG1: China).

> So they can order, no give us direction. You needed to do it, if you didn't do it maybe you will get disadvantages, they think like that… in Korea *I am worker, I belong to her* (FG2: Korea).

> We just *follow the textbooks,* everyone, we just have the text books so we just follow chapter 1, chapter 2 (FG3: China).

> When I was in China we actually we don't always focus in critical thinking, we *just follow doctor's order,* the doctor ask us to do something then I will do something (FG4: China).

> The students are not really involved– *the teachers must push us* and we do – if they don't push us we don't do. It is bad for the teacher if the class results are not good – so the teachers always push us (FG5: India).

## 3.8 Research Rigour

Rigour in research refers to the strictness in judgement and conduct that must be used to ensure that the steps of a project have been set out clearly and undertaken with attention to detail so that the findings can be trusted (Taylor et al., 2006). For this study, I have implemented an audit trail through the use of clear criteria, definitions of codes and themes to ensure accuracy and consistency. This exploratory descriptive study evolved from a single method to a mixed methods design. Rigour is established in a mixed methods design through

triangulation (Polit & Beck, 2012), which occurred at both the data gathering and analysis stages of this study. Data triangulation is achieved when multiple data sources are used to validate findings (Polit & Beck, 2012), such as the use of literature and participants from a variety of educational settings. Analysis triangulation is achieved when two or more approaches have been used to analyse the same set of data (Polit & Beck, 2012). In this study, initial and concurrent literature searches and the mixed methods design have contributed to the validity and reliability of the study. Key criteria to establishing rigour for the questionnaire were validity and reliability. Focus group rigour is established with trustworthiness. How these were managed for this study is explained under the following sub-headings.

### 3.8.1 Validity

Validity may be external or internal. External validity reflects a study where findings can be generalised, or applied to a population (Taylor et al., 2006). Ensuring external validity of this research project required that participants were selected from the population of interest. The participants fitted the inclusion criteria of having completed their initial nurse education in their homeland and being enrolled in an Australian university to undertake the Bachelor of Nursing with RPL. All participants in this study were purposively selected from this cohort to reflect the population of nurses from China, Korea and India studying at the university where the study took place, who fit the same inclusion criteria.

Internal validity is achieved when a study measures what it is supposed to measure (Taylor et al., 2006). Internal validity was enhanced by piloting the questionnaire and ensuring that all participants in the research encountered the same questionnaire. One threat to the internal validity of this study was the timing of administering the questionnaire. At the

beginning of each semester in which the questionnaire was to be distributed, a waiting period of three months was applied to allow potential participants to settle in to their new country and new place of study. This was rigorously adhered to for each survey period to ensure that all participants had the same level of experience of the Australian higher education system and that their previous teaching and learning experiences in their homeland were also still able to be recalled.

### 3.8.2 Reliability

Reliability is a quantitative term referring to the ability of a study to be measured consistently and results reproduced consistently (LoBiondo-Wood & Haber, 2010; Taylor et al., 2006). Likewise, the reliability of a questionnaire refers to its ability to yield the same findings with repeated use. Attributes of a reliable scale are; stability - the questionnaire to produces the same results with repeated testing; homogeneity - all of the items in an instrument measure the same concepts or characteristic; and equivalence - the questionnaire produces the same results if a parallel instrument or procedure is used (LoBiondo-Wood & Haber, 2010). If the ISNQ were to be used again, I would expect that the results would differ to reflect changing teaching and learning practices in the homelands of future students. Future use of the questionnaire is discussed in Chapter six.

### 3.8.3 Trustworthiness

Trustworthiness is a qualitative methodological term that can be used in place of validity and reliability for the focus group study. It refers to a study in which the end result accurately reflects the experience of the participants (Polit & Beck, 2012). Polit and Beck posit that trustworthiness of a research study is important to evaluating its worth. Trustworthiness involves establishing:

Credibility - confidence in the 'truth' of the findings.

Transferability - showing that the findings have applicability in other contexts.

Dependability - refers to the stability of data over time and over conditions.

Confirmability - a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Polit & Beck, 2012).

Credibility has been established through triangulation of data arising from the mixed methods. Data from the questionnaire are supported by focus group data. Data triangulation is also achieved through confirmation of findings amongst participants. Samples of these findings have been presented at research seminars at the university where the study took place and where delegates who were overseas educated nurses, took the time to approach me and concur that they had experienced what I had described in my presentation.

There may be some degree of transferability of the study findings to similar cohorts of international students at my and other Australian universities if the students being studied had similar student experiences in their homelands. However as time advances from the 2009 and 2010 data collection periods, it can be assumed that overseas teaching and learning strategies are also advancing. Dependability of the data can be demonstrated with consistent management of the focus groups and use of the same trigger questions which could be applied to all of the cohorts. In this study dependability has been established through my being present for all of the focus groups and the use of the same trigger questions to ensure a consistent approach to each of the focus groups. Audit trails were conducted where the interview data was compared with literature findings, shared with the research supervisors and data provided in one focus group could be confirmed in a following focus group.

Dependability of the data is strengthened since all of the participants were involved with the topic, and all the participants' viewpoints were heard (Ho, 2011).

Confirmability has been achieved partially, since the initial questions formulated for the ISNQ arose from research and scholarly literature as well as my own experiences. Therefore, my teaching and clinical experiences may have led to researcher bias in the way the questions were formulated. It is unlikely that the trigger questions for the focus group discussions were biased as they resulted from the ISNQ findings and further literature. However, there is the possibility that the trigger questions may have inadvertently been leading for some students because of my limited experience as a moderator in focus groups. There is also the possibility of researcher bias in the way the data were analysed, as my own professional experiences may have led me to focus more on some areas of data to the exclusion of other areas. Nevertheless, confirmability was enhanced by my conducting all of the focus groups and completing all the data transcription and data analysis. Regular meetings with my research supervisors, sharing my data analysis process and emerging themes with them, using a structured data analysis process, reflecting data findings in tables, and rigorous adherence to proven data analysis methods all add to the credibility of the research findings.

## 3.9 Conclusion

Chapter three has described the decisions made in relation to the study methodology and the approach taken to identify and recruit suitable participants for the study. Justification for the chosen method was provided with explanations of the ethical considerations addressed. The data collection methods and for both the questionnaire and the focus groups were

described along with the process of analysis employed for each method. The attention given to rigour has been explained to ensure confidence in the findings.

Chapter four follows with a description of the findings which emerged from the questionnaire data collection.

# CHAPTER FOUR

# QUESTIONNAIRE FINDINGS

## 4.1 Introduction

This chapter outlines the results of the International Student Nurse Questionnaire (ISNQ) as described in Chapter three. To assist the reader, the chapter is divided into sections reflecting four areas of the questionnaire which are headed; Demographic data, Overseas nursing education as a student nurse in the homeland, Overseas clinical nursing experience as a student nurse in the homeland, and Overseas clinical experience as a qualified nurse in the homeland. These headings also reflect the teaching and learning activities taking place; 'during class' or 'outside class', clinical experiences and assessments in the clinical laboratory and on clinical practice, and patient care experiences as a student nurse in the homeland followed by the expectations of a qualified nurse in the homeland. The chapter concludes with a description of the early findings of the quantitative data which informed the decision to undertake further data collection using focus groups.

## 4.2 Demographic Data

Section one of the ISNQ collected information regarding overseas educated nurses' previous teaching and learning experiences. The questions identified the participants' country of birth and how long they had lived in that country and where their first nursing qualification was obtained. The demographic information collected also identified the number of participants who undertook another course of study in Australia prior to commencing their current Bachelor of Nursing course. This data are summarised in Table 4.1 on the following page.

| Demographic items | China | Korea | India | Total |
|---|---|---|---|---|
| Country of birth | 34 | 6 | 10 | 50 |
| Country in which the participant has resided the longest | 34 | 6 | 10 | 50 |
| Country in which initial nursing qualification was gained | 34 | 6 | 10 | 50 |
| Study in Australia prior to commencing current course | 20 | 5 | 3 | 28 |

Table 4.1: *Demographic Findings.*

Analysis of the demographic and education history of the fifty (50) participants revealed that all the participants had resided in their country of birth for most of their life and that was where their initial nursing qualification was gained. In total, twenty eight (28) participants - 56% had already studied in Australia with twenty six (26) of those -52% undertaking an English language class prior to starting the bachelor degree. One participant had studied English at TAFE with the remaining participant in other university study.

Participants from China predominantly qualified in Diploma of Nursing courses of three or four year's duration at university or college, or high school. However within only twelve months, there was an increase in Chinese participants who had graduated from Bachelor of Nursing courses of four and five year's duration only available at university. Korean enrolments significantly declined during that time but the trend indicated a similarity to the Chinese trend showing an increase in participants graduating from four year Bachelor of Nursing courses rather than the Diploma of Nursing of three year's duration. Indian data showed little change with findings indicating equal numbers graduating from both Diploma and Bachelor of Nursing courses regardless of duration. Table 4.2 on the following page summarises these findings.

| Qualification | China | Korea | India |
|---|---|---|---|
| Diploma of Nursing 3yrs College | 8 | 2 | 4 |
| Diploma of Nursing 3yrs University | 3 | 0 | 0 |
| Diploma of Nursing 4yrs High School | 2 | 0 | 0 |
| Diploma of Nursing 4yrs College | 11 | 0 | 0 |
| Bachelor of Nursing 3yrs College | 0 | 0 | 1 |
| Bachelor of Nursing 3yrs University | 0 | 1 | 1 |
| Bachelor of Nursing 4yrs College | 0 | 0 | 2 |
| Bachelor of Nursing 4yrs University | 5 | 3 | 0 |
| Bachelor of Nursing 5yrs University | 2 | 0 | 0 |
| Total (missing data) | 31 (3) | 6 | 8 (2) |

Table 4.2: *Nursing Qualifications Gained in the Homeland.*

## 4.3 Nursing Education in the Participants' Homeland

Section two of the questionnaire sought to investigate the actual teaching and learning strategies that the participants experienced during the theoretical or 'classroom' component of nurse education in their homeland. Questions 7 to 11 in the questionnaire required participants to respond using the five point Likert scale (Frequently, Often, Sometimes, Rarely, Never) relating to teaching and learning strategies that they experienced as student nurses. These questions were grouped under the four headings; Interactions, Teaching and learning resources, and Study habits and Assessment.

### 4.3.1 Interactions

The participants were required to recall how classroom teaching and learning strategies were structured referring to the actual delivery modes of 'theory', the presentation

from teachers and the presentation of individual student seminars and group seminars. Table 4.3 presents these findings.

| Teaching & Learning Strategies | %Taught by nursing staff | | | %Taught by medical staff | | | %Use of Online resources | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 56 | 83 | 70 | 35 | 34 | 50 | 6 | 0 | 0 |
| Often | 29 | 0 | 30 | 29 | 33 | 20 | 12 | 0 | 0 |
| Sometimes | 12 | 0 | 0 | 24 | 0 | 20 | 32 | 33 | 0 |
| Rarely | 0 | 17 | 0 | 6 | 33 | 10 | 41 | 50 | 50 |
| Never | 3 | 0 | 0 | 6 | 0 | 0 | 9 | 17 | 50 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Teaching & Learning Strategies** | **%Self directed learning** | | | **%Student seminars** | | | **%Audio-visual resources** | | |
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 9 | 0 | 40 | 9 | 0 | 40 | 12 | 0 | 20 |
| Often | 32 | 0 | 10 | 18 | 50 | 10 | 27 | 17 | 40 |
| Sometimes | 24 | 67 | 10 | 35 | 33 | 30 | 52 | 83 | 30 |
| Rarely | 35 | 33 | 40 | 21 | 0 | 10 | 6 | 0 | 0 |
| Never | 0 | 0 | 0 | 18 | 17 | 10 | 3 | 0 | 10 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.3: *Teaching and Learning Strategies Utilised in the Classroom.*

The use of role play was another area of contrast where the Chinese participants indicated that this teaching and learning strategy was not commonly used ('Frequently'- 0%, 'Often'- 17%, 'Sometimes'- 47%, 'Rarely'- 21%, and 'Never'- 15%). However, the Korean participants indicated that role play was used 'Frequently' (17%) and the Indian participants also used role play 'Frequently' (33%).

Further analysis of Tables 4.2 and 4.3 was carried out to identify the frequency of selected teaching and learning strategies utilised in colleges compared to universities in each country. The following Tables 4.4 and 4.5 illustrate these results.

| College | %Use of online resources | | | %Student seminars | | | %Role play | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 0 | 0 | 0 | 5 | 0 | 57 | 0 | 0 | 43 |
| Often | 5 | 0 | 0 | 16 | 50 | 14 | 21 | 0 | 29 |
| Sometimes | 42 | 50 | 0 | 32 | 50 | 29 | 42 | 50 | 14 |
| Rarely | 42 | 0 | 57 | 21 | 0 | 0 | 26 | 0 | 14 |
| Never | 11 | 50 | 43 | 26 | 0 | 0 | 11 | 50 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **University** | **%Use of online resources** | | | **%Student seminars** | | | **%Role play** | | |
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Often | 20 | 0 | 0 | 20 | 50 | 0 | 0 | 25 | 0 |
| Sometimes | 10 | 25 | 0 | 40 | 25 | 0 | 70 | 25 | 0 |
| Rarely | 40 | 75 | 100 | 30 | 0 | 100 | 10 | 50 | 0 |
| Never | 10 | 0 | 0 | 10 | 25 | 0 | 20 | 0 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | Missing Data |

Table 4.4: *Comparison of Teaching and Learning Strategies Experienced in Colleges and Universities.*

In this comparison the Indian participants indicated that those who completed their studies at a college experienced student seminars and role play as teaching and learning strategies more frequently than those who completed their studies at a university. However, due to the small numbers of participants from each cohort who attended university and the missing data; the analysis is considered unreliable.

Participants were also asked to give an indication of the usual level of input provided by each student when involved in 'during class' group work and 'during class' discussions with the teacher. This question sought to identify the tendency of the student to initiate student discussions within the classroom. For the Chinese participants, individual student discussions 'during class' and discussions with the teacher 'during class', were far less frequent and the Korean participants indicated that, 'during class' discussions were even far more rare. However, data revealed that Indian participants commonly participated in 'during class' student discussions and teacher discussions, but that 'during class' group discussions were less likely to take place. Table 4.5 provides a summary of this data.

| During Class Interactions | %Discussion between students | | | %Discussion with teacher | | | %Group discussion | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 12 | 0 | 30 | 5 | 0 | 50 | 3 | 0 | 6 |
| Often | 21 | 0 | 50 | 15 | 0 | 30 | 18 | 0 | 16 |
| Sometimes | 47 | 50 | 20 | 65 | 33 | 20 | 50 | 50 | 42 |
| Rarely | 11 | 50 | 0 | 12 | 67 | 0 | 23 | 50 | 30 |
| Never | 9 | 0 | 0 | 3 | 0 | 0 | 6 | 0 | 6 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.5: *Frequency of Classroom Discussions.*

The final question in this section refers to the participant's experience of asking the teacher questions 'during class' or whether they would have sought a meeting with the teacher 'outside class' to have their questions answered. These results are presented in Table 4.6 on the following page.

| Asking Questions | %During class | | | %Outside class | | |
|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India |
| Frequently | 12 | 0 | 60 | 9 | 0 | 30 |
| Often | 23 | 0 | 30 | 6 | 33 | 20 |
| Sometimes | 41 | 67 | 10 | 38 | 67 | 30 |
| Rarely | 23 | 33 | 0 | 38 | 0 | 20 |
| Never | 0 | 0 | 0 | 9 | 0 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.6: *Tendency to Ask Questions.*

### 4.3.2 Teaching and Learning Resources

Questions in the resources section of the ISNQ were designed to seek information about the resources available to the participants during their overseas nursing education. Questions in relation to overseas educated nursing students having had worksheets and lecture notes provided by the teacher elicited very similar results. The provision of online worksheets as a teaching and learning strategy and online lecture notes being made available was also similar. Responses were reflected across all three countries of participants. Table 4.7 provides a summary of these results.

| Teaching and Learning Resources | %Lecture notes provided by teacher | | | %Online lecture notes provided by school | | | %Use of databases to source journal articles and selected readings | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 68 | 50 | 40 | 17 | 0 | 0 | 18 | 0 | 0 |
| Often | 12 | 17 | 30 | 9 | 16 | 0 | 6 | 17 | 20 |
| Sometimes | 15 | 17 | 10 | 15 | 17 | 0 | 0 | 33 | 20 |
| Rarely | 6 | 16 | 0 | 27 | 0 | 20 | 32 | 17 | 10 |
| Never | 0 | 0 | 20 | 32 | 67 | 80 | 50 | 33 | 50 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.7: *Availability of Teaching and Learning Resources.*

### 4.3.3 Study Habits

Participants were questioned about their individual and group study habits both 'during class' and 'outside class'. 'During class' study habits revealed similar responses between all participants from each cohort relating to rewriting and reviewing of lecture notes; individual learning and reflection; and reading text books and provided journal articles. Table 4.8 summarises these findings.

| During Class Study Habits | %Rewriting and reviewing lecture notes | | | %Individual learning and reflection | | | %Reading textbooks and provided journal articles | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 50 | 50 | 70 | 38 | 33 | 60 | 38 | 33 | 40 |
| Often | 21 | 33 | 30 | 32 | 50 | 30 | 30 | 50 | 50 |
| Sometimes | 29 | 0 | 0 | 15 | 0 | 10 | 24 | 17 | 10 |
| Rarely | 0 | 17 | 0 | 15 | 17 | 0 | 9 | 0 | 0 |
| Never | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.8: *During Class Study Habits.*

Participants were also asked to recall how often they would participate in 'during class' group study sessions and 'outside class' study habits with one question specifically referring to the use of memorisation prior to an exam. Table 4.9 summarises the results as follows:

| Study Habits | %'During class' group study | | | %'Outside class' study - Memorisation | | |
|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India |
| Frequently | 6 | 0 | 60 | 35 | 33 | 50 |
| Often | 9 | 0 | 20 | 41 | 50 | 30 |
| Sometimes | 47 | 67 | 10 | 18 | 17 | 20 |
| Rarely | 35 | 33 | 10 | 6 | 0 | 0 |
| Never | 3 | 0 | 0 | 0 | 0 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.9: *Specific Study Habits.*

Table 4.10 presents responses from the recipients experience of 'outside class' study habits such as listening to taped lectures and audio-visual presentations, and the use of library resources and online/internet resources. Again, 'during class' study habits for group work revealed that Indian participants were most familiar with this teaching and learning strategy however, the Chinese and Korean participants indicated that this strategy was utilised only 'sometimes' or 'rarely'.

| Outside Class Study Habits | %Rewriting and reviewing lecture notes | | | %Individual learning and reflection | | | %Reading textbooks and provided journal articles | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 29 | 13 | 52 | 41 | 67 | 70 | 32% | 33 | 80 |
| Often | 37 | 50 | 29 | 29 | 17 | 30 | 24% | 50 | 10 |
| Sometimes | 18 | 24 | 14 | 21 | 17 | 0 | 30% | 17 | 10 |
| Rarely | 13 | 13 | 5 | 9 | 0 | 0 | 15% | 0 | 0 |
| Never | 3 | 0 | 0 | 0 | 0 | 0 | 0% | 0 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Outside Class Study Habits** | **%Group study sessions** | | | **%Audio-visual resources** | | | **%Library and online/internet resources** | | |
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 3 | 0 | 60 | 0 | 0 | 0 | 25 | 17 | 25 |
| Often | 9 | 0 | 10 | 3 | 0 | 0 | 7 | 50 | 15 |
| Sometimes | 24 | 83 | 30 | 29 | 0 | 20 | 44 | 8 | 15 |
| Rarely | 62 | 17 | 0 | 12 | 83 | 20 | 43 | 8 | 15 |
| Never | 2 | 0 | 0 | 56 | 17 | 60 | 3 | 17 | 30 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.10: *Outside Class Study Habits.*

