REVIEWS AND DISCUSSION PAPERS

Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: a mixed methods systematic review

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ABSTRACT

Objective: This review aimed to better understand barriers to and facilitators of the professional integration of internationally qualified nurses (IQNs) in Australia.

Background: Nursing shortages are a critical global issue, including developed countries such as Australia, where about 20% of the nursing workforce has been trained overseas. IQNs face many challenges associated with the migration process itself; and their professional integration is crucial in retaining them in the workforce and in maintaining the quality of nursing care in Australia.

Study design and methods: This review followed the JBI methodology for mixed methods systematic review. Web of Sciences, Scopus, Informit, ProQuest, Ovid, and Cinahl databases were searched from inception. Qualitative, quantitative, and mixed methods original studies, published in English, were considered. Screening, data extraction and quality assessment were conducted independently by two reviewers. The assessment of methodological quality used the JBI Qualitative Checklist and Checklist for Analytical Cross-Sectional studies, and the data were extracted using the JBI data extraction tool. Disagreements were resolved by a third researcher and the synthesis used a convergent integrated approach.

Results: From an initial 110 studies, eight studies were included. Individual and social factors emerged as the main themes. The first theme was analysed in terms of two sub-themes: psychological adaptation plus communication and language. Social factors were analysed in terms of three sub-themes:
a) cultural differences in the nursing role;
b) support, mentoring and appreciation and
c) discrimination and racism.

Discussion: psychological adaptation and language proficiency are linked to personal factors. Cultural differences in the nursing role should be addressed with strong support and mentoring programs.

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Recognition of previous experience and appreciation of pre-existing skills are important facilitators. Discriminatory and racist behaviours continue in the work setting, yet are rarely reported.

Conclusion: Discrimination and racism from colleagues, co-workers, and patients should be addressed with a more direct approach than is currently in place. Training of locally and internationally qualified nurses in intraprofessional cultural competence may improve interaction and communication, reduce racism and discriminatory practices, and increase quality of care.

Implications for research, policy, and practice:

This research may be of interest to policy makers, healthcare educators, healthcare workforce planners and healthcare institutions. This study contributes to our understanding of the phenomena of nurse migration, retention, and professional integration, especially in high income countries. It is also a call to address the persistence of discriminatory and racist practices in the Australian context, as well as the education in intraprofessional cultural competence of some local nurses who work with IQNs.

What is already known about the topic?

- High-income countries like Australia rely on the attraction and retention of IQNs to meet their health outcomes.
- Personal characteristics, language proficiency, support and mentoring programs are strong facilitators for IQNs' professional integration.
- The persistence of discriminatory and racist practices are barriers to integration of IQNs in Australia.

What this paper adds:

- In Australia discrimination and racism continue to be dominant barriers to IQNs' professional integration.
- It is crucial to improve the reporting of situations involving discrimination and racism and discuss further consequences for patients, visitors, and co-workers.
- It is essential to promote training programs in intraprofessional cultural competence, and to focus on working with IQNs, as well as caring for patients from culturally and linguistically diverse (CALD) backgrounds.

Keywords: Australia, experience, foreign educated nurses, internationally qualified nurses, intra-professional cultural competence, professional integration, systematic review.

INTRODUCTION

The migration of nurses has been studied globally, particularly in the last 20 years.[1-3] The phenomenon has attracted significant attention, due to its consequences for both source and destination countries, in terms of health care coverage and ethical concerns regarding brain drain, brain gain and brain circulation.[3-5] The shortage of nurses has been a growing concern among experts, governments, and stakeholders in recent years and has become a common challenge for low, medium, and high-income countries worldwide.[6]

This situation was magnified during the COVID-19 pandemic, due to the prolonged exposure of nurses to stressful and difficult working conditions. Emergency and work conditions increased sick leave, burnout, and turnover globally.[6] A relevant report from the Nursing and Midwifery Council UK showed that, between the years 2019 and 2022, a growing proportion of nurses left their employment and changed their careers; for instance, over 25,000 nurses left the permanent register in 2022.[7]

The shortage of nurses is a challenge in developed countries more generally, where factors such as the ageing of the population, the increase in life expectancy, improvements in quality and safety standards, and the growth in the number of nursing hours required per patient have increased the demand for registered nurses. The International Council of Nurses (ICN) (2022) has made an urgent call for countries to plan and monitor their nursing workforce, in order to meet health care quality standards, especially in developed countries. Most of these nations rely on the attraction and retention of IQNs to meet the requirements of their health care systems.[8,9] As an example, nearly 40,000 registered nurse vacancies were reported in September 2021 in England and the need for 69,000 more nurses was projected by 2024-2025; 150,000 new nurses will be needed in Germany by 2025 and 65,000 nurses required in Switzerland by 2030.[6] Some of these high-income countries are known to adopt strongly competitive approaches to deal with nurse shortages and are making efforts to attract and retain IQNs. This situation will only intensify the demand for IQNs in countries such as Australia.

BACKGROUND

Australia, along with other high-income countries, such as Israel, Switzerland, Luxemburg, Ireland, Canada, the USA, and the UK, is heavily dependent on the employment of IQNs.[10,11] According to the Australian Government Department of Health (2022), the migration of IQNs has gradually increased over the last 20 years. IQNs now represent about 20% of the nursing workforce in Australia.[12, 13] Moreover, in sectors such as

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aged care, this percentage has reached 35% of the workforce.[14] In addition, a shortfall of nurses is projected by 2025 and it has been estimated that the nursing workforce must increase by 27% after that year.[15] Furthermore, it is expected that 20% of the Australian population will be over 65 years of age by 2031. This situation is magnified by the fact of Australia's high life expectancy: 85 years of age for women and 81 for men.[16] This is projected to increase the number of nursing hours required per patient. In 2022, the Australian Government announced that nurses would be employed twenty-four hours a day in each aged care home from July 2023, following the recommendation of the Aged Care Royal Commission.[17] All these factors indicate that the Australian health system would require the recruitment and retention of IQNs to be able to have sufficient numbers to ensure a high quality of nursing care, patient safety and responsive, humane care.

Social integration involves a wide range of challenges, which are experienced differently, depending on personal and external factors and may affect individuals independently of their educational or socioeconomic background. Social integration is said to have advantages for the improvement of mental and emotional health, interpersonal skills, and cross-cultural communication.[18] This is particularly important in the context of migration, since migration, which has been considered to be a social determinant of health in its own right, may constitute a risk to physical or psychological health.[19]

Professional integration into the workplace introduces a new range of challenges that can facilitate or interfere with the adaptation and retention of nurses in the selected workplace. Professional integration is a complex and multifactorial phenomenon, understood differently within different countries and institutions. In Canada, sociologists Neiterman and Bourgeault (2015) have defined 'professional integration' not only as the socialisation among professionals, but also as the active process of learning and understanding a work culture. This is a process that requires both adaptation to a new workplace setting and learning new skills, new responsibilities, and a new role.[20]

Despite the professional experiences of IQNs before migrating, there may be substantial differences in the scope of practice, the division and organisation of work and the nursing roles in a new country. In other words, professional integration is a process that comprises the acquisition of universal aspects of a new work environment, in this case, the Australian healthcare culture, and specific aspects of professional nursing practice linked to the professional ethos and professional identity of Australian nursing. Some of the issues most commonly listed by IQNs in developed countries relate to language and communication barriers,[21-23] social isolation,[21,23,24] discrimination and racism,[23,25] lack of recognition of nursing qualifications, lack of support and mentoring,[21, 23] underestimation of their skills by supervisors and colleagues,[23] and differences in nursing roles and professional responsibilities, compared to their country of origin.[22-24]

Some IQNs successfully overcome these difficulties, but a considerable proportion might leave Australia to find another destination country, return to their country of origin, choose a less qualified occupation, or work in a different field.[26] This situation of 'skills wastage' may be addressed by understanding these issues and generating policies, plans and processes to increase IQNs' retention and hence improve quality of care through improved staffing.

