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**PROFESSIONAL IDENTITY POSITIONING
OF INTERNATIONALLY QUALIFIED
NURSES DURING WORKPLACE
INTERACTIONS WITH COLLEAGUES IN
NEW ZEALAND HEALTHCARE SETTINGS**

A thesis presented in partial fulfilment of the requirements for the degree of

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ABSTRACT

The global nursing shortage has been a catalyst for the international migration of nurses. Internationally qualified nurses (IQNs) are valued in New Zealand as capable and competent healthcare professionals. As limited research exists into the professional identity of IQNs in New Zealand, my aim for this study was to explore IQNs' discursive identity positioning. Research determining ways to support IQNs' career sustainability was missing in the extant literature, which this study sought to address. Taking a social constructionist perspective, I employed narrative inquiry to empower eight IQN participants to tell stories of challenging and positive workplace interactions with their colleagues. The participants had English as their first or additional language and had been nursing in New Zealand for at least three years. Narrative data from participants were collected during COVID-19 pandemic restrictions in New Zealand by means of semi-structured interviews ('Story-Led Conversations') and peer-facilitated conversations via Zoom ('Zoom Pair Shares'). Participants' storied experiences were analysed to reveal aspects of IQNs' discursive positioning. This allowed me to identify:

- how IQNs positioned themselves and others as they told stories of participating in workplace interactions with colleagues in New Zealand healthcare settings;

- how they used discursive positioning in their stories to jointly construct aspects of their professional identity; and

- the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community.

I used thematic analysis to construct six themes related to IQNs' workplace interactions. I also developed an analytical framework based on positioning theory—the multimodal positioning analysis (MPA) model—to analyse participants' discursive positioning of self and others when telling their stories of workplace interactions. Research findings indicated that IQN participants' workplace interactions with colleagues impacted upon their professional identity positioning. The nature of this impact included IQNs' sense of professional self, agency, collegiality, and wellbeing, which are critical for IQNs' feelings of belonging and career sustainability. Findings from this study may lead to greater understanding and support of IQNs as they build a successful long-term nursing career in New Zealand.

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STATEMENT OF ORIGINAL AUTHORSHIP

I hereby assert my moral right to be identified as:

- i. the author of this thesis; and
- ii. the creator of the original data collection tool, ‘Story of a Challenging and/or Positive Workplace Interaction’ Flower Diagram; and
- iii. the creator of the original data analysis framework, the multimodal positioning analysis (MPA) model, which is based on the works of duly cited authors.

To the best of my knowledge, the thesis contains no material previously published or written by another person except where duly cited.

All writing, editing, and transcribing work involved in the production of this thesis has been completed by me.

Signature:  _____

Date: 24 May 2024

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Chapter 1: Introduction

1.1 Introduction

The goal of Immigration New Zealand (INZ) is for migrants “to settle well and feel at home in New Zealand [because] well settled migrants are generally happier, stay longer and contribute more to society” (INZ, 2019c, ¶1). Migrants contribute to professional dialogue and engage in social conversations with colleagues to integrate into the workforce (INZ, 2019a). However, within the first five years of their arrival, migrants often find it challenging to adapt to the New Zealand workplace culture and its culturally embedded discourse (Haneda, 2006; Riddiford & Joe, 2005). Walker and Clendon (2015), for instance, found that internationally qualified nurses (IQNs) wishing to participate fully in New Zealand healthcare settings found barriers to their integration, including discriminatory workplace practices, difficulties communicating with colleagues and patients, and low salaries not commensurate with their experience. These employment issues and multicultural tensions had a negative impact on IQN retention rates. Consequently, IQNs were likely to emigrate to Australia within five years for better remuneration and working conditions (McClure, 2023; NZNO, 2012).

According to Winkelmann-Gleed and Seeley (2005), work-related identities of migrant nurses have not been sufficiently researched. There is limited research into the professional identity of registered IQNs in New Zealand as revealed through their workplace communication with colleagues (i.e., doctors, administrators, and fellow nurses—both New Zealanders and other IQNs). Understanding migrant nurses’ professional identity is important because IQNs’ sense of professional self links to concepts such as their clinical confidence and competence (Maginnis, 2018), sense of belonging to a professional community of practice (Dahl et al., 2022), and nursing retention (Johnson et al., 2012). For example, IQNs who feel successful in understanding social interactions, hierarchy, and cultural expectations in New Zealand healthcare settings may report more positive workplace interactions (Brunton & Cook, 2018). There is thus a need to develop new knowledge about IQNs’ professional identity in New Zealand nursing contexts.

This chapter outlines the background and context of the study, along with the aim of the research. I describe the scope of this research and provide definitions of terms used. I then discuss ways in which scoping and framing discussions identified IQNs' communication needs and aspects of their workplace interactions and identities. The interviewees' use of non-literal language also revealed their feelings about, and perceptions of, IQNs' professional interactions and identity in New Zealand healthcare settings. I finish this chapter by considering the significance of this research, including the study's relevance and benefits, and provide an outline of the remaining chapters of the thesis.

1.2 Background to the Study

The Nursing Council of New Zealand (2022) stated that IQNs comprised nearly a third of the nursing workforce in New Zealand. IQNs often become registered in New Zealand by attaining language proficiency and competency standards. For example, in the past decade, around a quarter of migrant nurses in New Zealand gained their nursing qualification from overseas institutions, particularly India, the Philippines, and Malaysia (INZ, 2015). IQNs can apply for New Zealand registration if they hold an international nursing qualification equivalent to a Bachelor of Nursing degree from a New Zealand tertiary institution and are registered nurses (RNs) in their country of origin. According to the Nursing Council of New Zealand (2022), nurses with English as an additional language (EAL, referred to as 'migrant EAL nurses' henceforth for reasons of practicality) must also demonstrate their language proficiency via an internationally recognised test such as International English Language Testing System (IELTS) or Occupational English Test (OET). Such pre-registration criteria have implications for migrant nurses' sense of professional legitimacy, particularly when overseas trained nurses must take IELTS or OET to become registered practitioners in New Zealand (Walker & Clendon, 2012).

1.3 Context of the Study

The current global nursing shortage threatens the delivery of medical services to patients in the public and private healthcare sectors (Li et al., 2014). New Zealanders' healthcare needs are growing, particularly as a result of the population's

increasing rates of age- and obesity-related diseases (Ministry of Health, 2016). This is a key area of concern in New Zealand because our healthcare system relies heavily on IQNs to fill staffing gaps (Head, 2017; Nursing Council of New Zealand, 2021). However, IQNs' understanding of acceptable professional and cultural practices within New Zealand workplaces is generally developed through their interactions with colleagues, rather than from direct instruction from management (Brunton & Cook, 2018; Brunton et al., 2019). The major focus of this study is the workplace interactions that IQNs working in New Zealand healthcare settings report having with their colleagues which may impact upon their professional identity and wellbeing. This is because there is a significant need for IQNs, who are key members of the critically important healthcare workforce, to feel supported in the host (i.e., recipient) country, leading to their successful integration and retention (Pung & Goh, 2017). As Head (2017) indicated, New Zealand healthcare providers would strongly benefit from evidence-based policies and strategies that improve IQNs' retention and career sustainability.

1.3.1 Nurse Migration

Registered nurses have long migrated overseas in search of career opportunities. IQNs traditionally sought work in countries that shared language and cultural backgrounds; for example, British nurses would choose to immigrate to Australasia (Benton et al., 2014). There has been a noticeable trend in recent decades for IQNs to migrate to diverse countries whose health systems are struggling to cope with demand for healthcare services. Government agencies and healthcare providers around the world are increasingly seeking to employ registered nurses from countries such as China, India, and the Philippines to alleviate the pressure on medical services. In turn, nurses from these source countries choose to migrate to the USA, United Kingdom, Europe, and Australasia to benefit from higher salaries and career opportunities (Kingma, 2018).

1.3.1.1 Push and Pull Factors Influencing Nurse Migration.

Nursing industry researchers (e.g., Li et al., 2014; Philip et al., 2019; Walani, 2015) have identified the global nursing shortage as a catalyst for the international migration of nurses, particularly from low-income to middle- and high-income

countries. Li et al. (2014) found that leaving one's homeland to take up a perceived safe and financially secure role in a new country can be both rewarding and detrimental to IQNs as well as to their country of origin. Following are key push and pull factors that influence nursing migration:

- i. Push factors from low-income countries are the remittances that IQNs send back to their home countries for income and healthcare support (Humphries et al., 2009). According to Habermann and Stagge (2010), push factors in their home countries cause nurses to make the—often difficult—decision to leave their family and friends and find employment in an overseas country. Nurses may be dissatisfied with low rates of pay, substandard working conditions, and inadequate professional development (King-Dejardin, 2019). They may be seeking travel and lifestyle opportunities or escaping unsafe personal circumstances (Prescott & Nichter, 2014). Garner et al. (2015) also identified the low status of nursing in India as a significant push factor for Indian IQNs to seek work overseas.
- ii. Conversely, pull factors are those that entice IQNs to further their career in the receiving country. Such factors include nursing education and in-service training opportunities, attractive salaries, and beneficial working and living conditions (Kingma, 2008; Li et al., 2014; Walani, 2015). Pull factors in middle- and high-income countries are the financial benefits and career opportunities that IQNs expect to receive (Walani, 2015). Many IQNs send a percentage of their wages back to their home countries in the form of remittances to support their families' living and healthcare needs (Dimaya et al., 2012; Humphries et al., 2009; Squires & Amico, 2014).

1.3.1.2 Issues and Tensions.

There are, however, several issues and tensions related to international nursing migration. Prescott and Nichter (2014) noted that the exploitation of push and pull factors is a central strategy for recipient countries to secure the employment of IQNs, thereby reducing pressures on their health systems. This has led to severe nursing shortages in IQNs' countries of origin, which has subsequently impacted healthcare delivery, training, and policy development in source and recipient countries (Dimaya et al., 2012; Smith, 2021). Not only does a source country lose nursing skills with the

departure of trained and qualified registered nurses (Li et al., 2014), but standards of nursing care in these countries may be negatively affected (Bland & Woolbridge, 2011). Walker and Clendon (2015) argue that the recruitment of migrant nurses may solve the national nursing shortage in the short term, but it ignores the ongoing need for sustainable nursing education policies and processes in New Zealand.

Furthermore, IQNs encounter difficulties when orienting and integrating into their new workplace and wider communities. Researchers (e.g., Pung & Goh, 2017; Walker & Clendon, 2015) have found that migrant nurses reported feelings of professional devaluation when their career experience and qualifications were not recognised by employers and colleagues. IQNs often face significant challenges in integrating into their new workplace environments, including discrimination and communication barriers (Li et al., 2014; Philip et al., 2019). IQNs also experience cultural differences within their healthcare settings. A lack of social support networks comprising nurse mentors or peer nurses can lead to IQNs feeling isolated and marginalised, too (Pung & Goh, 2017; Walker & Clendon, 2012).

1.3.2 IQNs in New Zealand

Immigration New Zealand (2019b) reported that around 40% of New Zealand's health personnel—including doctors, nurses, and allied health professionals—were trained abroad. Compared with other OECD (Organisation for Economic Co-operation and Development) member countries, New Zealand has demonstrated a heavier reliance on short-term migrant nurses to meet community and hospital patients' needs (NZNO, 2018; Zurn & Dumont, 2008). The term 'internationally qualified nurse' and its acronym 'IQN' are used to refer to overseas-trained and New Zealand-registered nurses by the New Zealand Nurses' Organisation (Head, 2017) and the Nursing Council of New Zealand (2022). Additional terms in the research literature for migrant nurses are 'international nurse', 'foreign nurse', 'overseas nurse', 'expatriate nurse', 'overseas-trained nurse', and 'foreign-trained nurse' (Nursing Council of New Zealand, 2022). The term 'internationally qualified nurse' is the most appropriate for this study because the participant cohort includes migrant nurses from any country and from any language background, including English. I consider 'internationally qualified nurse' to be the most strengths-based term for

migrant nurses, emphasising the clinical skills and knowledge they bring to the New Zealand healthcare sector.

According to Brunton and Cook (2018), the nursing workforce in New Zealand has become more internationalised. The migrant nurse cohort in New Zealand in the 1990s was small in number and linguistic diversity. This was because IQNs tended to originate from inner circle English language countries (cf. Kachru, 1985), such as the United Kingdom, Canada, the United States, and Australia (Brunton & Cook, 2018). The number of IQNs in New Zealand has grown since the beginning of the 21st century, rising to over 26% of the nursing cohort in 2017 (Balante et al., 2021) and around 30% in 2022 (Nursing Council of New Zealand, 2022), with the majority of the source countries being India and the Philippines (Nursing Review, 2018). Since the COVID-19 pandemic restrictions ended in 2022, approximately half of IQNs who were granted work visas were from India, whilst IQNs from the Philippines received the second highest number of visa approvals (Blessen, 2023). The range of IQNs' language and ethnic backgrounds, along with their nursing approaches and values, continue to influence New Zealand's social and professional communities (Brunton & Cook, 2018). Brunton et al. (2019) found that nurses' ethnic diversity required healthcare managers to receive "support and training to help create a positive workplace for both host and migrant nurses [and] to manage teamwork, communication and clinical practice in increasingly diverse healthcare settings" (p. 165).

New Zealand suffered a shortage of IQNs during COVID-19 immigration restrictions in 2020 and 2021, resulting from the government's initial policy of eliminating the coronavirus (Alexander, 2022; Jefferies et al., 2020). The reduced number of qualified nursing staff led to the New Zealand healthcare sector experiencing immense pressure on its human and clinical resources throughout the COVID-19 pandemic (Witton, 2022). Consequently, IQNs and New Zealand-trained nurses alike needed to work together in high-stress conditions to provide care to patients or residents during pandemic restrictions (Manchester, 2020; Seymour, 2020).

1.3.3 IQNs' Professional Identity

A strong professional identity, which nurses develop through interacting with other healthcare professionals, has been shown to increase nurses' job satisfaction and retention rates, decrease their levels of burnout, and improve their career development and professional learning opportunities (Rasmussen et al., 2021). Norton (2000), however, found that migrants experienced difficulty becoming members of their community of practice, owing to colleagues and managers judging IQNs on their communicative competence as well as their cultural competence. The way that IQNs interact with their colleagues may impact upon their professional identity, integration, and retention (Johnson et al., 2012; Winkelmann-Gleed & Seeley, 2005). In addition, Sheehy et al. (2024) have reported that negative judgements from colleagues and managers of their clinical and communicative competence resulted in IQNs feeling excluded in the healthcare workplace. To support IQNs' career sustainability, migrant nurses' workplace interactions are therefore worthy of investigation. This is because, as Weston and Longmore (2020) observed, the global nursing shortage has contributed to higher attrition rates amongst IQNs in New Zealand.

1.4 Research Aim

This study focuses on migrant nurses who have English as their first or additional language. The New Zealand Nurses Organisation seeks to improve migrant nurse retention through encouraging employers to assist IQNs in integrating into New Zealand healthcare settings (NZNO, 2018). New Zealand has certainly prioritised the recruitment of IQNs from English-speaking countries, owing to similar sociocultural backgrounds which may allow them to integrate more easily into the community (INZ, 2015). Brunton and Cook (2018) discovered, however, that nurses who migrated to New Zealand found communicating with colleagues and patients difficult because of diverse cultural backgrounds, embedded context-specific communication norms, and culturally bound nursing practices. Consequently, I am interested in exploring how IQNs' storied experiences of workplace interactions with fellow healthcare workers might impact their identity positioning and their feelings of professionalism and integration.

Brunton et al. (2019, 2020) insist that it is through supporting and retaining IQNs in their healthcare careers that New Zealand's nursing supply and demand needs may be met in the long term. To that end, collegial and supportive workplace interactions may help sustain feelings of motivation and affinity in migrant nurses, as well as their managers and fellow RNs. There is a need for IQNs' perspectives concerning their workplace interactions with colleagues to be heard and responded to because "enhancing understanding and trust between employee stakeholders has the potential to significantly improve workplace experience for all" (Brunton et al., 2019, p. 172). In line with Phillips and Hayes (2006), I have selected social constructionism as the interpretive lens to: (i) help me understand co-constructed meanings within my narrative data; and (ii) guide my choice of research methods in this narrative case study. (I discuss the study's research philosophy, methodology, and methods in Chapter Three.) The study was designed to investigate IQNs' professional identity through discursive positioning to inform nursing practice and policy in New Zealand so that migrant nurses' careers may be supported and enhanced.

1.5 Researcher's Background

My former role as a life and disability insurance underwriter allowed me to develop an understanding of medical concepts and terminology that led me to tutor migrant EAL nurses as they prepared for the Occupational English Test. In December 2017, I underwent a double hip replacement at a private hospital in New Zealand. Several of my nurses were from the Philippines and India. Once they found out I was an English language teacher, they enjoyed talking with me about their difficult and rewarding nursing encounters in New Zealand. I was impressed how these IQNs were so positive about their nursing career in New Zealand, despite facing language and cultural challenges in their healthcare workplaces. Having graduated with a Master of Teaching English to Speakers of Other Languages (TESOL) Leadership in 2016, I was keen to learn more about the workplace interactions and professional identity of migrant nurses in New Zealand. My professional and personal life events have shaped me as a researcher by helping me recognise the power of stories to create and share knowledge. They have also showed me the value of understanding migrant nurses' perspectives and their contributions to the wider nursing community.

1.6 Research Scope

1.6.1 Scoping and Framing the Study

Scoping and framing discussions were held during the pre-study stages and were not part of the data collection phase. The purpose of the discussions was to guide the research design, identify issues from an emic perspective and guide the direction of my literature review. They helped me gain a sense of the discursive construction, communication, and language use issues in New Zealand nursing contexts. Even though the nurses' responses were not data, I draw on them in this section to help contextualise the study and provide a rationale for my choices.

IQNs might have English as a first language (including a variety of English; e.g., Indian English) or an additional language. IQNs' language background may have an effect on projecting their professional identity, positioning themselves, and being seen by others. Scoping and framing discussions supported my narrative inquiry processes and claims related to migrant nurses' workplace interactions with colleagues. They helped strengthen the research methodology choices I made to understand relevant issues for IQNs and nursing professionals in the New Zealand healthcare sector.

1.6.2 Rationale for Scoping and Framing the Study

In November and December 2018, I conducted scoping and framing discussions with three registered nurses in a New Zealand city to discuss IQNs' professional workplace interactions and aspects of identity. These discussions were not for data collection but were a guide for planning research decisions and understanding links between IQNs' real-world workplace interactions with those described in the literature. The registered nurses (RNs)—Kate, Mary, and Fran—were either nursing lecturers at a tertiary institution (Kate and Fran) or a registered nurse in private practice (Mary). Kate and Mary both had an IQN background. (Pseudonyms are used to maintain the nurses' anonymity and confidentiality.) I took thorough notes to record key learning points and quotes from the discussions, which helped me write up our conversations in depth. I also sent each nurse my notes after our interview for their confirmation and feedback.

I started every interview—one interview per nurse—by explaining the purpose of the conversation and why the nurse had been chosen. After asking each nurse for their informed consent to my recording and note-taking during our discussion, I confirmed that the information they provided would remain private and confidential. We first talked about each nurse’s understanding of IQNs’ professional communication skills. Kate, Mary, and Fran confirmed my findings from the literature (e.g., Attrill et al., 2016; Jamshidi et al., 2016; Newton et al., 2010) that migrant EAL nurses’ language use (e.g., accents) and sociocultural background impact their effectiveness in interacting with patients and colleagues.

1.6.3 From Competence Assessment Programme to Nursing Registration

Overseas trained nurses can enrol in short-course competence assessment programmes (CAPs) at tertiary institutions, which—along with their approved nursing qualification from their home country—allow them to apply for New Zealand registration. IQNs from India and the Philippines are commonly recruited onto these CAP courses (NZNO, 2017). As both Fran and Kate explained, IQNs arriving in New Zealand to nurse professionally are not given full recognition of their previous experience and therefore require further training in the local context. According to the Nursing Council of New Zealand (n.d.a), in line with Section 16(b) of the Health Practitioners Competence Assurance Act 2003, nurses who gained their qualification from a non-English speaking country must demonstrate that their English comprehension and communication skills are at a level that ensure public health and safety are maintained. To satisfy Nursing Council registration requirements, many IQNs attend a CAP course, which includes a six- to eight-week clinical placement where nurses acclimate to, and demonstrate capability within, the New Zealand healthcare environment. Fran wondered how their success in IELTS helped student nurses cope during the course: “It’s a starting point, but they need more than IELTS over time. It’s all about student support” (Fran, personal communication, December 13, 2018).