### 4.3.4 Assessment

Participants were asked to indicate how frequently selected assessment strategies were used to test knowledge both 'during class' time and 'outside class' time. Findings indicate that during class, Chinese and Korean participants' experienced multiple choice assessment methods and short answer assessment methods most 'Frequently' or 'Often', and Indian participants indicated that although short answer questions were experienced most 'Frequently' or 'Often', multiple choice assessment methods were experienced less frequently. The cohorts appeared to have varying experiences of essay style assessments and oral presentations; and online/computer assessments which were 'rarely' or 'never' utilised. Findings for 'during class' assessments are presented in Table 4.11.

| During Class Assessments | %Multiple Choice | | | %Short answer | | | %Essay style | | | %Online/computer | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 65 | 17 | 30 | 56 | 17 | 50 | 12 | 17 | 40 | 3 | 0 | 2 |
| Often | 15 | 50 | 0 | 23 | 66 | 30 | 3 | 0 | 30 | 0 | 0 | 0 |
| Sometimes | 20 | 17 | 50 | 12 | 17 | 20 | 23 | 33 | 0 | 6 | 17 | 6 |
| Rarely | 0 | 16 | 10 | 9 | 0 | 0 | 38 | 33 | 0 | 45 | 33 | 37 |
| Never | 0 | 0 | 10 | 0 | 0 | 0 | 24 | 17 | 30 | 46 | 50 | 55 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.11: *During Class Assessment Strategies*

Findings reflecting outside class assessments such as online computer examinations, written essays and reflective journaling indicate that those strategies were not commonly experienced by the participants, however outside assessment by completing workbooks was the most experienced form of assessment by the Indian participants. Table 4.12 on the following page summarises these findings.

| Outside Class Assessments | %Online/computer | | | %Written essay | | | %Workbooks | | | %Reflective journaling | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 3 | 0 | 0 | 3 | 33 | 10 | 21 | 0 | 50 | 3 | 16 | 10 |
| Often | 3 | 0 | 0 | 12 | 33 | 18 | 18 | 17 | 20 | 6 | 17 | 10 |
| Sometimes | 3 | 33 | 0 | 18 | 17 | 14 | 38 | 33 | 10 | 18 | 17 | 10 |
| Rarely | 29 | 0 | 30 | 29 | 0 | 22 | 6 | 50 | 20 | 38 | 17 | 20 |
| Never | 62 | 67 | 70 | 38 | 17 | 36 | 17 | 0 | 0 | 35 | 33 | 50 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.12: *Outside Class Assessment Strategies.*

## 4.4 Clinical Experience in the Homeland

Section three of the ISNQ sought to identify the teaching and learning strategies most commonly experienced by overseas educated nurses during clinical practice as student nurses in their homeland. The section required participants to respond by ticking a box in tables as well as using the same five point Likert scale from the previous sections. Responses sought to: identify how and when clinical practice was offered throughout the nursing course; the duration of each placement; specific specialty areas experienced by the participants, and an indication of the types of patient care duties the overseas educated student nurse were expected to perform.

### 4.4.1 Clinical Practice

Question one in this section identified the mode in which clinical practice was offered in the homeland and in which year of the course the practice occurred. This question was presented in a 'tick the box' table format and referred to clinical practice in a simulation centre on the university campus and/or external clinical practice settings such as hospital and

community placements. When reviewing results for the question, it appears that all participants were familiar with participation in clinical practice in an on campus clinical simulation laboratory. Results do not identify any significant year level where this practice took place more often, but appear to indicate that simulation practice is spread over all years of nurse education for all cohorts.

In relation to clinical practice in external settings, participants indicated limited first year experience particularly for Korean participants who did not undertake external clinical practice in first year at all. The Chinese participants indicated the majority of their external clinical practice took place in third and fourth year or in the case of a five year course in an extended block at the end of the course. The Indian participants experienced some external clinical practice in first year, but indicated that clinical practice took place more predominately in second and third year. The next item referring to external clinical practice asked participants to indicate how many days per week clinical practice was offered in their nursing course. Options presented were, clinical practice offered at the end of the semester in a block of weeks or in an extended block at the end of the course. These last two variables had missing data but appeared to indicate that depending on the length of the course undertaken, clinical practice was offered at the end of the semester in a block of weeks for courses of three or four years duration, or in an extended block at the end of the course in a four or five year course.

### 4.4.2 Specialty Experience

Question 13 of the questionnaire asked participants to indicate the duration of clinical experience they received. This question was divided into specialty areas most commonly experienced during external clinical practice as student nurses in their homeland. Participants

were required to indicate how many clinical practice days were spent in specific specialty areas, as listed in Table 4.13. It appeared that the participants misunderstood that this question was asking for a time period of days in each area, this resulted in many participants ticking the box rather than providing a figure. The table reflects the responses from participants who did provide information correctly in relation to areas visited on external clinical placement. The last line of the table provides the percentage of participants from each cohort who did respond correctly.

| Average Time on External Clinical Placement (days) | China | Korea | India |
|---|---|---|---|
| Acute hospital-medical | 38 | 15 | 110 |
| Acute hospital-surgical | 49 | 15 | 87 |
| Acute hospital-maternity | 35 | 15 | 50 |
| Acute hospital-paediatric | 31 | 13 | 45 |
| Acute hospital-high dependency unit | 14 | 15 | 40 |
| Acute hospital-outpatient clinic | 16 | 5 | 30 |
| Aged care | 7 | 12 | 10 |
| Palliative care | 7 | 13 | 7 |
| Mental health | 8 | 15 | 20 |
| Community clinic or home visits | 37 | 10 | 40 |
| Average of total days on placement / student | 242 | 118 | 439 |
| % of correct responses within each group | 56% | 50% | 20% |

Table 4.13: *External Clinical Placement Time.*

This question also provided the opportunity for the participants to add further qualitative details regarding the place and length of their external clinical placement experience; however no further narrative data were obtained.

### 4.4.3 Expectations of Student Nurses

Further questions in section three referred to the expectations from overseas educated student nurses as they worked on clinical practice placements. Participants were asked whether they were expected to 'observe Registered Nurses as they work' or whether they were given a patient care caseload 'working beside the Registered Nurse'. For 'observing Registered Nurses as they worked', all Korean participants indicated that this was the expectation for the entire clinical practice. The Chinese participants and the Indian participants elicited similar responses; however the question regarding 'working beside the Registered Nurse' elicited a mixed response, perhaps indicating that expectations of student nurses changed as they progressed through their course. Table 4.14 summarises these findings.

| Clinical Practice Expectations | Observing RN's only | | | Working beside the RN | | |
|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India |
| Frequently | 62% | 100% | 60% | 64% | 50% | 50% |
| Often | 29% | 0% | 30% | 27% | 0% | 0% |
| Sometimes | 9% | 0% | 10% | 9% | 50% | 10% |
| Rarely | 0% | 0% | 0% | 0% | 0% | 10% |
| Never | 0% | 0% | 0% | 0% | 0% | 30% |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.14: *Expectations of Clinical Practice.*

### 4.4.4 Patient Care

The next question explored actual patient care duties carried out by the overseas educated student nurse on clinical placement. The question was divided into sub-headings to assist the participant to isolate and clarify the activity. Within the sub headings, specific patient care duties were listed (see Appendix D). Analysis of this question was complex and the SPSS© function of reducing or collapsing the number of categories of a categorical

variable was utilised. Individual totals for each duty were tabulated and averaged to give a value for each sub-heading. For example, the subheading 'Patient Care' contained five categorical variables; Meet hygiene needs, Provide pressure area care, Make patients' beds, Assist with feeding patients and, Monitor dietary intake and output. All of the responses to these variables were collapsed to create a manageable value with which further cross-tabulation analysis could be carried out. Table 4.15 summarises the findings from the question exploring patient care provided on clinical practice.

| Clinical Practice Duties | %Admission procedures | | | %Patient assessment | | | %Patient care | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 14 | 17 | 60 | 34 | 31 | 66 | 38 | 40 | 86 |
| Often | 24 | 21 | 33 | 22 | 30 | 26 | 14 | 10 | 12 |
| Sometimes | 48 | 42 | 0 | 30 | 30 | 8 | 24 | 37 | 2 |
| Rarely | 12 | 21 | 2 | 11 | 6 | 0 | 12 | 10 | 0 |
| Never | 2 | 0 | 5 | 3 | 3 | 0 | 12 | 3 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Clinical Practice Duties** | **%Medication administration** | | | **%Wound care** | | | **%Discharge planning and Health teaching** | | |
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 56 | 21 | 65 | 23 | 0 | 60 | 33 | 16 | 80 |
| Often | 21 | 4 | 25 | 13 | 13 | 23 | 19 | 17 | 10 |
| Sometimes | 17 | 42 | 5 | 28 | 29 | 10 | 38 | 25 | 0 |
| Rarely | 5 | 21 | 5 | 16 | 17 | 5 | 10 | 17 | 5 |
| Never | 1 | 12 | 0 | 20 | 42 | 2 | 0 | 25 | 5 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.15: *Clinical Placement Duties.*

The most interesting finding in this question was the comparison of 'Patient Assessment' for which only thirty four percent (34%) of Chinese participants indicated took place 'Frequently' and 'Medication Administration' for which fifty six percent (56%) indicated took place 'Frequently'. These findings are explained in the discussion of themes where the participants state that patient assessment and critical thinking skills are not utilised as they are accustomed to just following the doctors' orders.

### 4.4.5 Clinical Supervision

Question 16 asked the participants to indicate which supervision methods they most commonly experienced as a student nurse on clinical practice. Options provided were that the student nurse would 'work directly with a Registered Nurse'; that the student nurse would 'work in a team with several Registered Nurses and other students'; or that the student nurse would 'work independently to perform set nursing tasks' and 'be assigned set tasks to complete unsupervised'. Results are summarised in Table 4.16.

| Clinical Supervision | %Work with specific RN | | | %Work in a team | | | %Work independently | | | %Complete tasks unsupervised | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 50 | 33 | 70 | 32 | 0 | 50 | 3 | 0 | 40 | 6 | 0 | 0 |
| Often | 26 | 17 | 20 | 24 | 33 | 30 | 32 | 17 | 40 | 15 | 20 | 20 |
| Sometimes | 21 | 50 | 0 | 32 | 50 | 10 | 30 | 33 | 10 | 41 | 0 | 0 |
| Rarely | 3 | 0 | 10 | 6 | 0 | 10 | 30 | 33 | 10 | 21 | 60 | 10 |
| Never | 0 | 0 | 0 | 6 | 17 | 0 | 6 | 17 | 0 | 18 | 20 | 70 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.16: *Clinical Supervision Methods.*

Results indicated that fifty percent (50%) of the Chinese participants and seventy percent (70%) of the Indian participants most frequently experienced 'working directly with a Registered Nurse'. Fifty percent (50%) of the Indian participants indicated that they frequently experienced 'working in a team with several Registered Nurses and other students' and forty percent (40%) experienced 'working independently to perform set nursing tasks'. The Korean participants indicated that none of these clinical supervision methods were utilised more frequently than any other. This question also asked the participant to give an example of the types of tasks that they could perform unsupervised and to describe any additional supervision methods they had experienced. Again, none of the participants provided further narrative data for this question.

### 4.4.6 Clinical Assessment

The final questions in this section asked the participant to indicate by whom they were formally assessed on clinical practice, options included were the: 'Registered Nurse'; 'Clinical Nurse Teacher'; or 'Doctor'. Table 4.17 summarises these findings.

| Clinical Assessment | %Registered Nurse | | | %Clinical Nurse Teacher | | | %Doctor | | |
|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 50 | 33 | 70 | 32 | 0 | 50 | 3 | 0 | 40 |
| Often | 26 | 17 | 20 | 24 | 33 | 30 | 32 | 17 | 40 |
| Sometimes | 21 | 50 | 0 | 32 | 50 | 10 | 30 | 33 | 10 |
| Rarely | 3 | 0 | 10 | 6 | 0 | 10 | 30 | 33 | 10 |
| Never | 0 | 0 | 0 | 6 | 17 | 0 | 6 | 17 | 0 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.17: *Clinical Assessment Methods.*

Participants were also asked to indicate the types of strategies for assessment that they had experienced as student nurses in their homeland. The examples of assessment strategies provided were: 'regular verbal feedback'; 'written record with marking criteria'; 'learning plans indicating areas which required improvement'; and 'self evaluation'. These results are summarised in Table 4.18.

| Clinical Assessment Strategies | %Regular verbal feedback | | | %Written record with marking criteria | | | %Learning plans | | | %Self evaluation | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | China | Korea | India | China | Korea | India | China | Korea | India | China | Korea | India |
| Frequently | 35 | 17 | 56 | 44 | 17 | 67 | 27 | 0 | 67 | 35 | 17 | 45 |
| Often | 38 | 0 | 33 | 15 | 33 | 22 | 42 | 20 | 22 | 29 | 17 | 33 |
| Sometimes | 18 | 66 | 0 | 32 | 33 | 0 | 24 | 0 | 0 | 29 | 33 | 11 |
| Rarely | 9 | 17 | 0 | 9 | 17 | 0 | 6 | 80 | 0 | 6 | 17 | 0 |
| Never | 0 | 0 | 11 | 0 | 0 | 11 | 0 | 0 | 11 | 0 | 17 | 11 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 4.18: *Clinical Assessment Strategies.*

## 4.5 Qualified Experience in the Homeland

From this point, the questionnaire only required responses from participants who had worked as a qualified nurse in their homeland. Question 20 of the ISNQ asked whether the participants worked as a qualified nurse in their homeland and required either Yes or No as an answer. In total, 24 of the 50 participants answered Yes. Of these, 8 of the 34 Chinese participants, and all the Korean and Indian participants worked as qualified nurses in their homeland. Question 21of the ISNQ asked how long each participant had worked as a qualified nurse in their homeland. Participants were required to 'tick a box' and responses are reflected in Table 4.19 on the following page.

| Length of Time Worked | China | Korea | India |
|---|---|---|---|
| Never | 2 | 0 | 0 |
| < 6 Months | 1 | 1 | 1 |
| 6 – 12 Months | 2 | 0 | 4 |
| 1 – 2 Years | 2 | 0 | 3 |
| 2 – 5 Years | 0 | 3 | 2 |
| > 5 Years | 1 | 2 | 0 |
| Total % of cohort | 24% | 100% | 100% |

Table 4.19: *Length of Time Worked as a Qualified Nurse.*

Participants were then asked whether they had worked as a qualified nurse in any country other than their homeland. All participants responded with No.

Question 23 was similar to Question 13 of the questionnaire and asked participants to indicate which specialty areas they had worked in as a qualified nurse in their homeland. Again participants were required to indicate how many working days were spent in specific specialty areas which were listed just as they were in Question 13. Similarly, the final quantitative question was similar to question 15 of the questionnaire and asked the participants to indicate actual patient care duties carried out by a qualified nurse in their homeland. Again, participants were required to indicate frequency of tasks using the five point Likert scale and the question was divided into sub-headings in the same format as question 15. Due to the number of participants who actually worked as a qualified nurse in their homeland being just under fifty percent (50%) of the participants, the findings were inconclusive. The final question in the questionnaire invited the participants to share any other experiences from their work as a qualified nurse in their homeland. None of the participants added further detail.

## 4.6 Early Findings Informing the Need for a Qualitative Approach

The aim of this research project was to describe the academic and clinical teaching and learning strategies experienced by the overseas educated nurse as a student nurse in their homeland along with their experiences of working as a qualified nurse in their homeland. Quantitative findings provided an indication of the participants' experience with various teaching and learning strategies commonly utilised in the Australian higher education setting. The design and structure of the questionnaire and the information it sought to identify was based on past research literature and prior assumptions of teaching and learning strategies experienced by the overseas educated nurse and common teaching and learning strategies that are utilised in Australian higher education. Despite provision having been made throughout the questionnaire for participants to add their personal perspectives of their teaching and learning experiences through narrative comments, there was zero response. Therefore, the quantitative data were missing the richness and depth that qualitative data would have afforded the study.

Insufficiently addressed questions that emerged related to how academic teaching and learning strategies were actually experienced by the overseas educated nurse. For example, What were the advantages of academic education offered in this way and what were the difficulties encountered? Questions also emerged relating to how clinical education was offered. For example: Did skill complexity reflect an increasing scope of practice with each year of the course? and; How was responsibility and accountability demonstrated for the care provided? Additionally, I felt that the questionnaire did not explore the participants' preparedness for teaching and learning strategies utilised at university in Australia and whether or not this initially affected their academic performance. To address these gaps in the data, a qualitative approach to data collection was added, utilising focus groups.

## 4.7 Conclusion

This chapter outlines the ISNQ with regards to the questions it contained and the method in which responses were expected to be completed. It has presented the findings of the ISNQ and also identifies the areas where questions may not have elicited the depth of information that was sought. In those instances I have endeavoured to provide an explanation of where question misinterpretation may have occurred. The chapter provides in-depth findings of each question in the questionnaire in summary using a table format and highlights those areas of significance which require further discussion. The following chapter will introduce the three key themes and related sub-themes generated from the focus group qualitative data collection.

# CHAPTER FIVE

# FOCUS GROUP FINDINGS

## 5.1 Introduction

This chapter presents the findings that emerged from the focus group data obtained to answer the research question: *What were the teaching and learning strategies most commonly experienced by overseas educated nurses from China, Korea and India in their previous nursing courses in their homeland?* The major finding to emerge from the focus group data is that the overseas educated nurse participants from China, Korea and India had little educational preparation in their homeland to take an active part in their learning and thinking critically or independently. The themes and sub-themes are presented in this chapter, supported by selected verbatim data excerpts in accordance with phase six of Braun and Clarke's (2006) framework. The International Student Nurse Questionnaire (ISNQ) findings and relevant literature are also used to support interpretation of the focus group data. These findings are reflected in the three themes and related sub-themes that emerged from the focus group data, as listed in Table 5.1.

| 1 | 2 | 3 |
|---|---|---|
| **They will tell you definitely what you need to do** | **We hardly talk to each other** | **No need to critical think** |
| Follow the textbook | Listen and keep silent | You don't find other resources |
| The teachers must push us | Not in front of them all | It's just a task |
| Just follow orders | You do not need to say something | Not perfectly prepared |

Table 5.1: *Themes and Sub-themes.*

## 5.2 Theme 1 - *They will tell you definitely what you need to do*

The theme *they will tell you definitely what you need to do* reflects the participants' experiences of teaching and learning in both the classroom and clinical environments. The theme explains the student nurses' expectations of being told exactly what to do in the classroom and in the clinical laboratory and extends to clinical placement where the students expected their supervising nurses and doctors to tell them exactly what to do. The sub-themes within this theme are: *follow the textbook; the teacher must push us*; and *just follow orders.*

### 5.2.1 *Follow the textbook*

The sub-theme *follow the textbook* reflects the reliance on textbooks as the main teaching and learning resource. All participants described a classroom environment with rigid boundaries where one prescribed textbook was the main resource. When describing how lecture content was delivered, the Chinese participants explained: 'they [the teachers] will tell you definitely what you need to do, they will hold your hand to help you' (FG4: China) and, 'we just follow the textbook - Chapter One, Chapter Two...' (FG3: China) and students would write in their copy of the textbook as the teacher went through it with the class. The Korean participants explained that the teacher would provide the information in a handbook, 'they would give us a handbook which was done made by the teacher … we had to hand in'. The participants explained that to succeed they needed only to 'follow what the teacher told them' and 'read the books without questions … copy and learn from the textbook' (FG4: China).

Another aspect of the sub-theme, *follow the textbook* was that the participants' did not question the information provided for their learning in their homeland. Participants from all cohorts explained that they just followed what the teacher said and read the books without question. The following excerpt explains:

> In my country, we just follow the textbook and follow what they say and what they think ... we just follow the textbook, what the text says (FG4: China).