Three pertinent studies have illuminated the experiences of IQNs in Australia by systematising findings; the first in 2006,[26] and two in 2018.[28,29] These studies encompassed the years 1985 to 2003, 2007 to 2016 and up to and including 2016. These valuable studies emphasised the importance of orientation programs centred on individual needs, the necessity for an organisational approach and budgets that support nurse leaders and Australian nurses to integrate IQNs, to recognise their previous experiences and value differences, and to address the differences in expectations, especially regarding scope of practice. Finally, all three studies recognised the existence of normalised racial prejudice and exclusion from supervisors, co-workers, patients and visitors and identified how informal interactions with local nurses were difficult to establish in the workplace. These studies agreed on the importance of researching and understanding the phenomenon, in order to improve the social and professional integration processes for IQNs. The significance of this current review relies on three important points; the first is that this systematic review will focus on the studies published between 2016 to 2022. This timeframe means that none of the selected studies for this review were analysed in the three preceding reviews. Secondly, as stated earlier, the COVID-19 pandemic ignited a crisis in the nursing sector within the global context, increasing the demand for nurses, while many nurses in clinical roles have resigned. Thirdly, the Australian healthcare system currently needs to fill a wide range of nursing vacancies, for instance in the aged care sector. Thus, this review seeks to understand barriers and facilitators to the professional integration of IQNs in Australia in this particular context to contribute to understanding and addressing these phenomena.

This current review has been conducted following the COVID-19 pandemic, amidst pressing workforce shortages. The review seeks to expose and understand contemporary challenges for IQNs entering the workforce, with the aim of enabling more effective approaches to professional integration, in the interests of providing sustainable, high-quality, nursing care in Australia.

AIM

The aim of this systematic review was to synthesise evidence of the barriers to and facilitators for the professional integration of IQNs in Australia between 2016 to 2022.

REVIEW QUESTIONS

The main question for this systematic review was: what are the current barriers and facilitators to the professional integration of IQNs in Australia?

INCLUSION CRITERIA

This systematic review considered studies between 2016 to 2022 that explored barriers and facilitators to the professional integration of IQNs working in Australia. The population for this study was IQNs working in Australia. The studies were not limited to the country of origin or language spoken by the nurses, the number of years living in Australia or their area of expertise. The phenomena of interest related to their professional integration. The context was not limited to any specific location in Australia, nor any clinical setting. The types of studies that this systematic review considered were original research published in the English language. There was no restriction of methodology imposed and the search included quantitative, qualitative, and mixed methods studies. Studies exploring experiences of both nurses and midwifes were excluded, as well as those studies analysing locally and internationally qualified nurses together.

METHODS

The review design followed the Joanna Briggs Institute (JBI) Mixed Methods Systematic Review process.[30] The PRISMA reporting guidelines were used to prepare this manuscript (Appendix 1).[31] The study protocol is available online,[32] and the data were synthetised using a convergent integrated approach. In the convergent integrated approach, the data from quantitative and qualitative research can be analysed and combined simultaneously to allow data transformation.[30,33] Synthesis of study results will be presented in narrative form.

SEARCH STRATEGY

A search was conducted between March and July 2022 in six electronic databases: Web of Science, Scopus, Informit, ProQuest, Ovid and CINAHL. As the most recent reviews relevant to this study covered the timespan up to 2016,[27-29] this review covered the timespan from 2016 to 30th June 2022. We limited the language requirements to studies published in English. We used Boolean operators to identify keywords and truncation symbols (*) to identify variations in root words. Some of the keywords used for the search were "*international** trained *nurs**", 'internationally qualified nurs *', "overseas trained *nurs **", "*foreign educated nurs**", "*migran** *nur**", *integration**, *adaptation**, *adjustment**, *transition**, *experienc**, "*job satisfaction**", "*career aspiration**", *retention**, *discrimination**. The search strategy is available in Appendix 2. The reference lists of selected articles were also screened for additional publications that met the inclusion criteria.

INFORMATION SOURCES

The databases that were searched included: Web of Science, Scopus, Informit, ProQuest, Ovid and CINAHL.

STUDY SELECTION

After finishing the search, the results were gathered, organised, and uploaded into COVIDENCE and Mendeley Reference Manager. Duplicates were removed and two researchers independently screened their abstracts and titles against the inclusion criteria for the review. The full texts of those studies that met the inclusion criteria were retrieved and assessed in detail against the inclusion criteria by two independent reviewers.

There was no disagreement amongst reviewers. However, a third reviewer was available in case of disagreement. Appendix 3 shows the search outcome table. The list of articles not selected and the reasons for their exclusion are available in appendix 4.

ASSESSMENT OF METHODOLOGICAL QUALITY

The Jonna Briggs Institute (JBI) Qualitative Checklist and Checklist for Analytical Cross-Sectional studies were used for critical appraisal of the studies that met the inclusion criteria (Appendix 5).[31] For the appraisal of the papers the options yes, no, or unclear were used. The option "Yes" indicated that the article contains a clear statement that directly responds to the question. The option "No", showed that the paper gave a negative response to the query and the option "unclear" showed that there was either confusing information offered in the research or no clear statement in the paper that answered the issue. Each study received a score between 0 and 1 indicating the proportion of "yes" scores overall in the JBI critical appraisal checklist (see details in Table 1 listed by date of publication).

TABLE 1. QUALITY APPRAISAL SCORES BY REVIEWERS LISTED BY DATE OF PUBLICATION

Studies (Author, Year)	Quality appraisal score	
	Reviewer 1	Reviewer 2
Crawford et al, 2016	0.6	0.6
Vafeas and Joyce, 2018	0.9	0.9
Mapedzahama et al, 2018	1	1
Philip, Woodward-Kron, Manias, et al., 2019	0.9	0.9
Philip, Woodward-Kron, & Manias, 2019	1	0.9
Dywili, O'Brien and Anderson, 2021	1	1
Zanjani et al, 2021 *	0.87	0.88
Joseph et al, 2022	1	0.8

* JBI critical appraisal checklist for analytical cross-sectional studies.

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DATA EXTRACTION

Qualitative and quantitative data were extracted from included studies by the first author using the JBI data extraction tool (Appendix 6).

The data were extracted using Excel under the following headings: author; title; barriers; facilitators; methods and design; sample setting; context, results (barriers and facilitators) and conclusions. Then results were organised around barriers and facilitators using a convergent approach and then main themes were identified.[34] None of the authors were contacted for missing information or additional data.

DATA TRANSFORMATION

Data from quantitative studies were transformed into narrative interpretation to facilitate the integration with data extracted from qualitative studies, using a convergent integrated synthesis approach and to answer the review question.[30]

DATA SYNTHESIS AND INTEGRATION

A convergent integrated approach was applied, according to the JBI methodology for mixed methods systematic review.[30] Convergent synthesis combines results from different sources of evidence, such as quantitative and qualitative, and compares and combines them to create a comprehensive summary of the evidence and to provide a more complete understanding of a research question.[30,35] Data were then categorised and grouped based on similarities to generate and integrate them in a narrative format.[30,35,36].