This critique of IELTS as an entry test of nurses’ communicative competence is supported by NZNO (2017), which argues that IELTS does not “give a robust indication of the level of understanding or communication competence in a New Zealand health setting [... and] there is, in fact, no evidence that the IELTS is an

effective discriminant or predictor of success for migrants in any country or occupation” (p. 7). Researchers (e.g., Head, 2019; O’Neill et al., 2007) have echoed Fran’s view that the passing standard for a language proficiency test used for entry to nursing training and practice in inner circle English-speaking countries like New Zealand (Kachru, 1992) is representative of basic language aptitude required within nursing contexts. While IELTS may fail to consider IQNs’ broader communication abilities and comprehension of idiomatic and everyday English, IQNs may develop these skills during their CAP work placement (Muller, 2011). Kate reported that, during their CAP course and work placement, IQNs develop their communication skills, therapeutic nursing care, cultural safety, and legal and professional aspects of nursing in New Zealand: “[They are] always going to be working on communication. You can’t expect [student nurses] to be fluent and aware in six to eight weeks” (Kate, personal communication, December 15, 2018).

1.6.3.1 Professional Communication Challenges for IQNs.

Jenkins and Huntington (2016) assert that nurses in New Zealand should communicate clearly and be aware of diverse cultural norms. The key challenges migrant nurses face relate to their use and understanding of spoken and written English, nursing terminology, and idiomatic language (Muller, 2011). IQNs may find it hard to understand—and be understood in—professional interactions within New Zealand healthcare settings (NZNO, 2017). Fran encouraged IQNs to listen to others, especially because “Kiwis [i.e., New Zealanders] talk fast and mumble. [Nurses] need to be mindful of speaking clearly and opening their mouth.” Mary supported Kate’s view that IQNs experience difficulties when talking on the phone because of problems with accent and rapid speech: “They need to slow down because their pronunciation is different” (Mary, personal communication, December 6, 2018). Kate also noted that IQNs often work in aged care facilities, caring for people with sensory difficulties. IQNs may feel shame in not understanding elderly residents and/or not making themselves understood. Kate advised, “Safety is absolutely paramount in nursing, so [IQNs] must ask questions.”

Certainly, Attrill et al.’s (2016) study confirmed that IQNs’ use of pronunciation, intonation, grammar, and vocabulary reduced the efficacy and professional impact of

their clinical interactions and writing skills. NZNO (2012) found that there was a need for nursing management to understand “the difficulties that accent, idiom and terminology can cause [go] (both ways)” (p. 2). Mutual misunderstanding of colleagues’ English may thus lead to unsafe communication in a healthcare environment. In line with O’Daniel and Rosenstein (2008), Mary confirmed that IQNs find face-to-face communication with patients and colleagues easier because non-verbal communication helps their understanding. Still, she (along with Kate) advised migrant EAL nurses to “break [the message] down and go slow.” IQNs should ask other people to slow down as well, especially when conveying clinical information over the phone, “otherwise there may be mistakes.” Mary also reported that IQNs complete hand-written observation notes (e.g., temperature, blood pressure, and respiratory rate) and treatment concerns regarding patients or aged care residents: “This works well when forms are legible, as they are a visual record on paper.” However, Fran disclosed that migrant EAL nurses’ writing can hinder their professional communication: “They often demonstrate poor English and writing style.”

1.6.3.2 Professional Communication Strategies for IQNs.

Receiving mentoring support and participating in multicultural teams help newly arrived IQNs gain access to professional resources in the healthcare workplace (Eriksson & Engström, 2018). Fran used the metaphorical expression “blossom and grow” when speaking about migrant EAL nurses’ progress through their clinical placement to registration and then to their New Zealand nursing career. Busen and Engebretson (1999) also described a nursing mentorship programme as being to a mentee nurse as a gardener is to a garden: taking responsibility for the care and nurture of the plant and helping it develop strong roots. When I asked Fran how nursing managers might help IQNs to ‘blossom and grow’ in their career, she suggested that migrant EAL nurses improve their language use in a range of settings. For instance, they could volunteer in the community to take up the opportunity of speaking English and developing their confidence. This confirms Deegan and Simkin’s (2010) conclusion that being able to use professional English permits migrant EAL nurses to access influential social systems that give voice to their identity.

Likewise, Deegan and Simkin (2010) discovered that EAL nurses often misunderstood medical abbreviations in patients' records and written instructions, as well as misconstrued slang words used by patients and colleagues. As Fran pointed out, migrant EAL nurses need to send and check e-mail messages, especially regarding urgent matters. She confirmed that IQNs often keep a notebook in their pocket to research new terminology, words, and phrases: "They work hard; they're keen and willing. The notebook helps them 'clarify their doubts' [about language because] they're here for a purpose." This is supported by Muller's (2011) findings that IQNs benefit from vocabulary lists that comprise both nursing and medical terminology, as well as colloquial words and phrases. Mary indicated the need for employers to have guidelines to support migrant EAL nurses' oral communication. Such guidelines might include standards for phone manners and strategies when experiencing difficulties talking with people on the phone (e.g., "Could you please repeat that?"). She recommended that IQNs access the *Kai Tiaki Nursing Journal*, in which IQNs write about their experiences communicating within New Zealand healthcare contexts.

1.6.3.3 Intercultural Communication Challenges for IQNs.

Within diverse vocational contexts, including hospitals, professionals are interacting with co-workers in English via face-to-face and online communication. This influences how they engage in teamwork with peers and senior colleagues (Rampton, 2017). Communication barriers can be the result of cultural differences across the range of workplace interactions that healthcare practitioners participate in within the ethnically diverse health sector (O'Daniel & Rosenstein, 2008). The interpersonal communication skills expected of New Zealand nurses may be different to IQNs' own experiences and expectations. For instance, Kate explained that nurses are encouraged to have eye contact with colleagues and patients, owing to the person-centred nature of healthcare in New Zealand.

Fran noted that IQNs have high expectations of themselves because they cannot afford to fail. Therefore, they should take advantage of ongoing professional learning for IQNs offered by the New Zealand Nurses Organisation, such as professional

development and recognition programmes (Nursing Executives of New Zealand, 2017). These professional development programmes assist nurses in developing their nursing competencies, whilst focusing on applying Te Tiriti o Waitangi (Treaty of Waitangi) principles and upholding cultural safety in New Zealand healthcare settings. Language and cultural differences may cause tensions for both local and migrant nurses, but these reduce over time as IQNs transition into their New Zealand nursing career (Walker & Clendon, 2012).

Mannion and Davies (2018) maintain that communication practices in healthcare settings are contextual and culture rich, which aligns with Kate's reflection that "cultural differences in nursing are huge." Indeed, nursing practices entail diverse cultural expectations and behaviours (Newton et al., 2010). IQNs arriving in New Zealand are often placed in aged care facilities, which may be new healthcare contexts for them. This is because, according to Kate, there are few rest homes in Asia and "[IQNs] may have never nursed people with dementia. It's a big cultural shift." In Kate's experiences, aged care facilities are mostly staffed by Indian and Filipino registered nurses, so there is support for IQNs who are new to New Zealand healthcare settings. This is in line with NZNO's (2017) findings that New Zealand relies heavily on migrant nurses to fill retirement homes' caregiving and nursing positions, owing to New Zealand's ageing society.

Kate described the difficulties that some IQNs may have when talking about death and dying with patients and their families. This requires IQNs to have sensitive conversations about palliative care, which may not be part of their own nursing culture and/or experience. Kate asked, "How should they start these conversations [with the patient]? In their own context, nurses only tell the next of kin that the patient is dying. [They say,] 'We don't tell our mother she's dying. That might make them depressed.'" Research by Morrow et al. (2013) and Hawken (2005) supports Kate's observations that in many cultures it is inappropriate to advise a patient that they have a terminal condition. Furthermore, in New Zealand, informed consent is crucial. Kate explained that nurses and doctors must tell the patient their prognosis, and the patient can refuse medication. This requirement is echoed by NZNO (2016), which adds that, along with discussing end-of-life care with the patient, depending

on the patient's culture, nurses may need to advise the *whānau* (extended family) for their communal agreement on treatment.

1.6.3.4 Intercultural Communication Strategies for IQNs.

Mary believed that developing communicative competence in healthcare settings is a complex social practice, as Zacharias's study (2010) also found. Building rapport with colleagues is key to enhancing intercollegial communication and understanding for the long-term benefit of staff and patients (Nørgaard, 2011). In Fran's view, nurses need to initiate and build relationships through conversational gambits. For instance, IQNs should practise using small talk to engage with patients by responding to questions like 'Where are you from?' with an informative, rather than a cursory, answer. IQNs ought not to be ashamed of their developing understanding of the language and culture of New Zealand healthcare settings. "[IQNs must] throw out the fear and be honest about their [level of] understanding. [Nursing is] a different ball game. It's not about me—it's about the patient," according to Mary. Certainly, Walker and Clendon's (2012) study of IQNs' acculturation to the New Zealand workforce found that, after a period of transition, migrant nurses worked effectively with colleagues, whom they saw as generally welcoming and helpful.

Fran's and Mary's recommendations for IQNs to demonstrate proactive communication and self-confidence in creating collegial relationships are upheld by NZNO (2018), which mandates that "nurses work respectfully with colleagues to best meet patient needs" (p. 16). Nurses in New Zealand are expected to "speak up and out," reported Fran, noting that IQNs need to be independent and autonomous, something she felt is especially difficult for Indian nurses. Migrant EAL nurses must engage with doctors, perhaps question a patient's treatment or medication, and advocate for patients. Fran explained the need for IQNs to learn how to be confident when communicating with colleagues from other cultures—a view which is consistent with Jamshidi et al. (2016). Mary conveyed similar views on IQNs' communicative confidence, advising that migrant nurses must take control of workplace interactions. She acknowledged that IQNs' cultural background may make it difficult for them to take responsibility for their own professional

communication: “They have high expectations for themselves; they want to please the boss.”

1.6.3.5 Workplace Culture Challenges for IQNs.

O’Daniel and Rosenstein (2008) claim that, as doctors hold the top position in healthcare hierarchies, collaboration and collegiality are reduced in nurse-doctor interactions: “When hierarchy differences exist, people on the lower end of the hierarchy tend to be uncomfortable speaking up about problems or concerns. Intimidating behaviour by individuals at the top of a hierarchy can hinder communication and give the impression that the individual is unapproachable” (p. 2-275). This assertion was validated by Fran, who noted that migrant nurses are hierarchy-oriented, owing to their cultural background which emphasises professional respect for superiors. She pointed out that New Zealand’s casual workplace culture places less importance on hierarchy. Nevertheless, the flat hierarchy and low power distance in New Zealand impact IQNs’ ability to interact with doctors as peers, as confirmed by Brunton and Cook’s (2018) findings. Physicians in a New Zealand hospital, for instance, might not resemble an IQN’s image of a doctor in his or her home country, owing to their less formal dress. Fran recommended that IQNs could ask colleagues who the doctor is to ensure they identify the right attending physician.

Kate also reported that some IQNs may come from a cultural background where men and women are treated inequitably. She confided, “Male nurses can sometimes be chauvinistic because their cultural identity holds that the man is in charge.” Kate explained that the cultural environment in healthcare in India, for example, is managed by doctors and is highly task oriented. Nurses take a patient’s blood pressure reading before passing the case on to the doctor.” This explanation is corroborated by O’Daniel and Rosenstein (2008), whose research found that gender differences in healthcare settings (i.e., doctoring is a male-dominated profession, while nursing is female) negatively impacted doctor-nurse intercollegial communication. Mary’s story of a bullying male physician endorses this conclusion:

They’re sussing you out, especially doctors. Doctors challenge you. You bring your own culture into the mix. Doctor is used to

getting [their] own way. My culture doesn't believe that the doctor is boss. We need each other to get to the same goal. This gives the best result for patients, but facing these issues is like ['the old days']. It feels like a step back in time, where we have to do what Doctor says.

1.6.3.6 IQNs' Professional Identity.

Mary—a fluent bilingual IQN—self-identified as a compassionate, professional nurse when she settled in New Zealand: “I was ready for [being a nurse again]. I knew I was a good nurse because of the love and care I give to patients.” She found it difficult to obtain a nursing role as she had no experience in New Zealand. Being unable to practise as a registered nurse was disappointing to her: “A body is a body, and in 20 years it hasn't changed a lot.” Mary subsequently enrolled in a nursing course over an 18-month period to gain her New Zealand nursing registration. These papers helped her understand health care in New Zealand, as well as the cultural aspects (e.g., Māori culture; the multicultural nature of health settings) of New Zealand nursing. Mary's developing understanding of the cultural aspects of nursing in New Zealand aligns with MBIE's (2020) recognition that migrant nurses come to work in rest homes with their own cultural understanding and needs. Nurses need training on ‘cultural empathy’ when taking care of patients from other cultures (Everson et al., 2015).

Mary noted that her social and professional identity has transformed throughout her nursing career, both in her home country and New Zealand. Migrants' ever-changing social and professional identities play a relevant and transforming role in their ability to communicate successfully in everyday settings (Firth & Wagner, 2007). Certainly, IQNs participate in workplace interactions based on their world knowledge, resulting from their symbolic, physical, and relational understanding of social, cultural, and historical processes (Thorne, 2004). Miller (1999) considered language the central means by which IQNs create, negotiate, and promote their social and professional identity. When IQNs experience “a transformation of self through discourse necessary for discursive assimilation” (Miller, 1999, p. 151), their professional identity undergoes a continual process of repositioning and reconstruction.

Migrants' identity positions can become channels for their self-expression and self-efficacy in negotiating the meaning of social interactions, a process which is particularly relevant for migrant healthcare professionals (Norton, 2010). Possessing 16 years of nursing in her home country, Mary confessed that, as Thomas and Beauchamp (2011) maintained, the process through which she developed her professional identity in New Zealand was slow and complicated. Mary also found it emotionally difficult: "Where do I find my identity because it's not my culture? [...] I held on to my professional identity, but it was a struggle. Others view me as inferior, but I'm a professional." Mary's views aligned with La Barbera's (2015) findings that migrants come to a new country and culture with their own identities (e.g., those of gender, ethnicity, personal, and professional).

1.6.3.7 Positive and Challenging Aspects of IQNs' Workplace Integration.

New Zealand workplaces comprise diverse ethnicities, cultures, and language backgrounds. Not only are migrants' beliefs and agentic acts shaped by their community, but society is shaped by incomers (Bandura, 2001; MSD, 2008). IQNs may face both positive and challenging experiences integrating into New Zealand nursing contexts.

1.6.3.7.1 Gaining Acceptance into a Community of Practice.

Owing to their mutual positioning of peers sharing ideas, IQNs integrating into the New Zealand healthcare workforce gain New Zealand nurses' acceptance within their community of practice (Block, 2007). This is illustrated by Fran's story of IQNs' career journeys in New Zealand. IQNs start by feeling overwhelmed: "There are more new avenues—new processes, people, situations—and they're finding their way around the community. They are excited and nervous; IQNs have great anxiety." IQNs grow in confidence and competence upon gaining registration in New Zealand: "They realise the enormity of their journey. [I ask them,] 'Where are you now?'" They can now function as New Zealand registered nurses. They are achieving enormous things, [which is] evident in their independence and autonomy. They have climbed up there." Fran clarified her use of this metaphorical expression through the

notion of scaffolding and the image of a ladder. Explaining that IQNs bring in their own experience and build on that experience when working in New Zealand healthcare settings, she said, “They are running things. They have the expectation to ‘do’ and they do it.” Fran’s scaffolding metaphor and Mary’s ‘blossom and grow’ analogy were both triggers for me to explore IQNs’ use of figurative language to express aspects of the sense of professional self.

1.6.3.7.2 Difficulties Joining the Community of Practice.

As Norton (2000) found, many migrants experience difficulties becoming members of a community of practice (Wenger, 1998, 2006). Patients and colleagues judge migrant nurses on their communicative competence, despite IQNs relying on workplace interactions to develop their understanding of New Zealand English. “There is racism and prejudice in New Zealand,” admitted Fran, who acknowledged that medical staff may not allow IQNs to carry out their nursing practice. “Is there a way we can support IQNs if they are labelled a struggler?” asked Fran. “Not one size fits all.” IQNs are often more susceptible than New Zealand-trained nurses to workplace discrimination and inequality, particularly not being valued or supported as team members (King-Dejardin, 2019).

Newton et al. (2010) identified the widespread discrimination and marginalisation of IQNs as being detrimental to their professional identity and wellbeing. This is illustrated by Mary’s story of a New Zealand doctor testing her understanding of the hospital chain of command. Mary portrayed herself as a strong-minded, independent professional and the doctor as an oppressor set on mistreating her: “I put Doctor in his place. He was unfair. [I told him,] ‘I’m not your doormat.’ I won’t be bullied, but this can happen in New Zealand. Since this encounter, Doctor has [left me alone]. My culture won’t let me be bullied.” It was true that Mary’s cultural background influenced her relationship with colleagues: “The [Western European] cultural identity is to stand up for oneself. It influences who you are with doctors and colleagues. [...] Filipino culture has a culture of ‘pleasing’ [seniors in the] hierarchy; people above are not to be questioned. This can open the door for bullying, especially for migrants in New Zealand. I see on the news that migrants can be bullied.”

1.6.3.7.3 Exploitation of IQNs.

Mary expressed concern, too, that IQNs are exploited by their employers: “There’s some exploitation of migrants. I haven’t experienced this in my own life.” Walker and Clendon’s (2015) survey of registered New Zealand nurses reported that IQNs complained of having workplace communication problems and being discriminated against by managers, peers, and patients, as well as being paid less than their professional skills merited. Whilst her colleague had eight years of experience in China, Mary believed that this was not recognised in New Zealand: “As a Chinese nurse, she was paid \$20.00 an hour, which is the same as a caregiver, and there was no raise. Migrant nurses are fearful of losing their job, leading to exploitation.” Moreover, a study conducted by NZNO (2017) determined that IQNs’ employers were mainly aged care facilities, which tended to offer lower wages and poorer working conditions compared with hospitals and medical centres.

1.6.3.7.4 Career and Family Pressures.

According to Kate and Fran, IQNs are happy to start their career in New Zealand. There is high pressure for them to succeed, though, and most have no family members in their new community. They may even have a spouse and children in their home country. “Many have left small babies behind; their sacrifices are enormous,” conceded Fran. Certainly, the financial and emotional burden on IQNs to send remittances to their family is immense. Research by Bland and Woolbridge (2011) and Li et al. (2014) confirmed that IQNs from low-income countries were drawn to positions in New Zealand that would pay them well enough to advance the living conditions of family members in their home country. Nevertheless, as Kate asserted, by gaining registration and their first nursing role, some IQNs have “got what they wanted,” so they move to Australia. Kate’s assertion is supported by NZNO (2017), which stated that newly registered IQNs may use the Trans-Tasman Mutual Recognition Agreement to find work in Australia. Researchers (e.g., Chun Tie et al., 2019; Walker & Clendon, 2015) have found, too, that many IQNs choose to move to Australia for improved wages and employment conditions, as well as career development and satisfaction.

1.6.3.8 Nursing Professionals' Use of Non-literal Language.

I noted that the nurses I interviewed for my scoping and framing discussions used non-literal language naturally and contextually when describing IQNs' experiences working towards New Zealand registration. Using non-literal language often depicts individuals' thoughts and emotions about a situation (Kupferberg & Green, 2005; Sharoff, 2007) and reveals aspects of their identity (Low, 2008). This observation prompted me to consider metaphorical language use as a source of understanding IQNs' conceptualisations of their workplace interactions in New Zealand healthcare contexts.

To discover nursing practitioners' views on IQNs' professional identities, I planned to ask them, 'If I were to ask an IQN you know to describe his/her professional identity, what metaphor might he/she use?' However, I found in my first interview with Kate that she was unable to use a specific metaphor to describe IQNs' feelings upon achieving registration. Whilst Sharoff's (2007) research specifically analysed nurses' use of metaphor as an analogy of their career, Kate's inability to think immediately of a metaphor is consistent with Thomas and Beauchamp's (2011) study in which participants offered inauthentic metaphors when asked to describe their feelings about their teaching practice. This was despite their having been given an example metaphor to base their own responses on. I realised at the end of my first interview with Kate that asking participants to volunteer a single metaphor to describe their feelings of identity is unnatural and inauthentic. This is because metaphorical language emerges naturally from conversations about oneself and one's emotional reactions to lived experiences (Ruiz de Mendoza Ibáñez & Hernández, 2011).