The situation appeared similar for the Indian participants, who stated also that they also just made notes, and 'prepared for exams from the textbooks – all from textbooks, we copied, then we have to learn' (FG5: India). The participants in this study described teaching and learning experiences which appear regimented providing little alternative for individual learning styles. The content was delivered without opportunities for students to challenge information or create their own ideas. Strategies that the participants had used to prepare for examinations are explained in the sub theme; *the teacher must push us*.

### 5.2.2 *The teacher must push us*

The participants considered that their teachers were more responsible for their learning than the students themselves. The sub-theme *the teacher must push us* illustrates the expectation that teachers would ensure that the students succeeded. The participants described strategies used to prepare for examinations and the step by step repetitious practise of clinical skills exactly as demonstrated without consideration of the individual students learning styles. In contrast to these teacher centered strategies, students also experienced episodes of unsupervised practice of clinical skills in the clinical simulation laboratories resulting in inconsistent teaching and learning strategies; teacher directed learning in the classroom and self directed learning during clinical practice.

The Chinese participants described the teachers' role in examination preparation; 'they [teachers] just give us the notes in class, they go through the notes when teaching us and they make us read all the notes and remember all the notes after that' (FG1: China). Although

strategies varied between teachers, the teachers remained responsible for student learning; 'it depends on the teacher, what they want you to do and how much she wants you to learn' (FG1: China). One participant stated:

> At exam time, our teacher will say which ones, which sentence or which articles will be on the exam. They will definitely say the definite answer or they will give questions and these questions are the same as the exam (FG4: China).

The Chinese participants explained that the teacher would tell them what questions to expect on the examination paper and described the need for a good memory to be able to remember the questions and the answers, explaining that 'the teacher will say which ones, which sentence will be on the exam' (FG4: China) and; 'Our teacher will highlight the keen points for us so we should prepare them for the final examination, if we don't do that we will be left because of too much information' (FG1: China). The Chinese participants made a comparison of their experiences in Australia regarding the impact of not being told what to expect on an examination:

> In China we can easily pass, we don't have to spend more time, the rest of time we just play, go to movies, relax but here (Australia) every day we have to learn, everything is busy because we cannot just memorise (FG4: China).

The Indian participants explained:

> In exams, the teachers have the preparation; it's more on the teacher for students to get good marks. The students are not really involved, the teachers must push us and we do, if they don't push us we don't do. It is bad for the teacher if the class results are not good so the teachers always push us. We don't have any pressure for study, just teachers have the pressure (FG5: India).

The Indian participants indicated that their success was dependent on the teacher and how well the teacher could motivate the students which resulted in the students' taking on the

role of the passive recipient and being successful provided that they listened, copied and memorised.

Repetitious step by step practise of clinical skills was a common teaching strategy experienced by the participants in a teacher centered learning (TCL) environment. In the clinical laboratory, students followed specific instructions for learning skills and completing tasks exactly as directed. The Chinese participants recalled having the skill 'making the bed' demonstrated, and then having to repeat the procedure until it was 'perfect'; 'so we practise that [bed making] a lot and we even have tests for that in the hospital' and 'make the bed' competitions (FG1: China; FG3: China). One participant explained:

> In China, more focus on the procedure, very strict procedure... Like this thing, you have to first do this and then do that - perfect; that is what we did and been told in laboratory (FG3: China).

Another Chinese participant described first year clinical laboratory as:

> It's about making the bed, we spend a lot of time making the bed, the main test for the laboratory is making the bed - fifteen seconds is limit, fifteen seconds for making whole bed and the teacher will set the task of making the bed fifty times to practise (FG1: China).

There was an emphasis on reproducing a procedure or skill exactly as demonstrated without regard for the strengths or limitations of individual students which demonstrate the emphasis on ritual rather than evidence based principles. The Chinese participants explained; 'the teacher will show us, will demonstrate very detailed' (FG2: China). One participant explained that this was problematic for her as she was left-handed.

> We are individual, sometimes we use left hand, but most we been told you must use right hand in all the procedures because this is a rule, you can't use your left hand, you know I am quite good at my left hand but I'm not allowed to use it, that's a problem they don't allow us to change, just follow it (FG3: China).

The Chinese and Korean participants described repeatedly practising skills such as intramuscular injections and intravenous cannulation under close supervision (FG3: China). However, these participants had practised on other students, their teachers and on family members, often unsupervised;

> We just focus on the skill. You know Chinese people practise with the nurse to put the cannula in, we put cannula by nurse themselves (in each other) that's the main skill we learn at uni - but when you do the cannula, first you do on the model but after that, when you test the skill, we put the cannula in each other, we test in each other (FG1: China).

The Korean participants identified similar practices:

> We just had our peer group, we practised each other or our teacher asked us to do for our parents, normally my mother is very kind to give her veins so then we can just give her IV which is nutrition so even I did many, many practise for my mum, so my mum can get nutrition from fluid (FG2: Korea).

The Indian participants also described episodes of unsupervised practice in contrast to the ritualised procedures performed in the Chinese and Korean clinical laboratories:

> In India, they just said 'it's your lab time' then they start setting things up and put dummies [*sic*] on beds - it's not pre-arranged and set up. No IV stands, fluids, monitors and things, it's not a clinical area (FG5: India).

The Indian participants implied that they were free to do anything during their clinical laboratory classes and then had the same expectations in the workplace. However, following their experiences of TCL in the school of nursing, the Chinese and Korean students and graduates continued to rely on direction from others in the workplace, as presented in the third sub-theme; *just follow orders*.

### 5.2.3 *Just follow orders*

The sub-theme *just follow orders* reflects similar contrasts of the previous sub theme where some students expected their supervising nurse and doctors to tell them exactly what to

do and then carry out tasks as directed, while others experienced less direction and supervision. Within this clinical learning environment, students were required to focus on completing the task rather than applying previously learned skills in a real setting without needing to apply critical thinking skills. The Chinese participants explained; 'in my clinical placement is just following the nurse, like the buddy and sometimes she says, you need do this and I haven't have to think anymore, I just done this' (FG4: China) and that they were 'more like just helpers so just follow what the doctor said' (FG3: China). These participants made a comparison to their experiences of nursing practice in Australia:

> In China the nurse is more likely to follow doctor's order, just follow doctors order, don't worry. They [the nurses] won't do anything for the patient. It's like the nurse is just waiting in the ward, so they can't do anything before the doctor comes but here [Australia] they will do that something (FG4: China).

The Chinese and Korean participants described learning to follow strict procedures 'perfectly' in the clinical laboratory but not practising the same skills during clinical placement (FG3: China) and that the opportunity to practise clinical skills was 'up to the [supervising] nurse' (FG2: Korea) and what the nurse needed done. These findings are confirmed by the ISNQ data which indicate that clinical procedures were rarely practised during clinical placement.

The Korean participants described their experiences as student nurses during clinical placement as being the 'worker' without consideration of their learning and having to get the job done to avoid negative consequences. The Korean participants explained: They [supervising nurse] give us direction. You needed to do it, if you didn't do it maybe you will get disadvantages, they think like that. In Korea I am worker, I belong to her [supervising

nurse] (FG2: Korea). These participants compared this to their Australian experiences during clinical placement explaining:

> The relationship between nurse and nursing student is quite different. In Australia it's like teamwork or a partnership with the Student Nurse and Registered Nurse, but it is not partnership in Korea. In Korea, when we are practising in the hospital, we might do vital signs for the nurse but then the nurse will take it for granted - that's our job. When I practice in hospital as student in Korea, the nurse can order, it's not like 'could you please'. It's 'you need to do it' and if you don't do it, you may get disadvantages (FG2: Korea).

This experience is in contrast to the supernumerary role assumed by student nurses in Australia whose clinical experiences reflect predefined learning outcomes (Ryan, 2008) which are expected to be completed during clinical placement and supported with facilitation from the supervising nurse.

As in the previous sub theme which focused on TCL in the school of nursing, the Indian participants experienced a contrast in their clinical placement experience with a lack of teacher direction and supervision, stating; 'in India we are free to do anything, yeah, do anything … sometimes we did injections on patients in the hospitals, if the teacher is not there' (FG5: India). One Indian participant compared their previous overseas clinical practice experience with their Australian clinical learning experience:

> In India, we are able to talk to and just watch the nurses but here the nurses are watching us, we have to do things and we have to be learning things and we are focussed on what we are meant to do and our scope of practice (FG5: India).

The participants explained that the formal structure of clinical teaching, such as predefined learning outcomes which guide the student through their clinical experience was not in place, as they had experienced in Australia (FG5: India) resulting in unstructured clinical placements. One participant explained further:

> We were not learning anything, I still remember we were students in 3rd year and we were in operation room and you know what we were not doing [anything] and my teacher was sitting outside and she no check, she no ask what are my students doing, that we were learning or not. We were just doing time pass, you know a students' life (FG5: India).

The Indian participants reported that they practised skills in a more opportunistic manner with little consultation with other members of the healthcare team. The Indian participants' described a specific scenario where they appeared to have learnt about lumbar punctures in their school of nursing laboratory and then took the opportunity to practise the procedure unsupervised. They explained:

> Sometimes we did injections on patients in the hospitals, if the teacher is not there. We would practise on manikins but then we would do on real persons, that was really different. I remember one of my class members she had a lumbar puncture; she did a lumbar puncture! We had too much confidence when we were in the hospital - nobody knows it's not legal - No laws - we just do. It's so funny - they didn't seen us (FG5: India).

The Chinese participants indicated that not only were they expected to follow orders and if they did have a question they were unlikely to have their learning needs met, stating that; 'sometimes if you are curious, you can ask the doctor and if they are not busy they might answer you' (FG3: China). The second theme; *we hardly talk to each other* addresses communication in the learning environment.

### 5.3 Theme 2 - *We hardly talk to each other*

The theme *we hardly talk to each other* reflects limited opportunities for communication in learning environments in the school of nursing and healthcare settings. Participants reported minimal verbal communication with other students or the teacher in the classroom. Task focused learning experiences and the lack of therapeutic communication in the clinical laboratory and during clinical placement extended to the workplace with limited communication with patients and other members of the healthcare team. The sub-themes

within this theme are: *listen and keep silent*; *not in front of them all;* and *you do not need to say something*.

### 5.3.1 *Listen and keep silent*

The theme, *listen and keep silent,* reflects the lack of classroom interactions as a result of teacher centered approaches and the volume of content delivered and expectations that students obtain good grades by listening and copying. The physical environment required that students concentrate to overcome difficulties in hearing due to large class sizes, lack of microphones and language differences.

The Korean participants explained that the absence of interaction in the classroom was related to the need to concentrate, to ensure high academic outcomes so that they would be allocated to a 'good' hospital for clinical placement (FG2: Korea). One participant explained:

> We can't interact, we hardly talk to each other, we just listen, listen, listen and keep silent because the important thing is your score, if your score is high you can go to a good hospital, if your score is low then you can't go to a good hospital (FG2: Korea).

Another participant in this group explained that the pace of the class was so fast that even if they did not understand they would not have had time to ask questions, stating; 'if the lecturer speaks to us … just listen, listen, listen … we can't interact with each other' (FG2: Korea).

The Chinese participants described strictly controlled teacher centered lectures, stating; 'we sit in one room, we had own space, like chair with the desk, every day the same seat and the lecturer front of us' (FG1: China) and 'all students are categorised in certain number of groups so we are educated in that group … like 40-50 people/students in class (FG3: China). These participants implied that where they sat in the class impacted on their

ability to interact, explaining; ‘if I sat in the back I would ask questions later, or just find a book you know, book always have answer’ (FG3: China). Similarly, the Indian participants recalled classroom facilities and large class sizes limiting interaction in the classroom, stating that they felt that their lectures were too large and that the lectures were ‘very rushed’ because ‘we were too much’ (FG5: India). One participant stated; ‘there were no microphones, we had to concentrate, difficult to hear, the last students couldn’t hear’ (FG5: India).

The Indian participants also explained that although lectures were delivered in English, the student decided which language they would use in class. Participants explained that they would use English or Punjabi languages and that ‘even mixing was acceptable’ (FG5: India). The mixing of languages when speaking in the classroom and in written work had the potential to reduce the students’ ability to interact with each other particularly for those who had varying degrees of English comprehension. One Indian participant explained further; ‘we hesitate [to speak to one another] because of language … we are thinking maybe everyone will laugh on us’ (FG5: India). The accepted mixing of languages, although probably intended as a strategy to improve the students’ English, was a source of embarrassment for the students struggling with English, resulting in their reluctance to speak in the classroom.

The ISNQ findings support the findings of limited experiences in classroom communication and interactions that emerged from the focus group data. For example, Korean participants reported little participation in classroom discussion and only 33% of the Chinese participants reported that they had interacted in a classroom ‘frequently’ or ‘often’ (see Chapter Four - Table 4.6). These findings correlate with previous research findings that Asian students tend to be quiet students who are accustomed to little interaction in class and

will not interrupt the teacher to ask a question (Lawson et al., 2006; Wang et al., 2008). The limited class participation also contrasts significantly with the Australian expectations of higher education students as outlined in the 'Study in Australia' website which advises international students that they are expected to 'raise questions, develop a logical argument and participate in discussions and debates with other students and teachers' (Australian Government, 2008).

The experience of limited classroom interaction is problematic for overseas educated nurses coming to study in Australia as they are expected to adapt to the active deep learning strategies where students are expected and encouraged to generate discussion and ask questions (Chinn & Kramer, 2008; Sidoryn & Slade, 2008; Wang et al., 2008). The participants from all cohorts described an environment where classroom discussion was discouraged and the presentation of seminars did not take place in front of other class members. The participants' experiences of classroom discussions are described further in the second sub-theme; *not in front of them all*.

### 5.3.2 *Not in front of them all*

The second sub-theme for *we hardly talk to each other* is *not in front of them all* and describes the lack of opportunities provided by teachers for students to speak in a group or in front of a group or ask questions in class.

All participants explained that their teachers in their homelands would never expect a student to stand up and speak in front of the class or participate in presentations or group work. One Chinese participant explained; 'if they [the teacher] ask you to do a presentation, it is not often and not in front of them all, maybe just in front of the teacher' (FG1: China).

Participants in each focus group similarly explained that student presentations and group work were never experienced in their overseas classrooms. The Indian participants explained; 'we didn't [do] group work, nothing, no presentation' (FG5: India). The ISNQ data support this finding indicating that only 22% of Indian or Chinese participants 'frequently' or 'often' experienced classroom group discussion and all the Korean participants reported never participating in classroom group discussions (see Chapter Four - Table 4.6).

The participants confirmed that it was unusual for students to ask questions in the classroom. Participants from the Korean and Chinese groups explained that questions could be asked of the teacher at the end of the class, outside the classroom or at the teacher's office in private stating 'not in front of other students' (FG2: Korea) and 'we won't ask a question in the lecture … if we have a question we can go after class to ask the teacher' (FG1: China). The Indian participants explained that in their homeland, asking a question might be interpreted as a sign of disrespect or an interruption and that although they could ask questions in class with their hand raised, they were hesitant to do this (FG5: India). The reluctance to ask questions and speak within a group is an antecedent to the next sub-theme; *you do not need to say something*.

### 5.3.3 *You do not need to say something*

The final sub-theme of *we hardly talk to each other* is *you do not need to say something* and refers to the participants' experiences of integrating therapeutic communication and nursing skills during their clinical practice and includes inter-professional communication in the workplace. Participants explained that busy clinical settings and structured role expectations led to limited communication between nurses and patients, nurses and nurses and other health professionals.

The Chinese participants described a busy clinical laboratory where skills were practised repeatedly without the need to speak and without consideration of therapeutic communication with the patient. Participants reported similar experiences, for example:

> When we do the injections, our teacher will not focus on our communication, you do not need to say something [to the patient], the teacher will focus on the skills, they do not think you need to say something (FG1: China).

The Chinese participants made a similar comparison of their experiences in the homeland to those they have had in their Australian nurse education. The participants referred to the use of manikins which the students were required to treat as patients and apply clinical skills from a scenario along with the therapeutic communication and critical thinking necessary to accompany the skill. One Chinese participant explained; 'Here [Australia] we need communicate (with the manikins) when doing skill but I didn't do that in China, the practise is how you can do the skill - communication is a different thing' (FG4: China). These participants also explained that therapeutic communication was disregarded due to time restraints, stating; 'we don't have time' and 'we don't like to talk' (FG4: China). One Chinese participant explained further; 'we don't need explain much for the patient – just do it, we do not have time' (FG4: China). The Korean participants also explained that therapeutic communication was unnecessary when practising a skill, because gaining 'experience' in a skill did not count toward assessment so the therapeutic communication which might accompany the skill was overlooked (FG2: Korea).

Limited communication extended from the clinical laboratory to clinical placement in the healthcare setting. Participants from each cohort described scenarios where they did not

communicate with the patients. The following excerpt describes a participant's experience of measuring a patient's blood pressure:

> If need to take blood pressure, we don't say, what's your name, how are you feeling, how are you, like very patient. We sometimes are very rushed so we just say, give your hand, so blah, blah, everything done, cuff on, take the blood pressure, cuff off, OK, that's done, your blood pressure is a little high or that's fine. (FG1: China).

Chinese participants from another focus group described a similar scenario also reflecting the limited expectation to speak with the patient. This excerpt is related to asking for permission from the patient prior to a procedure and providing an explanation to the patient.

> If it's a cannula or something I just say; 'Show me your hand', and I do it, sometimes they say it is sore and I say; 'Yes, it is sore, that's normal'. We don't explain too much, we just say 'according to doctor's order' and when they listen to 'doctor', they think doctor is great, doctor is power. The doctor can explain but for the nurse we never explain a lot to the patient (FG4: China).

The Chinese participants further explained: 'we don't like communication, we don't like [to] touch the patient, we don't like to - 'are you allow me to do that?' We just do that' (FG3: China). For practices such as giving medication, they explained; 'they [nurses] just ask the name and there is not too much talking about with the patient' (FG1: China). The participants explained that those practices stemmed from a crowded hospital system where there were more doctors than nurses on the ward. When the patient needed to talk then they would prefer to speak to the doctor, as reflected in the following data excerpts; 'if the patient asks us a question we would give a quick answer but if the patient asks us more, like doctor things, we will say 'OK, you need to talk to the doctor" (FG1: China).

> It's different communication from Australia … you can't have focus on the communication with them [patients] because we have lots, you need to do everything done before you are leaving and give medication in time so we probably just - OK, this is your drugs, you take every day, every time, you know how to drink or eat … (FG1: China).

The Indian participants described a learning environment where therapeutic communication with the patient was limited to 'OK, I'm going to do this'. The participants explained that they would just carry out the procedure 'if the patient ready or not' stating that this was common practice during clinical placement (FG5: India).

The health professionals' limited communication in the workplace also impacted on student learning through role modelling. One Indian participant recalled that when working in the homeland they were not required to notify anyone when leaving the ward area, explaining; 'you go to lunch whenever you want, you don't have to tell anyone, you just go' (FG5: India) regardless of the ongoing care that patients may have required. It was also explained that the doctors expected nurses to be able to provide details regarding the patients' progress but the nursing staff did not view this form of communication as an important part of their role, stating; 'the doctors really want to know what to do about patients, it is not really serious work in India [for the nurses]' (FG5: India) implying that communication is not considered an important part of their role.