RESULTS

STUDY INCLUSION

The review search resulted in n=175 studies. Sixty duplicates were removed, and 115 abstract and title studies were screened by MC and KM. Nine studies were screened for full-text assessment, which resulted in seven studies being selected, based on inclusion criteria. One additional study was retrieved from the bibliography of the selected studies. In total n=8 studies were included for this systematic review. The quality appraisal applied shows a high quality of the included studies and a solid level of coincidence between the researchers. Figure 1 illustrates the search process of this systematic review.

METHODOLOGICAL QUALITY

The selected studies were analysed by two independent reviewers using The JBI Qualitative Checklist and Checklist for Analytical Cross-Sectional studies, as was explained in the Assessment of Methodological quality section. The appraisal used the terms Yes, No or Unclear. Papers were not excluded based on the score. The detail about the score of each reviewer can be found in appendix 7. The high-quality score obtained by most of the included studies impacted positively on the results.

CHARACTERISTICS OF INCLUDED STUDIES

Overall, eight studies met the inclusion criteria. Most of them relied on qualitative methods (n=7), such as semi-structured interviews, focus group interviews, participant observation and journals, and one study adopted a quantitative approach in a cross-sectional survey. There were no mixed method studies in the search. A summary of the included studies can be found in Table 2.

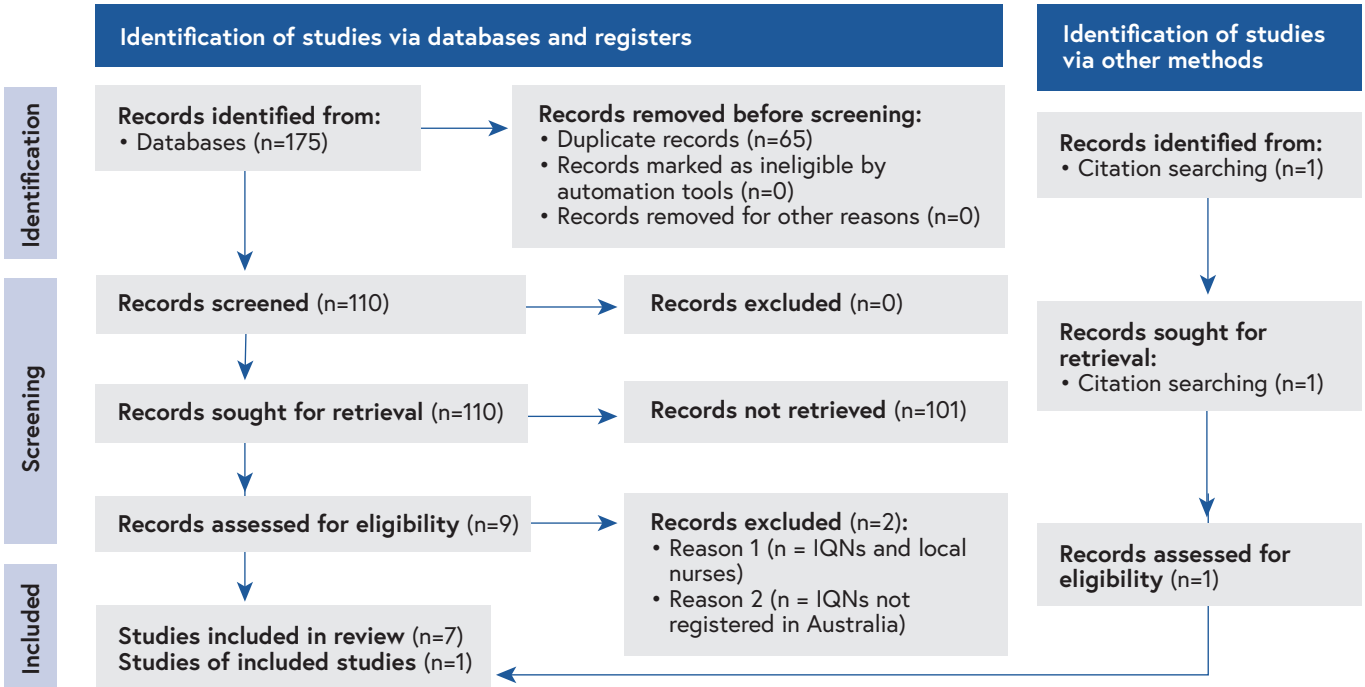

FIGURE 1. PRISMA 2020 FLOW DIAGRAM

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TABLE 2. SUMMARY OF INCLUDED STUDIES LISTED BY DATE OF PUBLICATION AND DESIGN

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristic	Setting	Location	Main findings
Crawford et al, 2016	This study explores IQNs' experiences and perceptions of communicating with patients	Qualitative	Semi structured interviews And the use of a researcher journal	4	IQNs from 4 different countries (Zimbabwe, China, Iran and Philippines)	A 183-bed private acute care hospital in Sydney	Sydney, Australia	The findings were organised in one central theme called 'adjustment' which was connected to the other 4 themes: (1) professional experiences with communication (2) ways of showing respect (3) displaying empathy and (4) experiencing vulnerability.
Vafeas et al 2018	This study aimed to find similarities in the migration journeys of IQNs from the UK	Qualitative	Heuristic inquiry. It used snowball and purposive sample. Data collection was made through focus group interviews, individual semi-structured interviews, and an author journal.	21	IQNs from the UK	IQNs working in different clinical settings in Perth	Perth, Australia	There were three main findings as coping strategies. First the development of resilience; second, defining a new professional identity and third, the capacity of adaptation to the new reality. To achieve a successful experience, the feeling of belonging was key. Developing new friendships and finding a substitute family were considered significant priorities by the participants.
Mapedzahama et al, 2018	The goal was to fill a research gap by utilising the idea of "systemic ignorance" with the concepts of structural violence and faciality to interpret the experiences of black African IQNs who reported instances of racialisation and racial discrimination.	Qualitative	Unstructured conversational style, interviewee-guided interviews	14	IQNs from African countries who migrated to Australia under the skilled temporary visa (457).	It used personal networks and snowball sampling to recruit 14 black, 13 females, 1 male. The study was carried out in different clinical settings.	A large Australian metropolitan city in Australia	The lack of knowledge that black African IQNs have about their work environment is established, sustained, and replicated through actions such as holding complete and crucial information about the workplace, underestimating their expertise, maintaining organisational secrecy and racial stereotypes. Systemic ignorance is perpetuated by creating a perception of IQNs as both ignorant and untrustworthy. Consequently, IQNs are seen as incompetent and requiring constant monitoring. These perceptions result in the underutilisation of the skills of black IQNs and reinforce institutional racism. Simultaneously its undermining the economic advantages of migration and detracting from the rationale for enlisting black African IQNs in Australia's nursing workforce.