Kate did use descriptive metaphorical language naturally and contextually, though, without realising she was doing so. She talked about IQNs being "possums in headlights" at the start of their New Zealand placement, getting used to the New Zealand accent and learning to understand New Zealanders' rapid speech. Nonetheless, they "got there in the end... They have finished one journey, but they're just at the start of another." As a nursing lecturer, Kate understood from her professional experience that IQNs may feel frightened by not "[knowing the] questions to ask and language to use," just as a possum might stand still in fear in the

path of an oncoming car. IQNs face significant challenges when integrating into the New Zealand healthcare workforce that may cause them to become overwhelmed (Li et al., 2014). Both Kate and Mary constructed IQNs as scared and stunned “newbies,” as Mary called herself, in New Zealand healthcare contexts.

1.6.3.8.1 Discursive Construction of Workplace Norms.

Woodhams (2014) found nurses’ use of metaphorical language during their socialisation process within New Zealand healthcare contexts allowed them to discursively construct workplace norms. For instance, Mary commented that a doctor had been dictatorial in his interactions with her: “Doctor wants to test you out to see how they can trigger your buttons.” This metaphorical expression—‘trigger your buttons’—referred to Mary’s annoyance about the doctor-nurse hierarchy in New Zealand compared with a more equitable partnership in her home country. “Doctors are always right? I don’t agree, and I argue. [...] [My] cultural identity is to stand up for oneself. It influences who you are with doctors and colleagues.” Mary’s story of interacting with a bullying doctor accords with Sharoff’s (2007) viewpoint that non-literal language indicates awareness and reflexivity based on personal experiences, leading to greater self-knowledge.

1.6.3.8.2 Discursive Construction of Metaphorical Self.

Sharoff (2007) recommends helping nurses analyse their own metaphorical language to help them imaginatively clarify and boost their practice-based skills, beliefs, and attributes for the benefit of themselves, their patients, and their colleagues. Mary told me, “[When I gained New Zealand registration,] I was proud to be a nurse again and [it was] strange because it comes with responsibility. It weighs heavier.” Mary’s reference to the everyday metaphor (Lakoff, 1994) of responsibility being conceptually connected with heaviness gave rise to an image of a bodybuilder lifting weights. I proposed to Mary that perhaps she felt prepared for the responsibility of being a registered nurse but needed strength to ‘shoulder the responsibility’. Mary agreed with this proposal, saying “I’ve made it. I got through the process—writing and studying in English. I learnt new things... Blood, sweat, and tears. But if you put your mind to it, you can achieve a lot.” The metaphorical expressions Mary used (i.e., “made it,” “got through,” “blood, sweat, and tears”) indicated her

conceptualisation of having followed a soldier's journey. Mary positioned herself as a strong, brave champion, whose goal-oriented activities led her to reach her goal of registration. Although military metaphors referring to nurses' professional identities is pervasive in nursing, critics (e.g., Beuthin, 2015; Mitchell et al., 2003) argue that such soldierly language is inappropriate, owing to nurses' professional dedication to caring for individuals and the local community. Nevertheless, Mary's use of military language was simply an expression of her thoughts and did not diminish her caring nature.

1.6.3.9 Scoping and Framing Implications for this Research.

My three scoping and framing discussions with registered nurses allowed me to determine the linguistic and cultural challenges faced by IQNs in New Zealand, as well as the barriers to their full participation in the healthcare workforce. Linking the three nurses' observations with findings in the literature, I found that IQNs often: (i) lack confidence communicating in new cultural contexts; (ii) endure financial and emotional pressures of providing for family members; and (iii) experience workplace discrimination and exploitation. Furthermore, the nurses often used non-literal language to describe and discuss aspects of IQNs' participation within New Zealand nursing contexts. For instance, Fran described a migrant nurse's job offer as being "the icing on the cake," showing the IQN had "made it."

Based on the scoping and framing discussions, I identified several themes concerning IQNs' workplace interactions and professional identity for further exploration in my review of the literature (Table 1). It became clear in the discussions that IQNs' identity positioning is impacted by participation in workplace interactions with patients and colleagues, which validates the need for my study. There are underlying dimensions to IQNs' professional identity, including cross-cultural communication skills, expectations, and burdens, whose complexity has been revealed in these discussions. Indeed, Mary said she saw value in this study as there is a need for exploring IQNs' experiences in New Zealand. My discussions with Kate, Mary, and Fran therefore demonstrated that exploring migrant nurses' stories of workplace interactions would help me discover aspects of IQNs' professional communication and identity positioning in healthcare settings in New Zealand.

Table 1*Key Themes from the Scoping and Framing Discussions*

Scoping and Framing Themes	Scoping and Framing Subthemes
Workplace communication	Professional interactions Telephone communication Cultural differences Communicative confidence Person-centred care
Workplace culture	Working in aged care Relationship-building Racism in nursing contexts IELTS: Sufficient entry for IQNs? Informal workplace culture Bullying of IQNs Exploitation of IQNs Financial and emotional burdens on IQNs
IQNs' communication needs	Nursing communication tools Cross-cultural training Cultural empathy
IQNs' professional identity	Gender roles and expectations Caring for the elderly Resilience Feelings of responsibility Feelings of success
Analysing IQNs' professional identity	Use of non-literal language Aspects of identity positioning Methods of linguistic analysis

1.7 Significance of the Study

The significance and relevance of this study relate to the links it makes between narrative approaches and perspectives with the multicultural nature of New Zealand's healthcare settings. Nørgaard's (2011) study of nurses' workplace interactions found that nurses need to demonstrate confident patient- and colleague-centred communication. I am therefore following Johnson et al.'s (2012) recommendation for further research to be conducted on migrant nurses' professional identity and workplace interactions. There is also a need for a set of guidelines for managers of New Zealand healthcare facilities to help IQNs develop their professional communication skills. Moreover, this research is consistent with NZNO's (2017) recommendations for the creation of government policies which support healthcare employers in enhancing workplace wellbeing for IQNs.

This study is thus relevant to the needs of:

- i. IQNs, who already possess a professional identity through their experience of nursing in their home country, wishing to integrate fully into their New Zealand workplace;
- ii. healthcare employers, who want to reduce attrition rates of migrant nurses for whom workplace challenges (e.g., discrimination, communication issues) are overly burdensome (Walker & Clendon, 2015); and
- iii. the New Zealand government, whose strategic orientation is to help migrants settle into local communities and enrich New Zealand society (INZ, 2019c).

1.7.1 Benefits to Nursing Research

This study is significant because it explores IQNs' professional identity in New Zealand nursing contexts through empowering IQN participants who have English as their first or additional language to tell stories of their experiences engaging in workplace interactions with colleagues (Thompson & McNamara, 2022; Wang, 2017; Wang & Geale, 2015). This will assist in the construction of new knowledge about IQNs' professional identity revealed through their stories of challenging and positive workplace interactions in New Zealand healthcare settings. Jenkins and Huntington (2015) pointed out that little research has been done into how migrant nurses' long-term career success within their host country's community of practice is

affected by both the barriers and benefits of integration. Through their participation in this study, IQN participants may better understand their own nursing practice and communication style, as well as their ever-changing and situational positioning within the nursing community.

1.7.2 Benefits to IQN Participants and the Wider Nursing Community

This study explores how IQNs experience workplace interactions with colleagues in New Zealand healthcare facilities to reveal the situations and conversations that make them feel welcome and encourage them to continue living and working in New Zealand (Walker, 2017; Walker & Clendon, 2012). Johnson et al. (2012) recommended further studies into nurses' professional identity, particularly if there are positive outcomes for nurses' career pathways and employers' operational processes and policies. I hope my research will offer mutual benefit for participants and the wider nursing community, owing to the opportunity for IQNs to tell and retell 'small stories' (Georgakopoulou, 2007) of social interactions with colleagues that have "left marks on [their] lives" (Denzin, 1999, p. 96). Their stories are a communication channel for IQNs' voices to be heard and for aspects of their professional identity to be analysed. This research may lead to greater understanding of IQNs' lived experiences as they integrate into New Zealand healthcare environments. Furthermore, a valuable research output may be the creation of guidelines for managers within nursing and wider medical contexts to help IQNs assimilate fully into their workplace and settle comfortably into their local community.

1.8 Thesis Outline

This thesis is divided into seven chapters. This first chapter provides an introduction to the research, as well as some background and context regarding the international and domestic shortage of registered nurses and the migration of internationally trained nurses. Scoping and framing discussions with three migrant nurses were held prior to data collection to identify the challenging and positive workplace interactions of IQNs in New Zealand healthcare settings. This chapter concludes by highlighting the significance of this research, particularly the need to investigate the

professional identity positioning of internationally qualified nurses during COVID-19 pandemic restrictions in New Zealand.

Chapter Two outlines the literature search process and critically reviews the relevant literature. This literature review discusses previous studies on the workplace interactions and identity positioning of IQNs in their destination countries. It concludes by presenting the research problem and research questions that guide the study's research methodology and methods.

Chapter Three discusses the study's research methodology and methods. It defends the selection of social constructionism as the conceptual approach that underpins this study. The chapter explains why positioning theory was chosen as the most appropriate theoretical and analytical framework for this research. It then describes the selection and recruitment of IQN participants, the process of data collection and analysis, and the measures taken to uphold research ethics and trustworthiness.

Chapter Four presents the findings from thematic analysis of the research conversations with IQN participants. The chapter first describes the eight participants' background and involvement in this study, before presenting the thematic findings. Six themes related to IQNs' workplace interactions with colleagues were constructed from the study's narrative data.

Chapter Five outlines the findings from multimodal positioning analysis (MPA) of the narrative data. The MPA model I created to analyse participants' stories allowed me to investigate aspects of IQNs' professional identity, thereby answering the study's research questions.

Chapter Six discusses the findings from thematic analysis and multimodal positioning analysis and situates them within the existing literature. Findings are interpreted to respond to the study's research questions, thereby moving the scholarly conversation forward towards new knowledge.

Chapter Seven concludes the thesis by summarising the key future research outputs and implications of the study. I also reflect upon the limitations and strengths of the

data collection and analysis tools and processes. The chapter then provides recommendations for nursing policy, practice, and research.

1.9 Chapter Summary

This chapter has introduced the background, aim, and significance of my doctoral study. It identified significant communication issues which can affect both IQNs and their colleagues and patients. This research therefore set out to elicit IQNs' experiences of both challenging and positive workplace interactions with colleagues. This was so that aspects of the participants' professional identity positioning could be revealed in order to gain a better understanding of the challenges they face with integrating into the New Zealand health sector. In line with Wang and Geale (2015), outcomes from this research may help IQNs, along with their colleagues and managers, understand the implications of migrant nurses' interactions with colleagues upon IQNs' sense of professional self and career fulfilment in New Zealand. Through exploring IQNs' identity positioning, I may be able to determine ways to support IQNs' career sustainability so that New Zealand benefits from their work and experience. The following chapter will critically review selected literature that have investigated the workplace interactions and identity positioning of IQNs to locate the research gap and identify appropriate research questions.

Chapter 2: Literature Review

2.1 Introduction

Researchers (e.g., Li et al., 2014; Philip et al., 2019) have found that IQNs often face significant challenges in integrating into new workplaces, including discrimination (i.e., being treated unfairly because of their cultural background or personal characteristics) and communication barriers (i.e., experiencing difficulties sharing information with colleagues and/or patients). An additional complication for IQNs' workplace integration has been the COVID-19 pandemic, which severely disrupted the local and international healthcare industry in 2020 and 2021 (NZNO, 2020; Turgut et al., 2022). According to nursing literature during the global pandemic (e.g., Broughton & Tso, 2020; Longmore, 2021; Sarabia-Cobo et al., 2021), the outbreak of COVID-19 resulted in high levels of emotional and financial burdens for frontline healthcare workers. The stress and fatigue experienced by nurses were exacerbated by their conflicting feelings of compassion (i.e., caring for others) and resilience (i.e., caring for self) (Seymour, 2020). This led to nurses' attrition and burnout, exacerbating the nursing shortage in New Zealand and overseas (Broughton & Tso, 2020; Longmore, 2021). Based on the themes identified during scoping and framing discussions with nursing consultants, this literature review will examine contemporary research on IQNs' workplace integration and interaction experiences, as well as IQNs' communication training needs. It will then consider conceptualisations and theoretical frameworks related to IQNs' professional identity positioning revealed in the literature, before outlining the research problem and research questions.

2.2 Literature Search and Review Methodology

2.2.1 Literature Search Aim and Selection Criteria

According to Hek and Moule (2006), a systematic literature search allows a researcher to assess the nature and extent of previous investigations of the research topic and its subtopics. Cook et al. (2001) recommend specifying inclusion criteria and search terms for source articles from the peer-reviewed and grey literature to enhance reliability and relevance. They also maintain that it is crucial for researchers

to record all search strategies and outcomes so that time and effort during the search process are not wasted. My key selection criteria for articles are that they would:

- i. be free, full-text articles in English;
- ii. have been published between the years 2000 and 2023 (for contemporary literature) and between 1990 and 2000 (for seminal articles);
- iii. demonstrate relevance to the contexts and concepts of my study (i.e., IQNs' professional identity and positioning, workplace interactions with colleagues, New Zealand healthcare settings);
- iv. be methodologically sound; and
- v. possess findings that are transferable to New Zealand contexts.

2.2.2 Literature Search Stages

I first searched for peer-reviewed articles in EMBASE (a health-related database), Google Scholar (a multi-disciplinary database), the System for Information on Grey Literature (SIGLE) database, and the Cochrane Library (a collection of seven health-related databases) in conjunction with the three main nursing databases MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsycINFO. I also conducted ancestry searching to locate articles that met my inclusion criteria by examining the citations included within a suitable research article or book chapter in order to identify additional studies targeted to my research topic (Conn et al., 2003).

I used the following keywords and Boolean operators to narrow the search results: 'nurse migration', 'international nurse labour', 'international OR overseas nurs*', 'overseas educated OR trained nurs*', 'internationally qualified nurs*', 'Filipino nurs* OR Philippine nurs* AND New Zealand', 'Indian nurs* AND New Zealand', and 'foreign nurs*'. I conducted my first sub-search to find articles related to IQNs' professional workplace interactions by combining to the above search terms the word 'AND' along with: 'positiv*', 'challeng*', 'workplace', 'culture', 'professional', 'communic*', 'identity', 'registered nurse' and 'New Zealand OR North America OR Australia OR United Kingdom'. My second sub-search comprised the following search terms related to IQNs' challenging and positive workplace interactions by combining to the above search terms the word 'AND' along with: 'racis*', 'bully*', 'exploit*', 'burden', 'resilien*', and 'success*'.

2.2.3 Literature Evaluation Process

I followed Cook et al.'s (2001) advice by applying a clear and comprehensive evaluation process to confirm source articles' eligibility for inclusion. Each source text was evaluated to determine the extent to which it met the literature review's aims, including research methods and transferability to New Zealand's aged care and healthcare settings. The evaluation process I used was based on Boswell and Cannon's (2020) four-stage critique of a research report:

1. Identify the research purpose and problem.
2. Check that the research methodology and design are aligned with the research aim.
3. Ascertain the extent to which the research methodology, findings, and conclusions are appropriate and conclusive.
4. Consider the reports' strengths and limitations, including quality of research and writing. Note any gaps and/or areas for further research in the specific context.

This final stage was important because an additional benefit of critiquing studies within nursing and aged care contexts is that the researcher's reflections upon evidence-based research can be shared with nurses in diverse healthcare settings to enhance their own practice (Polit & Beck, 2021).

In sum, I followed a structured methodology to search the peer-reviewed and grey literature for source articles related to IQNs' professional interactions and identity positioning within the New Zealand nursing and aged care sectors. I hoped to develop relevant research questions to: (i) meet my research aim and fill a gap in the extant literature; and (ii) support the professional development needs of participants and those of the wider nursing community. Table 2 presents the themes guiding this literature review based on those identified during scoping and framing conversations with the nurse consultants in November and December 2018 (refer Chapter One). My rationale for taking such a deductive approach for my literature review was to understand from the nursing and wider literature the tensions and issues experienced by IQNs in New Zealand per the insights from my nurse consultants, two of whom were IQNs themselves.

Table 2*Themes and Subthemes for Literature Review*

Theme	Subthemes
IQNs' registration and orientation in New Zealand	Language proficiency for migrant EAL nurses Nursing role and expectations Collegial support Working in aged care
Workplace communication	Professional interactions Telephone communication Cultural differences Communicative confidence Person-centred care
Workplace culture	Relationship-building Informal workplace culture Racism in nursing contexts Bullying of IQNs Exploitation of IQNs Financial and emotional burdens on IQNs
IQNs' communication needs	Nursing communication tools Cross-cultural training Cultural empathy
IQNs' professional identity	Feelings of professional resilience Feelings of professional responsibility Feelings of professional success
Analysing IQNs' professional identity	Use of non-literal language Aspects of identity positioning Methods of linguistic analysis

2.3 IQNs' Registration and Orientation in New Zealand

2.3.1 Acquiring and Assessing Competencies for New Zealand Registration

Registered migrant nurses who wish to practise nursing in New Zealand are obliged to provide evidence of their nursing qualifications and home country registration, language proficiency, and applied healthcare experience to the Nursing Council of New Zealand. This is because healthcare employers and regulatory bodies must be certain that IQNs are competent to practise safely in New Zealand nursing contexts. IQNs from countries other than Australia must provide proof of their current registration or licensure from the country in which they received their nursing qualification (Nursing Council of New Zealand, n.d.a). Nonetheless, there is a trend for IQNs to come to New Zealand, obtain registration, work for three to five years, and then migrate on a pathway to Australia via the Trans-Tasman Mutual Recognition Act 1997 provisions (Head, 2017).

According to the Nursing Council of New Zealand (2022), IQNs seeking New Zealand registration should be able to communicate clearly and accurately within their scope of practice to safeguard public health and safety. There are three pathways for IQNs to demonstrate their English language proficiency:

1. a test-based pathway, comprising either International English Language Testing System (IELTS) results of 7 in Reading, Speaking, and Listening, and 6.5 in Writing subtests or Occupational English Test (OET) results of 350 in Reading, Speaking, and Listening, and 300 in Writing subtests
2. an education-based pathway, comprising evidence of an ION's education leading to nursing registration having been conducted and assessed in English in North America, the United Kingdom, Ireland, or Singapore
3. a registration-based pathway, comprising evidence of an IQN's registration in North America, the United Kingdom, or Ireland having been secured from their successful English language test results.

Nonetheless, Read and Wette (2009) concluded that both IELTS and OET test candidates' English language proficiency and not the person-centred communication skills that nurses need to use in New Zealand healthcare settings. Whilst the IELTS and OET assess candidates' ability to understand others and make themselves understood (NZNO, 2014), they do not test IQNs' use of appropriate and effective

non-verbal language or patient-nurse interactional language. Moreover, test-takers are not required to demonstrate their ability to seek clarification of others' meaning, particularly in a range of clinical or emotional contexts (Ghazal et al., 2020; Zanjani et al., 2018).

IQNs are also required to demonstrate their nursing competence to be registered in New Zealand. After considering an IQN's nursing experience and qualifications for their alignment with New Zealand healthcare contexts, the Nursing Council of New Zealand (n.d.a) determines whether the successful completion of a Competence Assessment Programme (CAP) is needed for New Zealand nursing registration. In line with competency assessment programmes in the United Kingdom, Canada, and Australia, the New Zealand CAP comprises both written assessment and applied clinical practice (Ghazal et al., 2020; Xu & He, 2012). IQN trainees enrolled on a CAP attend a two-week classroom learning component prior to their work placement, whilst completing a range of theoretical and practical assessments of their nursing skills and knowledge. Nursing competencies prescribed by the Nursing Council of New Zealand that are taught on a CAP include professional, legal, and ethical responsibility, cultural safety, management of nursing care, interpersonal relationships, interprofessional health care and quality improvement, and reflective practice within multidisciplinary teams. For instance, competency outcomes for cultural safety sessions are for IQNs to demonstrate their ability to apply Te Tiriti o Waitangi (Treaty of Waitangi) principles to nursing practice, practise nursing in a culturally safe manner, and practise nursing in partnership with the health consumer (Nursing Council of New Zealand, 2022).