The Chinese participants also referred to the lack of communication between staff and the expectation that they would accomplish their tasks without needing to speak to each other; 'we had our task…but it's very busy hospital…they won't say something' (FG3: China). The participants explained that not speaking to each other was not as problematic as might be expected. Many of the procedures requiring nurse to nurse, or nurse to doctor communication, such as medication preparation and administration, were prepared in advance for the nurse, limiting the need for the nurse to consider or question the orders and thereby limiting the need to consult. This finding is further explained in the next theme; *No need to critical think.*

## 5.4 Theme 3 - *No need to critical think*

The theme *no need to critical think* reflects the participants' learning environment from the classroom to clinical practice where students were not encouraged to question, apply evidence to practice and therefore have not had the opportunity to develop lifelong learning skills including critical thinking. In the classroom environment, teachers provided resources and precise information without expecting students to source and evaluate their learning materials nor develop information literacy skills. In the clinical environment students' learning experiences focused on tasks without assessment or evaluations of patient outcomes, often without documentation. In the workplace, the participants recalled feelings of not being prepared to work as a graduate nurse and relying on senior staff to keep them informed of changes in practice. The sub-themes within this theme are: *you don't find other resources*; *it's just a task;* and *not perfectly prepared*.

### 5.4.1 *You don't find other resources*

The sub-theme *you don't find other resources* extends the expectation that the teacher would provide the students with additional learning materials and also tell the student what they need to learn and what they need to read without the student needing to evaluate the source of the information or research for information themselves.

The Korean and Indian participants described similar experiences of teaching and learning resources being provided with; 'they give us a lot of information, they give the information and we need to write everything down, so we just write' (FG2: Korea) and; 'the teacher is giving everything to us, they have prepared notes, they give us the information, everything is prepared for us (FG5: India). As in sub-theme 5.2.2 *the teacher must push* us,

the Chinese participants again referred to the responsibility of teaching and learning being placed more on the teacher than the students and made a comparison to their teaching and learning experiences in Australia:

> In China, the teacher will have the main points for us and here [Australia], we should do the research our self. When I came here, the first thing that I feel shocked with was that I should do everything by myself to find resources. In my country, the teacher will tell you if we have a writing assignment, what information you should find, they will give you information on where you can find (FG1: China).

And:

> In China, all the work is given to you; you just have to sit there. On my first tutorial here, I was so shocked because I thought the tutor didn't know what she was doing, she just set up a few questions and let the students talk and I was taught quite different because back in China, the teacher had to talk the most in the class so I thought 'oh, why are you just sitting there and leave it to us?' I thought that was ridiculous, it was a shock to me (FG3: China).

The overseas educated nurses' experiences of having learning materials provided contrasts with the Australian Government's 'Study in Australia' website, which states that international students entering Australia to study are expected to be able to collect and analyse data and conduct research independently (Australian Government, 2008). The expectation that all the resources will be provided also conflicts with the current inquiry based teaching and learning strategies commonly utilised in Australian nurse education where the student is expected to independently source their own materials (Lawson et al., 2006; Wang et al., 2008) and where the responsibility for learning is placed on the student.

Participants from all cohorts explained that all learning resources were provided by the teacher and the students did not consider information quality, explaining; 'that's what text are for, you know, and we are taught less about the critical thinking cause I think we are more focused on the knowledge base … we are full of knowledge (FG3: China). The Chinese participants explained:

> You don't have this information is right or wrong or this information is over dated or new - it's just the right information, you don't find other resources … I not judge which one [resource] is good because each one has positives and negatives for education (FG4: China).

All participants explained that students were not required to work independently or source any learning materials beyond their textbook independently. The Indian participants described similar experiences; 'we had never heard of research articles, here we have to find, but there we never' (FG5: India).

Data from the ISNQ indicate that 70% to 80% of participants from all cohorts 'frequently' or 'often' received additional teaching and learning materials prepared by the teacher. Only 24% of Chinese participants indicated that they would 'frequently' or 'often' source additional materials independently, with 60% of the remaining participants from Korea and India, indicating that they would 'never' or 'rarely' source any additional teaching and learning materials (see Chapter Four - Table 4.6).

The participants' explanation of students' having everything prepared for them and not having to find resources thereby limiting their opportunity to critical think is a result of their task focused orientation to learning and practice which will be explored in the next sub-theme.

### 5.4.2 *It's just a task*

The sub-theme *it's just a task* reflects the students' learning experiences during clinical placement where the focus was on completing tasks rather than using analytical skills to assess and evaluate patient outcomes. Administration of medications and nursing documentation were significant examples which illustrate the lack of critical thinking in

clinical practice that resulted from their TCL experiences. The following excerpt provides the participants' rationale for the emphasis on task focused nursing:

> Here [Australia] more like patient centred care, like it's always about patient and our care is full up with patients condition, but that's how the nurses work in the hospitals in Australia but back in China we got so many patients, but not us many nurses will able to follow up the patient role so we actually, um, you know, categorise nurses into different tasks, more like task focused nursing (FG3: China).

Participants from China explained that when administering medications, they were only required to check the patient's name on the medication package before administration. The Chinese participants explained that they did not have access to a resource such as the 'MIMS' (see Glossary of Terms) to check medications prior to administration to check the suitability of a medication order for the patient. Also calculating the specific dose was not required because the pharmacy or doctor had already prepared the medications in advance. All participants explained that they were taught in the school of nursing to carry out the 'the six rights' and the 'three checks' (see Glossary of Terms) prior to giving the medications, but in clinical practice, it was just a quick check. The Chinese participants explained; 'we just compare and we don't need the calculator, we have a pharmacy already done this kind of procedure, they [medications] are ready to give' (FG3: China). The participants again referred to the nursing workload as being the catalyst for this practice explaining:

> The doctor has prepared it for us. He has already prepared for us, there is a specific area for preparing this stuff in our hospital because we got too many things to do and we got a lot of patients (FG1: China).

The participants explained that patient medications were prepared in advance and were transferred to the wards when required (FG1: China), eliminating the need for the nurse to reconstitute medications or titrate tailored doses. A Chinese participant explained:

> There is a specific place and they transfer the drugs to the different wards and it's already compared - like this is Normal Saline and the patient name

> is on normal saline and antibiotics also put the label on and you just need to OK (FG1: China).

The Chinese participants made comparisons to their experience of antibiotic preparation in Australia, saying 'we didn't do the drug calculations because the doctor's order is easy for us' and 'it's not like we should put 2 mLs in and drop off 1 mL' (FG1: China). This statement refers to antibiotic preparation where the dispersion factor of the powder in the vial needs to be taken into consideration when tailoring specific doses for the patient. However, one Chinese participant disagreed, explaining that they did have to calculate but 'we just did it in our mind' and 'the doctor's orders are very clear' (FG3: China). She explained; 'we don't need to calculate it's not so difficult, we just have to follow the doctor's orders' (FG3: China). When asked to explain what was meant by the doctor's orders being very clear, the participants explained that medications such as tablets and mixtures were prescribed in such a way that whole tablets or millilitres were administered so the nurse did not have to calculate the number of tablets or millilitres of liquid medications (FG3: China).

The Korean participants recalled learning intramuscular injection and intravenous cannulation skills in the clinical laboratories and referred to using the 'KIMS' (equivalent to the Australian MIMS) as part of their medication checking procedures. These participants explained that 'we just mix in bags … 50 mLs of fluid, or 100 [mLs]'. However, as explained previously, the opportunity to practise these skills during clinical placement was 'up to the [supervising] nurse' and they were rarely allowed to use these skills during clinical placement (FG2: Korea). When discussing medications, the Indian participants described differing experiences; 'the people are not much educated and they don't know much about medications … we do checks, yes, rights and checks but we give morphine to so many patients, I just grab myself, just give' (FG5: India). These participants explained further; 'we see their medical

chart, we see their history, so we know everything, we can be checking whether the patient had before … but we don't sign' (FG5: India). The Indian participants' references to signing for medications leads to the next example in this sub-theme which relates to documentation.

Participants from all of the cohorts explained that due to their task orientated model of nursing, it was the role of the more senior nurses to complete all documentation including recording vital signs and signing for medications, which they may not have administered themselves. The Korean participants explained the lack of importance placed on learning documentation skills during their clinical placement with the following comment; 'I will not choose to follow senior nurse because the senior nurse will not move a lot; they will just be writing, documentation, so I would find another nurse' (FG2: Korea). The participant implied that there was little to learn from the nurse who was documenting and not providing direct patient care.

The Chinese participants described their experiences of documentation during clinical placement; 'We don't do the documentation, like the charts, their formal charts, we don't do, discharge chart, we can't do' (FG1: China). Both the Chinese and Korean participants explained that they 'don't' or 'can't' do documentation because it is not a task allocated to nursing students during clinical placement. The participants explained that the student nurses would write their patient observation findings or fluid balance totals on a piece of paper and these were given to the senior nurse for consideration but it was the night nurses' responsibility to put this information into the 'graph' in the patient's chart. This participant explained the documentation responsibilities of qualified nurses; 'they did different separate tasks for each nurse, like you did vital signs, you did medication, the nurse will collect the data during the day and the night nurse will put the data into graph' (FG4: China).

It appears that this process minimised the critical thinking required of the nurse in regards to the patient's condition since all the information was entered in the patient's chart during the night in readiness for review by the doctors in the morning. Not being able to chart the patient's vital signs into the graph or monitor fluid balance levels as they fluctuated throughout the day precluded the nurse from critically analysing any subtle changes in the patient's condition and increased the nurses' dependence on receiving doctor's orders. One Chinese participant explained that this process of documentation was efficient, explaining that the documentation process in China was quite complex and time consuming. Therefore it was much more efficient to allocate the task of measuring observations then passing those findings on to the more senior nurse or night nurse who would then document and graph the results. The following excerpt describes this experience further:

> For documentation, I just grab the paper, paper of blood pressure and temperature and write everything down and write the bed number on it and give to them [Senior Nurse] and they write it in the documentation there because they need to know the fluid balance chart, or normal chart, the blood pressure and the pulse, they need draw the lines. I can't do that, they have 20 or 40 lines over there. Save the time (FG1: China).

For the Indian participants, the majority of whom had also worked as qualified nurses in their homelands, it appeared that documentation, whether it was documenting progress notes in the patients' charts or documenting nursing care at the patient's bedside, was rarely performed. The Indian participants explained; 'we didn't sign after giving medication, we can give anytime, if late, didn't matter' and 'we had fifteen nurses in one ward and everyone just gave medications anywhere, we just ask each other or the patient' (FG5: India). They explained; 'there is some documentation but it's not really written, we do write things but the law is not strict' (FG5: India). When asked about documenting the patient's progress [in the patient's chart] in order that other healthcare professionals could review the patient's

condition, an Indian participant explained; ‘we are doing progress notes the same … we need to write down time and date and nursing entry … but it is not really serious work in India’ (FG5: India).

The participants indicated that due to the teacher centered task focus of their learning and the differences between what they were taught in the nursing school and what they experienced in clinical practice, they did not feel prepared for the workplace. This situation is addressed in the sub-theme; *not perfectly prepared.*

### 5.4.3 *Not perfectly prepared*

This final sub-theme *not perfectly prepared* reflects the participants’ feelings of unpreparedness for clinical placement whilst a student nurse and in the workplace when graduated. The participants explained that teaching and learning experiences based on observation and the rigidity in their clinical education did not prepare them for practice in the clinical environment. The sub-theme *not perfectly prepared* reflects the disconnection between the teaching and learning during the participants’ theoretical nurse education and their clinical experiences in their final year of practice and then when qualified in the workplace. It would appear that graduate nurses did not feel prepared for the workplace as they relied on others for direction and ongoing learning.

The participants reflected that the theoretical content of their course did not integrate with clinical content which contributed to their being unprepared for practice. This was a result of the skills taught and practised during their nursing education being individual tasks that were difficult to integrate into their clinical experience. One participant from China explained; ‘you focus on information literally, it’s not for real practice’ (FG4: China). One

Korean participant stated; ‘we are not perfectly prepared to perform any clinical skills confidently or give patients knowledge when we work in the hospital as a new graduate nurse’ (FG2: Korea). An Indian participant had similar feelings of unpreparedness, explaining:

> In India we were not really taught about the ethics, conducts, fundamentals, scope of practice, duty of care. When I got selected in really high hospital, I was ICU nurse, I was not really happy to do that, they put me in that … I was not confident, when I went there I was not ready for that. All the patients were on ventilators, unconscious, coma, everything and the medications I didn’t have knowledge of (FG5: India).

The quality of supervision as a graduate in the workforce also had an impact on the participants’ feelings of preparedness. One Korean participant explained; ‘my hospital was newly built so there was a lot of demand for nursing staff so I was under pressure to become competent more quickly so my preceptor was quite quick and after I finished my preceptorship, I still didn’t feel confident about my nursing skill’ (FG2: Korea).

The participants explained that the lack of consideration for the ethical issues which accompany practice and their limited experience in communication and documentation and not maintaining qualifications impacted on their performance in the workforce. The Chinese participants in this study implied that due to the lack of emphasis on professional development and continued learning, particularly in relation to maintaining competency to work, there are limited opportunities to develop further skills and competencies in the workplaces:

> I think we, when you are, as a nurse you don’t keep studying anymore I think. I mean as a full time nurse I only focus on my work, I won’t do some research, I won’t keep study. If there are something new then the doctors or the higher chief will say something and we will know but we won’t do it by ourselves (FG4: China).

The final theme *no need to critical think* presented the participants' experiences of a teaching and learning environment where they were not encouraged to question information or evaluate by applying critical thinking skills and engaging in reflective practice. This has resulted in the participants feeling that they were not prepared for practice as qualified nurses in their homelands.

## 5.5 Summary of Findings from the ISNQ and Focus Group Data

Findings from the ISNQ indicate that current teaching and learning strategies, for example, self directed learning and online learning and independently sourcing research materials, were rarely or never experienced in Korea and India and only sometimes experienced in China. These findings were supported by the focus group data which indicated that the participants in this study were accustomed to receiving all the information they needed to succeed and had not been prepared to take an active part in their learning through the use of independent and critical thinking strategies. The findings indicate that these participants did not use evidence based practice or reflective practice strategies to enhance their learning and subsequent delivery of nursing care which also limited their professional development.

The ISNQ and focus group data illustrate a very rigid teaching and learning environment which inhibited interpersonal interactions in the classroom and during clinical practice which resulted in the participants' limited preparation for therapeutic and interpersonal professional communication. Participants reported that much of their clinical practice experience required that they 'observed the Registered Nurses at work' and that Registered Nurses used a task orientated model to provide nursing care (Berman, Snyder, Kozier, Erb, Levett-Jones, Dwyer, et al., 2010) and expected direction from the medical

profession. This situation resulted in these participants appearing: unprepared to deliver patient centered care and education, unprepared to work in a collaborative healthcare environment, and unable to contribute to the professional development of others. Due to not having been prepared for working in a collaborative environment, the participants in this study have indicated that they were less likely to recognise and respond to unsafe practice, promote patient advocacy, or practice within professional boundaries. The participants describe a teaching and learning environment which does not equip them with the knowledge and experience to lead and delegate safely.

## 5.6 Conclusion

Chapter five has presented the focus group findings with support from the ISNQ and literature. The major findings to emerge are that the overseas educated nurse participants from China, Korea and India were not equipped to take an active part in learning or thinking critically or independently as is expected in the Australian higher education system. The participants highlighted some of their difficulties in adjusting from a highly structured, teacher centered environment to a student centered environment which embraces strategies such as group learning, independent learning, critical thinking, expression and reflection. The following final chapter of this thesis presents a discussion of the key aspects, implications and limitations of the study, recommendations and directions for future research.

# CHAPTER SIX

# DISCUSSION AND CONCLUSION

## 6.1 Introduction

This final chapter concludes my thesis in which I have explored the previous teaching and learning experiences of overseas educated nurses from China, Korea and India. The research was conducted to answer the question: *What were the teaching and learning strategies most commonly experienced by overseas educated nurses from China, Korea and India in their previous nursing courses in their homeland?* This chapter commences with a reflection of the conduct of the literature review, its key findings and gaps evident in the literature. I will then reflect critically on how the objectives of the study in Chapter One were met during the stages of the research process and evaluate how the literature review, methods of data collection, including adherence to ethical processes and data analysis contributed to the findings that answered my research question. I will also show: how the expected outcomes of the study have been addressed and have provided a framework for recommendations from the findings and literature. I will also demonstrate how the findings and literature have provided guidance for me to discuss the significance and implications of the study for future research, education and practice. I will also outline the limitations of the study. The thesis concludes with a summary of the study and a conclusion that integrates all aspects of the study.

## 6.2 Literature Review

Literature searches focused on overseas and Australian nurse education and the previous education experiences of international students and in particular, overseas educated nurses from China, Korea and India who had come to Australia for further study. Although there were large amounts of literature describing the nurse education infrastructure in China,

Korea and India, obtaining details of the teaching and learning strategies was difficult. It may be that there is research but it is not published in English.

Literature that was available provided me with insights into the teaching and learning methods used in international education in Asia particularly and their value to the student studying in a second language, such as using memorisation as a strategy to allow information to be interpreted prior to deeper analysis (Watkins & Biggs, 2001). The literature reported that Asian students were passive learners who seldom participated in classroom discussions, did not question or challenge ideas and were not prepared for critical thinking and decision making in their professional role (Lawson et al., 2006; Watkins & Biggs, 2001). However, much of this literature related to international students and was not specific to nurse education. Despite my early review of literature identifying that international students coming to Australia, particularly those of Asian cultures struggle with many of the teaching and learning strategies inherent in Australian higher education (Australian Government, 2008; Lawson et al., 2006; Watkins & Biggs, 2001), I focused on Chinese, Korean and Indian nurses teaching and learning experiences. This was to keep my study manageable as well as to focus on the countries that were most represented at my university. Nevertheless, the lack of literature specifically describing the previous teaching and learning experiences of nurses educated in China, Korea and India provided focus for the course of this study, both in questionnaire development and focus group discussions.

Performing separate reviews of the academic and clinical teaching and learning strategies utilised in each country provided me with an understanding of the teaching and learning strategies that the participants who would be involved in the study may have experienced. However many of the articles were commentaries of expert opinion rather than

the result of research demonstrating the limited primary research conducted in this area. My strategy of reviewing each country separately seemed appropriate for the initial quantitative approach using a questionnaire. However, having the literature review structured in this way resulted in review findings being clustered into countries of origin rather than focusing on the teaching and learning strategies experienced in the countries of origin. Structuring the literature review to focus on teaching and learning strategies would have more clearly reflected the research question and subsequent questions for the questionnaire and focus groups.

More recently (since my initial literature review and questionnaire development), literature which explores the development of a student centered pedagogy using strategies such as problem based learning and evidence based practice has emerged particularly in Hong Kong and Thailand (Lee et al., 2011; Oh et al., 2011) but not so in the countries targeted for this study. Further literature has also focused attention on the inadequacy of the current teaching and learning strategies applied to overseas educated nursing students from China, Korea and India enrolling in Bachelor of Nursing programs with RPL in Australia. This literature has also identified the unpreparedness of academic staff for the range of student entry behaviours with which these students present (Wang et al., 2008). My study may have benefitted from an earlier exploration of literature on the Australian nurse educators' experiences of implementing student centered teaching and learning strategies to classes with overseas educated nursing students, as this literature may have provided more guidance for the overall research methodology, items in the questionnaire and focus groups.

## 6.3 Research Methodology

Due to the exploratory descriptive nature of this study, I initially intended to use only a quantitative approach with a purposely designed questionnaire. The research question and

questionnaire was informed by the literature in order to collect a wide range of exploratory descriptive data from as many participants as possible. Despite conducting a pilot study of the questionnaire with some minor interpretive problems being identified and subsequently addressed, the pilot study did not identify that the participants would be reluctant or unable to fully complete the questionnaire where narrative responses were sought. This resulted in a mixed methods methodology with the use of focus groups for further data collection which also required a change in my philosophical approach from a purely descriptive quantitative method using questionnaires to answer my research question which asked 'What?' to a qualitative exploratory method using focus groups which also answered the research question but also provided more 'Why?' in the findings (Crossan, 2003; Polit & Beck, 2012).