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristic	Setting	Location	Main findings
Philip, Woodward-Kron, Manias, et al., 2019	Investigated the factors that facilitate or impede clinical communication among IQNs using a community of practice perspective	Qualitative	Exploratory qualitative study. Semi -structured interviews. For the analysis open coding was used.	21	IQNs (4 males, 17 females) from non-English-speaking countries. Their ages ranged between 25 and 50 years of age. They had between 7 months to 20 years of nursing experience in Australia.	A semi- acute clinical setting at a major hospital in Melbourne.	Melbourne, Australia	The analysis produced two primary themes. The first theme encompassed the inherent characteristics of the individual, which acted as both impediments and facilitators. This theme had sub-themes of adaptability in language and preparedness. The second theme was centred on interactions with colleagues and patients, and had sub-themes of expectations, adjustment, and career advancement. Viewed through the lens of a Community of Practice, these themes had a relational aspect, with the IQNs' interactions with co-workers and patients having an effect on their growth in an unfamiliar healthcare setting.
Philip, Woodward-Kron, & Manias, 2019	The aim is to comprehend how overseas qualified nurses communicate within and between healthcare teams as they collaborate to provide patient care in Australian hospitals	Qualitative	This study used qualitative participant observation and discourse analysis. Data was collected through observation in periods ranging from 2.5-3 hours. Analysis was made using inductive an analytical framework from the data.	13	IQNs from India (n = 6), the Philippines (n = 6) and Nigeria (n = 1) participated.	An acute, subacute, and interventional cardiology settings in a Melbourne metropolitan hospital.	Melbourne, Australia	This study, based on genre analysis and observations, discovered that intra- and interprofessional communication was more frequently observed during the coordination of patient care and less often during the facilitation of interventions. Communication techniques ranged from structured interactions with the use of communication tools to spontaneous, unplanned interactions. An examination of the discourse patterns demonstrated that the efficacy of these interactions was influenced by hesitation, a lack of assertiveness, and a limited number of strategies to handle inadequate or aggressive communication from other team members. Additionally, suboptimal clinical communication with peers was not always attributable to IQNs from non-English-speaking backgrounds. Positive interpersonal interactions, including laughter, switching languages, and casual conversation, were apparent in conversations with nurses from comparable cultural backgrounds, but were infrequent with local colleagues.
Dywili et al, 2020	The study focused on the accounts of black sub-Saharan nurses who have worked in rural Australia and reported instances of racial discrimination	Qualitative	Qualitative hermeneutical phenomenological approach. Data were collected through face-to-face interviews and focus groups	18	IQNs from sub–Saharan Africa who migrated to Australia with the general skilled visa (457)	Different clinical settings	Rural New South Wales, Australia	Through the exploration of the experiences of these IQNs, issues related to race and skin colour emerged in the interactions between them and both their colleagues and patients. IQNs experienced instances of discrimination based on their race and skin colour, which made them feel unwelcome, untrusted, and undervalued. As a result, they adopted a range of coping mechanisms to adapt to being perceived differently.

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristic	Setting	Location	Main findings
Joseph et al, 2021.	The goal of this study was to investigate the experience of transition for Indian-trained nurses who are working in mental health settings in Australia	Qualitative	Hermeneutic phenomenological methodological approach. Purposive sampling. Data were collected through in-depth interviews and analysed with thematic analysis.	16	IQNs from India	Mental health setting across Australia	Australia	The results identified four themes. First, the experience of living in two cultures simultaneously; second, feelings of isolation and loneliness; third, experience discrimination, and finally, a sense of feeling incomplete.
Zanjani et al, 2021	The primary focus of this study was to investigate the factors that contribute to the sociocultural adaptation of IQNs to the Australian healthcare system. A secondary objective was to determine if there was a relationship between IQNs' sociocultural adaptation and their physical and mental wellbeing	Quantitative	Cross-sectional survey. Random sampling Plus 250 questionnaires sent to a target group, plus 50 questionnaires to personal contacts. Analysis was made using linear regression analysis	200	IQNs from countries where English was not their first language, and had completed bridging courses in Australia prior to registration	Online questionnaire	Australia	The questionnaire was completed by 200 participants. In the adjusted multivariate linear regression, job satisfaction (β=0.24,95%CI0.13to0.36), current work environment (β=0.27,95%CI0.05to0.49) and feeling at home (β=0.32,95%CI0.13to0.50) were positively associated with sociocultural adaptation. This association was independent. There was a negative association between Sociocultural adaptation and Perceived Stress Scale (r=−0.14,β=−0.16,p=0.04) and GHQ12(r=−0.36,p<0.001,β=−0.59). The most significant factors that impact IQNs' successful adaptation to the Australian healthcare system are job satisfaction and a sense of workplace support.

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FINDINGS OF THE REVIEW: INDIVIDUAL AND SOCIAL FACTORS.

Our synthesis was organised into two main themes relevant to the professional integration of IQNs in Australia: individual factors and social factors. Individual factors referred to those aspects of personality and life experience that affect IQNs' professional integration and was further divided into two subthemes: psychological adaptation and communication and language. The second theme, social factors, analysed the extent to which the nursing culture in Australia may affect IQNs' professional integration. It was divided into three sub-themes:

a) cultural differences in the nursing role;

b) support, mentoring and appreciation; and

c) racism and discrimination.

Figure 2 provides a graphic illustration of these main findings.

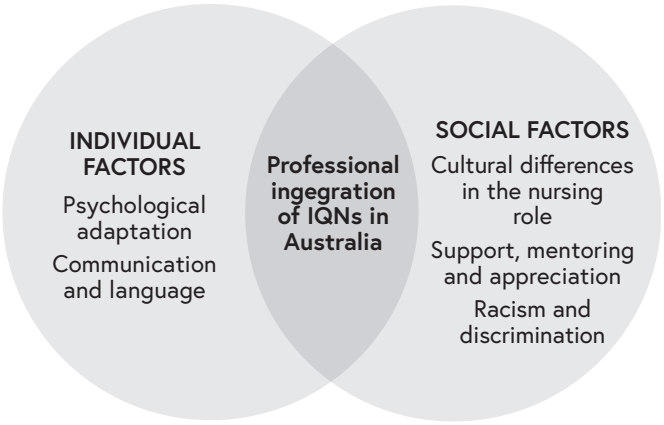

FIGURE 2. BARRIERS AND FACILITATORS TO THE PROFESSIONAL INTEGRATION OF IQNS IN AUSTRALIA

1. INDIVIDUAL FACTORS

a) Psychological adaptation

The studies identified that the IQNs had individual characteristics such as personalities and life histories that influenced the process of psychological adaptation. Characteristics included resilience, flexibility, and the ability to adjust to changing situations. IQNs had to adapt to the Australian culture,[37-41] to the hospital setting,[42,43] the Australian accent,[42] colloquialisms,[40, 42] and other foreign accents,[42,43] without their usual social support networks.

To be resilient to adapt to a new way of life, IQNs developed coping strategies such as to be flexible,[42,43] remain optimistic,[39] to make deliberate efforts to fit in socially and to be accepted.[37,39,40] Overall, IQNs had a positive view about life in Australia. They enjoyed living in the country, they felt safe, found places to practise their religion and were able to make new friends from other countries.[38,40] However, some of them felt themselves to be outsiders, had no sense of belonging or felt incomplete.[37,40] These feelings were stronger in the early stages of immigration and were softened as they became more adapted to the new location and could develop new social connections.[40] For others, they remained as an issue until they found a balance between living in two cultures.[37]

Loneliness is a common feeling experienced by IQNs. Families back in their home countries played an important role in supporting newly arrived IQNs and helped them to deal with isolation, especially for those who came from non-Western cultures.[37,38] Then, the studies reveal that IQNs utilised a range of strategies to cope with loneliness: for instance, to engage in hobbies, to make new friends, to make deliberate efforts to talk to colleagues and initiate social relationships or by having or making friends from the same country of origin, the diaspora. The last one positively contributed to feeling optimistic about living in Australia.[38]