IQNs often complete their initial placement and begin their career in New Zealand in aged care facilities to meet staffing requirements, particularly during the COVID-19 pandemic restrictions and the ongoing nursing shortage (Hughes, 2020). Aged care facilities prove to be challenging healthcare settings for IQNs, though, as they need time to understand the cultural expectations of their new work environment (Choi et al., 2019). Pung and Goh (2017) found that IQNs experienced difficulties when being asked to perform personal care tasks because these were tasks that were normally done by patients' family members. Findings from Choi et al.'s (2019) study of IQNs completing a CAP showed that specialty-trained IQNs felt discouraged by their

inability to use their specialist nursing skills. Participants were also frustrated that they were expected to perform gerontology and general cares to patients, which negatively impacted their sense of professional self-concept in new healthcare settings. In addition, Aggar et al. (2021) found that bridging programmes, such as the CAP, needed to help IQNs develop their interpersonal and cross-cultural communication skills and confidence. This is in line with the Nursing Council of New Zealand's expectations for IQNs to communicate effectively with patients and colleagues (Nursing Council of New Zealand, 2022).

2.3.2 Understanding the Nursing Role and Expectations

IQNs face changing their style of nursing care and communication upon beginning their nursing career in the host country. New Zealand, Australia, United Kingdom, and North America follow a person-centred approach to nursing, which is less familiar to IQNs from non-Western countries (Bland & Woolbridge, 2011; Waters & Buchanan, 2017). Patient-centred care focuses on building collaborative decision-making relationships between patients, their family, and their healthcare providers through creating targeted health management plans (NEJM Catalyst, 2017). IQNs in New Zealand, though, are surprised by their increased workload when caring for patients in hospital or aged care settings. This is because they may have received assistance from patients' family members in their home countries. IQNs also face challenges when managing patient notes and care plans and explaining clinical decisions to patients, whilst upholding privacy and confidentiality (Bland & Woolbridge, 2011). Xu et al. (2012) found that IQNs' patient-centredness is compromised when they fail to use appropriate non-verbal communication, such as smiling and eye contact. They concluded that standards of patient care are increased when nurses communicate effectively using appropriate non-verbal behaviours.

Whilst pre-registration bridging programmes do boost IQNs' sense of collegiality, wellbeing, and success (Aggar et al., 2020), IQNs have expressed disappointment that their nursing qualifications, skills, and experience are not seen as valuable or credible by colleagues (Philip et al., 2019). IQNs have reported feeling frustrated that their own speciality nursing skills and clinical experience overseas were not recognised by their colleagues (Walker & Clendon, 2012). In Walker and Clendon's (2012) survey of migrant nurses in New Zealand, IQNs reported feeling "de-skilled

and underutilised” (p. 6). They were not given opportunities to use their clinical skills obtained in their home country, or their colleagues were sceptical of IQNs’ qualifications or experience. Yet, IQN survey respondents recognised the importance of acculturating to New Zealand workplace culture and nursing practice in order to deliver high-quality care to patients (Walker & Clendon, 2012). Bland and Woolbridge (2011) also found that IQNs’ professional experience was scrutinised by New Zealand colleagues, especially when their norms, role expectations, and ways of working led to misunderstandings within their New Zealand healthcare context. As a result, many IQNs might gravitate towards colleagues from their own home country as there was no need to explain their nursing training and applied practice (Choi et al., 2019).

2.4 Workplace Communication

IQNs’ job satisfaction and professional practice are impacted by their workplace interactions with colleagues and managers (Kamau et al., 2022). Moreover, the Nursing Council of New Zealand (2022) acknowledges that, since nurses practise in high-pressure workplaces, “in some situations, miscommunication can lead to severe harm or death” (p. 1). It is therefore crucial for IQNs to understand and use effective workplace communication processes to generate shared meanings with other healthcare workers (Brunton et al., 2019).

2.4.1 Engaging in Professional Interactions

Nurses’ personal and professional satisfaction is positively influenced by participating in collegial and supportive workplace dialogue, especially when their individual skills and perspectives are recognised by their peers and employers (Noguchi-Watanabe et al., 2016). During COVID-19 restrictions, nurses responded to work pressures by engaging in open communication, collaborative teamwork, and flexible learning, all of which were crucial in the ever-changing pandemic context (Riddell et al., 2022). Winkelmann-Gleed and Seeley (2005) found that IQNs’ collegial workplace interactions “formed a bridge between the ‘stranger’ [the IQN] and the institution [the employer and its professional community]” (p. 905), which may have both positive and negative impacts upon their professional identity. Certainly, when IQNs are satisfied with the ways in which their colleagues respect

their professional expertise, they position themselves as valued participants within their workplace (Chun Tie et al., 2018; Winkelmann-Gleed & Seeley, 2005). Supportive employers, in turn, reap the ‘diversity dividends’ of migrant workers’ increased motivation, engagement, and commitment to organisational goals (Spoonley, 2014).

There is strong evidence in the nursing literature that professional interactions between IQNs and their colleagues can lead to mutual misunderstanding and miscommunication (Balante et al., 2021; Javanmard et al., 2017). Indeed, Ghazal et al. (2020) found that interpersonal and cross-cultural communication poses a significant barrier to IQNs’ acculturation in healthcare workplaces. IQNs make sense of workplace interactions with their colleagues at the following levels: interpersonal (between two or several individuals); intrapersonal (through their own cognition processes); organisational; and wider social level (Philip et al., 2015). Nursing researchers (e.g., Manankil-Rankin et al., 2022; Pressley et al., 2022) have determined that migrant nurses who focused on using appropriate verbal and non-verbal communication techniques at each of these levels experienced mutual understanding with their colleagues.

Communication barriers can result from the accents, speech patterns, and slang and idioms used by IQNs for whom English is their additional language (Buttigieg et al., 2018; Pung & Goh, 2017). During a normal working day, nurses are expected to follow doctors’ and nurse managers’ instructions, respond to patients’ queries, and convey information to patients, colleagues, and government agencies (DiCerbo et al., 2014). However, New Zealanders’ rapid speech and migrant EAL nurses’ English pronunciation and intonation—particularly segmental sounds and word stress—can cause communication breakdowns for IQNs, which may impact their patients’ wellbeing. English ability, in particular, is a barrier to IQNs’ integration and employment. Gu and Shah (2019) explored the problems caused by non-acceptability of migrants’ accents to employers.

Migrant EAL nurses often misunderstand informal workplace language: colloquialisms, conversational gambits, and idioms, too (Brunton & Cook, 2018; Levis, 2011). Blythe et al. (2009) found that differences between interlocutors’ use of

body language, silence, tone to represent emotion, and humour resulted in misunderstanding amongst colleagues. Brunton and Cook's (2018) study of migrant nurses identified the benefits of IQNs' seeking clarification of others' meaning when feeling uncertain about colleagues' use of idiomatic or sarcastic language. It is thus beneficial for migrant EAL nurses to reflect on how their verbal and non-verbal communication skills meet their patients' and colleagues' needs, particularly in critical medical situations. This is because they may make themselves better understood if their accent, intonation, or body language is familiar to interlocutors (Wright, 2012).

The learning outcomes and teaching approaches of IQNs' training courses focus on learners' immediate language and vocational objectives (Oesch & Bower, 2009; Walker, 2010). IQNs face several cognitive, affective, linguistic, and paralinguistic, discursive, sociocultural, and contextual communication challenges, though, once they start their nursing position within a hospital or medical centres (Lum et al., 2014; Walker, 2010). The key interactional challenge is for migrant EAL nurses to develop their sociolinguistic and sociopragmatic competencies so they feel more at ease as effective communicators in healthcare environments (Candlin & Crichton, 2011). Still, even IQNs who have English as their first language can find it difficult to assimilate to workplace culture, norms, and ways of working in their host country (Chun Tie et al., 2019).

Brunton and Cook's (2018) study found that IQNs who were more proficient in English adapted their communication style to that of their colleagues in order to assimilate to their healthcare workplace. Engaging in telephone conversations with colleagues has proven to be problematic for all IQNs who are new to New Zealand, whether they have English as their first language or as an additional language. This is because understanding New Zealand accents and idioms is difficult, especially over the telephone (Brunton et al., 2019). Besides, as registered nurses, IQNs are expected to make and answer phone calls in healthcare settings. They may initially feel anxious about answering the telephone, though, owing to their fear of not understanding the caller and responding inappropriately (Philip et al., 2015). According to Gu and Shah (2019), when IQNs apply accent modification strategies and listening skills, as well as attend to their own and others' tone and pronunciation,

they may develop their communicative confidence and enhance their feelings of collegiality in nursing contexts.

2.4.2 Negotiating Cultural Differences

The Health and Safety at Work Act 2015 requires New Zealand organisations to provide workers with a healthy and safe workplace, in which discrimination on the grounds of racial or cultural background is unlawful. Employers are also obliged to make sure that workers do not feel threatened or intimidated (New Zealand Government, 2023). This is in line with the World Health Organization and International Labour Organization's (2022) recommendation for employers to manage the psychosocial work environment so that workplace culture, norms, beliefs, and practices support workers' physical and emotional wellbeing. As a result, employers are encouraged to minimise risks associated with worker discrimination and exploitation by providing cultural awareness or unconscious bias training to staff members (Schilgen et al., 2019). There are many studies in the nursing literature (e.g., Brunton & Cook, 2018; Javanmard et al., 2017; Walker & Clendon, 2015; Zanjani et al., 2018) where IQNs have reported instances of professional misunderstanding or miscommunication, owing to cultural differences.

Communication practices in healthcare workplaces are contextual, multi-layered, and culture rich, owing to team members' diverse beliefs and values; cultural norms, and workplace protocols (Rampton, 2017). International nursing researchers (e.g., Chun Tie et al., 2018; O'Daniel & Rosenstein, 2008; Zanjani et al., 2018) acknowledge that IQNs have difficulty adapting to their host country's workplace expectations and communication styles. In Smith et al.'s (2022) review of the workplace interactions that migrant nurses had with their colleagues, IQNs' verbal and non-verbal language were either not accepted or understood by healthcare workers. It was found that New Zealand colleagues were not open to understanding IQNs' communication efforts, leading to feelings of alienation and inequity. Conversely, Chun Tie et al. (2018) found that IQNs' experiencing mutual understanding with their colleagues felt respected and listened to by their colleagues.

Many IQNs have feelings of discomfort when communicating cross-culturally, especially if they do not understand aspects of effective cross-cultural

communication. Moreover, newly arrived IQNs have reported experiencing hesitation adjusting to New Zealand's informal, person-centred communication styles in healthcare settings (Muntasir & Nurviani, 2020). Myles (2009) argued that employers increasingly expect professionals to demonstrate self-assured, socially appropriate behaviour, and intercultural understanding. However, such a perspective overlooks the extent to which personal factors, such as language, identity, and culture, are interlinked in the workplace. Migrant EAL nurses are especially impacted by native English-speaking nurses' perceptions of their language proficiency. In Brunton and Cook's (2018) study, a Chinese nurse felt embarrassed that inadequate lexico-grammatical and sociocultural awareness resulted in a sense of 'otherness': "We can speak English, but they can't really expect we will know how to deal with things" (p. 21).

2.4.3 Developing Communicative Confidence

Nurses who possess an international nursing qualification equivalent to a three-year Level 7 Bachelor of Nursing degree from a New Zealand tertiary institution are eligible to apply for New Zealand registration. Migrant EAL nurses must also demonstrate professional English language skills to be registered with the New Zealand Nursing Council. The most widely accepted evidence of English language proficiency is a score of 7 (good user) for three language skills—listening, reading, and speaking—and 6.5 (competent user) for writing out of 9 (educated, native-like user) on an International English Language Testing System (IELTS) test (Nursing Council of New Zealand, 2022). According to Walker (2010), migrant EAL nurses often attend language training and nursing practicum courses to enhance their language proficiency, employability, and technical skills suitable for healthcare workplaces.

The future career success for IQNs is influenced by their demonstrating effective communication skills in the New Zealand healthcare workplace. Wright (2012) concluded that EAL nurses need to produce accurate segmental and suprasegmental pronunciation, listen carefully and compassionately, use appropriate non-verbal communication, be aware of diverse cultural norms, and communicate in professional and plain English via spoken and written means. There is a need for a practice-based communication needs analysis for IQNs, comprising key

stakeholders' perspectives and recommendations. There is an even more pressing need for migrant EAL nurses to overcome their beliefs of being a 'deficient communicator' (Firth & Wagner, 2007, p. 757). By learning how to discern culturally embedded connotations within the discourse of a New Zealand healthcare setting, IQNs may reduce their workplace culture shock and feel more motivated to acculturate within their workplace community-of-practice (Haneda, 2006; Oesch & Bower, 2009; Riddiford & Joe, 2005).

IQNs are expected to competently recognise and use both informal and professional English in their interactions with colleagues and patients. Yet, migrant nurses who have English as an additional language may not possess the basic interpersonal communication skills to engage in workplace interactions (Cummins, 2008; Lum et al., 2014). In line with Dudley-Evans and St John (1998), migrant EAL nurses may struggle to write contextual medical texts, such as patient reports, owing to their inadequate lexico-grammatical width and depth, as well as an imprecise use of sociopragmatic language. They therefore need to learn the appropriate contextual language to understand and produce requests, instructions, explanations, and diagnoses in diverse professional settings (Brunton & Cook, 2018).

IQNs' written and spoken communication may not align with New Zealand workplace communication styles (e.g., asking clarifying questions), as Muntasir and Nurviani (2020) reported. Nursing researchers (e.g., Philip et al., 2019; Pung & Goh, 2017) found that IQNs had difficulties being understood and understanding their colleagues' verbal and non-verbal communication during workplace conversations. This led to IQNs feeling unconfident or isolated from their colleagues, owing to other healthcare workers incorrectly assuming IQNs' meaning or not being open to understanding IQNs' communication efforts. To overcome their feelings of isolation or misunderstandings with colleagues, IQNs may find it reassuring to speak their first language with IQNs from their home country, although this can be confronting for New Zealand nurses (Ali & Johnson, 2017; Balante et al., 2021).

The Communicative Proficiency Model outlined by Baker (2011, p. 173) suggests migrant EAL nurses' workplace interactions may range from cognitively undemanding and context-embedded (e.g., helping patients to take their medication)

to cognitively demanding and context-reduced (e.g., decoding an instruction manual). IQNs build their sociopragmatic communication knowledge through applying a combination of top-down processing strategies (e.g., using cultural understanding to respond to a family member’s concern for a terminally ill patient) and bottom-up strategies (e.g., noticing intonation) to their workplace interactions (Ma & Oxford, 2014; Vandergrift, 2003). Brunton and Cook (2018) observed that migrant nurses use self-regulation (e.g., recording new vocabulary—particularly slang and idioms—in a notebook to check with a colleague or search on Google later) and other-regulation (e.g., seeking feedback from colleagues or supervisors) to monitor their conversational and technical language development. IQNs have thus reported developing their confidence in workplace interactions by working with a ‘buddy’ from the same language and cultural background (Zanjani et al., 2021). Seeking clarification of their colleagues’ meaning and adapting their communication strategies to make themselves understood helps migrant EAL nurses become more confident communicators, especially when facing instances of disrespect or discrimination (Philip et al., 2019; Pressley et al., 2022). Nonetheless, it has been noted that the majority of studies in the nursing literature seem to focus on the communication challenges of IQNs who have English as their additional language. This is despite the high percentage (64% of IQNs in New Zealand) of migrant nurses who have English as their first language (OECD, 2020).

2.5 Workplace Culture

2.5.1 Acculturating to the New Zealand Workplace Culture

Newly arrived IQNs benefit from participating in nursing pre-registration courses, owing to their focus on workplace communication, cross-cultural awareness, and clinical adaptation in the host country’s healthcare settings. Such courses help IQNs navigate workplace diversity and cultural practices, boost their sense of wellbeing, and increase retention rates through the process of acculturation (Aggar et al., 2020). According to Choi et al. (2019), acculturation “is the process of change, to accommodate some aspects of another culture, ideally without erasure of normative values and practices of one’s own culture” (p. 2). Consequently, Aggar et al. (2020) have identified the need for bridging programmes to include more language and

communication support to enhance IQNs' workplace acculturation in the host country.

Mowat and Haar (2018) and Chok et al. (2018) found that newly arrived IQNs felt frustrated and upset by the stressors involved with transitioning into the host country's nursing workforce and, for many, missing family and friends in their home country. Once IQNs had settled into their nursing career in the host country, they were able to step back from the emotion and 'unknowingness' of challenging or confusing aspects of workplace culture. This was because IQNs had time to reflect on workplace dynamics, professional interactions, and cultural practices, allowing them to develop cultural understanding and feel more confident in their nursing practice.

In addition, Zanjani et al. (2021) reported that IQNs' feelings of professional success and collegiality led to their greater sociocultural and professional adaptation in the host country's workplace culture. In recruiting migrant nurses to overcome the global nursing shortage, nursing agencies and employers are obliged not only to prioritise IQNs' financial and emotional needs but also ensure the nursing workplace environment is healthy and safe. It is thus imperative for healthcare providers and policymakers to support both migrant and host nurses in their long-term career in New Zealand through reducing the potential for nursing burnout and increasing IQNs' career sustainability (Roth et al., 2021).

2.5.2 Building Professional Relationships

Understanding workplace relationships is crucial for IQNs' acculturation and integration within their host country's healthcare setting (Kalisch, 2011). Many IQNs may not realise that in New Zealand, for instance, the work hierarchy is generally flatter and possesses closer power distance and informal power dynamics (Choi et al., 2019). Kamau et al.'s (2022) research on migrant nurses' relationships with other medical professionals found that when IQNs acted with integrity and focused on collegiality, they were accepted as part of the team by their colleagues, despite differences in cultural and professional backgrounds. Whilst IQNs from hierarchical nursing backgrounds may believe that they are obliged to listen to colleagues

perceived as holding a senior position, over time IQNs feel more comfortable interacting in an equitable way with healthcare colleagues (Choi et al., 2019).

IQNs also benefit from management support and guidance as they develop their clinical skills within their host country's healthcare contexts (Aggar et al., 2020). Having a positive relationship with a manager who is responsive to IQNs' clinical training and workplace communication needs may not lead to increases in IQNs' job satisfaction, though (Aloisio et al., 2021). Nevertheless, Noguchi-Watanabe et al. (2016) reported that IQNs were frustrated by not receiving regular or sufficient information from management to help them respond to patients' needs, participate in workplace decision-making and reporting processes, and manage staffing and technical resources. Nurse managers and clinical leads are therefore advised to focus on maintaining reciprocal communication processes to enhance staff-supervisor relationships. This might strengthen communication channels within the healthcare organisation and assist IQNs in fully integrating into the host country's nursing workforce (Noguchi-Watanabe et al., 2016).

It is also clear from the nursing literature (e.g., Schilgen et al., 2019) that IQNs benefit from collegiality in the healthcare workplace. The IQNs in Thistlethwaite's (2015) study acknowledged the importance of embracing teamwork and felt satisfaction in being part of a team. Findings from this study indicated that the advantages for IQNs when working in mixed teams included building peer relationships with teammates with whom they shared similarities. Roth et al. (2021) found that IQNs valued sharing their nursing workload so that all team members could work safely and productively. Furthermore, enjoying friendly and social relationships with colleagues allowed migrant nurses to integrate culturally and linguistically into the healthcare workplace and enhance their health and welfare (Javanmard et al., 2017; Pung & Goh, 2017; Schilgen et al., 2019).

Supportive workplace relationships help boost IQNs' feelings of confidence when communicating interpersonally and cross-culturally with other healthcare professionals within nursing contexts (Roth et al., 2021). Effective, inclusive team communication and collaboration thus allow IQNs not only to feel part of their team but also more confident in participating in workplace interactions with their

colleagues (O'Daniel & Rosenstein, 2008). IQNs in Schilgen et al.'s (2019) study declared their increased sense of community as migrant nurses when they shared commonalities with, and were listened to, by their colleagues and managers. Indeed, IQNs in healthcare workplaces also benefited from developing their ability to understand local accents and colloquialisms in Gu and Shah's (2019) study.

2.5.3 Understanding Workplace Culture in New Zealand Healthcare Settings

Brunton et al.'s (2020) research on migrant nurses within New Zealand primary and aged care facilities reported that IQNs had initial feelings of discomfort when communicating cross-culturally. There are two features of workplace culture in New Zealand healthcare settings that may be confusing to IQNs: *Tikanga Māori* (i.e., Māori cultural values and practices) and *Te Whare Tapa Whā* (i.e., a multi-dimensional Māori model of wellbeing). *Tikanga Māori* guides nursing protocols in New Zealand to ensure that the correct principles, processes, customs, and knowledge are followed to support the wellbeing and cultural safety for both healthcare staff and patients (Brunton et al., 2020). Moreover, McBride-Henry et al. (2022) acknowledge the significance of *Te Whare Tapa Whā* (i.e., a multi-dimensional Māori model of wellbeing) in guiding cultural safety in New Zealand nursing contexts. The four dimensions of *taha whānau* (social/family wellbeing); *taha wairua* (spiritual wellbeing); *taha hinengaro* (mental and emotional wellbeing), and *taha tinana* (physical wellbeing) are inherently linked, whereby "if you remove one of these dimensions, wellbeing is damaged or cannot exist" (McBride-Henry et al., 2022, p. 2).