Focus groups were selected as an appropriate method of further data collection as I sought further in depth information to clarify responses obtained from the ISNQ in order to more fully answer the research question. Open ended trigger questions were used as prompts to generate discussion and provide insight into the participants' previous teaching and learning experiences in both the academic and clinical setting. For example; the ISNQ asked participants to indicate how often student - teacher discussions and student - student discussions took place during class. Responses varied between cohorts with only 5% of Chinese participants indicating that student - teacher discussions took place 'frequently' whilst 50% of the Indian participants experienced student - teacher discussions during class. The focus group trigger question asked participants 'What strategies did you use if you had a question during the lecture?' Data revealed that Chinese participants were not expected to ask a question during class, directly speak with the teacher during class and certainly not in front of other class members. One Chinese participant described oral presentations of work given to the teacher outside class time in private or with a small select group from the class.

The interaction between focus group members added richness to the data producing a level of insight that could not be obtained by the use of the ISNQ alone. During the focus groups individual participants were prompted by their peers to elaborate further on responses to questions thereby adding to the discussion and data collected. The focus groups added to the reliability of the ISNQ data by providing consensus and also revealing differences among participants' experiences (Polit & Beck, 2012).

The change to a mixed methods approach required a change in my approach and position as the researcher. The questionnaire data collection phase required the concise, objective measurement of responses from the sample (Polit & Beck, 2012) where I was clearly separated from the participants in the sample and the data collection process, and the findings extended what was already known about the topic. I then moved from an objective, distant relationship to a more interactive and subjective relationship with the participants in the focus group interviews. Having this deeper level of involvement during the focus group interviews provided a more holistic approach in which I became integral to the findings and subsequent development of theories by exploring meaning and describing relationships (Polit & Beck, 2012). This change in approach required not only a change in my relationship with the participants but also in my role in the data collection phase and the impact that my presence may have had on data collection.

### 6.3.1 Data Collection

After completion of the questionnaire data collection, it was evident that although the questionnaire obtained the data sought in that instrument, the nominal and ordinal nature of the data and the lack of participant narrative data did not provide sufficient information on the

previous teaching and learning experiences of the participants (Polit & Beck, 2012). The questions requiring narrative data may have been answered more fully if I had conducted focus groups following the review of literature and then developed the questionnaire based upon the analysis of the focus group data. One issue could have been the complexity and length of some questions, which resulted in missing data. For example, question 13 (see Appendix D) asked the participant to indicate the area in which they experienced specialty clinical practice and the period of time that they spent in each specialty practice area. Given the level of recall required to answer this question, the responses reflected the highest amount of missing data and were of limited value. This question may have been of more value had it been broken down into a series of smaller questions with more emphasis on the role of the student nurse and the tasks practised rather than length of time in the area. Had the focus group data been available to guide questionnaire development, the question could have been structured differently or may not have been required.

The reliability of the questionnaire data was also affected by the distribution of the questionnaire at a time when the participants had just completed a class and were focused on the class content and therefore Australian nursing teaching and learning strategies. The required change of focus from the present to the past could have affected the participants' ability to recall previous teaching and learning strategies from their homelands. The gaps in the data collected may also have been due to the structuring of the items in the questionnaire as well as the timing of the questionnaire completion. The questionnaire required a high level of detailed recall from the English Second Language (ESL) participants immediately following a one hour class when they may have been mentally fatigued from the effort required to listen and write in class and then complete the questionnaire in a compressed timeframe at the end of the class.

For the ISNQ to be used in future studies, the validity and reliability of the tool would need to be established. Reliability is measured through the instrument's internal consistency, where the different subparts of the questionnaire are tested for reliability in measuring the critical attribute (Polit & Beck, 2012). For example, the reliability of each variable within the question relating to availability of teaching and learning resources needs to reflect a consistent method of measurement of each resource, such as the Likert scale used in this study. This then contributes to validity, which is the degree to which an instrument measures what it is supposed to measure (Polit & Beck, 2012). When using a self reporting method of data collection as in this study, reliability of the questionnaire would have been increased if questions were asked differently but obtained the same response. Asking questions in this way would also have contributed to analysis reliability (Polit & Beck, 2012). Had the aim of the study been to test the instrument design and had a larger sample been available, the sample could have been divided in half and a cross-validation of structure and scale reliabilities could have been conducted (Polit & Beck, 2012). However, this instrument was designed to collect data for this specific study and was piloted before data collection to ensure internal consistency and validity rather than reliability of the instrument.

The focus groups were planned to represent each of the countries of interest in this study. I found this to be a useful strategy as it meant that due to participants' similar experiences of teaching and learning in their homelands, they were able to support and elaborate on each other's stories, providing a rich quality of data that assisted me to understand the participants' experiences of teaching and learning in their homelands. However, one aspect of data collection which does concern me is whether or not the participants, when telling their clinical practice stories in the focus groups, were involved in a

degree of ‘one upmanship’ to tell the most bizarre stories they could to impress their friends. An example is the story of an Indian nurse surreptitiously doing a lumbar puncture on a patient during their clinical practice when they were not being observed or supervised. When I interrupted the focus group discussion to clarify that this indeed happened, the Indian participants assured me that situations such as these did occur. After studying the theoretical component of a procedure in class at the school of nursing and they would take the opportunity to practice the skill when on clinical practice. These participants explained that ‘scope of practice’ was a concept introduced to them in their Australian nursing practice experience.

Originally, I planned to have one focus group from each country (three focus groups in total); however more students than expected accepted the invitation to take part in the focus groups resulting in five groups being established. Upon reflection, I believe that this higher than expected participation reflected the trust that the participants placed in me as the researcher and the appreciation and support for the study by the students.

Time constraints during the focus group data collection period (a period of one week) did not allow for simultaneous data collection and analysis of focus group transcripts, a measure which would have ensured that the data collected were as complete as possible (Polit & Beck, 2012) as further focus questions would have targeted gaps in the data and clarified data. This timetabling situation was quite frustrating because had I been more aware of what the data were revealing during the focus group discussions, the gaps which emerged during analysis may have been fewer. On reflection, spacing the focus groups to allow time in between for transcription and analysis, rather than conducting all five focus groups within one

week, would have promoted more in-depth focus group discussions adding to the richness of the data.

### 6.3.2 Data Analysis

Data analysis took place following each of the data collection phases. Findings to emerge from the questionnaire data analysis were used to inform the focus group questions and support or contrast the findings from the focus groups. Analysis of the questionnaire data revealed that the questions requiring a 'tick the box' response appeared to be answered well overall. The few questions which did require the participant to provide a written response resulted in very brief answers which were contradictory in some cases. For example, when asked; 'Please give an example of the tasks you could perform unsupervised', one response was 'We could perform tasks independently under teacher supervision'. Other responses were 'vitals' and 'changing the drip bag'. Had I been able to clarify with the participant, I would have liked to confirm whether the vital signs were then reported back to the supervising nurse or the intravenous fluids checked with the supervising nurse prior to the student nurse replacing the bag.

Analysis of the focus group data required a process of coding and recoding in order to establish sub-themes and themes. During the coding process, I constantly referred to a codebook to check definitions of codes to ensure that the data entered accurately reflected the data from the participants and the corresponding themes and sub-themes. This was a very difficult process as I tended to be all inclusive of the data excerpts, trying to incorporate them all into the stories being told. To ensure that the data supported the themes and sub-themes I constantly returned to the research question to ensure that data were describing the previous teaching and learning experiences of the participants. Creating an audit trail of theme

development as illustrated in Tables 3.4, 3.5, and 3.6 also assisted with the clarification of data and confirmation that the research question was being answered accurately. Braun and Clarke's (2006) method of data analysis provided a simple six step method which I felt addressed the needs of this study and greatly assisted me, as a novice researcher, in providing structure when writing the analysis.

## 6.4 Ethical Considerations

Despite my concerns that potential participants may feel coerced to participate in the study due to the study being conducted by myself, as their teacher, these concerns were not reflected in the responses from students invited to participate. The thorough explanations provided prior to the distribution of the questionnaires and the deliberate care taken to ensure that participants could not be identified if they chose not to complete the questionnaires and that participation or non-participation was not linked to their standing in the university appeared to reassure the participants. The participants were made aware that only they could identify their questionnaire and that they could withdraw their questionnaire if they changed their mind at a later point. None of the questionnaires needed to be withdrawn.

The initial careful attention to minimising feelings of vulnerability resulted in the building of trust which later became apparent when the study was extended to include focus groups. The number of volunteering participants wishing to be involved in the focus groups reflected the confidence felt that their personal stories would be gathered with care and respect. All participants appeared to be confident with the reasons for conducting the research and how the research data would be protected. None of the participants appeared to become distressed during the focus group discussions or needed to withdraw. I will now move on to discuss the findings of the study.

## 6.5 Research Findings

This research has achieved its study objectives, identified in Chapter One which were to describe the previous academic and clinical teaching and learning strategies experienced by overseas educated nurses from China, Korea and India in previous nursing courses in their homelands. Following are my critical reflections of the research findings in relation to the objectives of the study. The research findings are framed to meet the objectives of the study and describe the participants' experiences of how they were taught and how they experienced the teaching and learning strategies utilised in their overseas nursing education.

### 6.5.1 Academic Teaching and Learning Strategies Experienced in Previous Nursing Courses in their Homelands

The participants in this study comprised of students who had completed Diploma and Bachelor of Nursing courses at high school, college and university level. The range of qualification levels is reflected in the findings referring to the participants' previous teaching and learning experiences. The participants from all countries explained that teaching and learning experiences and particularly access to resources, varied according to where their study took place. This included the variations in the intuitions providing the education or the location of that institution within the country. This was particularly evident within the Chinese and Indian cohorts who justified discrepancies in focus group discussions with statements like 'but you went to university and I was only at college' and 'but my district did not have that [referring to facilities such as computers]' (FG3: China; FG5: India). Those participants who did complete their qualification at university level indicated slightly higher levels of classroom interactions such as the participation in seminar presentations.

Overall, the classroom behaviours which were described by the participants reflect TCL approaches where student participation and interaction were not taught or encouraged and the student role was to receive predefined information centered on passing a final paper based examination as the only indicator of academic success. The Korean participants described their motivation to study related to academic grades or outcomes explaining that the overall score achieved in the classroom directed their clinical placement allocation.

In Australia, the ANMC National Accreditation Standards and Criteria, states that nursing curricula must contain a variety of assessment types and contexts enhancing individual and collective learning to ensure demonstration of skills leading to competence (Ryan, 2008). The overseas educated nurses in this sample studying a Bachelor of Nursing with RPL in Australia had not been prepared for the variety of assessment types that they would encounter and the compressed nature of the course limits the preparation that they could receive during the course. The unpreparedness for SCL approaches that overseas educated students experience when they commence study in Australia and the additional time that it takes to facilitate their learning due to the change in teaching and learning approaches has a negative impact on the overseas educated students' initial academic outcomes. Wong (2004) found that Asian undergraduate students enrolled in courses at a South Australian University perceived that their difficulties with learning experiences were due to different learning styles, cultural barriers and language problems. The different learning styles, comprising of more discussions, independent learning and critical thinking, were described as a stumbling block for quality learning in a western higher education system. However Wong (2004) identified that most participants demonstrated flexibility in adapting to student centred styles of learning and only 12% of the students were not happy with the change from a passive, accepting and absorbing teaching and learning style. Clark, Baker and Mingshing

(2007) also found that although students valued informal collaborative learning, their limited prior experience in SCL approaches resulted in a limited opportunity to learn to work together constructively and cooperatively in collaborative teaching and learning tasks. These findings by Clark, Baker and Mingshing (2007) and Wong (2004) support my claim that overseas educated nurses from non English speaking Asian countries entering Australia for further study are not adequately prepared for the teaching and learning strategies commonly utilised in the Australian higher education setting and require additional teaching and learning support to facilitate transition to university study in Australia and practice in Australian healthcare settings.

The previous teaching and learning strategies experienced by participants in this study were characterized by the transmission of knowledge principally through a repetitive memorizing process of information that provided the teacher as the main source of knowledge where students were not expected to question or challenge the information provided limiting the students ability to construct knowledge using analysis, synthesis, and evaluation (Clark, 2010). These teacher centered practices emphasized dispensing knowledge to students, using lectures as primary teaching methods, and assessments that focused on the memorization of facts and details, all of which do not initiate lifelong or collaborative learning practices (Attard et al., 2010). The TCL approaches described reflected students as passive receptors of information which did not provide opportunities for the participants to become actively involved in the learning process. This resulted in the participants' limited experiences with classroom interactions such as group discussions, participation in individual debate and questioning information. The participants explained that they would not ask questions because their teachers did not like to be interrupted during class, therefore in the event that students did have questions, teachers were consulted after the class (FG4: China). This in

turn further lessened the opportunity for debate and collaborative learning opportunities and supports findings that students were inadequately prepared for working collaboratively (Clark & Baker, 2006; Clark et al., 2007), thus impacting on interpersonal and therapeutic communication in the clinical setting and conflicting with the expectations of Australian nurse educators.

The participants also indicated that independent study strategies favoured rewriting of class notes with little application of critical thinking skills. This practice reflected the participants' exposure to the TCL environment where both the teacher and the textbook were regarded as authoritative sources of knowledge and neither was to be challenged (Fang, 2007). Findings from both the ISNQ and the focus groups indicated that the participants relied purely on the teacher to provide the majority of the teaching and learning resources and up to 90% of the participants indicted that they would 'frequently' or 'often' study from only one textbook source and that independent learning or individual research did not take place and was not required in order to succeed. This finding also explains the participants' attitudes to referencing sources in their written work. Collaborative presentations and essay style individual work requiring research were rarely experienced in previous overseas education and therefore the participants were not familiar with the need to reference work taken from another author. The participants explained that by using the author's work, 'honour' was bestowed upon the author and therefore citing the source was unnecessary (FG3: China). Since all teaching and learning resources were provided and independent inquiry was not required, the participants were not familiar with Australian laws that protect intellectual property (Australian Government, 2010) or rules pertaining to academic honesty in higher education. The participants in the study indicated that their unfamiliarity with these rules resulted in their misunderstanding what constituted a breach in academic honesty or the many

forms that academic dishonesty may take, for example, plagiarism, collusion or recycling (ACU, 2012c; FG3: China; FG5: India).

Teaching and learning resources such as the use of library and internet databases for independent inquiry and research were not always available to the students, particularly in the case of some Indian participants who indicated that their teachers also did not have access to internet resources. This access varied according to the location of the study institution. The Indian participants described their distress when coming to Australia and encountering teaching and learning strategies and facilities, such as computers and the use of electronic databases, with which they were completely unprepared. Samuel (2003) supports these findings, adding that Indian nursing faculty also lacked opportunities to attend conferences or workshops for further development of teaching and learning strategies. They also lacked the autonomy to apply emerging SCL approaches. This is in stark contrast to the ANMC National Accreditation Standards and Criteria which stipulate that students must have facilities and resources sufficient in quality and quantity to attain the required graduate competency outcomes and that approaches to teaching and learning and assessment procedures are developed in line with best practice research and practice (Ryan, 2008).

The participants from each of the countries studied explained that they expected that the classroom teaching and learning practices with which they were familiar would continue and ensure their study success in Australia. The participants expressed shock when they found that classroom information was not presented in the way that they were accustomed (FG3: China) and they were expected to participate in SCL teaching and learning strategies commonly utilised in Australian nurse education (Australian Government, 2008; Lawson et al., 2006) unprepared. In 2008, Yu found that teacher-dominated lectures were still

mainstream strategies in Chinese schools of nursing and Chinese nurse educators only recently had begun applying Western teaching and learning strategies to facilitate a more active teaching and learning environment (Sherwood & Liu, 2005; Yu, 2008). In recognising this, teaching and learning strategies for overseas educated students in Australia need to be flexible, appropriate and effective in encouraging a transition from their traditional passive role in teaching and learning, to an active role where students take control of their own learning, are encouraged to contribute opinions, allow mistakes to be explored objectively and one which guides the student to build on concepts being developed (Parker & McMillan, 2007). All of these factors determine study success and transition for overseas educated nursing students. Wong (2004) found that the preferred style of teaching and learning changes with the length of time students spent in their program. When Asian students commenced study in Australia, initially more than 33 percent preferred a TCL approach but as they moved on through their courses of study their preference changed to a more SCL approach to teaching and learning despite their previous position and qualifications (Wong, 2004). The students undertaking the Bachelor of Nursing with RPL have less time to become comfortable with the SCL style of teaching and learning they experience in Australia.

Literature reflecting broader South East Asian teaching and learning practices have identified SCL strategies being introduced in Taiwan as a strategy to engage nursing students as active learners (Wang et al., 2008). However, literature reflecting China, Korea and India indicates that overseas educated nurses arriving in Australia to study were unequipped to apply critical thinking and problem solving skills to their learning and clinical practice (Evans & Green, 2007; Sidoryn & Slade, 2008; Wang et al., 2008). The previous teaching and learning experiences of the participants in this study reflected an environment of limited communication which reduced their ability to think critically or engage in problem-solving

activities, therapeutic and interpersonal communication or contribute to their own professional development, all of which are valued outcomes in Australian nurse education. This not only impacts on their ability to study in an Australian SCL environment but also affects their ability to integrate into the workforce as autonomous decision makers as expected of an Australian Registered Nurse (Sidoryn & Slade, 2008; Wang et al., 2008) and also raises questions regarding their ability to meet Australian national competency standards.

In order to facilitate a shift from previous TCL approaches experienced in their homeland education to the SCL approaches that the overseas educated nurse can expect to experience in the Australian higher education setting, new experiences need to be created in the classroom where students learn to learn from each other and construct and reflect on new knowledge together (Clarke, 2010). Overseas educated nurses need to develop skills which assist them to identify their learning need and then self-direct their learning to meet that learning need (Biggs & Tang, 2011). In using inquiry and problem based scenarios, a student centered, collaborative, and reflective learning environment is created (Biggs & Tang, 2011; Clarke, 2010) with the added benefit of facilitating the development of lifelong learning skills.

### 6.5.2 Clinical Learning Strategies Experienced in Previous Nursing Courses in their Homelands

Findings from the ISNQ indicated that the participants experienced on campus clinical simulation practice throughout the duration of their nursing course with external clinical practice predominately in their second, third and fourth years depending on the course length. In addition to the clinical experience offered in previous years, the Chinese participants undertaking a five year university course experienced external clinical practice for the entire duration of their final year. Despite what appears to be a reasonable amount of clinical

experience, the lack of teaching and learning strategies that the participants experienced limited their opportunities to practise therapeutic communication, apply critical thinking, problem solving and decision making skills and develop autonomy in their professional role. All of these qualities are skills emphasised in both academic and clinical experiences in Australian nurse education. Those students undertaking the Bachelor of Nursing with RPL in Australia enter at second year level and can expect to attend clinical practice within their first six months of course commencement where they are immediately faced with a conflict in expectation of their Australian clinical practice where students are expected to demonstrate these skills at a beginning level.

The participants in this study described clinical teaching and learning experiences similar to their academic experiences. In their on campus nursing laboratories, repetitious step by step practice of clinical skills was the main teaching and learning strategy experienced. The clinical skills reflected task orientated nursing where the focus was on one task being completed without consideration for the provision of holistic patient care. An example of this would be not incorporating therapeutic communication whilst performing a task. The participants in this study reported that the clinical skills practiced in the clinical laboratory were isolated tasks only, and were not integrated into a patient scenario which would require therapeutic communication. The participants added that the tasks practiced in the clinical laboratory had minimal integration with the theoretical content being taught in the classroom. This added to the concept of skills being tasks unrelated to each other and contributed to the theory to practice gap which the ANMC aims to remove. The ANMC Statement of Intent outlines that the timing and length of clinical experience placements should complement the academic content of the course and that clinical experience placement takes place as early as practicable in the first year of study to facilitate professional

engagement, with extended final clinical experience placement towards the end of the course to consolidate competency outcomes and facilitate transition to professional practice (Ryan, 2008). The participants in this study also explained that frequently during their external clinical practice they were only permitted to observe the Registered Nurse working. This was more often the case during the first and second years and added to the theory to practice gap.