Personal and professional identity are also modified in the migration process. One study found that IQNs had to re-build their personal identity, when they arrived in Australia, as part of the psychological adaptation in a new country.[40] Also, they had to re-build their professional identity once they entered the Australian healthcare setting. They had to gain respect from co-workers by demonstrating their knowledge and expertise in nursing, and this was independent of their qualifications and previous professional experience.[38,40]

Finally, the capacity to deal with stress influenced how IQNs displayed empathy, built therapeutic relationships, and provided emotional care.[42,43] The studies mentioned that working under pressure or having a high patient-to-nurse ratio, were situations that increased stress and negative perceptions about the nursing role and their capacity to deal with it. Other situations that increased stress, tension, or personal discomfort in non-English-speaking IQNs were linked to their foreign accents, mispronunciation, or rapid speech of patients, during extended verbal exchanges. In those situations, some patients reacted by showing frustration, intolerance, or even racist behaviours. Consequently, IQNs felt vulnerable and unable to provide adequate emotional care. Sociocultural adaptation was inversely proportional to stress level and directly proportional to reported better general health.[38]

b) Communication and language

Communication was a common issue in the studies, especially but not exclusively, for IQNs who came from non-English-speaking countries. The Australian accent,[43] the use of Australian colloquialisms,[40,43] patterns of communication in the hospital setting and strong accents of individuals from different nationalities,[42,43] were mentioned by native and non-native English speakers as barriers to fluent communication. The English proficiency levels described in the studies were variable, ranging from proficient or advanced to intermediate. In some cases, language barriers remained high, despite a reasonable length of time living in the country.[44]

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Communication and language barriers could negatively affect the interaction with patients and co-workers. Some participants mentioned that the differences in the tone of voice and the pattern of language used in the Australian clinical settings affected their understanding during interactions.[38,43] These situations caused feelings such as vulnerability and stress, and led them to avoid communicating with patients, as the patients tended to ask more questions and look for longer interactions. Such situations even brought up the idea of going home and giving up.[42] Communication was also affected when the IQNs did not feel well-adjusted into the workplace or when they felt concerned about their language fluency. For instance, the inability or the delay in finding the right word in a conversation generated tension with co-workers, increased concerns about their English proficiency and created self-doubt about their preparedness to work in Australia.[43] However, it has been suggested the poor communication with co-workers, including locally qualified nurses, were not always the sole responsibility of IQNs.[44]

IQNs utilised multiple strategies in attempting to improve language and communication. Some of them tried to adopt local communication patterns, slang, or colloquialism in general conversations, also they adopted the use of non-verbal communications and smiles or seeking clarification and paraphrasing.[43] Adjusting and improving their patterns of communication empowered IQNs to become more active members of the team. However, four studies revealed that local nurses tended to be reluctant to engage in social conversations with IQNs, regardless of whether they came from English or non-English-speaking backgrounds.[39,41,42,44] Interprofessional interactions tended to follow a communication protocol to minimise risks and avoid misinformation.[44] In those situations, the interaction between locally educated nurses and IQNs was minimal and limited to dealing with specific responsibilities. Only one study mentioned that being bilingual or multilingual worked as an enabling factor in gaining acceptance.[42]

The relative lack of hierarchy, and straightforward communication, in the Australian healthcare setting also required cultural adaptation from some IQNs.[42,43] Initially they interpreted it as rude and confronting but, after adjusting to this direct approach, they saw some benefits. The adaptation required the use of a range of strategies to develop self-awareness and made them conscious of barriers in communication and ways of overcoming them.[40,42,43]

2. SOCIAL FACTORS

a) Cultural differences in the nursing role

An IQN's cultural background (not only the language or foreign accent) influenced interaction with co-workers and patients, producing confusion and highlighting the importance of strong cultural orientation programs.[38,43,44] Studies described, for example, cultural differences in how to demonstrate respect and communicate with elder patients, co-workers, and supervisors, for instance by avoiding eye contact.[43] Also, there are cultural differences in establishing social and professional relationships. As an example of this, some cultures consider it inappropriate to argue with others or defend themselves, in order to avoid conflict and to demonstrate respect for hierarchy. Such situations make it challenging for IQNs to stand up for or even express themselves in the Australian work setting.

Finally, a recent study found that clinical encounters were different in their host countries, increasing confusion during the first stages of nursing practice in Australia.[42]

b) Support, mentoring and appreciation

Adequate team members support,[39, 42] comprehensive orientation programs and effective communication channels were facilitators to IQNs' professional integration.[38, 39, 41, 42] From a positive perspective, most IQNs believed that their working conditions were good and safe, and that their salaries were equivalent to their colleagues. They described their nursing roles as professionally rewarding and said that working in Australia provided them with opportunities to develop their nursing knowledge. As one participant said "*I still miss the UK but I'm happy now and I love the work here and the rest of the family are so happy here*".[40]

Lack of appreciation or trust,[39, 42, 43] loss of autonomy,[39, 40] and lack of recognition of previous knowledge and experiences were the concerns most frequently mentioned by IQNs regarding their professional integration.[39- 41] Numerous studies found that IQNs perceived that they were not trusted and suffered a loss of autonomy in activities in which they had extensive experience prior to migrating. They also reported they felt more respected in their home countries and strongly believed that their expertise and knowledge was not being fully utilised by their employers. These situations produced disillusionment and professional dissonance, making the adjustment harder. For instance, one participant reported having changed jobs three times in a year until they found a place where their capabilities were valued.[40] Only one study found that their nursing experience prior to migration was positively welcomed by their managers, yet they still felt unwelcome and untrusted by co-workers and patients.[39] The sense of belonging increased when participants felt appreciated and, combined with the creation of new support networks, resulted in higher retention in the work setting and, in the country.[38, 40]

c) Discrimination and racism

Discrimination and racism were the most frequently cited barriers affecting professional integration, referred to in six of the eight studies.[37-39,41,42,44]

Discrimination and racism were expressed in different ways: these included direct confrontation, insubordination from staff, hostile interactions with colleagues, lack of professional development opportunities, and non-inclusive behaviours. Also, patients reported discomfort about being nursed by IQNs, especially black nurses,[39,41] and those who came from non-English-speaking countries.[37,42,44] Two studies found that everyday racism in the work environment was naturalised and socially accepted.[39,41] In these studies, IQNs reported discrimination and racism from nursing colleagues, staff members, patients and visitors based on their skin colour, as they came from Africa. In one study, patients feared "the black nurse in charge of their care", and subordinates tended to be disrespectful or did not follow directions given by them.[39]

IQNs reacted differently to adjusting to situations involving discrimination and racism. Some of the strategies used were rationalisation of the experience offering an alternative nurse to oversee the care, avoiding exposure to abusive situations, focusing their minds on their migration goals, reciprocating with a similarly negative approach, or blocking negative attitudes.[37,39] Resilience, fortitude, and self-determination played important roles in overcoming these challenging situations. Sadly, in two studies those incidents involving discrimination or racism were not reported to supervisors.[39,43]

The consequences of discriminatory and racist behaviours had a direct negative impact on the mental health of IQNs.[37-39,41,42] In one study, a shocking 27% of the IQNs in the study experienced explicit racism within the workplace.[38]

DISCUSSION

This study has identified the elements that act as **barriers and facilitators** to the professional integration of IQNs in the provision of nursing care in Australia. In the previous section the findings retrieved from the studies are organised and explained in a narrative form. In this section, these results are interpreted, and it is established whether each of them is a barrier or a facilitator to professional integration.