Migrant nurses are generally seen to be culturally sensitive, owing to the widely held belief that nurses have empathy (Kaihlanen et al., 2019). IQNs in New Zealand are guided by CAP educators and workplace nurse mentors to uphold *tikanga Māori* and *Te Whare Tapa Whā* values in providing holistic care to patients and engaging in wellbeing-oriented interactions with colleagues (Nursing Council of New Zealand, 2021). Yet, Brunton et al. (2019) found that some IQNs who did not attend a CAP did not understand Māori cultural concepts when they began nursing in New Zealand healthcare settings. Whilst IQNs attending a CAP learn about, and practise applying, *tikanga* values in healthcare workplaces, McBride-Henry et al. (2022) observe that IQNs' interactions with Māori and other cultural groups may be impeded by limited

cultural training. Once IQNs have developed their cultural awareness, they may feel more integrated into the host country's nursing workforce (Kaihlanen et al., 2019). It is through understanding *tikanga Māori* practices and applying cultural safety processes per the Nurses Act 1977 in New Zealand nursing contexts that IQNs and host nurses seek to navigate cultural differences within the healthcare workplace (Brunton et al., 2020).

2.5.4 Experiencing Racism, Bullying, and Exploitation in Nursing Contexts

International researchers (e.g., Choi et al., 2019; Chun Tie et al., 2018; Dahl et al., 2017, 2022; Gillespie et al., 2017) have found that IQNs experience racism, bullying, and exploitation that negatively impact their sense of self. IQNs who encounter racism and prejudice caused by cultural 'othering' may feel that their nursing career progression and professional experience are not acknowledged by colleagues, thereby reducing their receptivity to workplace adaptation (Choi et al., 2019). Yet, healthcare practitioners in New Zealand are obliged by Te Tiriti o Waitangi (Treaty of Waitangi) to practise cultural safety, which aims to enhance health equity (Nuku, 2020; Nursing Council of New Zealand, n.d.b). As Nuku (2020) observes, "Health professionals work with people whose life experiences and cultures differ from their own. If they are not open-minded and non-judgmental towards other cultures, the care they offer and the wellbeing of their patients will be compromised" (p. 4). Furthermore, there is strong evidence that IQNs in New Zealand face bullying and harassment in the workplace, leading to high attrition rates of migrant nurses (Jenkins & Huntington, 2016; Walker, 2010). IQNs have reported experiencing exploitation and bullying by being given a large caseload or high acuity (Smith et al., 2020) and being alienated and excluded from workplace interactions (Chun Tie et al., 2018).

Inclusive workplace interactions help migrant nurses manage their emotional burdens in the healthcare workplace, though. Schilgen et al.'s (2019) study of the psychosocial health of migrant nurses identified collaborative team relationships and sympathetic managers as the key coping mechanisms for IQNs when facing others' cultural and language prejudices and verbal harassment. Reducing discrimination and exploitation in the healthcare workplace may not only require IQNs to develop close professional relationships with colleagues but also oblige managers to appreciate

IQNs' ethnic and linguistic differences. When healthcare managers understand the value that IQNs' cultural backgrounds bring to their nursing practice, they will "consider diversity as enriching rather than hindering" (Schilgen et al., 2019, p. 64). IQNs may notice their colleagues' unconscious biases, but when they receive their colleagues' acceptance and support of them as professional nurses despite cultural differences, IQNs' feelings of alienation are minimised (Ghazal et al., 2020).

2.6 IQNs' Communication Needs

According to Brunton and Cook (2018), IQNs experience challenges when communicating with colleagues and patients. IQNs need to produce clear pronunciation and intonation, listen carefully and compassionately, use appropriate non-verbal communication, be aware of diverse cultural norms, and communicate in professional spoken and written English (Wright, 2012). The future career success of IQNs is influenced by their ability to demonstrate effective communication skills in the New Zealand healthcare workplace. The communicative competence and confidence that migrant EAL nurses develop in their nursing role is therefore central to their objective of participating actively in the New Zealand workforce (Rossner, 2009).

2.6.1 Negotiating Meaning During Workplace Interactions

As Crawford et al. (1998) observed, "The language of nursing shapes [nurses'] relationships with colleagues and clients and defines the work they do" (p. vii). New Zealand healthcare providers thus require nurses to transmit humanistic knowledge (e.g., using interpersonal communication skills, conveying medical information) and demonstrate metaknowledge (e.g., applying critical thinking, using negotiation strategies). Caza et al. (2018) noted that workers' communication encompasses both the content and manner of expression found in work stories and banter, as well as professional interactions with colleagues and clients. IQNs' positive interactions in the healthcare workplace enhance their patients' sense of wellbeing, improve their adherence to medication, and reassure their families that they are receiving the most appropriate treatment (Wright, 2012).

The formal language needs of migrant EAL nurses include medical terminology, descriptive vocabulary, professional etiquette, and persuasive devices in both spoken and written communications. These are all relevant nursing communication topics and skills that a pre-registration training course like CAP could teach (Crawford et al., 1998). Furthermore, the contextual and informal language that migrant nurses use with their colleagues and patients is critical for mutual understanding amongst colleagues and for patients' emotional wellbeing. If IQNs fail to demonstrate appropriate register and tone in sensitive situations or understand colloquialisms (e.g., 'going to the loo' for using the lavatory), euphemisms (e.g., 'passing away' for dying), and lay terms (e.g., 'peeing' for urinating), patients may feel uncomfortable or upset (Wright, 2012).

2.6.2 Following Effective Nursing Communication Processes

Developing communicative competence in healthcare settings is a complex social practice whereby migrant EAL nurses adapt to New Zealand workplace environments and cultural practices (Zacharias, 2010). According to Myles (2009), understanding an organisation's formal and informal cultural aspects, power distance, and interpersonal relationships helps employees identify the level of directness required to convey their meaning clearly in workplace interactions. IQNs may struggle to understand cultural symbols, behaviours, and linguistic devices (i.e., register and tone) inherent to culturally constructed organisational communication (Olajoke, 2013). For example, Brunton and Cook (2018) found that IQNs misconstrued humour and collegiality in professional situations and were bemused by informal interactions between managers, doctors, and nurses in New Zealand hospitals.

Migrant EAL nurses may also lack the confidence and ability to seek clarification if they do not understand managers' directions or colleagues' explanations (Buchanan, 1990). In a high-stakes healthcare environment, IQNs need to show initiative by asking questions and solving problems—even querying a doctor's actions for the sake of patient safety (Brunton & Cook, 2018). Checking their understanding of colleagues' conversational topics and gambits may allow migrant EAL nurses to overcome any interpersonal communication challenges. Many IQNs have expressed anxiety, though, when having to ask conversation partners to repeat themselves.

IQNs thus benefit from learning and using effective listening strategies, including repeating or paraphrasing information received from managers and colleagues (Zanjani et al., 2018).

2.6.3 Working Effectively in a Team

Developing interpersonal communication skills and understanding the professional norms for working collaboratively in a healthcare team help IQNs provide quality care to patients (Thistlethwaite, 2015). IQNs face interpersonal and organisational challenges when working in a team, though. These challenges include managing conflict, lacking agency, being excluded from decision making processes, and negotiating responsibility for clinical tasks (Kalisch, 2011). However, when IQNs have the opportunity to give and receive professional support within a multidisciplinary team, they may feel more valued within the healthcare workplace (Ohr et al., 2016). IQN mentors were reported by Aggar et al. (2021) to appreciate supporting new RNs in developing their clinical skills and confidence. Mentoring consequently affords a reciprocal exchange of professional knowledge that enhances nurses' clinical skills and insights (Harding & Mawson, 2017; Skår, 2010).

In addition, IQNs experience communication challenges with healthcare colleagues because of personality differences (Aggar et al., 2021) or their lack of effective interpersonal skills (Philip et al., 2015). Whilst IQNs and their colleagues may have different personalities, they value supportive, uplifting interactions with peers. This is especially true for those colleagues who share the same cultural background as their IQN colleagues (Philip et al., 2019). The key interactional challenge for IQNs is to develop their sociolinguistic competence (i.e., using appropriate language in a variety of social settings) and sociopragmatic competence (i.e., knowing how to use social conventions, like apologising or making requests) so they feel more at ease as effective communicators and nursing practitioners in New Zealand (Candlin & Crichton, 2011).

IQNs' communication with fellow nurses, doctors, and administrators needs to be clear and context-appropriate to mitigate any cultural and language issues that may occur in a fast-paced healthcare environment (Brunton & Cook, 2018; Candlin & Crichton, 2011). Since patient safety rests on the ability of IQNs to interact

collegially, Brunton and Cook (2018) recommended that IQNs receive mentoring from New Zealand nursing peers to minimise cultural and communication misunderstandings. It is equally important for healthcare practitioners to understand and respond to IQNs' communication challenges (Nørgaard, 2011). Wright (2012) advised nurses to reflect on how their verbal and non-verbal communication skills meet their colleagues' needs, particularly in critical medical situations. This is because nurses may make themselves better understood if their accent, intonation, or body language is familiar to conversation partners.

2.6.4 Developing Cultural Competence

It has become common for healthcare professionals around the world to care for patients, and to work with colleagues, who come from diverse cultural and language backgrounds. Developing cultural competence helps nurses demonstrate cultural appreciation and sensitivity when providing high quality patient care and collegial support (Kaihlanen et al., 2019). This is especially important in the mental health and aged care sectors in which many IQNs work (Head, 2017). Kaihlanen et al.'s (2019) research sought to investigate how IQNs developed their cultural competence to meet the needs of patients and peers, as well as enhance their understanding of aspects of their own cultural background.

Possessing cultural empathy, too, allows IQNs to work professionally with patients and colleagues from different cultural backgrounds. Cultural empathy refers to the extent to which IQNs are able to share an understanding of others' cultural beliefs, norms, and attitudes. Therefore, pre-registration bridging programmes that help develop IQNs' cultural awareness have positive outcomes for patient care and interpersonal communication (Everson et al., 2015). According to Everson et al. (2015), "Clinical encounters that do not acknowledge cultural factors contribute to adverse patient outcomes and health care inequities for culturally and linguistically diverse people. Cultural empathy is an antecedent to cultural competence" (p. 2849). Brunton et al.'s (2020) New Zealand survey results indicated that IQNs appreciated having supportive conversations with their colleagues and managers, especially when their own and others' cultural beliefs and practices were valued. IQNs needed to navigate working within teams in which the diverse personalities of team members

both helped and hindered their mutual ability to develop nursing skills (Brunton et al., 2020).

Furthermore, a central requirement for nurses in New Zealand is to appreciate, understand, and apply *tikanga Māori* in their nursing practice within healthcare settings (Wilson et al., 2021). Healthcare frameworks that incorporate indigenous cultural beliefs and norms within nursing protocols enhance the standards of medical care for patients. For migrant nurses, learning and applying Māori language and cultural practices in their nursing improves their cultural empathy and competence (Wilson et al., 2021). According to Barton and Wilson (2008), incorporating Māori cultural norms and concepts such as *awhi* (i.e., caring, nourishing, and cherishing) into nurses' clinical practice is beneficial to patient and staff relationships.

2.7 IQNs' Professional Identity

2.7.1 Conceptualising Nurses' Professional Identity

Several nursing studies (e.g., Bagnasco et al., 2019; Thomas & Beauchamp, 2011) have found that nurses' professional identity formation and its representation is flexible and complex. It is a challenging process, through which nurses develop and convey their professional understanding, resilience, and commitment. Young's (2019) analysis of Foucauldian concepts of identity, whereby society may either prohibit or permit discourses, resulted in the assumption that migrant workers must renegotiate their professional identity within their adopted community and its approved discourses. Language is the central means by which IQNs create and promote their professional identity and access influential social systems that allow them to voice their identity (Miller, 1999; Thompson & McNamara, 2022).

Professional identity is developed through self-understanding as a nurse, along with experience in clinical practice, interpersonal and organisational communication, and understanding of the nursing role within healthcare settings (Rasmussen et al., 2021). It is therefore essential to understand how IQNs negotiate their sense of professional self in moment-to-moment interactions in line with Norton's (2010) concept of identity being flexible and dynamic. How, then, does the literature conceptualise nurses' role positioning and discursive displays of identity positioning? This section

will discuss five key characteristics of IQNs' professional identity found in the nursing literature: (i) being a skilled and experienced IQN; (ii) being a qualified and registered migrant nurse; (iii) being an effective communicator; (iv) having agency as a nurse manager or mentor; and (v) feeling supported in developing nursing skills.

2.7.2 Being a Qualified and Experienced IQN

IQNs' sense of professional self is impacted by the extent to which their clinical skills and experience are valued by colleagues and managers. Newton et al. (2010) and Garner et al. (2015) identified the widespread discrimination and marginalisation of IQNs as being detrimental to nurses' professional identity and wellbeing. When IQNs feel that their overseas qualifications and experience are valued, it makes them want to stay working and living in the host country (Philip et al., 2015). There is evidence in the literature that IQNs who report feeling more settled in their host country are respected for their specialised clinical training and expertise (Timilsina Bhandari et al., 2015), are accepted and listened to by managers and colleagues (Eriksson et al., 2018), and can cope with being asked to perform a variety of nursing tasks (Viken et al., 2018).

Nevertheless, nursing researchers (e.g., Roth et al., 2021; Smith et al., 2022; Walker & Clendon, 2012) have determined that IQNs' nursing qualifications, clinical experience, and transferable skills obtained in their home country are oftentimes not recognised by their peers. Limited professional respect and support from colleagues, recruiters, and managers indicated widespread deskilling and disregard of IQNs' expertise, leading to IQNs' career dissatisfaction and attrition rates (Roth et al., 2021). Gotehus (2022) observed that it can be difficult for IQNs to encounter their colleagues' lack of understanding of the in-depth specialist and generalist nursing training that migrant nurses receive in their home country. Furthermore, Chun Tie et al. (2018) found that IQNs reported experiencing passive racism when being denied professional development opportunities or not receiving management support when facing workplace prejudice or exploitation. IQNs may also be assigned to a healthcare job that offers lower status and salary, such as being a caregiver in an aged care facility, than that which they performed in their home country (Stuart, 2012).

2.7.3 Being an Effective Communicator

IQNs' professional identity and career sustainability is both enhanced and endangered by their workplace interactions with colleagues and managers. Several recent studies in the nursing literature (e.g., Balante et al., 2021; Brunton & Cook, 2018; Gao et al., 2015) show that IQNs focus on using effective communication skills and strategies to overcome workplace challenges and thrive in a supportive work environment. For example, migrant participants in Gao et al.'s (2015) study explained that when they "felt valued, and when they were able to meet the challenges in day-to-day work, difficulties might become rewards" (p. 120). This was in line with IQNs in Chun Tie et al.'s (2018) research, who reduced workplace tension by engaging in informal conversations with their peers. Indeed, IQNs have reported feeling encouraged by other colleagues—both host country and migrant nurses—to speak out against injustices in their workplace (Smith et al., 2020).

Walker and Clendon (2012) found that communication breakdowns caused by diverse cultural norms, for instance, can result in an IQN encountering challenging workplace interactions. Researchers (e.g., Brunton & Cook, 2018; DiCerbo et al., 2014; Levis, 2011) have determined that IQNs often misunderstand informal workplace language, such as colloquialisms, conversational gambits, and idioms, when following doctors' and head nurses' instructions and conveying information to colleagues. IQNs' developing understanding of New Zealand English and the cultural expectations of New Zealand healthcare settings also impact their expression of professional identity and positioning as experienced nurses (Walker, 2008). IQNs may have English as a first language (including a variety of English; e.g., Canadian English, Indian English) or an additional language, but they will not have New Zealand English as their first language. This may impact their expression of their professional identity—who they are and their linguistic constructs. That is, their language background may have an effect on positioning themselves, and being positioned by others, which Thompson and McNamara (2022) identified as a factor in nurses' identity construction or representation.

2.7.4 Being an Agentic, Collegial Healthcare Professional

Agency in healthcare contexts refers to nurses having "the power to originate action" (Bandura, 2001, p. 3). Agentic nurses are able to use intentionality, self-regulation,

self-efficacy, and forethought to manage their nursing behaviours and beliefs in responding to workplace interactions and situations (Ryan & Deci, 2000). Liaschenko and Peter (2016) noted that “nurses are not only shaped by [healthcare] organisations but also have the power to shape them” (p. S18). This is because nurses’ professional agency and professional identity are connected, and both are needed for a sense of moral community within nursing contexts (Liaschenko & Peter, 2016).

The literature (e.g., Aggar et al., 2021; Ghazal et al., 2020) reveals that IQNs use intentionality and self-regulation when accepting opportunities to develop their clinical skills. IQNs set goals and focus on working towards their learning objectives in order to benefit from professional development. Therefore, they feel supported by their manager when clinical skills training is offered, which increases nurses’ goal-orientedness. IQNs then display self-efficacy and forethought in motivating themselves and guide their actions to prepare for the anticipated outcome of gaining new skills and knowledge (Ghazal et al., 2020). Bandura (2006) explains that self-efficacy is a person’s reflecting upon the effectiveness of their beliefs and actions in meeting their goals and adjusting their cognitive and behavioural processes as required.

IQNs who are motivated by their career and who possess self-esteem as a nursing professional may be better able to manage their own and others’ performance (Johnson et al., 2012). They may also demonstrate higher feelings of self-efficacy and positive attitudes towards being a nurse, nurse mentor, or nurse manager (Dörnyei, 2003). In New Zealand, though, time constraints and staffing shortages appear to be closely linked with healthcare workers’ increased stress levels, incidences of burnout, and attrition rates (Lovelock et al., 2017). Harding and Mawson’s (2017) research into mentoring in nursing contexts found that when nurses discuss their own challenging experiences, they help colleagues (especially junior nurses) identify “the pros and cons of a situation, so that [they]are able to make an informed decision” (pp. 5–6). According to Adeniran et al. (2013) and Kakyo et al. (2022), nurses benefit from receiving mentoring support to develop their clinical skills and enhance their commitment to the healthcare organisation.

2.8 Sociocultural Frameworks for Analysing IQNs' Professional Identity

Over the past two decades, research into the professional identity of nurses has become more prominent. For instance, Killeen and Saewert (2007) identified the core norms and values (e.g., collegiality, loyalty, and compassion) that are markers of nurses' professional identity and their influence upon a nurse's individual choice of clinical practices. Johnson et al. (2012) assert that nurses develop their professional identity through aligning their personal ethics and personality characteristics with their nursing role's expectations and values, thus integrating a nurse's sense of personal self and professional self. By determining the valid and relevant theoretical frameworks through which IQNs' professional identity is investigated and analysed, I will be able to determine the intercultural and clinical communication issues that impact IQNs' sense of professional self. In line with ten Hoeve et al. (2014), this may enhance the communication channels and processes between IQNs, managers, and healthcare colleagues to support migrant nurses' professional identity and career sustainability in New Zealand.

2.8.1 Social Identity Theory

Firth and Wagner (2007) believe that each individual possesses myriad social identities that play a relevant and transforming role in their ability to communicate successfully in everyday settings. Identity theorists (e.g., Firth & Wagner, 2007; Hall, 1995) consider social actors to possess numerous social identities—colleague, employee, professional, for instance—that are both changeable and communal. According to Miller (1999), language allows migrants not only to create their social identity but also to access influential social systems, through which they can voice their identity. Since IQNs' lived experiences are “mediated through social practices, language use, and [...their] reflexive responses” (Miller, 1999, pp. 150-151), the social identity of migrant nurses undergoes a continual process of repositioning and reconstruction.

Conceptualising social identity involves linking the context within which social actors—in this case, IQNs—interact, thereby revealing aspects of their professional identity. Maginnis (2018) describes nurses' professional identity as comprising their

professional sense of self (wherein being a nurse is congruent with their personal values and beliefs), “professional socialisation, a sense of belonging to the profession, and clinical placement” (p. 91). The literature also refers to workers’ social identities encompassing their appreciation of: (i) using humour to alleviate the emotional burdens of challenging workplace conditions (Bennett, 2003; Haavisto, 2014); (ii) feeling motivated for the sake of the professional collective (Haslam et al., 2003; Lewis, 2011); and (iii) managing nursing processes to overcome workplace stressors and increase job satisfaction (Pung & Goh, 2017; Smith et al., 2022; Teo et al., 2013).