The rigorous emphasis on repeatedly reproducing a procedure or skill exactly as demonstrated also puts the student nurse at risk of diminished self-image and empowerment serving to weaken professional self-esteem, and limiting professional growth and development (Kuokkanen & Leino-Kilpi, 2000). This was particularly evident during external clinical practice where the Korean participants described their experiences of being 'just a worker' resulting in their diminished self-esteem during their clinical practice (FG2: Korea). Both the Chinese and Korean participants explained that they were expected only to follow orders and there was no need to think (FG2: Korea; FG4: China). The Korean participants described themselves as workers belonging [*sic*] to the supervising nurse and doing what they were told without the opportunity to apply critical thinking to make clinical decisions regardless of their teaching and learning needs (FG2: Korea). These findings were supported by Yi and Jezewski (2000) who observed that Korean nurses entering the United States of America experienced problems with differences in decision-making styles, teaching and learning strategies and expectations of the professional role. Again, the previous clinical teaching and learning experiences of these overseas educated nurses are in conflict with Australian expectations. The ANMC National Accreditation Standards and Criteria stipulate that curriculum content and approaches to teaching and learning and assessment procedures are mapped against National Competency Standards for the Registered Nurse and

comprehensively address knowledge and skills associated with best practice research incorporating use of critical thinking skills (Ryan, 2008).

The frequency of direct patient care activities that participants had delivered during their overseas education varied significantly between the Chinese and the Korean participants, and the Indian participants. Up to only half of the Chinese and the Korean participants had 'frequently' or 'often' experienced direct patient care practices such as administering medications and providing wound care during their clinical practice. This was in contrast to the findings reflecting the Indian participants' experiences who all indicated that these tasks were 'frequently' experienced during clinical practice despite their data also explaining that both their on campus clinical laboratory and external clinical practice experiences were often unstructured and unsupervised (FG5: India). These participants provided examples of clinical skills performed, where they were both unsupervised and unaware that they were practicing outside their scope of practice and without emphasis on safe practice principles. The Australian Nursing and Midwifery Accreditation Council (ANMAC) stipulates in its Guidelines on Delegation and Supervision for Nurses and Midwives the outline of accountability and responsibilities that nurses and midwives have in relation to delegation and supervision (ANMAC, 2007). The guidelines define supervision as 'a nurse preceptoring a student undertaking a course for entry into the profession...' and stipulates that nursing students should 'only undertake activities for which they have the legal authority and the competence to perform' and that the registered nurse 'retains accountability for evaluating whether the person carrying out the delegated activities maintains the relevant standards and outcomes' and remains 'accountable for his or her own actions and is also accountable to the registered nurse or midwife' (ANMAC, 2007).

Participants in this study from each cohort described episodes of conflict during their clinical practice in Australian regarding scope of practice and supervision. The conflicts described ranged from participants expecting to perform tasks in which they felt they were qualified but outside their scope of practice in the student role to expecting to be an observer only whilst on clinical practice. This data contrasts with external clinical practice in Australia which requires that students demonstrate targeted skills under supervision leading to competence which complement theoretical learning and learning outcomes aligned with the curriculum (Ryan, 2008). This requirement also includes the requisite that academic and clinical staff engaged in supporting and assessing students during clinical practice are experienced in and prepared for the role (Ryan, 2008). The key issues will now be identified and recommendations made in relation to the expected outcomes of the study.

## 6.6 Key Issues and Recommendations

I have developed recommendations which relate to each of the three expected outcomes of the study (see Chapter One). The first outcome was to develop guidelines for the development and implementation of appropriate teaching and learning strategies to facilitate transition to university study in Australia for overseas educated nurses followed by the development of guidelines for the implementation of appropriate clinical placement, facilitation and support processes for overseas educated nurses in transition to practice in Australian healthcare settings. The final outcome was to develop guidelines for the implementation of strategies to increase academic staff awareness of the range of student entry behaviours. Tables 6.1, 6.2, 6.3 on the following pages summarises my recommendations and strategies for their implementation.

| | |
|---|---|
| **Expected outcome** | **Development and Implementation of Appropriate Academic Teaching and Learning Strategies to Facilitate Transition to University Study in Australia for Overseas Educated Nurses** |
| **Recommendation One** | **To provide preparation programs aligning overseas educated nurses commencing a Bachelor of Nursing with RPL to second year entry level through collaboration between Student Support Services, English Language Centres and Faculty**<br>- preparation for student centered teaching and learning strategies used in nursing education, e.g. Inquiry Based Learning (IBL).<br>- development of information literacy and technology skills workshops for the Australian context<br>- therapeutic and interpersonal communication in professional contexts |
| **Strategies for Implementation** | First semester workshops conducted through Student Support Services incorporating the use of case study scenarios, role play, concept mapping and reflective journaling to prepare students for the collaborative SCL approaches.<br>Prerequisite completion of a pathway preparation program through English Language Centres targeting academic literacy providing evidence of literacy development, competency in locating appropriate learning resources, and the ability to identify and assess learning needs.<br>Implementation of early identification strategies by Faculty to refer students at risk to Student Support Services and/or English Language centres for assistance. |

Table 6.1: *Summary of Recommendation One.*

| | |
|---|---|
| **Expected outcome** | **The implementation of appropriate clinical placement, facilitation and support processes for overseas educated nurses in transition to practice in Australian healthcare settings** |
| **Recommendation Two** | **To provide additional clinical practice opportunities to assist overseas educated nurses commencing a Bachelor of Nursing with RPL in Australia to meet clinical competency expectations**<br>- on campus supervised practice<br>- on campus self directed skills practice<br>- preparation for specific external clinical practice placements |
| **Strategies for Implementation** | Supervised clinical skills practice sessions in addition to classes in a clinical simulation laboratory utilising patient care scenarios and appropriate teaching and learning resources to consolidate clinical skills introduced in the classroom.<br>Additional unsupervised clinical skills practice sessions in a clinical simulation laboratory can be accessed when the student has demonstrated ability to further develop the skill independently.<br>Tailored clinical skills practice sessions in a clinical simulation laboratory which prepare students for their specific external clinical practice areas. For example: Nursing roles in the Medical/Surgical ward areas; the intensive care and emergency departments and the perioperative area. |

Table 6.2: *Summary of Recommendation Two.*

| Expected outcome | Implementation of Strategies to Improve Academic and clinical Staff Awareness of the Range of Student Entry Behaviours |
|---|---|
| Recommendation Three | **To provide staff development opportunities for university teachers to appreciate and understand the diverse entry behaviours and teaching and previous teaching and learning experiences of overseas educated nurses**<br>- awareness of previous teaching and learning experiences<br>- strategies that enable a shift from TCL to SCL strategies<br>- preparation of clinical teachers both in the on campus clinical simulation centre and in collaboration with external health care facilities |
| Strategies for Implementation | Early collaborative planning between teachers of overseas educated nurses, the English Language Centre, Library Services and Student Support Services regarding student cohorts and possible cultural variations within class groups to support early identification of learning needs.<br>Support for teachers of overseas educated nurses to develop strategies to identify students' self-directed learning ability and readiness in order to implement suitable teaching strategies.<br>Professional development opportunities for all teachers of overseas educated nurses to develop competencies and support transition from teacher centered teaching to student centered teaching strategies. |

Table 6.3: *Summary of Recommendation Three*

A discussion of each of these expected outcomes will be addressed, along with the related recommendations and strategies for implementation which now follow.

### 6.6.1 Development and Implementation of Appropriate Academic Teaching and Learning Strategies to Facilitate Transition to University Study in Australia for Overseas Educated Nurses

Overseas educated nursing students with differences in experiences and cultures, come with their own expectations arising from the educational practices of their homeland. Australian university based nursing education aligns with international efforts to promote the quality, national consistency, and level of education for Registered Nurses (NMBA, 2011). In order to maintain this quality and level of education overseas educated nurses need to be prepared for SCL approaches used in nursing education, require information literacy and technology skills and therapeutic and interpersonal communication skills. I have made the following recommendation to facilitate transition of overseas educated nurses to university study in Australia.

**Recommendation One**

**To provide preparation programs aligning overseas educated nurses commencing a Bachelor of Nursing with recognised prior learning to second year entry level through collaboration between Student Support Services, English Language Centres and Faculty**

Students who have been awarded exemption from completion of components of their degree in Australia through the RPL system enter the Bachelor of Nursing as second year nursing students who have bypassed the initial introduction to the SCL environment. These students will start their university studies with students who received entry level preparation for SCL approaches to teaching and learning in their first year. This means that they

commence their studies in Australia unequipped for the SCL approaches that they will immediately encounter and be assessed in their course. I recommend that a preparation program for these students who have been actively recruited by Australian universities, be introduced as early as possible into the Bachelor of Nursing with RPL to introduce scaffolding which supports deep learning and the establishment of lifelong learning skills consistent with the aim of SCL. Workshops incorporating the use of case study scenarios, role play, concept mapping and reflective journaling will prepare students for the collaborative SCL approaches which they will encounter in their Australian nurse education and also introduce interpersonal communication skills which they will require in the Australian healthcare environment.

Orientation week provides a timely opportunity for students enrolling in a Bachelor of Nursing with RPL to attend classes preparing students for SCL including information literacy and communication workshops. Workshops need to be provided in collaboration with student support services, the university English language centres and Faculty to meet the graduate outcomes of the profession. Workshops should be continued during the first semester of study until the student demonstrates evidence of satisfactory literacy development and evidence of satisfactory achievement in units of study. Previous literature indicates that attendance rates tend to be low when activities are voluntary, supporting evidence that preparatory classes should be inclusive to the degree and managed collegially by discipline-based staff, student support services and English language centres (Dunworth, 2010). In order to promote a shift from TCL to SCL these classes should promote an environment where the student learns that they are in control of their learning, focusing not on finding the answer but on finding sources that might have information that could lead to the answer and where the teacher is viewed as a facilitator of learning, guiding the direction of learning (Attard et al.,

2010). These workshops also need to provide students with strategies for sourcing information independently through the university library and intranet sites.

The preparation program needs to introduce effective information literacy skills, the ability to know when there is a need for information, to be able to identify, locate, evaluate, and effectively use that information (Australian Library and Information Association, 2011). The participants in this study explained that if they needed to know something new, they expected to be told and did not expect to source information themselves. Research has found that when information literacy skills were embedded into first year nursing courses, students demonstrated significant increases in confidence to choose appropriate articles and the ability to cite them correctly (Perrin, Hossain & Cumming, 2008). In order to enhance and promote information literacy, Beck, Blake-Campbell and McKay (2012) suggest utilising library and librarian resources from the earliest opportunity to create a culture of inquiry and develop lifelong learning skills.

The preparation program also needs to introduce these students who have bypassed the first year of the Bachelor of Nursing to information technology used to facilitate SCL both in the classroom and the clinical simulation area. In this case, overseas educated nurses who are accustomed to TCL where all their learning tools are provided will need to be made aware prior to the commencement of their Bachelor of Nursing with RPL that they will need to be equipped with appropriate technology to enhance their learning in Australian classrooms. The participants in this study described teaching and learning environments in both the academic and clinical areas which did not allow them to participate in therapeutic and interpersonal communication. Incorporating exercises where students develop collaborative work contracts, question information and discuss their ideas with their peers and their teachers will

assist them to use therapeutic and interpersonal communication in a professional context in order to prepare them for clinical placement in Australian healthcare settings.

### 6.6.2 Implementation of Appropriate Clinical Placement, Facilitation and Support Processes for Overseas Educated Nurses in Transition to Practice in Australian Healthcare Settings

Findings from this study indicate that when learning clinical skills, overseas educated nurses are unfamiliar with the use of case studies and scenario based teaching and learning strategies where the student is required to identify their own knowledge deficit and meet their own learning needs. The overseas educated nurse requires support to become familiar with Australian clinical practices. This can be facilitated through initial supervised clinical skills practice moving towards self directed practice, which includes reflective practice, health teaching and promotion and peer teaching which will demonstrate their progress in a clinical simulation laboratory prior to their clinical practice in a health care setting. In order for these overseas educated student nurses to succeed during their Australian clinical practice and subsequent practice as an Australian Registered Nurse, I make the following recommendation.

**Recommendation Two**

**To provide additional clinical practice opportunities to assist overseas educated nurses commencing a Bachelor of Nursing with recognised prior learning in Australia to meet clinical competency expectations**

During their first placement in Australia, overseas educated nurses with RPL are expected to perform at the level of a second year student nurse who is consolidating knowledge to plan and implement safe, person centered, evidence based nursing care for a patient experiencing an acute or chronic health condition. The students' scope of practice at

this level requires that they are developing accurate monitoring, assessment and intervention skills, for example, vital signs, oxygen therapy and health teaching. The clinical skills that students may be assessed on (depending on the curriculum of the University of focus) include the establishment and management of intravenous infusions and administration of intravenous medications, pain assessments and the management and care of complex wounds (ACU, 2012b). Some of the participants in this study have indicated that they were not required to perform all of these skills during clinical practice in their homelands and therefore were not able to accurately perform them without additional instruction. Again, usually these skills are introduced in the first year of a Bachelor of Nursing bypassed by students completing the Bachelor of Nursing with RPL course. Although, in the university of focus, these students do complete a unit of study aimed at introducing them to Australian nursing practice which includes the above clinical skills, sufficient mastery of skills in the compressed timeframe of the classroom is often inadequate to for them to meet clinical competency expectations.

Overseas educated nurses enrolled in a Bachelor of Nursing with RPL require additional supervised clinical practice opportunities in clinical simulation laboratories to consolidate clinical skills introduced but not mastered in class time. To be most effective this additional clinical simulation practice must incorporate patient care scenarios including therapeutic and interpersonal communication and initially be supervised but allow for self directed learning opportunities which increase with student competence. The participants in this study explained that students were able to access practice time in clinical simulation laboratories to practice clinical skills learnt during class time however, without supervision, the students were practicing skills from memory and at times incorrectly. During these practice sessions, equipment was provided but the students did not have access to practice scenarios to provide structure to their practice. For example; students wishing to practice the

establishment and maintenance of an intravenous infusion, were able to access practice time when laboratory time permitted and were provided with the basic equipment required for the skill. However, the students did not have access to intravenous orders or patient care scenarios to guide the skills that they were practicing. When they were then assessed poorly on that skill, they explained that they had 'practiced and practiced'. Unfortunately their unsupervised practice with limited access to teaching and learning resources left them unable to meet clinical competency expectations. In order to address this concern, a Bachelor of Nursing with RPL course must have additional supervised practice opportunities with relevant scenarios and resources embedded into the curriculum. The initial supervision provided could then decrease as the students' competency increases and they are able to meet their own self directed learning needs. When the student has demonstrated ability to further develop the skill independently, unsupervised clinical practice sessions could continue until the student is confident that they have attained mastery. The students would become responsible for recognising their own learning needs which they can address through dedicated practice sessions allocated throughout the semester. Structuring clinical practice opportunities in this way would increase the students' responsibility for their own professional development consistent with the aims of SCL and prepare them to meet ongoing registration requirements throughout their Australian nursing career.

External clinical practice experiences are provided to familiarise the student with the Australian health care environment and provide student nurses with the opportunity to combine cognitive, psychomotor and affective and problem-solving skills to develop competence in the application of knowledge, skills, attitudes and values in clinical situations (Chan, 2001). During clinical practice, overseas educated nursing students are expected to work collaboratively in established Australian interpersonal nursing roles such as change of

shift handovers, completing clinical documentation and patient planning meetings with other health care professionals. This level of participation requires that the student is able to reflect on and evaluate the patient care that they have provided, recognise and promote patient advocacy and practice within professional boundaries. Again, the participants in this study indicated that not all overseas educated nurses were prepared to meet these Australian nursing practice requirements which integrate theory into practice and provide the student with the opportunity of demonstrating professional accountability for patient care (Ryan, 2008; Lee et al., 2011; Oh et al., 2011).

Due to the growth in student nurse numbers and the competitive market for external clinical placement providers that schools of nursing are experiencing, all student nurses need to be adequately prepared to meet minimum standards of practice prior to attending placement. In order to achieve this, overseas educated nurses require additional clinical practice opportunities using simulation that focuses on the specific roles that the student nurse can expect to experience and the competencies which must be demonstrated during clinical practice in Australian healthcare facilities. These clinical simulation experiences should be designed to include structured scenarios including programmed manikins and integration with disciplines within the Health Sciences Faculty. Using interdisciplinary role play scenarios which incorporate case studies of patients and relatives, Registered Nurses, Midwives, Paramedics, Physiotherapists and Occupational Therapists, and so on, would assist the students to reflect on and evaluate the patient care that they have provided, recognise and promote patient advocacy and practice within professional boundaries all whilst practicing therapeutic and interpersonal communication skills.

For any of the above recommendations to be successfully implemented, the teachers within the Faculty need to be made aware of the range of entry behaviours with which overseas educated nursing students present. The final recommendation to emerge from this study addresses this concern.

### 6.6.3 Implementation of Strategies to Improve Academic and Clinical Staff Awareness of the Range of Student Entry Behaviours

Teachers of overseas educated nurses need to be aware of the diverse previous educational experiences with which overseas educated nurses from just one country may present. Academic and clinical teachers need to be equipped with strategies which will enable the overseas educated nurse to adapt to SCL and the variety of assessment strategies that they will encounter to ensure that students have an opportunity to demonstrate the required learning outcomes. In order to support teachers of overseas educated, I recommend the following.

**Recommendation Three**

**To provide staff development opportunities for university teachers to appreciate and understand the diverse entry behaviours and previous teaching and learning experiences of overseas educated nurses**

To address the diverse entry behaviours of overseas educated nurses commencing a Bachelor of Nursing with RPL, teachers need to be accurately briefed regarding student cohorts and possible cultural variations within their class groups. Clarke (2010) found that teachers of overseas educated nurses need some knowledge of the history and culture of their student cohort in order to avoid rash judgements about their previous teaching and learning experiences and the ability to constantly reflect whilst planning and teaching to ensure successful and

ethical academic outcomes for their students. These points become particularly relevant for the teachers of overseas educated nurses, who have received recognised prior learning and who start their shortened Bachelor of Nursing at second year level. Collaboration by teaching staff with the university English Language Centre, Library Services and Student Support Services will assist in identifying those students whose previous teaching and learning experiences leave them unprepared for the SCL approaches being used education in Australia. Embedding support from the English Language Centre and Student Support Services from the commencement of the Bachelor of Nursing with RPL will identify students who may benefit from previously mentioned strategies to enable their shift from TCL to SCL approaches and provide the additional benefit of empowering these students to confidently participate in both the academic and clinical components of their course.

To prepare teachers of overseas educated nurses entering the Australian SCL environment, strategies for transferring the responsibility for learning from the teacher to the student need to be introduced. Previous research in this area indicated that students need to be trained for group work and their teachers themselves also need guidance to train students for group work and assessments (Clark et al., 2007; Yuan et al., 2012). One strategy involves motivating and engaging the students by aligning topics in areas of their interest. This requires that staff understand the impact of class sizes on SCL and strategies to create groups of student interest (Clark et al., 2007). For example, rather than the entire class working on the same topic, teachers would be required to assist students to identify their own areas of interest and create groups accordingly. Teachers could intervene in the group process when there are difficulties, but hold the group accountable for individual learning and subsequent assessment results. Teachers need to ensure that students struggling with SCL styles and assessment approaches have an opportunity to successfully demonstrate learning outcomes

(Pederson & Liu, 2003). This strategy requires a balance of assessment styles to ensure that students inexperienced with collaborative learning strategies have the opportunity to demonstrate required learning outcomes. Yuan et al. (2012) suggest use of the self-directed learning readiness scale (SDLR) to assist nurse educators in the diagnoses of students' attitudes, abilities and personality characteristics necessary for student centered learning. In their study using the SDLR scale, Yuan et al. (2012) found that more senior students scored significantly higher than students in their first academic year supporting the need for early intervention to identify learning needs.