PERSONAL FACTORS

Our findings are consistent with what the previous literature has revealed about immigrants' **psychological adaptation**. Previous studies in the field indicated that immigrants in general tend to display higher levels of anxiety and depressive symptoms as part of the psychological adaption in the host country: this phenomenon has been called acculturative stress.[45-47] The findings of this review suggest that the capacity to overcome acculturative stress relies on the personal attributes of IQNs, such as personality, life experiences, and family and social support. This is consistent with the extant literature.

The findings show that a significant barrier to professional integration is the lack of English language proficiency. An interesting finding is that this barrier, **communication and language,** is not exclusive to non-native English speakers, although it may be harder for them. Language proficiency is required to a successful transition to a new social context, and it is also required to adjust into the professional nursing setting.[48,49] This is particularly important when the results showed that IQNs made deliberate efforts to expand their communication skills, but some local nurses were not willing to improve mutual communication and understanding. There is evidence of accent discrimination in multicultural work settings where diverse languages are spoken[50]; similarly, some of these situations have been documented in the New South Wales healthcare settings.[51] We return to this issue further in analysing the barriers of racism and discrimination. Conversely, language proficiency becomes a facilitator for professional integration since it is directly related to social and economic achievements of immigrants.[48,49]

SOCIAL FACTORS

We turn now to focus on social factors relevant to the professional integration of IQNs in Australia. Some of the barriers that emerged regarding **cultural differences in the nursing role** were the influence of the culture of origin in daily-life interactions and the differences in clinical encounters. There are several similarities in the nursing role within the global context. However, there are also key differences that could be mentioned, such as the legal and professional responsibilities, and the scope of practice[52]. More specifically in the Australian context there were differences in the expectations regarding the behaviour of patients and families, the Australian approach to end-of-life care and medication management and pain thresholds of patients.[53] Consequently, a valuable facilitator would be to carry out comprehensive professional and cultural orientation programs for the IQNs. In addition, improving intra-professional cultural competence among locally trained nurses could be a crucial facilitator to professional integration. It is anticipated that this might increase the willingness of local nurses to communicate with and value IQNs, despite their accents or other barriers to communication. This in turn might avoid any form of accent discrimination.

Cultural competence is described as the ability to work effectively in situations when cultures play a role. Cultural competence has been defined as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or professions to work effectively in cross-cultural situations".[54] Even though cultural safety and

cultural competence have been part of the curriculum for locally educated Registered Nurses (RNs) in Australia, the main focus for cultural competence knowledge has been to support the indigenous and culturally and linguistically diverse (CALD) communities they care for, rather than their colleagues. However, this review identifies a poor application of cultural competence in the intra-professional relationships between nurses, especially where IQNs are involved. The Code of Conduct for Nurses of the Nursing and Midwifery Board of Australia (NMBA) (Principle 3) says that "Nurses engage with people as individuals in a culturally safe and respectful way, foster open, honest and compassionate **professional relationships** and adhere to their obligations about privacy and confidentiality" and the Australian Nursing and Midwifery Accreditation Council (ANMAC) requires cultural competence to be part of the BN curriculum.[55,56] Such requirements illustrate the expectation that Australian educated RNs will be able to recognise, avoid and report any form of racism and discrimination in the Australian work setting. Consequently, the focus of research and actions should be placed on understanding how this content is taught to Australian educated RNs and how they implement such requirements.

This emphasis on cultural competence is consistent with the findings of the three previous reviews conducted in Australia.[27-29] The Nursing and Midwifery Board includes in its program for IQNs seeking registration a two-module "Orientation to the health care in Australia". The first module has to be completed before registration and the second is required within the first six months of registration.[57] However, deeper, and more specifically oriented programs, would be valuable once IQNs enter a specific work setting to reinforce general content, but also to explain organisational, administrative, and cultural aspects of the role. A cultural orientation program would facilitate professional integration and increase awareness about cultural differences, biases.[53] In addition, it might identify implicit ethnocentrism that may be present in daily interactions.

When it comes to **support, mentoring and appreciation**, some of the *barriers* to professional integration identified in this study were the lack of recognition of previous experiences, the lack of autonomy and the perception of not being trusted. These were linked to the lack of support and the absence of mentoring programs. Under-appreciation and lack of recognition of previous IQNs' experience has been documented in Australia and in other countries such as the USA, Canada and the UK.[53,58]

The existence of a support programs or the guidance of a more experienced colleague were strong *facilitators* to professional integration. Feeling valued and having appropriate channels to obtain support and mentoring helped IQNs to increase adjustment to their local nursing role, to be more prepared to work independently, thereby increasing the sense of belonging and also retention.[59]

The final, and most significant, sub-theme is **discrimination and racism,** which was referred to in six of the eight studies.[37-39,41,42,44] The persistence of discrimination and racism is serious indeed and is identified as a fundamental barrier to professional integration. It was unearthed in the three previous studies and is (sadly) still present in the Australian nursing workforce setting.[27-29] A recent publication from the NSW Nurses and Midwives' Association (NSWNMA) found that about 25% of the participants had experienced racial discrimination on a monthly basis. However, only 31% of the total of these situations had been reported.[51]

The role that locally educated nurses are reported to play in displaying non-inclusive, discriminatory, and racist behaviour is the main barrier to professional integration identified in this study and therefore it is critical to explore the issue further. Additionally, the tendency to avoid interactions and display a non-inclusive behaviour towards IQNs may affect teamwork and may have negative consequences for patients' safety and quality of care.[60,61] Training in intra-professional cultural competence and improving intercultural skills for locally educated nurses could play a crucial part in a comprehensive approach and may constitute a significant facilitator to professional integration.

The studies have not referred to the consequences of experiencing discrimination or racism in the workplace. However, it is important to mention that, as many of the situations involving racism and discrimination were not reported to superiors, they could not be formally addressed by the institutions. There is an entire body of regulation focused on the control of racism and discrimination, and these concerns are part of the undergraduate programs regulated by ANMAC. As both the regulatory and the educational requirements already exist, it becomes important to improve channels to report them and discuss further consequences that contribute to educating patients, visitors, and co-workers.

This review has reinforced the findings from the previous publications in the field in Australia,[27-29] which used literature published after 2016 and was carried out after the COVID-19 crisis in a global context of higher demand for nurses.[6,7,10,11,17] Additionally, it revealed that acculturation in the workplace is infrequent, and that the integration of IQNs was understood as their own responsibility and was not always seen as a mutual process. Also, there was a lack of appreciation of the potential benefits that IQNs bring into the workplace, due to their different experiences and skills.

This review will hopefully serve to raise awareness about racism and discrimination, in order to encourage nurses to report these incidents and to intensify education to co-workers, patients, and visitors regarding the Nursing and Midwifery Board of Australia and The Australian Charter of Healthcare Rights and Responsibilities. [55,62]

Additionally, the significance of this study highlights the importance of closely examining the training on intra-professional cultural competence for Australian qualified nurses. Whilst it is understood that the curricula are required to focus strongly on cultural competence with indigenous and CALD patient communities, this review suggests there may be a gap in these competencies when it comes to working with IQNs. Thus, the education of Australian qualified nurses needs to focus equally on working with colleagues from culturally and linguistically diverse backgrounds. This is critical in a country where more than 20% of the nursing workforce was trained overseas and more than 29.8% of the population was born overseas.[13,63,64] These results may be useful to understand in the Australian context but might also be valuable in other high-income countries receiving IQNs.

The findings of this systematic review have limitations. Firstly, generalisability and transferability are limited to nurses and do not explore the experience of other healthcare professionals. Secondly, the first author is herself an IQN in Australia, although she has tried to eliminate any bias by having a second and third reviewer to check her interpretation of the findings. Thirdly, the search was conducted only in the English language, hence publications in a different language may have been missed.