2.8.2 Sociocultural Theory

Nursing researchers (e.g., Andrew et al., 2009; Philip et al., 2019) have used a Community of Practice lens (Lave & Wenger, 1991; Wenger, 1998, 2006) to investigate IQNs’ stories of positive and challenging experiences interacting with colleagues as they progress from peripheral participation to full integration in healthcare settings. It is their mutual positioning of peers sharing ideas that may contribute to IQNs integrating into the New Zealand workforce and being accepted within their community of practice via legitimate peripheral participation (Block, 2007). The concept of legitimate peripheral participation considers learning to be a social process in which an EAL nurse works within a community of practice to a limited extent without taking responsibility for the final product of his or her work (Hanks, 1991; Wenger, 2006). Still, IQNs’ workplace integration and sociocultural adaptation may be hindered by their experiences of not having their professional experience accepted, or being discriminated against, bullied, or exploited, by their colleagues (Choi et al., 2019).

2.8.3 Sense-Making Theory

In line with Lakoff and Johnson’s (1980) perspectives, non-literal and metaphorical language is a sense-making tool for migrant nurses to reflect upon and understand their workplace interactions in New Zealand healthcare settings. When people interact with others, they often use non-literal language to express their beliefs about their social world and their lived experience within that world (Cameron, 2010). According to Asmali and Çelik (2017), “Metaphors reflect the way people think and know the world” (p. 1). Skilled migrants in New Zealand, for example, often use

non-literal or metaphorical language to position themselves within their profession and make meaning of their professional role and identity (Flores & Day, 2006). In Brunton and Cook's (2018) study of migrant nurses in a New Zealand hospital, nurses from different cultural backgrounds found it difficult to discuss caring for the dying. However, one New Zealand nurse observed, "[You] pull together and work together [...] I gain as much from my colleagues as they learn from me" (p. 22). These nurses were not merely bringing together their individual resources to complete a task (the metaphor's inherent property) but were valuing the knowledge-building communication between team members (the metaphor's interactional property).

2.8.4 Positioning Theory

In comparison with social identity theory, positioning theory holds that identity is situated, flexible, and dynamic (Davies & Harré, 1990). Van Langenhove and Harré (1999) note that workers position themselves and others within a professional storyline, which frames what one is expected to say, do, and be during a workplace interaction. This positioning can be accepted, modified, or rejected by a colleague via co-construction of shared meaning and negotiation of professional relationships (Boston, 2015). IQNs' identity positions can become channels for their self-expression and self-efficacy in negotiating meaning (Norton, 2010). In the retelling of stories about their interactions with colleagues within healthcare settings, nurses are reliving and reconstructing their feelings of professional self. They may also be repositioning themselves within the situation or context to continue their process of meaning-making as they relive the interaction. This may then lead to IQNs' potentially learning from their storied experiences through making "judgements about what is right or wrong" (van Langenhove, 2017, p. 2).

Positioning theory was developed by Davies and Harré (1990) to examine how people locate 'self' and 'other' within a physical and/or temporal space during a social interaction. Identity can therefore be conceptualised as a process of "becoming not being" (Alvesson et al., 2008, p. 15). It is a contextual and relational experience constructed in the moment (Iversen, 2019). McVee (2011) and van Langenhove and Harré (1999) assert that positioning denotes the rights and duties that a person has to speak and act within a social episode. Speech and other acts are a person's actions

that have been considered meaningful by conversation partners within a social setting. Storylines frame the moral context of positioning and acts within a social episode.

Positioning theory is an offshoot of social identity theory to understand and respond to the dynamics of identity, which Norton (2010) considers not to be a pre-set category of identity. Researchers such as Harré et al. (2009) and Woolhouse (2023) conceptualise professional identity as being discursively constructed in the moment. Identity is a process and an independent experience, in line with the social constructionist understanding of identity and positioning. In Phillips and Hayes's (2006) study, positioning theory was used to analyse the role that language played in the nurses' interactions. Consistent with Lakoff and Johnson (1980, 2003), Ruiz de Mendoza Ibáñez and Hernández (2011), and Steger (2007), literal and non-literal language may be used by IQNs as expressive and interpretive tools to conceptualise and (re)tell stories of complex or emotionally laden workplace interactions.

Although the majority of studies on IQNs' professional identity use quantitative or mixed methods to collect and analyse data, there are several key narrative inquiry studies (e.g., Haigh & Hardy, 2011; Lindsay & Schwind, 2016; Semino et al., 2016) that found that nurses make meaning of their professional identity by telling stories about workplace interactions. Phillips and Hayes (2006) used positioning theory to analyse nurse participants' positioning of self and others when sharing their workplace interactions with colleagues and making meaning of the positions enacted within these interactions (Steen, 2011). Low (2008) also recommends positioning theory as a potential tool for analysing non-literal language in workplaces. Haydon et al. (2018) investigated IQNs' stories—specifically the story structures and positioning—to access participants' constructions of professional identity within their professional community. Yet, IQNs' developing understanding of New Zealand English and the cultural norms of New Zealand healthcare settings may impact their expression of professional identity and positioning as experienced nurses (Walker, 2008). Positioning theory is the theoretical framework used in this study, and it will be expanded on in Chapter Three.

2.9 Research Problem

Research studies within the nursing and applied linguistics literature identified and discussed in this chapter revealed that IQNs now comprise a significant proportion of the nursing workforce in New Zealand. IQNs experiencing bullying, racism, and exploitation are less likely to feel motivated and satisfied in their nursing career (Cheung et al., 2018). It is therefore crucial that healthcare providers and policy makers respond to IQNs' workplace interactions in order to understand and support migrant nurses' professional identity and career sustainability (Song & McDonald, 2021). Smith et al. (2022) noted that, although recent studies have investigated IQNs' lived experiences of racism, bullying, and exploitation, there is limited evidence that healthcare employers and nursing organisations have responded to IQNs' concerns about discrimination in the workplace. This is in line with the aim of the NZNO Strategy for Nursing 2018 - 2023 to reduce the harmful effects of racial and cultural discrimination and mental health issues for IQNs in New Zealand (NZNO, 2018).

From the literature review, it is evident that few research studies collect IQNs' stories of their workplace interactions that may impact upon their feelings of professional self and career sustainability in New Zealand. The research problem I am exploring is the ways in which IQNs negotiate their sense of self as they participate in workplace interactions and integrate into the New Zealand workplace culture (Carter et al., 2014). Social constructionist approaches to eliciting IQNs' stories of workplace interactions will allow me to research and understand participants' workplace interactions and feelings more fully. This study's research aim therefore focuses on investigating the professional identity positioning of IQNs revealed through their stories of workplace interactions with colleagues in New Zealand healthcare settings, not on researching IQNs' workplace interactions themselves. Walker and Clendon (2012) acknowledged that additional research into the extent to which healthcare employers appreciate and utilise IQNs' skills and experience is needed to determine the connections between IQNs' professional recognition and retention rates.

Furthermore, articles sourced in this literature review have identified that IQNs' challenging and positive workplace interactions impact their professional

conceptualisation and sense of self. Jenkins and Huntington (2015) noted that few research studies have focused on the extent to which positive workplace interactions have supported IQNs' sense of professional or personal wellbeing. IQNs' professional identity is most commonly researched using social-constructionist conceptual frameworks. Narrative inquiry is the most appropriate method for this project as it is naturally focused on mutual benefit for participants and the researcher. An open and flexible approach to obtain emic data (i.e., from the participant's perspective, rather than etic data from the researcher's perspective), narrative inquiry is a channel for sourcing and observing participants' views of the world. A narrative approach reflects my own position as a qualitative researcher: I want this research study to be mutually beneficial rather than extractive. In line with Lindsay and Schwind (2016), as a researcher engaging in conversations with IQNs and eliciting their stories of workplace interactions, I recognise the importance of the *tikanga Māori* values of care and wellbeing in narrative research. These values are epitomised by the practice of giving *koha* (a gesture of appreciation, such as a gift voucher) to participants to thank them for their time and insights.

IQN experience barriers to full integration in New Zealand healthcare settings (Walker & Clendon, 2015). I have identified a need to develop new nursing knowledge about IQNs' professional identity in New Zealand nursing contexts to uncover aspects of IQNs' identity that support their wellbeing and integration into New Zealand social and professional communities. Inspired by Rampton's (2017) research on interactional communication, I am interested in peeling back the contextual, culture-rich layers of IQNs' workplace interactions within healthcare settings. This may result in the following benefits to the local and international nursing profession: (i) empowering IQNs to give voice to their workplace interactions with colleagues; (ii) helping healthcare employers and policymakers understand IQNs' storied experiences and their impacts; and (iii) revealing aspects of the local and political discourse impacting on IQNs' professional identity and career sustainability. In addition, through their participation in this study, IQN participants—along with their colleagues, managers, and healthcare organisations—may better comprehend their own nursing practice and sense of professional self within the wider nursing community.

2.10 Research Questions

According to NZNO (2017), IQNs are valued as capable participants in the New Zealand nursing workforce. IQNs come to New Zealand with professional experience in their home countries, yet they must cope with transforming their communication style to integrate into the workplace culture here (Walker & Clendon, 2012). This is an issue because IQNs' difficulties assimilating at work and becoming members of a nursing team may challenge their pre-existing identity as experienced health-care workers. Garner et al. (2015) identified the widespread discrimination of IQNs as being detrimental to nurses' professional identity and wellbeing. IQNs are often more susceptible than New Zealand-trained nurses to workplace harassment and inequality (King-Dejardin, 2019). Moreover, Walker and Clendon (2012) found that communication breakdowns can result in IQNs encountering challenging workplace interactions. Language differences mean that sometimes IQNs cannot understand colleagues' requests. As a result, IQNs develop communication strategies to respond appropriately.

IQNs in the New Zealand nursing workforce seek to gain their peers' acceptance and recognition (Philip et al., 2019). Nurses and nurse managers alike support their colleagues' skills development and learn how to be optimistic and assertive when building collegial relationships for the long-term benefit of staff and patients (Block, 2007; Nørgaard, 2011). Roth et al.'s (2021) research into IQNs' experiences acculturating to the host country's workforce found that, after a period of transition, migrant nurses worked effectively with peers and managers. IQNs' demonstrations of proactive communication and self-confidence in creating collegial relationships is upheld by NZNO's (2018) vision for nurses to "work respectfully with colleagues to best meet patient needs" (p. 16).

My research focus is not on IQNs' workplace interactions themselves but on IQNs' storied experiences of those interactions that may reveal aspects of their identity. Through their stories of challenging and positive workplace interactions, IQNs may indicate how their collegial conversations have impacted on their sense of professional self. This research into IQNs' workplace interactions with their colleagues to reveal aspects of their professional identity may have constructive

outcomes for their career pathways and healthcare facilities' operations. To what extent, then, do IQNs use discursive positioning to express aspects of their professional identity when interacting with their colleagues in New Zealand healthcare workplaces? Following are the three research questions to be answered by this study:

Research Question 1

How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings?

Research Question 2

How does IQNs' use of discursive positioning in their stories jointly construct aspects of their professional identity?

Research Question 3

What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?

Whilst Research Question 1 considers IQN participants' discursive positioning of self and others when telling and retelling stories of workplace interactions, Research Question 2 allows for the co-constructed meaning-making that is central to the storytelling process. Research Question 3 focuses on analysing IQNs' discursive positioning within the overarching social, political, and/or cultural discourses in which they participate via workplace interactions with colleagues in order to recognise how these discourses may impact IQNs' sense of professional self. This question shows the need for IQNs' own recommendations to inform practice and policy related to employment and work conditions for migrant nurses in New Zealand. Indeed, my scoping and framing discussions indicated that IQNs experience communicative, cognitive, and emotive tensions when communicating with their colleagues (including nurses, doctors, managers, and other healthcare workers) in New Zealand healthcare settings. In line with Schegloff (1997), Research Question 3 responds to IQNs' co-constructed and contextual storied experience of interacting with their colleague(s) within the wider nursing community.

2.11 Chapter Summary

In Chapter Two, I outlined the literature search process and the key findings from the nursing, applied linguistics, and workplace communication body of literature. Themes discussed in this literature review included IQNs' experiences of registration and orientation, workplace communication, workplace culture, and communication needs. I also presented common conceptualisations of professional identity within the nursing community and four theoretical frameworks for analysing IQNs' professional identity. This literature review has revealed that there is a gap in the literature for IQNs to tell their stories of both challenging and positive workplace interactions. As Song and McDonald (2021) point out, if healthcare providers and policymakers are to meet IQNs' professional and emotional needs, IQNs should "be encouraged to speak about these issues and have their voices heard" (p. 762). Talking about, and learning from, their workplace interactions with colleagues may enhance migrant nurses' sense of professional wellbeing to enhance IQNs' career sustainability for the benefit of New Zealand's wider nursing community. To show how I intended to respond to the research problem and research questions, Chapter Three will present and discuss the research methodology and methods, including the theoretical framework, tools for data collection and analysis, participant identification and recruitment, and ethical considerations.

Chapter 3: Methodology and Methods

3.1 Introduction

This chapter discusses my research paradigm, encompassing my epistemological, ontological, and axiological assumptions and the narrative hermeneutic approach I have selected to respond to my research problem and questions. I first outline my rationale for the theoretical perspectives behind this narrative inquiry study, situating the way I have generated, interpreted, and understood knowledge within my research philosophy (Crotty, 1998). I then examine social constructionism and narrative inquiry, which provide a backdrop for the rapport I developed with my participants and the nature of the research methods I chose. Next, I outline the research design, including the study's data collection tools and techniques, selection and recruitment of participants, data analysis procedures, and trustworthiness and credibility. I conclude this chapter by discussing the research design's ethical considerations, strengths, and limitations.

3.1.1 Research Problem

The research problem I am exploring is IQNs' experiences when negotiating their perceptions of personal self (*Who am I?*) and professional self (*Who am I as a nurse in New Zealand?*) as they participate in workplace interactions and integrate into the New Zealand workplace culture (Carter et al., 2014). I am investigating the features of IQNs' discursive positioning and their professional identity revealed through participants' stories of workplace interactions with colleagues. This narrative case study examines the ways in which IQNs make sense of their social world and their storied experience within that world. Developing a greater understanding of IQNs' identity positioning may benefit migrant nurses' career sustainability and the wider healthcare sector.

3.1.2 Research Questions

The research questions I will answer are meant to address the research problem that has been identified through scoping and framing discussions and the review of extant literature. The study's research questions relate to IQNs' discursive positioning of self and others. My three research questions are as follows:

Research Question 1

How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings?

Research Question 2

How does IQNs' use of discursive positioning in their stories jointly construct aspects of their professional identity?

Research Question 3

What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?

3.2 Research Paradigm

My research paradigm comprises my worldview as a qualitative researcher and my ontological, epistemological, and axiological assumptions. Ontology refers to how the researcher sees reality (Scotland, 2012), whereas epistemology is the philosophical nature, basis, and scope of knowledge (Moser, 2010). Both Crotty (1998) and King and Horrocks (2010) recommend that researchers ask ontological questions (e.g., What is reality?) and epistemological questions (e.g., How can reality be understood?) concurrently. This means that there is often conceptual overlap of ontology and epistemology.

Moreover, according to Saunders et al. (2019), axiology is concerned with the value of research itself, the participants' values, and the researcher's own values, intersubjectivity, and interpretation that impact the study. Underpinning all aspects of my study, my research philosophy provides a coherent framework for answering the study's research questions. That is, I have selected a subjective interpretivist ontology, social constructionist epistemology, reflexive and empathic axiology, and hermeneutic methodology to respond appropriately to the experiential and interactional nature of the research problem and questions. Guba and Lincoln (1994) maintain that researchers' worldviews frame their research paradigm, which comprises the ontological, epistemological, and theoretical perspectives and methodological approaches they select for research studies.

Indeed, my worldview will shape the ways in which I—as a researcher engaged in co-constructed knowledge—study, interpret, and understand IQNs’ professional identity (Crotty, 1998; Guba & Lincoln, 1994). My research philosophy has impacted my selection of data collection tools and techniques. For example, I value one-to-one conversations with people—rather than a survey—to elicit their views and experiences. This, in turn, can provide value to the participants themselves as well as their wider professional community. In line with Saunders et al. (2019), my research philosophy is also pragmatic in that the methodology has had to respond dynamically to COVID-19 pressures for the healthcare sector. Furthermore, I intend for my study to have industry-focused outcomes to inform nursing practice.

3.2.1 Ontological Assumptions

Ontology refers to the study of being and what we consider to be reality. It is a belief system revealing an individual’s interpretation of how truth is established (Kivunja & Kuyini, 2017). A subjective ontology considers social actors’ perceptions of the world to be dynamic, reflexive, and individual (Scotland, 2012; Wahyuni, 2012). My research demonstrates a subjective ontological perspective because I hold reality to be situated within specific contexts and generated by an individual’s social experiences and interactions. The situatedness of a subjective interpretivist ontology is demonstrated by the researcher asking questions and responding to the participant’s storied experiences (Wang, 2017).

3.2.2 Epistemological Assumptions

Consistent with Wang (2017), the epistemology of constructionism demonstrates a clear link with the ontology of relativism. I have selected social constructionist epistemology because it involves the researcher and participants co-constructing knowledge (Scotland, 2012). This results in both parties mutually generating new knowledge and sharing ownership of the research process (Higginbottom & Lauridsen, 2014). Closely linked with grounded theory and positioning theory approaches, social constructionism holds that “social and psychological worlds are made real (constructed) through social processes and interaction” (Young & Collin, 2004, p. 375). In other words, social interactions and relationships within society—or a professional community—construct knowledge.

There is some confusion in the literature as to whether a particular research study employs a constructivist or a constructionist epistemology. Both terms have been used interchangeably over the years—or bundled together under the generic term ‘constructivism’—because of ambiguity in their usage across the humanities literature (Andrews, 2012; Young & Collin, 2004). According to Young and Collin (2004), constructivism refers to the cognitive process through which a person makes meaning of their subjective realities, whereas social constructionism considers an objective reality to be the product of social processes and historical and cultural constructs. Social constructivism and social constructionism are differentiated by their focus on learning and positioning respectively (Hackett, 2015). Nzilano (2015) notes that research using a social constructivist approach can be found in the literature surrounding teaching and learning, particularly training teachers to improve their students’ learning outcomes.

A social constructionist approach is used in the areas of professional practice and education. This approach focuses on individuals positioning themselves (reflexive positioning) and positioning others (interactive positioning) to understand their lived experiences within the social environment at interpersonal, institutional, and societal levels (Andrews, 2012; Davies & Harré, 1990). People construct and communicate meaning from and within dynamic social systems and discourses (Allen, 2005). As a tool in the creation of these discourses, language will play a central role in shaping my participants’ understanding and expression of their realities. Indeed, Blundell (2016) argues that a social constructionist viewpoint deems an agent’s identity—and that of their conversation partners—to be constructed and upheld within social interactions. Phillips and Hayes (2006), for example, discovered that their IQN participants constructed strong migrant voices that rejected a stereotypical identity, such as uncommunicative foreigner, that native English-speakers assigned them. Therefore, a social constructionist research approach is appropriate for investigating IQNs’ discursive identity positioning revealed through their stories of workplace interactions. This is because social constructionism “facilitates the understanding of meanings and themes that emerge from the important moment-to-moment interactions that occur in practice” (Phillips & Hayes, 2006, p. 226).

3.2.3 Axiological Assumptions

According to Kivunja and Kuyini (2017), axiology refers to the researcher's reflection upon ethical practices and human values when planning, conducting, and presenting research to meet the needs of study participants and stakeholders. As an ethical researcher, I needed to consider the values that would: (i) guide my data collection, analysis, and interpretation; (ii) uphold participants' rights and needs and minimise cultural issues; and (iii) help me build rapport with IQNs so that participant retention is maximised and goodwill retained throughout the study. Axiology therefore focuses on limiting potential harm to participants and their professional and cultural communities (Saunders et al., 2019). It also allows for my own subjectivity and empathy as an educator with over 20 years' experience teaching adult EAL learners to be incorporated into my research.