In assisting the overseas educated nurse to identify areas of interest within the topics which will meet the learning outcomes of the curriculum, the teacher will need to develop a degree of connectivity with the student and the student group. Forums where teachers could discuss their experiences and reflect on the nature of SCL and their facilitator role in ensuring that learning outcomes are met can provide teachers with strategies to connect with students and allow them to explore ways to apply their theoretical beliefs to the collaborative learning environment (Pederson & Liu, 2003). Additionally, just as teachers encourage reflective practice in students, the same reflectivity needs to be applied to their own teaching and learning experiences. Uses of reflective questioning to self assess the teachers' role, student engagement and methods in alignment with SCL provide the teacher with an evaluation of their own progress in student centered teaching (Chen, Brown, Hattie and Millward, 2012; Clarke, 2010; Pederson & Liu, 2003).

In order to prepare clinical teachers, a collaborative partnership between universities and health care providers needs to be developed supporting a clinical practice culture conducive to learning. For this objective to be achieved, staffing levels and skills mix in

health care facilities providing clinical placements for students must be adequate so that the clinical learning experience is optimised. Clinical teachers must meet minimum requirements of clinical experience in addition to minimum academic requirements. Close collaboration between the university and the clinical teachers in the healthcare facility is required to provide regular briefing to ensure teachers understand the expected standard of student nurse competency and that they are equipped to use evidence based professional judgement to assess competence (ANMC, 2006).

The experienced nurses within the healthcare facility who are supervising student nurses also require additional education and support to meet their clinical, education and mentoring responsibilities. Both the healthcare facility and the university need to develop educationally supportive clinical learning environments, not only suitable for overseas educated student nurses but which will also facilitate the continued development and enhanced job satisfaction of the remainder of the nursing team. This strategy will empower the clinical teachers, the nurses in the clinical setting and the student nurses to recognise their accountability to their clinical teaching and learning roles, allowing them to develop improved teaching and learning experiences. Overseas educated student nurses will benefit from improved clinical skills, critical thinking and problem solving skills and interpersonal and therapeutic communication skills allowing them to transition more successfully into the Australian healthcare environment.

## 6.7 Limitations of the research

There were a number of limitations of the research including the size of the sample and the disproportionate numbers within the sample. The small sample sizes for both the questionnaire and the focus groups diminished the ability of the data to identify trends or

provide a clear response to a variable. The small sample size also limited the ability of the findings to be generalised to other Chinese, Korean or Indian students or to Asian students as a population. Due to the smaller than expected Korean numbers, the questionnaire data alone were unable to provide reliable data to reflect the previous teaching and learning experiences of the Korean participants. The disproportionate number of Chinese participants as compared to Korean and Indian participants resulted in much of the data reflecting the Chinese participants' previous teaching and learning experiences.

The reliance on self reporting of the participants' teaching and learning experiences may have impacted on many areas of the study. The time lapse between the participants' previous nursing education and their participation in this study may have resulted in aspects of their previous teaching and learning experiences being overlooked. Some of the participants had worked as qualified nurses for some years prior to their coming to Australia to study perhaps affecting their recall of their school of nursing experiences. Administering the questionnaire immediately following a class and the compressed timeframe in which the questionnaire was administered may have contributed to the lack of narrative data sought in the ISNQ therefore limiting the richness and depth of ISNQ findings.

The decision to target participants solely from China, Korea and India also resulted in limitations in the study due the unforseen changes in student enrolment demographics. At the time of the research being proposed, the projected number of student enrolments who would meet the inclusion criteria of the study was significantly higher than those who actually commenced. External factors including the Global Financial Crisis (GFC) and concerns for international student safety which occurred at that time may have contributed to the lower than expected student enrolment numbers from these cohorts.

Consideration will now be given to where future research needs to be conducted in order to more fully understand the previous teaching and learning experiences of overseas educated nurses and better support and facilitate their transition to learning and practice in Australia.

## 6.8 Directions for Future Research

The findings of this study highlight a number of areas for further research. Firstly, this study could be replicated with overseas educated nurses across a number of campuses of the same university, and/or across a number of different universities. This research design would allow for a much larger sample size from each country and therefore allow better opportunity for generalisation of the findings. Secondly, the transition experiences of overseas educated nurses to theoretical and clinical education in Australia could be explored in a mixed methods research design. Thirdly, another study is required to identify strategies which Australian teachers have found that assist students to make the transition from TCL to SCL environments. Fourthly, research could to be conducted to investigate university preparation programs and student support services and the contribution these programs make to enhance the overseas educated nurses' transition to the Australian teaching and learning environment. Finally further exploration of the cultural underpinnings resulting in overseas educated nurses' not being taught or encouraged to use therapeutic or interpersonal communication would be useful to inform teaching and learning practices when assisting overseas educated nurses to make the transition to study and work in Australia. An understanding of these cultural underpinnings would assist the teachers of overseas educated nurses to support these nurses to develop therapeutic and interpersonal communication and collaborative practices as expected of an Australian Registered Nurse.

## 6.9 Conclusion

This research has expanded the limited existing knowledge of the teaching and learning strategies experienced by overseas educated nurses from China, Korea and India. The study has identified that some overseas educated nurses are unprepared to undertake nurse education in Australian higher education or for practice in Australian healthcare settings. The participants indicated that they were prepared for their country's standards and teaching and learning strategies and had little educational preparation in their homeland to take an active part in their learning as required in Australian nurse education and were not taught to use critical thinking and problem solving skills to practice with autonomy, all of which are expected in the Australian healthcare environment.

The different entry behaviours with which these overseas educated nurses' present and the areas where they are unprepared for SCL approaches in nurse education in Australia have been identified and recommendations made to improve the overseas educated nurse to make the transition to university study in Australia. Recommendations to assist the overseas educated nurse to achieve clinical competency expectations during clinical practice in Australia have also been made. Given that we are experiencing increasing global mobility and Australian education exports, research of this nature is necessary to meet the ethical responsibility of Australian universities to better support overseas educated nurses when they are accepted for study in Australian institutions of higher education.

## GLOSSARY OF TERMS

**InVivo**

InVivo coding has also been labelled 'literal coding' and 'verbatim coding' in selected methods literature. Its root meaning is 'in that which is alive' and as a code refers to a word of short phrase from the actual language found in the qualitative data record.

**Clinical Laboratory**

Clinical Laboratory refers to the clinical experience provided on the school of nursing campus.

**Clinical Practice or Placement**

Clinical practice or placement refers to the clinical experience provided in a clinical facility such as a hospital during their nurse education program.

**MIMS**

An independent publication suppling pharmaceutical product information to Australian healthcare professionals.

**Scope of Practice**

The range of roles, functions, responsibilities, activities and decision-making capacity to which individuals within the profession are educated, competent and authorised to perform.

**Student Centered Learning**

The focus of what is learnt and how it is learnt and to what depth it is learnt is the responsibility of the learner.

**Teacher Centered Learning**

The focus of what is learnt rests on the teacher's ability to transmit the information to the learner.

**The Six Rights**

A safety checklist used by nursing staff to ensure they meet all responsibilities of medication administration. They include; Medication, Route, Time, Client, Dosage, and Documentation.

**The Three Checks**

Another safety checklist used by nursing staff prior to drug administration: 1st check - when reaching for the package that contains the drug, 2nd check - during preparation of the drug for administration, 3rd check - at the patient's bedside just before the drug is given.

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# APPENDICES

## Appendix A

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

ACU National

Human Research Ethics Committee

Committee Approval Form

**Principal Investigator/Supervisor:** Dr Monica Nebauer Brisbane Campus

**Co-Investigators:** Dr Karen Flowers Brisbane Campus

**Student Researcher:** Ms Rita Adnams Brisbane Campus

**Ethics approval has been granted for the following project:**
An exploration of the previous teaching and learning experiences of overseas-educated nurses from China, Korea and India. (Exploring the previous teaching and learning experiences of overseas-educated nurses.)

**for the period:** 30 July 2009 to 30 November 2009

**Human Research Ethics Committee (HREC) Register Number:** Q2009 24

**The following standard 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.

K. Pashley.

Signed: Date: 30 July 2009
(Research Services Officer, McAuley Campus)

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## Ethics extension to June 30, 2010.

**From:** Kylie Pashley
**Sent:** Thursday, 18 March 2010 11:51 AM
**To:** Monica Nebauer; Rita Adnams
**Subject:** Q2009-24 Ethics Extension Approved

Dear Monica and Rita,

Thank you for returning the Ethics Progress Report for your project Q2009-24 *An exploration of the previous teaching and learning experiences of overseas-educated nurses from China, Korea and India. (Exploring the previous teaching and learning experiences of overseas-educated nurses.)*

The Deputy Chair of the Human Research Ethics Committee has approved your request to extend the period of data collection. The new expiry date for data collection is the **30 June 2010**.

We wish you well in this ongoing project.

Kind Regards,

Kylie

Kylie Pashley
Research Services
McAuley at Banyo Campus
PO Box 456
VIRGINIA QLD 4014
AUSTRALIA
I am available Monday, Thursday and Friday.
Tel (+61 07) 3623 7429 Fax (+61 07) 3623 7328
EMAIL: kylie.pashley@acu.edu.au

Australian Catholic University Ltd
ABN 15 050 192 660
CRICOS Registration codes:00004G, 00112C, 00873F, 00885B

## Ethics extension to September 30, 2010.

**From** Kylie Pashley **Date** Thu Jun 24 2010 09:11:09 GMT+1000 (E. Australia Standard Time)
**To** Monica Nebauer; Rita Adnams
**Cc**
**Subject** Q2009 24 Ethics Modification Approved

Dear Monica and Rita,

Thank you for submitting the request to modify form for your project Q2009-24 *An exploration of the previous teaching and learning experiences of overseas-educated nurses from China, Korea and India. (Exploring the previous teaching and learning experiences of overseas-educated nurses.)*

The Chair of the Human Research Ethics Committee has approved the following modification(s):
1. Add focus groups and Extension of Data Collection to 30/9/2010

We wish you well in this ongoing research project.

Kind Regards,

Kylie

Kylie Pashley
Research Services
McAuley at Banyo Campus
PO Box 456
VIRGINIA QLD 4014
AUSTRALIA
I am available Monday, Thursday and Friday.
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Australian Catholic University Ltd
ABN 15 050 192 660
CRICOS Registration codes:00004G, 00112C, 00873F, 00885B

## Appendix B

ACU National
Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

Brisbane Campus (McAuley at Banyo)
1100 Nudgee Road Banyo QLD 4054
Locked Bag 456
Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328
Email: **www.acu.edu.au**

**Invitation to Participate in a Pilot Study**

TITLE OF PROJECT:

**Exploring the previous teaching and learning experiences of overseas-educated nurses.**

RESEARCH SUPERVISORS: Dr Monica Nebauer, Dr Karen Flowers
STUDENT RESEARCHER: Rita Adnams
PROGRAMME ENROLLED: Master of Nursing (Research)

Dear Participant/Student,

You are invited to take part in a pilot study for a research questionnaire to identify the previous teaching and learning strategies most commonly experienced by overseas-educated nurses in their homeland. The pilot study is being conducted to find any problems with the way the questionnaire has been developed and written. The questionnaire will be piloted with a group of 6-9 students, with 2-3 each from China, Korea and India, who commenced their enrolment in 2008. It should take no longer than 30 to 40 minutes to complete.

A questionnaire pilot is conducted to ensure that the questions are understood, and will provide valid and reliable information to answer the objectives of the study. The pilot will also discover if the questionnaire is likely to cause participants any anxiety or discomfort. Careful review of the pilot study results and feedback from you will identify areas where the questions are confusing or misunderstanding is a risk. Information obtained from the pilot study will not be included in the final data analysis.

Any questions regarding this project should be directed to the research supervisors and/or the student researcher:

Dr. Monica Nebauer
Tel: 07 3523 7216

Dr. Karen Flowers
Tel: 07 3623 7292

Rita Adnams
Tel: 07 3623 7525

School of Nursing & Midwifery (QLD)
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014

It is anticipated that the risks, inconveniences and/or discomforts associated with completing this questionnaire will be minimal; however your reflection whilst answering the questions may result in feelings of homesickness or anxiety related to past experiences in your homeland. Should you feel that this questionnaire is distressing to you in any way please refer to the contact listed below for appropriate support or counselling.

Ms. Carolyn Toonan
C/o Counselling Services
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014
Tel: 07 3623 7377
Fax: 07 3623 7326

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study or if you have any query that the research supervisors or student researcher have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee.

QLD: Chair, HREC
C/o Research services
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328

Any complaint or concern will be treated in confidence and fully investigated and you will be informed of the outcome.

Completing the questionnaire indicates your consent to participate in the research project.

| Dr. Monica Nebauer | Dr. Karen Flowers | Rita Adnams |
|---|---|---|
| Research Supervisor | Research Supervisor | Student Researcher |

## AppendixC

ACU National
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Tel: 07 3623 7429
Fax: 07 3623 7328
Email: **www.acu.edu.au**

**Information Letter to Participants**

TITLE OF PROJECT:

**Exploring the previous teaching and learning experiences of overseas-educated nurses.**

RESEARCH SUPERVISORS: Dr Monica Nebauer, Dr Karen Flowers

STUDENT RESEARCHER: Rita Adnams

PROGRAMME ENROLLED: Master of Nursing (Research)

Dear Participant/Student,

You are invited to take part in a research project to identify the previous teaching and learning strategies most commonly experienced by overseas-educated nurses in their homeland. This research is part of the requirement for a Master of Nursing degree which I (Rita Adnams) as the student researcher am undertaking. The research is in the form of a questionnaire. It will be distributed to all overseas-educated nursing students from China, Korea and India who are undertaking the shortened Bachelor of Nursing course at the Brisbane Campus of the Australian Catholic University.

The questionnaire should take no longer than 30 to 40 minutes to complete. As the student researcher, I will come to your classroom to introduce and explain the research and then I will leave the room. A research assistant will remain with you to help you with the questionnaire if necessary and to collect the questionnaire when you have finished. The questions will require you to complete tables and provide 'tick the box' answers, all related to your past educational experiences in your homeland.

The benefit of this research for you is minimal; however it will help you to become aware of the teaching and learning strategies that you have experienced at home. The broader benefits of this research will include the identification of learning strategies previously experienced by overseas-educated nurses. From this information, support strategies to assist other overseas-educated nurses in their transition to study in Australia will be developed.

Questionnaire completion is voluntary and you are free to refuse to participate without having to justify your decision, or withdraw consent and discontinue participation in the study at any time without giving a reason. Refusal to be involved or withdrawal from the research will not affect your academic progress or relationships in the university in any way.

Please do not write your name or student number on the questionnaire as it is non-identifiable. The questionnaires will be collected and secured confidentially. Only I as the student researcher and my two supervisors will have access to data collected. In the event that you wish to withdraw from the research it would be necessary to identify which survey questionnaire is yours. For this reason it is suggested that you identify your questionnaire with a series of numbers that only you would know, e.g. your mothers date of birth in a (6) six digit format (dd/mm/yy), in the space provided on page one.

The results of the research will be published in my Masters thesis and may be published in research literature and conference presentations. Data obtained will not be identifiable to you as a participant in the study in any way. If you wish to receive feedback regarding the progress of the study and its results please contact me, as the student researcher.

Any questions regarding this project should be directed to the research supervisors and/or the student researcher:


| Dr. Monica Nebauer | Dr. Karen Flowers | Rita Adnams |
|---|---|---|
| Tel: 07 3523 7216 | Tel: 07 3623 7292 | Tel: 07 3623 7525 |

School of Nursing & Midwifery (QLD)
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014


It is anticipated that the risks, inconveniences and/or discomforts associated with completing this questionnaire will be minimal; however your reflection whilst answering the questions may result in feelings of homesickness or anxiety related to past experiences in your homeland. Should you feel that this questionnaire is distressing to you in any way please refer to the contact listed below for appropriate support or counselling.

Ms. Carolyn Toonan
C/o Counselling Services
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014
Tel: 07 3623 7377
Fax: 07 3623 7326

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study or if you have any query that the research supervisors or student researcher have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee.

QLD: Chair, HREC
C/o Research services
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328

Any complaint or concern will be treated in confidence and fully investigated and you will be informed of the outcome.

Completing the questionnaire indicates your consent to participate in the research project.

| Dr. Monica Nebauer | Dr. Karen Flowers | Rita Adnams |
|---|---|---|
| Research Supervisor | Research Supervisor | Student Researcher |

## AppendixD

ACU National
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1100 Nudgee Road Banyo QLD 4054
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Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328
Email: **www.acu.edu.au**

**International Student Nurse Questionnaire**

TITLE OF PROJECT:

**Exploring the previous teaching and learning experiences of overseas-educated nurses.**

STUDENT RESEARCHER: Rita Adnams

RESEARCH SUPERVISORS: Dr Monica Nebauer Dr Karen Flowers

Full details of the research study are available in the information letter attached.

To protect your privacy, please do not write your name or student number on the questionnaire. In the box below there is space for you to enter a code that is specific to you, so that your information can be retrieved if you change your mind after submitting the questionnaire. Please use a (6) six-digit format, and enter a number that only you would know, e.g. your mother's date of birth.