CONCLUSION

This systematic review hopes to contribute to updating the scientific literature published since 2016 regarding the professional integration of IQNs in Australia. Its findings reinforce previous publications in the area, but also add new evidence to the field. The importance of professional and cultural orientation programs for IQNs and the need to examine closely the training of locally qualified nurses in cultural competence are the two most significant findings to emerge from this study.

Further research is needed in order to understand barriers and facilitators better, depending on country of origin, clinical setting, or geographical location, and to understand how pathways and requirements for registration prepare IQNs to perform their work and to integrate into the Australian health care setting. It would also be helpful to understand colleagues' and society's views and expectations regarding the performance of IQNs in Australia. Moreover, this study points to the need to conduct further studies into discrimination and racism between colleagues, as a basis for strengthening the safety and quality of nursing care in Australia through the improved professional integration of IQNs into Australian healthcare settings.

IMPLICATIONS FOR RESEARCH, POLICY AND PRACTICE

This research study has the potential to be of interest to a variety of stakeholders in the healthcare industry, including policymakers, healthcare educators, healthcare workforce planners, and healthcare institutions. The findings of this study shed light on the complex and multifaceted issue of nurse migration, retention, and professional integration, particularly in high-income countries where the demand for healthcare professionals is high.

By analysing research on the experiences and perspectives IQNs who migrated to Australia, this review provides important insights into the challenges and opportunities that they face in their new work environments. In doing so, it highlights the need for healthcare organisations to create more inclusive workplaces that support the integration of IQNs into the local healthcare system. This study also serves as a call to address the persistence of discriminatory and racist practices in the Australian context. It underscores the importance of promoting cultural competency education among local nurses who work with IQNs, as this can help to mitigate potential misunderstandings and conflicts in the workplace. By fostering a more culturally competent workforce, healthcare organisations can create a more inclusive and supportive environment for all nurses, regardless of their background or country of origin.

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REFERENCES

1. Buchan J, Sochalski J. The migration of nurses: Trends and policies. *Bull World Health Organ.* 2004;82(8):587–94.
2. Pittman P, Aiken LH, Buchan J. International migration of nurses: Introduction. *Health Serv Res.* 2007;42(3 II):1275–80.
3. Siyam A, Poz MRD. Migration of health workers: WHO code of practice and the global economic crisis. 2014. 1–220 p.
4. Short S, Marcus K, Balasubramanian M. Health Workforce Migration in the Asia Pacific: implications for the achievement of sustainable development goals. *Asia Pac J Health Manag.* 2016 Oct 1;11(3).
5. World Health Organization. WHO Global Code of Practice on the International Recruitment of Health Personnel. 2009.
6. Shaffer FA, Buchan J, Catton H, Shaffer F. Sustain and Retain in 2022 and Beyond Chief Executive Officer, International Council of Nurses. 2022. [cited 2023 April 3th] Available from: www.intlnursemigration.org
7. Nursing and Midwifery Council UK. The Nursing and Midwifery Council register. 2022.
8. Organization for Economic Cooperation and Development. Health Workforce Policies in OECD Countries. 2016.
9. World Health Organization. State of the World's Nursing Report – 2020. 2020. [cited 2023 April 3th] Available from: https://www.who.int/publications/i/item/9789240003279
10. Marc M, Bartosiewicz A, Burzynska J, Chmiel Z, Januszewicz. P. A nursing shortage–a prospect of global and local policies. *Int Nurs Rev.* 2019;66:9–16.
11. Organisation for Economic Co-operation and Development. Recent trends in international migration of doctors, nurses and medical students. Paris: OECD Publishing; 2019. 1–138 p.
12. Australian Government Department of Health and Aged Care. Factsheet Selector dashboard. 2023. Factsheet Selector Dashboard. [cited 2023 Apr 17] Available from: https://hwd.health.gov.au/nrmw-dashboards/index.html
13. Marcus K, Quimson G, Short SD. Source country perceptions, experiences, and recommendations regarding health workforce migration: A case study from the Philippines. *Hum Resour Health.* 2014 Oct 31;12(1).
14. Department of Health, Australian Government. 2020 Aged Care Workforce Census Report. 2020. [cited 2023 April 3th] Available from: https://www.health.gov.au/sites/default/files/documents/2021/10/2020-aged-care-workforce-census.pdf
15. Christopher SA, Fethney J, Chiarella M, Waters D. Factors influencing turnover in GenX nurses: Results of an Australian survey. *Collegian.* 2018 Apr 1;25(2):217–25.
16. Australian Institute of Health and Welfare. Deaths in Australia web report. 2021.
17. Royal Commission into Aged Care Quality and Safety. Final report: care, dignity and respect. volume 1. 2021.
18. Ward C. Probing identity, integration and adaptation: Big questions, little answers. *Int J Intercult Relat.* 2013 Jul;37(4):391–404.
19. Vandenberg M, Fan S, Cooling N, Harris KM, Chin J. Skilled migration: a structural determinant of health. *Int J Migr Health Soc Care.* 2019 Oct 18;15(4):262–71.
20. Neiterman E, Bourgeault IL. Professional integration as a process of professional resocialization: Internationally educated health professionals in Canada. *Soc Sci Med.* 2015 Apr 1;131:74–81.
21. Omeri A, Atkins K. Lived experiences of immigrant nurses in New South Wales, Australia: searching for meaning. *Int J Nurs Stud.* 2002 Jul;39(5):495-505.
22. Kishi Y, Inoue K, Crookes P, Shorten A. A model of adaptation of overseas nurses: exploring the experiences of Japanese nurses working in Australia. *J Transcult Nurs.* 2014;25(2):183–91.
23. Pung LX, Goh YS. Challenges faced by international nurses when migrating: an integrative literature review. *Int Nurs Rev.* 2017;
24. Brunero S, Smith J, Bates E. Expectations and experiences of recently recruited overseas qualified nurses in Australia. *Contemp Nurse.* 2008;28(1–2):101–10.
25. Mapedzahama V, Rudge T, West S, Perron A. Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace. *Nurs Inq.* 2012 Jun;19(2):153–64.
26. Efendi F, McKenna L, Reisenhofer S, Kurniati A, Has EMM. Experiences of healthcare worker returnees in their home countries: A scoping review. *J Multidiscip Healthc.* 2021;14:2217–27.
27. Konno R. Support for overseas qualified nurses in adjusting to Australian nursing practice: a systematic review. *Int J Evid Based Healthc.* 2006 Jun;4(2):83–100.
28. Chun Tie Y, Birks M, Mills J. The Experiences of Internationally Qualified Registered Nurses Working in the Australian Healthcare System: An Integrative Literature Review. *J Transcult Nurs.* 2018 May;29(3):274-284.
29. Ng Chok H, Mannix J, Dickson C, Wilkes L. The factors impacting personal and professional experiences of migrant nurses in Australia: An integrative review. *Collegian.* 2018 Apr 1;25(2):247–53.
30. Lizarondo L, Stern C, Carrier J, Godfrey C, Rieger K, Salmond S, Apostolo J, Kirkpatrick P, Loveday H. Chapter 8: Mixed methods systematic reviews. Aromataris E, Munn Z, editors. JBI Manual for Evidence Synthesis. JBI; 2020. Available from: https://synthesismanual.jbi.global. https://doi.org/10.46658/JBIMES-20-09
31. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ.* 2021 Mar 29;372:n71.
32. Correa-Betancour M, Marcus K, Balasubramanian M, Short S. Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: a mixed methods systematic review protocol. Open Science Framework [Internet]. 2022 [cited 2023 Apr 19]; Available from: https://osf.io/wmsh3
33. Sandelowski M;, Voils CI;, Barroso J. Defining and Designing Mixed Research Synthesis Studies. Vol. 13, Research in the Schools; Spring. 2006.
34. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol.* 2008;8.
35. Bettany-Saltikov J. Synthesizing, summarizing and presenting your findings. In: How To Do A Systematic Literature Review In Nursing : A Step-By-Step Guide. McGraw-Hill Education; 2012. p. 1–194. [cited 2023 April 3th] Available from: www.prisma-statement.org/
36. Hong QN, Pluye P, Bujold M, Wassef M. Convergent and sequential synthesis designs: implications for conducting and reporting systematic reviews of qualitative and quantitative evidence. *Syst Rev.* 2017 Mar 23;6(1):61.