3.3 Research Methodology

3.3.1 Overview of Narrative Hermeneutics

I agree with DeForge and Shaw's (2012) advice to choose a methodology and research design that match my epistemological and theoretical perspectives, thereby filling a previously identified knowledge gap. A qualitative research methodology will help me examine the workplace interactions and critical events in which IQNs participate that impact their social reality (Denzin & Lincoln, 2011). I have therefore selected narrative hermeneutics as a research methodology. It is through narrative that people develop and project their identity, as their 'storied' representations of themselves and their lived experiences help them make sense of their past and its connection with the present (Pavlenko, 2004, 2006; Ricoeur, 1984). Narrative hermeneutics allows people to express and explore aspects of their identity, since it "brings together engagement with issues of storytelling in linguistic [...] contexts with the wider existential relevance of narrative practices for our (self-) understanding and being in the world" (Brockmeier & Meretoja, 2014, p. 2). This methodology fits within my chosen research approach and aligns with my worldview and the research aim because people are given the opportunity to tell stories through which they can make sense of their own lived experiences (Brockmeier & Meretoja, 2014; Finch, 2004).

3.3.2 Rationale for Narrative Hermeneutics

My study reflects Pavlenko's (2002) and Riessman's (2005) claims that stories do not represent the facts of reality but rather discursive constructions and re-imaginings of the storyteller's experience of reality. Hermeneutics and social constructionism focus the researcher's attention on: (i) remaining flexible, participatory, and open to multiple realities; and (ii) collecting and analysing data using iterative and emergent methods (Willis, 2007). In line with Thanh and Thanh's (2015) study, I expected that a hermeneutic methodology would help me investigate IQNs' stories to access perceptions of reality from participants' own experiences within their professional and community groups. This is because, as Harré et al. (2009) and Woolhouse (2023) explain, aspects of one's professional identity are dynamically constructed through conversations with others.

The concept of stories as sources of participants' sense-making aligns with my social constructionist epistemology. Stories allow me to examine discourse as a larger entity as well as smaller meaning units, which may be factual statements. Moreover, they are jointly shaped by the researcher and participant (Barkhuizen & Wette, 2008). My study investigates IQNs' identity, which is defined by Norton (2000) as "how a person understands his or her relationship to the world, how that relationship is constructed across time and space, and how the person understands possibilities for the future" (p. 5). For instance, IQNs' aspirations for, and access to, appreciation and collegiality feed into their self-efficacy, resulting in a professional identity that is fluid and situated within workplace contexts (Finch, 2004; Norton, 2000).

3.4 Research Method

According to Lincoln and Guba (1985), research methods must be selected that will obtain usable data to meet research aims. I have selected narrative inquiry as a method to collect and analyse participants' storied experiences of workplace interactions with colleagues via research conversations and reflexive journalling (Clandinin & Connelly, 2000; Webster & Mertova, 2007). As Wang (2017) points out, "We are interpretive beings, and storytelling is in our blood. [...] By telling and retelling stories, we interact and respond to and with one another; we share and understand who we are, who we have been, and who we are becoming" (pp. 44–45).

A researcher is then able to identify aspects of participants' professional identity that are co-constructed during research conversations (Lindsay & Schwind, 2016; Savin-Baden & van Niekerk, 2007). In this section, I explain how my narrative hermeneutic methodology responds appropriately to the research aim and questions through the study's narrative inquiry research design.

3.4.1 Overview of Narrative Inquiry

As a qualitative methodology, narrative inquiry allows the researcher to investigate participants' recollections of interpersonal communication episodes, including interlocutors' use of positioning through linguistic devices, thereby better understanding how participants experience social interactions (Harré & van Langenhove, 1999). Narrative researchers maintain that it is specifically through telling and retelling stories about one's own and others' speech acts that a person can generate meaning from workplace interactions (Christensen et al., 2017; Tan & Moghaddam, 1999). Groleau et al. (2006) note, however, that stories concerning specific events and people are filtered, revised, and censored by participants to fit the objectives of their personal narratives.

3.4.2 Rationale for Narrative Inquiry

Narrative inquiry, as explained by Lindsay and Schwind (2016), involves the investigation of the commonplaces of a storyteller's experience, namely the place, time, and relationships (with self or others) that experience occurred in. Language is a vehicle through which the storyteller engages in self- and other-positioning in constructing their narrative with temporal, spatial, and social dimensions. As Liaschenko and Peter (2016) explain, aspects of one's professional identity are observed and understood through communicative activities. My study's research aim is to investigate IQNs' professional identity positioning revealed through their storied experiences of participating in challenging and positive workplace interactions with their colleagues in New Zealand healthcare settings. The mutually beneficial, iterative exploration process of narrative inquiry suits this research study, especially since the nature and role of language in nurses' identity positioning is gaining more attention in healthcare research (Lindsay & Schwind, 2016). Furthermore, IQN participants may be empowered in their role as experts, which links positioning theory with narrative inquiry. This is because participants are

invited to share their own perspectives, thereby reflecting their view of the world (Barkhuizen, 2015; De Fina, 2013).

3.4.3 Data Collection Tools and Techniques

There were four key data-gathering instruments used in this narrative inquiry study: Story-Led Conversation, Zoom Pair Share, Flower Diagram, and Optional Reflections. The Story-Led Conversation and Zoom Pair Share were a verbal interaction representation of the stories, but the Flower Diagram was a visual and kinaesthetic representation of stories. Punch (2009) recommends individual interviews and peer-led discussions as flexible, needs-based, and inclusive tools for researchers to identify participants' perspectives surrounding complex issues. I thus used semi-structured questioning techniques to access qualitative data via research conversations held in person or via Zoom at mutually convenient times. (See Appendices A and B for participant confidentiality and consent documents.) The aim of these interconnected data collection instruments was to identify aspects of IQNs' beneficial and challenging workplace interactions with colleagues that may impact their working environments and nurse retention.

3.4.3.1 Rationale for Research Instruments.

According to Roth et al. (2021), the workplace communication encounters which increase (e.g., receiving management support) or decrease (e.g., experiencing workplace stress) IQNs' retention rates are valuable data to be shared with healthcare providers to help attain and retain nurse recruits. Most studies on IQNs in New Zealand use survey-based instruments within mixed method studies to collect data on IQNs' experiences integrating into New Zealand culture (e.g., Brunton et al., 2020; Mowat & Haar, 2018). Findings from surveys are often then discussed by IQNs via interviews or focus groups to generate qualitative data, thereby enhancing the value and trustworthiness of survey data. Through my research, I aimed to understand IQNs' professional identity through narrative accounts of their workplace interactions with colleagues. Participants were thus invited to "tell a story" about what they experienced and felt during and after a challenging or positive workplace interaction. In telling their stories, participants were reliving and co-constructing their sense of professional self, generating meaning with others (Wang, 2017); i.e., the researcher and other IQNs.

3.4.3.2 Description of Tools and Techniques.

On the advice of my nursing consultant Kate (pseudonym), I decided upon a 14-month data collection period. This was because potential IQN participants would be busy with their nursing duties, especially during the emergent COVID-19 pandemic, as well as their personal commitments (Kate, personal communication, July 5, 2020). It would therefore be difficult for participants to engage in more frequent interviews and meetings. As Clandinin (2013) recommended, I also allowed sufficient time for transcription and analysis. This was so I might work more collaboratively with participants to conduct member checking throughout the data collection and data analysis phases (Fraenkel et al., 2012; Polkinghorne, 2007).

For the data collection phase (October 2020—January 2022), participants were invited to contribute up to nine hours to the project, comprising:

- i. a Zoom Pair Share (ZPS) at the middle and the end of the study respectively (2 x up to two hours);
- ii. a Story-Led Conversation (SLC) of up to 50 minutes per conversation every three months (4 x 50 minutes);
- iii. reviewing and commenting on transcripts and researcher notes (one hour);
and
- iv. [Optional] a monthly reflection (around 30 minutes per month).

Termed ‘research conversations’ in this study, SLCs and ZPSs were neither planned nor conducted as formal interviews, in which the researcher asks questions and receives information from participants. I emailed participants SLC and ZPS transcripts within 10 days. I also arranged Capstone Conversations (see Chapter Four) for member checking of the study’s themes and subthemes with participants either in person or via Zoom within six months of the final research conversation.

Holding research conversations with local participants via Zoom rather than face to face was essential during COVID-19 pandemic restrictions in August 2021.

Fortunately, my participants and I had already built rapport, which made changing to a Zoom meeting environment a simple and convenient process. I was unable to collect Flower Diagrams from participants in person, though, and had to rely on their returning coloured-in Flower Diagrams via the self-addressed envelope I provided.

Plus, I had to post my participants the SLC and ZPS materials and thank you vouchers, which incurred courier fees.

The times and locations of research conversations (i.e., SLCs and ZPSs) were scheduled at the participants' convenience. I audio-recorded in-person research conversations using the TapMedia PRO voice recorder and audio editor app on my iPhone. This app records, transcribes, and saves the interview onto an MP3 file in the cloud. I video-recorded research conversations with participants who lived further afield and with local participants during COVID-19 level restrictions via the voice over internet protocol (VoIP) platform Zoom. I used Zoom for virtual interviewing because, as Weller (2017) found, such a VoIP platform is easy to use and allows for audio-visual conversations to be recorded and synchronous text conversations transcribed. Zoom emailed me the audio and/or video recordings and transcriptions to me immediately after the Zoom meeting for data storage and cleaning. I then cleaned the data by editing the app's transcription for clarity (without correcting grammar unless essential for comprehension) and putting the participant's and the researcher's utterances onto their respective lines.

3.4.3.3 Story-Led Conversation.

Each SLC lasted around 50 minutes and was kept informal and relaxed to enhance participants' comfort and the researcher-participant relationship (Swain & King, 2022). Research conversations were held at participants' workplace (in a private meeting area or office), home, café, or via videoconferencing (e.g., Zoom). In research conversations, I asked IQN participants to tell me about one challenging and one positive workplace interaction with a colleague. I invited participants to: (i) explain what they and their colleague(s) said; and (ii) surmise what a fly on the wall might have noticed about aspects of the interaction. Participants then chose a petal on the Flower Diagram, as well as a coloured pencil from the set I gave them, that represented their feelings about this interaction. They coloured in and/or modified the petal with text or illustrations, whilst explaining their reasons for choosing the petal and specific colour. After discussing any additional petal(s) they chose, I asked participants to give advice: (i) for another IQN who experienced a similar workplace interaction; and/or (ii) for healthcare management to support IQNs experiencing a similar positive or challenging situation at work.

3.4.3.4 Zoom Pair Share.

I had originally planned to have two focus group meetings. However, owing to my participants living in diverse New Zealand regions and the COVID-19 pandemic restrictions being enforced in 2021, I was unable to hold focus group meetings in person. I therefore decided to hold three-way research conversations between participants paired up according to their professional backgrounds, which I termed 'Zoom Pair Shares' (ZPSs). I considered that videoconferencing would allow co-participants to feel safe at home and support their authentic responses, leading to the collection of rich data. As Archibald et al. (2019) found, videoconferencing platforms like Zoom are useful data collection channels because they are straightforward and convenient tools for participants to interact with the researcher and their co-participants.

Furthermore, the New Zealand nursing workplace is stressful: Healthcare staff are under stress because of high workloads and a difficult working environment (Professor J. Carryer, personal communication, March 2, 2020). The insights and advice provided by IQN co-participants during Zoom Pair Shares might enhance their mutual understanding of clinical practice and professional communication. Research on mentoring in nursing by Harding and Mawson (2017) and Skår (2010) supports such opportunities for reciprocal peer support and exchange of professional knowledge.

After confirming the ethics statements at the start of the Zoom call, IQNs introduced themselves and their nursing background briefly. We started the first Zoom Pair Share with a *mihi* (i.e., IQN participants' self-introduction of their pseudonym, home country, and nursing background) to build mutual understanding. As indicated by Wilson et al.'s (2021) review of the Māori healthcare literature, a *mihi* for participants would contribute to co-participants' greater honesty and authenticity in sharing ideas, thereby promoting greater rapport, engagement, and knowledge co-creation. It acknowledged who we (co-participants and researcher) were as knowledge co-creators, where we came from, how we would all conduct ourselves, and what our values and background were. Indeed, our *mihi* was integral to the constructionist approach of this study. This was because we could talk with each

other to build knowledge, owing to the shared trust and respect elicited through our *mihi* (Wilson et al., 2021).

I then presented some of the themes from Story-Led Conversations related to IQNs' challenging (the first ZPS) and positive (the second ZPS) workplace interactions. Participants were invited to share their ideas about some of these themes as they related to their own knowledge or experiences of workplace interactions with colleagues in New Zealand. Next, participants took turns telling a story of a challenging or positive workplace interaction for mutual reflection, support, and advice. This approach aligned well with the aims of narrative inquiry, wherein participants co-construct knowledge to make sense of shared experiences as Clandinin et al. (2015) observed.

Finally, I asked participants for their advice for another IQN who experienced this kind of workplace interaction with a colleague. I also elicited IQNs' recommendations for management to support IQNs who were experiencing such interactions. The purpose of the ZPS was for co-participants to share insights, allowing IQNs' language used during the Zoom call to reveal aspects of their professional identity. I expected the ZPS to build rapport amongst participants, thereby giving a sense of professional solidarity and teamwork (Archibald et al., 2019).

3.4.3.5 Flower Diagram.

The 'Story of a Workplace Interaction' Flower Diagram was designed to allow participants to creatively express their feelings about a dialogue with a colleague, thereby revealing aspects of their professional identity positioning. The Flower Diagram is a tool for participants to depict visually their emotions about a challenging or a positive workplace interaction they experienced with a colleague. The aim of the Flower Diagram was to enable IQN participants to relive, feel, and accept the emotions elicited through retelling their story of a workplace interaction. Rice et al.'s (2018) research into art therapy in nursing supported the idea of participants selecting a coloured pencil to represent their emotions because "art often symbolises how people feel and serves as means to communicate feelings" (p. 148).

In the same way that Kalaja et al. (2013) used participants' drawings as symbols of their learner/teacher identity, the Flower Diagram was designed to reveal aspects of IQNs' professional identity. After telling their story of a challenging or a positive workplace interaction, the participant chose a petal and/or part of a petal that represented their feelings about the interaction to colour in. They expressed their emotions by using colour, hand pressure, words, symbols and/or sketches on the Flower Diagram. Through completing their Flower Diagram, participants were engaging in a "present time 'workshop' [to] make sense of the past and orient themselves to a better future whereby insights gained from the past can be applied" (Kupferberg, 2010, p. 373). This then led to participants' reflecting on how they might participate in future interactions with colleagues.

Figure 1 shows the original Flower Diagram that was piloted by Mary prior to data collection. The nature and concept of the Flower Diagram and its application as a data collection tool were further developed as follows:

- i. Mary added personalised descriptors to the Flower Diagram, which enhanced the existing descriptive terms (e.g., 'A-ha!' for the 'Triumph' petal) within the petals. These descriptors were intended, as in Cowie et al.'s (2000) FEELTRACE instrument, "to identify the [participant's] strong, archetypal emotions" (p. 2). Another example of personalisation of the Flower Diagram was the line Mary drew between the 'Uh-huh' ('Agreement') and the 'Ah...' ('Understanding') petals. This line connecting the two petals showed her initial "safe reaction" but then, after reflection, her "coming together in agreement" with her colleague. Mary's proactive modification of the research instrument helped her achieve her own need for self-expression, as well as my purpose for the Flower Diagram as a research tool.
- ii. At my confirmation event, Dr G. Skyrme (personal communication, March 2, 2020) suggested that I leave one petal blank so that respondents could insert their own word into this area if they did not feel any of the other terms applied. Figure 2 shows the revised Flower Diagram flower head, which comprises eight petals:
 - three petals along the top that are more positive-oriented; i.e., 'Ah...' ('Understanding'), 'A-ha!' ('Triumph'), and 'Uh-huh' ('Agreement');

- two petals on each side ('Oh!'), which are left blank for the participant to write a word to represent their own emotion about the interaction; and
- three petals along the bottom that are more negative-oriented (i.e., 'Huh?' ('Misunderstanding'), 'Uh-oh...' ('Disaster'), and 'Ugh!' ('Disagreement')).

Incorporating such flexible data collection instruments in narrative research allows for “valid and reliable multiple and diverse realities, multiple methods of searching or gathering data, [...and an] open-ended perspective to assist the researcher in the research question” (Golafshani, 2003, p. 604).

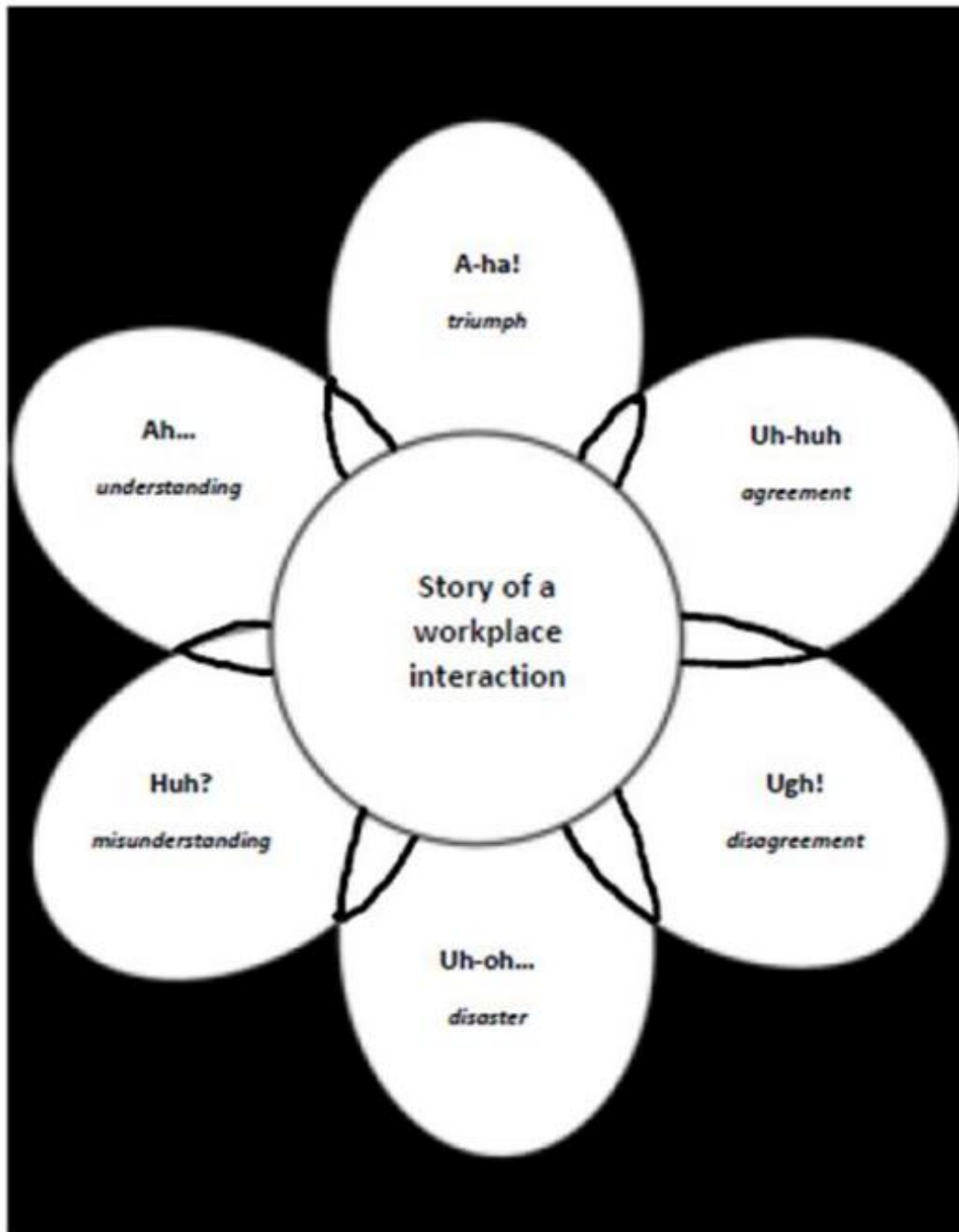
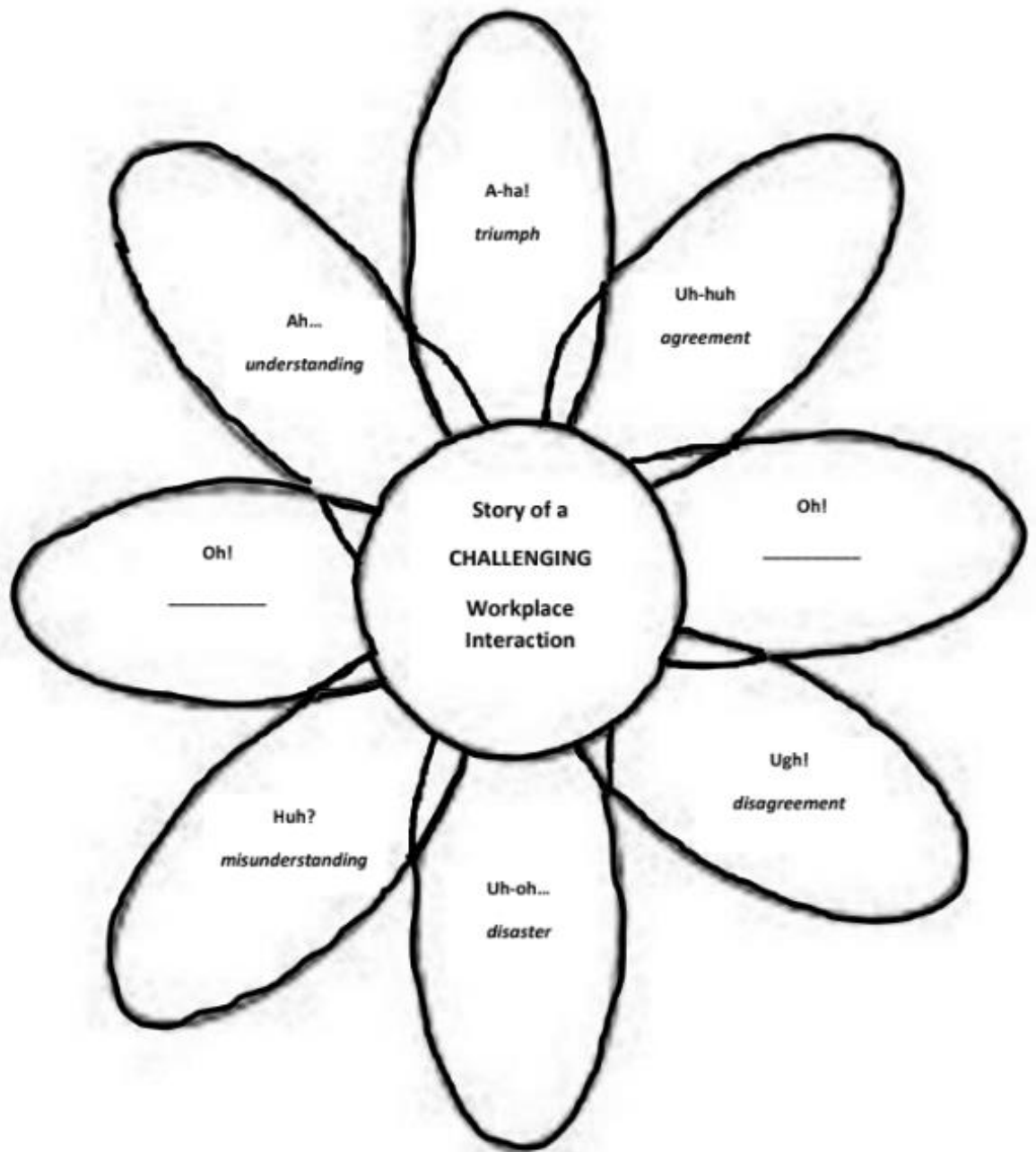