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

Please indicate when you commenced study in the Bachelor of Nursing at ACU. February 2009 ☐
July 2009 ☐

**Instructions:**

**Please do not talk with other students while completing this questionnaire – the responses should be yours alone.**

**If you have any problems answering the questions, please ask the research assistant in the room.**

**Please tick / the box which best matches your response.**

**In some cases you may need to tick ✓ as many times as required or give a short written answer in English where indicated.**

**Please do not mark the researcher column to the right.**

**Thank you for your cooperation.**

## Section 1. Demographic Information

Researcher

1. Country of birth:- ☐China ☐Korea ☐India ☐Other _____ 1, 2, 3, 4, 5,

2. Country where you have lived the longest:-
☐China ☐Korea ☐India ☐Other _____ 1, 2, 3, 4, 5,

3. Country where your previous nursing education was completed:-
☐China ☐Korea ☐India ☐Other _____ 1, 2, 3, 4, 5,

4. Have you undertaken a course of study in Australia before commencing this course at ACU?
☐Yes ☐No 1, 2, 3,

If Yes, please indicate where. ☐English Language Class ☐TAFE ☐University 1, 2, 3, 4,

## Section 2. Overseas Nursing Education Information – as a student nurse in your homeland.

5. Please list the nursing qualifications that you have obtained which allow you to practice as a nurse in your own country:- Please tick / where the qualifications were obtained:-

| Nursing Qualification | Length of Course Months / Years | High School | College | University | Other (Please explain) | |
|---|---|---|---|---|---|---|
| E.g. Diploma of Nursing | 3 years | | ✓ | | | 1, 2, 3, 4, 5, 6, 7, |
| | | | | | | 1, 2, 3, 4, 5, 6, 7, |
| | | | | | | 1, 2, 3, 4, 5, 6, 7, |
| | | | | | | 1, 2, 3, 4, 5, 6, 7, |
| | | | | | | 1, 2, 3, 4, 5, 6, 7, |
| | | | | | | 1, 2, 3, 4, 5, 6, 7, |

6. Did you complete senior high school before you started your nursing course?
☐Yes ☐No 1, 2, 3,

**Please turn the page-**

Teaching and Learning

| | | | | | | Researcher |
|---|---|---|---|---|---|---|
| 7. | Please indicate how often the following teaching and learning ***strategies*** were used in your first nursing course in your homeland. | Never | Rarely | Sometimes | Often | Frequently | |
| | Formal theory class by qualified nursing staff | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Formal theory class by qualified medical staff | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Online resources using the school computer system | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Self-learning workbooks / worksheets | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6 |
| | Preparation & presentation of student seminars | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Role-play by students | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Viewing of audiovisual materials (Video/DVD) | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Other (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, 8, |
| | _____ | | | | | | |
| 8. | Please indicate how often the following ***interactions*** were used in your first nursing course in your homeland. | Never | Rarely | Sometimes | Often | Frequently | |
| | During class time | | | | | | |
| | Discussion between students | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Discussion with the teacher | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Students asking teacher questions for clarification | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Dividing into groups to discuss a topic | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Outside class time | | | | | | |
| | Student seeking meeting with teacher | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Other ***interactions*** (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, 7, |
| | _____ | | | | | | |
| 9. | Please indicate how often the following teaching and learning ***resources*** were used in your first nursing course in your homeland. | Never | Rarely | Sometimes | Often | Frequently | |
| | Materials prepared by teacher | | | | | | |
| | Lecture notes provided by teacher | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Worksheets provided by teacher | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Selected readings provided by teacher | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Online resources | | | | | | |
| | Lecture notes | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Quizzes and practice exams | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Selected readings from teacher | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Library databases for searching journal articles | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| | Other ***resources*** (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, 7, |
| | _____ | | | | | | |

Study Habits

10. Please indicate how often you used the following ***study habits*** in your first nursing course in your homeland.

| | Never | Rarely | Sometimes | Often | Frequently | Researcher |
|---|---|---|---|---|---|---|
| <u>During class time</u> | | | | | | |
| Writing lecture notes | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Group study sessions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Individual learning / reflection | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Reading textbooks or journal articles | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Reviewing class notes | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Use of idea / concept maps / flowcharts | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| <u>Outside class time</u> | | | | | | |
| Group study sessions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Individual learning / reflection | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Reading textbooks or journal articles | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Memorising information | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Rewriting class notes | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Reviewing class notes | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Listening to taped lectures | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Using library resources | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Using the internet | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Use of idea / concept maps / flowcharts | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other ***study habits*** (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, 7, |

_____

Assessment

11. Please indicate how often the following ***assessment tasks*** were used in your first nursing course in your homeland.

| | Never | Rarely | Sometimes | Often | Frequently | |
|---|---|---|---|---|---|---|
| <u>During class time</u> | | | | | | |
| Multiple choice exam | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Short answer exam | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Essay style exam | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Online / computer exam | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Oral presentations | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| <u>Outside class time</u> | | | | | | |
| Online / computer exam | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Written essay assignments | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Completion of workbooks | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Reflective journal writing | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other ***assessment tasks*** (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, 7, |

_____

## Section 3. Overseas Clinical Nursing Experience – as a student nurse in your homeland

Researcher

Clinical Practice

12. In your first nursing course ***how and when*** was your clinical practice experience offered?
Please indicate by placing ticks ✓ where applicable in the table below:-

| Clinical Practice | Year of Course | | | | | |
|---|---|---|---|---|---|---|
| | 1st year | 2nd year | 3rd year | 4th year | 5th year | |
| In a simulated laboratory setting ***within the university campus*** | | | | | | 1, 2, 3, 4, 5, 6, |
| In an ***external clinical setting*** in a hospital or health care facility | | | | | | 1, 2, 3, 4, 5, 6, |
| ***During*** the semester for a set number of days per week | | | | | | 1, 2, 3, 4, 5, 6, |
| ***After*** the semester in a block of weeks eg., 3 weeks | | | | | | 1, 2, 3, 4, 5, 6, |
| In an extended block at the ***end of the course*** eg., weeks/months | | | | | | 1, 2, 3, 4, 5, 6, |
| Other – Please explain _____ | | | | | | 1, 2, 3, 4, 5, 6, |

13. In your first nursing course, ***in which area*** was ***each external clinical practice*** completed and ***how much time*** was spent in each? Please write the number of days in the table below:-

| Facility | Time in Facility (days) | | | | |
|---|---|---|---|---|---|
| | 1st year | 2nd year | 3rd year | 4th year | |
| Acute hospital - medical nursing | | | | | 1, 2, 3, 4, 5, |
| Acute hospital - surgical nursing | | | | | 1, 2, 3, 4, 5, |
| Acute hospital - maternity nursing | | | | | 1, 2, 3, 4, 5, |
| Acute hospital - paediatric nursing | | | | | 1, 2, 3, 4, 5, |
| Acute hospital - high dependency nursing ( eg., Intensive care nursing) | | | | | 1, 2, 3, 4, 5, |
| Aged care nursing | | | | | 1, 2, 3, 4, 5, |
| Palliative care nursing | | | | | 1, 2, 3, 4, 5, |
| Psychiatric / Mental health nursing | | | | | 1, 2, 3, 4, 5, |
| Hospital clinic - outpatients department | | | | | 1, 2, 3, 4, 5, |
| Community clinic (day treatments / health checks / doctor's surgery) | | | | | 1, 2, 3, 4, 5, |
| Community home visits (the nurse visits the patient in their own home) | | | | | 1, 2, 3, 4, 5, |
| Other – Please explain _____ | | | | | 1, 2, 3, 4, 5, |

14. As a ***student nurse on clinical practice***, were you required to:-

| | Never | Rarely | Sometimes | Often | Frequently | |
|---|---|---|---|---|---|---|
| Observe Registered Nurses as they worked | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Work beside a Registered Nurse to provide care | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |

_____ 7,

**Please turn the page-**

**Overseas Clinical Nursing Experience – as a student nurse in your homeland – continued.**

| | Never | Rarely | Sometimes | Often | Frequently | Researcher |
|---|---|---|---|---|---|---|
| 15. As a ***student nurse on clinical practice***, did you provide the following patient care:- | | | | | | |
| Admission procedures | | | | | | |
| Interview patients to complete hospital paperwork | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Interview patients to establish nursing care needs | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Identify patient problems and health goals | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Assist in creating nursing care plans for patients | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Patient Assessment | | | | | | |
| Observe and monitor patients eg., vital signs | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Identify a change in patient's condition | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Report changes in condition to RN or doctors | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Perform physical assessments | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Perform pain assessments | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Provide pain relief interventions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Patient Care | | | | | | |
| Meet hygiene needs eg., showering, sponging in bed | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Provide pressure area care | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Make patients' beds | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Assist with feeding patients | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Monitor dietary intake and output | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Medication administration | | | | | | |
| Administer oral / topical preparations | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Administer intramuscular injections | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Administer intravenous injections | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Manage parental infusions eg., intravenous infusions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Wound care | | | | | | |
| Perform wound care as required | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Prepare supplies for RN or doctor for wound care | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Insert naso-gastric tubes | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Insert urinary drainage catheters | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Discharge Planning / Teaching | | | | | | |
| Health teaching eg., education of disease process | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Discharge eg., medication or wound care instructions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| _____ | | | | | | 7, |

**Please turn the page-**

Clinical Supervision

16. As a ***student nurse on clinical practice*** which of the following ***supervision methods*** did you experience:- Tick / as many as are applicable.

| | Never | Rarely | Sometimes | Often | Frequently | Researcher |
|---|---|---|---|---|---|---|
| Work directly with a specific RN | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Work in a team with several RNs & other students | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Work independently to perform set nursing tasks | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Being assigned set tasks to complete unsupervised | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Please give an example of the tasks you could perform unsupervised _____ | | | | | | 7, |
| _____ | | | | | | |
| Other ***supervision methods*** (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| _____ | | | | | | 8, |

Clinical Assessment

17. As a ***student nurse on clinical practice***, by whom were ***clinical assessments*** carried out:-

| | Never | Rarely | Sometimes | Often | Frequently | |
|---|---|---|---|---|---|---|
| Registered nurse | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Clinical teacher / University teacher | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Doctors | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| _____ | | | | | | 7, |

18. When ***clinical assessments*** were conducted, were any of the following ***strategies*** used:-

| | | | | | | |
|---|---|---|---|---|---|---|
| Self evaluation | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Regular verbal feedback | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Written record with marking criteria | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Learning plans for areas requiring improvement | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| _____ | | | | | | |

19. Are there any other teaching and learning experiences from your nursing studies in your homeland that you would like to share? _____

_____

_____

_____

_____

_____

**Please turn the page-**

## Section 4. Overseas Clinical Experience – as a qualified Registered Nurse

Researcher

20. Have you worked as a ***qualified Registered Nurse***, in your homeland?

☐Yes ☐No 1, 2, 3,

**If "No" to question 20 above, there are no more questions for you to answer. Thank you – you have completed the questionnaire.**

**If "Yes" to question 20 above, please continue.**

21. How long have you worked as a ***qualified Registered Nurse***, in your homeland?

☐Never ☐<6 months ☐6-12 months ☐1-2 years ☐2-5 years ☐>5 years 1, 2, 3, 4, 5, 6, 7,

22. Have you worked as a ***qualified Registered Nurse***, in a country other than your homeland?

☐Yes ☐No 1, 2, 3,

If "Yes" - in which country? _____ For how long? ____ / ____ months / years 4, 5,

23. As a ***qualified Registered Nurse*** in your homeland, ***in which area*** did you work and ***how much time*** was spent in each? Please write the number of months/years in the table:-

| Facility | Time in Facility (months/years) | |
|---|---|---|
| Acute hospital - medical nursing | | 1, 2, |
| Acute hospital - surgical nursing | | 1, 2, |
| Acute hospital - maternity nursing | | 1, 2, |
| Acute hospital - paediatric nursing | | 1, 2, |
| Acute hospital - high dependency nursing (eg., Intensive Care Unit) | | 1, 2, |
| Aged care nursing | | 1, 2, |
| Palliative care nursing | | 1, 2, |
| Psychiatric / Mental health nursing | | 1, 2, |
| Hospital clinic - outpatients department | | 1, 2, |
| Community clinic (day treatments / health checks / doctor's surgery) | | 1, 2, |
| Community home visits (the nurse visits the patient in their own home) | | 1, 2, |
| Other – Please explain _____ | | 3, |

**Please turn the page-**

24. As a ***qualified Registered Nurse*** in your homeland, did you:-

| | Never | Rarely | Sometimes | Often | Frequently | Researcher |
|---|---|---|---|---|---|---|
| Organise patient referrals to allied health personnel | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Alert doctors to changes in patients' conditions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Contact patients at home for follow up care | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Contact relatives/family members to advise of changes in patient condition | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other (please explain) _____ | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| _____ | | | | | | 7, |

25. As a ***qualified Registered Nurse*** in your homeland, did you provide the following patient care:-

| | Never | Rarely | Sometimes | Often | Frequently | |
|---|---|---|---|---|---|---|
| <u>Admission procedures</u> | | | | | | |
| Interview patients to complete hospital paperwork | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Interview patients to establish nursing care needs | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Identify patient problems and health goals | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Create nursing care plans for individual patients | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Alter nursing care plans as patients' needs changed | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| <u>Patient Assessment</u> | | | | | | |
| Patient observation and monitoring eg., vital signs | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Identify a change in patient's condition and provide appropriate care independently | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Perform physical assessment | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Perform pain assessments | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| <u>Patient Care</u> | | | | | | |
| Meet hygiene needs eg., showering, sponging in bed | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Provide pressure area care | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Make patients' beds | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Assist with feeding patients | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Monitor dietary intake and output | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| <u>Medication administration</u> | | | | | | |
| Administer oral / topical preparations | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Administer intramuscular injections | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Administer intravenous injections | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Manage parental infusions eg., intravenous infusions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |

**This question is continued over the page-**

**Overseas Clinical Experience – as a qualified Registered Nurse in your homeland – Question 24 continued.**

**Researcher**

As a ***qualified Registered Nurse*** in your homeland, did you provide the following patient care:-

| | Never | Rarely | Sometimes | Often | Frequently | |
|---|---|---|---|---|---|---|
| Wound care | | | | | | |
| Perform wound care as required | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Prepare supplies for doctors to perform wound care | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Insert naso-gastric tubes | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Insert urinary drainage catheters | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Insert intravenous cannula | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Discharge Planning / Teaching | | | | | | |
| Health teaching eg., education of disease process | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Discharge eg., medication or wound care instructions | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Documentation | | | | | | |
| Document and chart patients progress | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Management | | | | | | |
| Liaise with other health care professional's | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Attend "doctors rounds" | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Manage staff – rostering / nurse to patient ratios | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Manage material resources and budgets | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| Other cares provided as ***qualified Registered Nurse*** | ☐ | ☐ | ☐ | ☐ | ☐ | 1, 2, 3, 4, 5, 6, |
| (please explain) _____ | | | | | | 7, |

25. Are there any other teaching and learning experiences from your nursing studies in your homeland that you would like to share.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Thank you for your participation**

## AppendixE

**Subject:** An invitation to participate in international student research.

Dear International Student from China,

I am a Master of Nursing (Research) student investigating the teaching and learning experiences of overseas educated nurses from China studying in the Bachelor of Nursing 120/160/200cp. This email is to invite you to participate in a focus group discussion on the teaching and learning experiences that you have had in China. It is hoped that the outcome of this research will be used by ACU to improve the teaching and learning experiences and academic outcomes of overseas educated nurses at ACU.

Focus group discussions will take place in a quiet room where confidentiality can be maintained at a time which is convenient to you and the group. Your focus group will comprise only of participants from China. Refreshments will be served.

Examples of trigger questions that you will be asked are:
-What were the most helpful teaching and learning experiences that you had in China?
-Could you please provide an example of how a formal lecture was conducted in China?
-What strategies did you use if you had a question during the lecture?
-How are clinical practice experiences for students provided in China?
-Did the on-campus clinical experience prepare you for your off-campus clinical experience?

If you would like further information please feel free to contact me by phone or email at the numbers/addresses below. I really need your help to finish my study and your participation is greatly appreciated. I look forward to hearing from you soon.

Thank you,

Rita Adnams

---

Rita Adnams
Mob. 0412376233
Student email. S00063062@myacu.edu.au

## Appendix F

Brisbane Campus (McAuley at Banyo)
1100 Nudgee Road Banyo QLD 4054
Locked Bag 456
Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328
Email: **www.acu.edu.au**

**Information Letter to Participants volunteering to participate in a focus group**

TITLE OF PROJECT:

**Exploring the previous teaching and learning experiences of overseas-educated nurses.**

RESEARCH SUPERVISORS: Dr Monica Nebauer, Associate Professor Karen Flowers
STUDENT RESEARCHER: Rita Adnams
PROGRAMME ENROLLED: Master of Nursing (Research)

Dear Participant/Student,

You are invited to take part in a research project to identify and describe the previous teaching and learning strategies most commonly experienced by overseas-educated nurses in their homeland. This research is part of the requirements for a Master of Nursing (Research) degree which I, Rita Adnams, as the student researcher am undertaking. I am using focus group discussions as a research method to generate data through the experiences expressed by you and other participants. These focus group discussions will complement questionnaire data that have already been gathered. This invitation to participate in the focus group is extended to all overseas-educated nursing students from China, Korea and India who are undertaking the shortened Bachelor of Nursing course at the Brisbane Campus of the Australian Catholic University.

The focus group discussions will be approximately of one hour's duration. The focus group method of data collection is a technique of group interview. I envisage up to six participants in each group. Participants in each group will be from one country only, therefore, your focus group will be comprised only of participants from your homeland. Discussions will be directly related to your past educational experiences and clinical practice experiences in your homeland. A tape recorder will be used to ensure accuracy when transcribing information from the focus group discussions.

The benefit of this research for you is minimal; however it will help you to become aware of the teaching and learning strategies that you have experienced at home and also assist you with English language skills. The broader benefits of this research will include the identification of learning strategies previously experienced by overseas-educated nurses. From this information, support strategies to assist other overseas-educated nurses in their transition to study in Australia will be developed.

Focus group participation is voluntary and you are free to refuse to participate without having to justify your decision, or withdraw consent and discontinue participation in the study at any time without giving a reason. Refusal to be involved or withdrawal from the research will not affect your academic progress or relationships within the University in any way.

Data collected will be confidential. The results of the research will be published in my Masters thesis and may be published in research literature and conference presentations, however direct quotes will not be identifiable to any participants. If you wish to receive feedback regarding the progress of the study and its results please contact me, as the student researcher.

Any questions regarding this project should be directed to the research supervisors and/or the student researcher:


| Dr. Monica Nebauer | Assoc. Prof. Karen Flowers | Rita Adnams |
|---|---|---|
| Tel: 07 3523 7216 | Tel: 07 3623 7292 | Tel: 07 3623 7525 |

School of Nursing & Midwifery (QLD)
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014


It is anticipated that the risks, inconveniences and/or discomforts associated with focus group participation will be minimal; however, your reflections from the discussion may result in feelings of homesickness or anxiety related to past experiences in your homeland. Should you feel that the focus group discussion has distressed you in any way please refer to the contact listed below for appropriate support or counselling.

Ms. Carolyn Toonan
C/o Counselling Services
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014
Tel: 07 3623 7377
Fax: 07 3623 7326

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study or if you have any query that the research supervisors or student researcher have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee.

QLD: Chair, HREC
C/o Research services
Australian Catholic University
Brisbane Campus
PO Box 456
Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328

Any complaint or concern will be treated in confidence and fully investigated and you will be informed of the outcome.

| Dr. Monica Nebauer | Dr. Karen Flowers | Rita Adnams |
|---|---|---|
| Research Supervisor | Research Supervisor | Student Researcher |

## Appendix G

ACU
AUSTRALIAN CATHOLIC UNIVERSITY

Brisbane Campus (McAuley at Banyo)
1100 Nudgee Road Banyo QLD 4054
Locked Bag 456
Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328
Email: www.acu.edu.au

**CONSENT FORM**
**PARTICIPANT COPY**

TITLE OF PROJECT:

**Exploring the previous teaching and learning experiences of overseas-educated nurses.**

RESEARCH SUPERVISORS: Dr Monica Nebauer, Associate Professor Karen Flowers
STUDENT RESEARCHER: Rita Adnams
PROGRAMME ENROLLED: Master of Nursing (Research)

I..... *(the participant)* have read and understood the information provided in the Letter to Participants and am volunteering to participate in a focus group. Any questions I have asked have been answered to my satisfaction. I agree to participate in this focus group realising that participation is voluntary and I am free to refuse to participate without having to justify my decision. I understand that I can withdraw consent and discontinue participation in the group at any time without giving a reason. I understand that discussions within the focus group will be tape recorded to ensure an accurate record for transcription and I agree to maintain confidentiality of the discussion. I understand that only the student researcher and her supervisors will have access to the information obtained from the focus group discussions. I also understand 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 INVESTIGATOR (or SUPERVISOR): .....

DATE: .....

SIGNATURE OF STUDENT RESEARCHER: ..... DATE: .....

ACU
AUSTRALIAN CATHOLIC UNIVERSITY

Brisbane Campus (McAuley at Banyo)
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Virginia QLD 4014
Tel: 07 3623 7429
Fax: 07 3623 7328
Email: **www.acu.edu.au**

**CONSENT FORM**
**RESEARCHER COPY**

TITLE OF PROJECT:

**Exploring the previous teaching and learning experiences of overseas-educated nurses.**

RESEARCH SUPERVISORS: Dr Monica Nebauer, Associate Professor Karen Flowers
STUDENT RESEARCHER: Rita Adnams
PROGRAMME ENROLLED: Master of Nursing (Research)

I..... *(the participant)* have read and understood the information provided in the Letter to Participants and am volunteering to participate in a focus group. Any questions I have asked have been answered to my satisfaction. I agree to participate in this focus group realising that participation is voluntary and I am free to refuse to participate without having to justify my decision. I understand that I can withdraw consent and discontinue participation in the group at any time without giving a reason. I understand that discussions within the focus group will be tape recorded to ensure an accurate record for transcription and I agree to maintain confidentiality of the discussion. I understand that only the student researcher and her supervisors will have access to the information obtained from the focus group discussions. I also understand 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 INVESTIGATOR (or SUPERVISOR): .....
DATE: .....

SIGNATURE OF STUDENT RESEARCHER: ..... DATE: .....