37. Joseph B, Olasoji M, Moss C, Cross W. Transition experiences of Indian nurses into Australian mental health system. *J Transcult Nurs.* 2022 Jan 1;33(1):41–8.
38. Zanjani ME, Ziaian T, Ullrich S, Fooladi E. Overseas qualified nurses' sociocultural adaptation into the Australian healthcare system: A cross-sectional study. *Collegian.* 2021 Aug 1;28(4):400–7.
39. Dywili S, O'brien L, Anderson J. "It's only the skin colour, otherwise we are all people": The changing face of the Australian nurse. *Aust J Adv Nurs.* 2021;38(2):13–22.
40. Vafeas C, Hendricks J. A heuristic study of UK nurses' migration to WA: Living the dream downunder. *Collegian.* 2018 Feb 1;25(1):89–95.
41. Mapedzahama V, Rudge T, West S, Kwansah-Aidoo K. Making and maintaining racialised ignorance in Australian nursing workplaces: The case of black African migrant nurses. *Australas Rev of Afr Stud.* 2018;39(2):48–73.
42. Philip S, Woodward-Kron R, Manias E, Noronha M. Overseas Qualified Nurses' (OQNs) perspectives and experiences of intraprofessional and nurse-patient communication through a Community of Practice lens. *Collegian.* 2019 Feb 1;26(1):86–94.
43. Crawford T, Roger P, Candlin S. Are we on the same wavelength?' International nurses and the process of confronting and adjusting to clinical communication in Australia. *Commun Med.* 2016;13(3):263–75.
44. Philip S, Woodward-Kron R, Manias E. Overseas qualified nurses' communication with other nurses and health professionals: An observational study. *J Clin Nurs.* 2019 Oct 1;28(19–20):3505–21.
45. Berry J, Annis RC. Acculturative stress- The role of ecology, culture and differentiation. *J Cross Cult Psychol.* 1974;5(4):1–25.
46. Torres L. Predicting levels of Latino depression: Acculturation, Acculturative Stress, and Coping. *Cultur Divers Ethnic Minor Psychol.* 2010 Apr;16(2):256–63.
47. Ward C, Szabó Á, Schwartz SJ, Meca A. Acculturative stress and cultural identity styles as predictors of psychosocial functioning in Hispanic Americans. *Int J Intercult Relat.* 2021 Jan 1;80:274–84.
48. Guven C, Islam A. Age at migration, language proficiency, and socioeconomic outcomes: evidence from Australia. *Demography.* 2015 Mar 7;52(2):513–42.
49. Lum L, Dowedoff P, Bradley P, Kerekes J, Valeo A. Challenges in oral communication for internationally educated nurses. *J TranscultNurs.* 2014 May 12;26(1):83–91
50. de Souza LEC, Pereira CR, Camino L, de Lima TJS, Torres ARR. The legitimizing role of accent on discrimination against immigrants. *Eur J Soc Psychol.* 2016 Aug 1;46(5):609–20.
51. The New South Wales Nurses and Midwives' Association. The Cultural Safety Gap. Sydney; 2019 [cited 2022 Dec 27]. Available from: https://www.nswnma.asn.au/wp-content/uploads/2019/09/CaLD-Report-FINAL-lr.pdf
52. Birks M, Davis J, Smithson J, Cant R. Registered nurse scope of practice in Australia: an integrative review of the literature. *Contemp Nurse.* 2016 Oct;52(5):522-543.
53. Cathy O'Callaghan C, Loukas P, Brady M, Astrid Perry A. Exploring the experiences of internationally and locally qualified nurses working in a culturally diverse environment. *Aust J Adv Nursi*[Internet]. 2018 [cited 2023 Apr 3];36(2). Available from: https://www.ajan.com.au/archive/Vol36/Issue2/3OCallaghan.pdf
54. Cross TL, Bazron BJ, Dennis KW, Isaacs MR, Benjamin MP. Towards a culturally competent system of care. A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. 1989. [cited 2023 April 3th]. Available from: https://files.eric.ed.gov/fulltext/ED330171.pdf
55. Nursing and Midwifery Board of Australia. Code of Conduct for Nurses 2018. [cited 2023 April 3th] Available from: www.nursingmidwiferyboard.gov.au
56. Australian Nursing and Midwifery Accreditation Council. Registered Nurse Accreditation Standards 2019. 2019. [cited 2023 April 3th]. Available from: https://www.anmac.org.au/search/publication
57. Australian Nurse and Midwifery Board. Ahpra. 2023 [cited 2023 Apr 12]. Orientation to Health Care in Australia. Available from: https://www.nursingmidwiferyboard.gov.au/Accreditation/IQNM/Orientation-Part-1-and-Part-2.aspx
58. Pressley C, Newton D, Garside J, Simkhada P, Simkhada B. Global migration and factors that support acculturation and retention of international nurses: A systematic review. *Int J Nurs Stud Adv.* 2022 Dec;4(1):100083.
59. Primeau MD, Champagne F, Lavoie-Tremblay M. Foreign-trained nurses' experiences and socioprofessional integration best practices: an integrative literature review. *Health Care Manag.* 2014 Jul-Sep;33(3):245-53.
60. Neff DF, Harman J. Foreign-Educated Nurses: Effects on nurse, quality of care, and patient-safety-indicator outcomes. *J Nurs Regul* [Internet]. 2013 Apr [cited 2023 Jan 28];4(1):19–24. Available from: https://www.journalofnursingregulation.com/article/S2155-8256(15)30163-0/fulltext
61. Wheeler RM, Foster JW, Hepburn KW. The experience of discrimination by US and Internationally educated nurses in hospital practice in the USA: a qualitative study. *J Adv Nursi.* 2013 Jun 20;70(2):350–9.
62. Australian Commission on Safety and Quality in Healthcare. Australian Commission on Safety and Quality in Healthcare. Australia; 2020 [cited 2023 Mar 22]. p. 1–1 Australian Charter of Healthcare Rights. Available from: https://www.safetyandquality.gov.au/our-work/partnering-consumers/australian-charter-healthcare-rights
63. Moyce S, Lash R, de Leon Siantz M Lou. Migration experiences of foreign educated nurses. *J Transcult Nurs* [Internet]. 2016;27(2):181–8. Available from: http://journals.sagepub.com/doi/10.1177/1043659615569538
64. Australian Bureau of Statistics. Migration Australia. 2021 [cited 2023 Apr 17]. Statistics on Australia's international migration, internal migration (interstate and intrastate), and the population by country of birth. Available from: https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release#data-downloads