Figure 1. 'Story of a Workplace Interaction' Flower Diagram (Original)

Flower Diagram clip art adapted from:

<http://www.clipart.com/cliparts/c/VV/D/1/1>



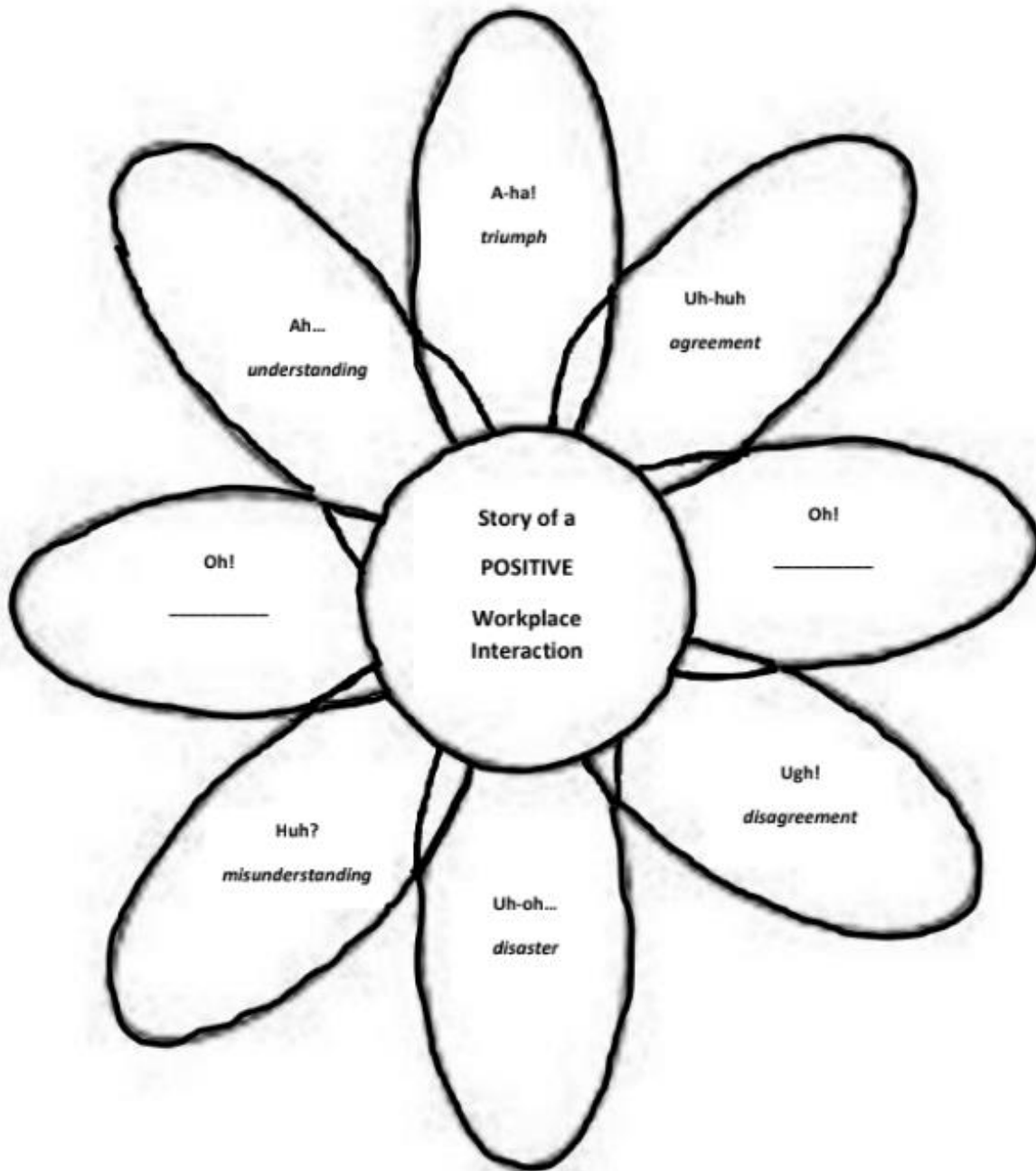


Figure 2. 'Story of a Challenging and/or Positive Workplace Interaction' Flower Diagram (Revised)

3.4.3.6 Optional Reflections.

I invited IQN participants to submit Optional Reflections whenever they experienced a positive and/or challenging workplace interaction they wanted to reflect upon. In their Optional Reflections (see Appendix C), participants could write bullet-point notes or short stories about a positive and/or challenging workplace interaction with a colleague per the reflection question prompts:

1. What happened during the interaction? Where were you? What were you and your colleague doing?
2. What did your colleague say to you, and what did you say to your colleague?
3. What would you say to a colleague who experienced this kind of workplace interaction?
4. Where to from here? Is there anything you want to do as a result of this interaction?
5. What would you say to a colleague who experienced this kind of workplace interaction?
6. They would then look at the 'Story of a Workplace Interaction' Flower Diagram and colour in a petal and/or part of a petal that represented their feelings about the workplace interaction.

Participants were asked to write their reflections in the notebook I gave them at the start of the study and return it, along with their Flower Diagram(s), at our next research conversation. They could also share their journal entries with me via Google Drive (i.e., Google Doc for the journal entry; JPG image for a photo/scan of their Flower Diagram) or via a photo as an email attachment or WhatsApp/text message. Nevertheless, I agreed with feedback from my Nursing Consultants that IQNs dislike writing because of time pressures or feelings of disenfranchisement when expressing themselves in English (Assoc Prof M. Brunton, personal communication, November 23, 2020). I consequently encouraged IQN participants to send me voice recordings of their reflections via text or WhatsApp. This potentially less time-consuming way for participants to share their reflections aimed to minimise any perceived burden on IQNs per Assoc Prof Brunton's advice (personal communication, November 23, 2020).

3.4.3.7 Transcribing Research Conversations.

The first step in my analysis of data was transcribing each research conversation. To uphold confidentiality and anonymity, I decided to transcribe research conversations myself, rather than paying a transcriptionist. I recorded each conversation on my iPhone using the Apple Store app ‘Voice Recorder’, for which I paid a small monthly subscription fee. This app allowed me to record the conversation clearly and supported the transcription process by transcribing interlocutors’ utterances. The in-app transcription software was not completely accurate. However, it did demonstrate machine-learning capability by transcribing my own utterances to a high degree of accuracy. Utterances of participants who had English as their first language or as their additional language were generally not transcribed as accurately, particularly if participants’ speech was fast and/or heavily accented. (Machine learning was nonetheless evidenced by the app recognising each participant’s accent over time as conversation data were recorded.)

It was necessary for me to use the app-sourced transcription only as a foundation for my own verbatim, naturalised transcription protocol (cf. Nascimento & Steinbruch, 2019). Per this protocol, I followed formal rules of written speech by noting punctuation marks and using written discursive conventions. I did not focus on transcribing and/or noting paralinguistic features, such as laughs or gestures, of participants’ utterances. This was because my research focus was on the language IQNs used in their stories to express their feelings about workplace interactions they had with colleagues in the healthcare workplace. I set myself the timeframe of one week following a recorded meeting with the participant(s) to transcribe each research conversation.

Emailing my transcript—and the recording, if requested—with each participant while their memory of our conversation was fresh meant that I obtained the participant’s confirmation of the transcript’s accuracy. As I was taking a social constructionist approach to collecting and analysing my narrative data, I valued participants’ feedback on the accuracy of my transcription of their utterances. I also wished to safeguard participants’ anonymity by camouflaging/redacting identifying details and unrelated utterances (e.g., interruptions by a third person). Some participants took the opportunity to make changes to their transcripts or request

additional redactions during data collection. For instance, Ricky (pseudonym) carefully checked each transcript for the accurate transcription of the words she used and duly made editing suggestions. This was especially useful when the Zoom recording's sound quality led me to inadvertently mistype her utterances. Such a mutually trusting, quality-focused member-checking process was only possible due to the strength of my relationship with my participants and their own reflexivity.

My transcribed field texts became data-rich research texts, which I used for deeper analysis and reflection during subsequent data collection and interpretation stages (Marshall & Rossman, 2011). Still, as Nascimento and Steinbruch (2019) imply, following a reflective and comprehensive transcription process is time-consuming. Each 50-minute research conversation with my participants usually took at least five hours to transcribe, check, and edit. The transcription process, comprising global and detailed listening and transcribing and member checking, of my research conversations helped me develop and strengthen the theoretical and analytical frameworks that best supported my analysis and interpretation of such rich narrative data.

3.4.3.8 Consultations prior to data collection.

3.4.3.8.1 Piloting the Materials.

Piloting research materials and procedures gives a study ecological validity. This is because the researcher can be more confident that data collection instruments elicit the kind of information that is consistent with the study's method, context, and participants. Piloting materials and procedures is especially valuable in narrative research, whose iterative and exploratory stages encourage the ongoing generation and expansion of co-constructed knowledge (Lindsay & Schwind, 2016). As recommended by Malmqvist et al. (2019), I piloted the study's materials and procedures with two non-participating self-identifying IQNs, Mary and Bailey (pseudonyms). The purpose of these piloting consultations was for me to: (i) ascertain any gaps, inaccuracies, or errors in the wording of my data-collection instruments; and (ii) gain experience in leading participant-driven narrative and facilitating open questioning techniques using less structured methods. I wanted to know whether, for instance, the semi-structured questions would allow participants to present their stories in an authentic, reflective way.

It was imperative for me to pilot my data collection materials with Mary (pseudonym), one of the IQNs who was involved in my scoping and framing discussions. In December 2019, I met Mary to explain the study and ask her to pilot the materials. Mary agreed, saying that her participation in the pilot would be useful in checking the instruments' instructions and questions for relevance to IQNs in community and public health settings. "[Participants] in this study are pioneers for other IQNs living and working in New Zealand. Our insights will help the IQNs coming after us" (Mary, personal communication, December 15, 2019).

Mary confirmed that recruiting more experienced IQNs was appropriate to my study. This perspective echoed Grobecker's (2016) belief that nurses who have developed a sense of belonging, and whose colleagues see them as belonging, are often treated as equals. Mary said that if participants felt negative emotions about a workplace interaction with a colleague, they should wait two or three days before telling their story to the researcher/co-participant or writing an entry in their Optional Reflections. Mary's belief that participants' feelings about a challenging interaction might resolve over time was consistent with Skår's (2010), whose nurse participants reflected that their negative workplace experiences with colleagues were learning opportunities.

Mary noted that having a registered nurse and IQN piloting the data collection tools and processes would enhance their validity. This aligns with Malmqvist et al.'s (2019) view that piloting procedures allows the researcher to identify, and subsequently rectify, possible problems with data collection materials. Piloting the materials with Mary played a crucial role in enhancing my research instruments and data elicitation questions, as Malmqvist et al. (2019) found. Consequently, I further developed my data collection tools and techniques in the following ways:

- i. I invited participants to colour in, draw, and write comments on the Flower Diagram as they feel.
- ii. I advised participants to wait two or three days after the positive or challenging workplace interaction—what Mary considered a period of 'settling one's emotions'—before writing their Self-Reflective Journal (later

known as Optional Reflections) entry and then colouring in their Flower Diagram.

- iii. At the start of each research conversation, I asked follow-up questions about the participant's workplace interactions based on comments they had previously made about work relationships and social interactions with colleagues.

3.4.3.8.2 Piloting the Interview Procedures.

In line with Lear et al. (2018), I piloted my interview procedures with Bailey (pseudonym), a New Zealand-trained nurse. Bailey self-identified as a migrant because she had nursed in the United Kingdom for nearly 30 years before returning to New Zealand. Piloting the interview procedures allowed me as a doctoral researcher to practise asking open-ended and participant-focused questions, attend to my researcher talk (particularly minimising unnecessary fillers), and validate my data collection methods (Lear et al., 2018). Bailey and I held our pilot interview in August 2020, conducting a Story-Led Conversation of a challenging and positive workplace interaction Bailey had experienced in her healthcare workplace. Bailey's insights during our pilot were not aimed at generating data. Instead, they allowed me to: (i) ascertain the nature and type of data obtained through my data collection instruments; and (ii) rehearse the interview process prior to my first participant interview with Lilly (pseudonym) in early September 2020.

3.4.3.8.3 Discussing Research Methods with Nursing Consultants.

Qualitative research focuses on confirming fair representation of attitudes and processes within the study population and relies on the skills of the researcher as the instrument of inquiry (Given, 2008; Patton, 2002). To inform my research project, I asked two nursing lecturers—Kate (pseudonym), IQN and nursing lecturer; Associate Professor Margaret Brunton from Massey University—to discuss my research aims and methods and provide feedback on their relevance to IQNs' nursing practice and communication contexts. I also requested their advice on nursing protocols that I needed to follow during my study. Following are each consultant's key contributions and recommendations.

I met Kate in July 2020 to discuss IQN participant recruitment and data collection tools. Kate's initial observations were that IQNs were busy with their jobs, so I needed to ensure tasks were not too onerous for participants. Kate considered the Optional Reflections to be valuable for participants because nurses in New Zealand follow the Nursing Council of New Zealand's (2011) *Guidelines for Cultural Safety*. These guidelines encourage nurses to reflect on their communication practices and beliefs after each shift. In Kate's view, Zoom Pair Shares would be "so beneficial" for IQNs to build a sense of community with a co-participant and provide peer support and feedback. Kate considered my research questions to be applicable for the needs of IQNs and those of the wider nursing community. She also agreed that my data collection tools would help me learn about participants' professional identity.

In November 2020, I spoke with Assoc Prof Brunton, who noted that expecting participants to give me spoken or written reflections on a regular basis would be perceived as overly burdensome. Instead, one-to-one or pair-based research conversations would be the most effective data collection methods. Her advice was to increase the number of Story-Led Conversations per participant from three to four and remove the obligation for participants to complete Self-Reflective Journal entries. Assoc Prof Brunton recommended that I invite IQNs who had at least three years' nursing experience in New Zealand to join my study as "this might bring in interesting data from nurses who had chosen to stay in New Zealand." Potential IQN participants might be more inclined to speak honestly about their experiences than if they felt they were still new to the New Zealand healthcare work context.

Following my consultation with Assoc Prof Brunton, I applied for—and received in December 2020—ethics approval from MUHEC to: (i) recruit IQNs with at least three years' New Zealand nursing experience (no upper limit); and (ii) make Self-Reflective Journal entries (later termed 'Optional Reflections') voluntary. I duly updated my recruitment website, flyer (see Figure 4), and participant information sheet to reflect changes to participant inclusion criteria and to data collection methods. Increasing the pool from which I could recruit IQNs helped me meet my target of eight IQNs for this study.

3.4.4 Participants

Sandelowski (1991) observed that it is “the human impulse to tell tales” (p. 165). It was my priority to recruit IQN participants who were willing to reflexively share their storied experiences of interacting with their colleagues in the healthcare workplace. I recognised that the narrative, linguistic, and visual elements of participants’ SLC and ZPS conversations and Optional Reflections would become the source of discursive positioning data to help answer the study’s research questions (Polkinghorne, 1995). In line with NZNO’s (2012) guidelines for IQNs to “have had adequate orientation to the Aotearoa New Zealand health system, and to nursing specialties and levels of practice autonomy or teamwork required” (p. 3), I sought to recruit IQN participants who had at least three years’ post-registration experience. Furthermore, as Winkelmann-Gleed and Seeley (2005) found, IQNs may feel vulnerable during the initial period of their employment while they are awaiting their work papers. They might also have worked for more than one organisation during the three or more years following New Zealand registration. This ought to reduce the likelihood of a participant being connected with a particular workplace, thereby upholding the study’s ethical principles of privacy, anonymity, and confidentiality.

3.4.5 Participant Recruitment

In line with Lewis (2018), who noted that data collection and analysis are time-consuming, a small participant group would allow me to access the rich data which are central to narrative inquiry. Not only would it permit more in-depth conversations with participants, but ZPS co-participants would also feel more comfortable telling authentic, personal stories in a more intimate setting (Haydon et al., 2018). This section discusses my recruitment and selection of participants in this study, focusing on the recruitment criteria, channels, and methods that suited my research questions. I also discuss the challenges of recruiting eligible IQN participants during New Zealand’s COVID-19 pandemic restrictions in 2020. Table 3 shows pertinent demographic information about the eight IQN participants working in New Zealand towns and cities. All were unknown to me prior to participating in my research.

Table 3*Demographic Information of Participating IQNs*

Pseudonym	Continent of origin	New Zealand experience	Role	Healthcare setting
Lilly	South-East Asia	Four years	Clinical Lead	Aged care provider
Mons	Africa	15 years	Facility Manager	Aged care provider
Carmel	South-East Asia	≈ Five years	RN Virus Control Lead	Aged care provider
Rose	South-East Asia	18 years	Nurse Manager	Private healthcare provider
Jessie	South-East Asia	≈ Seven years	Nurse Educator	Patient assessment software provider
Nightingale	South-East Asia	Three years	RN Nurse Educator	Public healthcare provider
Ricky	Europe	12 years	Mental Health Nurse	Public healthcare provider
Lola	Europe	15 years	Dementia Care Nurse	Public healthcare provider

I recruited and selected participants from a range of continents/regions to ensure diversity of language and cultural backgrounds. (See Appendices D and E for information sheets given to prospective participants and institutions.) All eight IQN participants were female. These participants originated from four different continents and gained either a bachelor's degree or a diploma in nursing in their respective home countries.

3.4.5.1 Promoting the Study to Potential Participants.

Bonisteel et al. (2021) observe that participant recruitment involves communicating research aims and data collection methods to potential participants in a timely, cost-effective, and engaging manner. This is to pique their interest in the study and enhance their belief in the study's credibility. To encourage eligible IQNs to participate in my study, I took Horn et al.'s (2011) advice to foster IQNs' trust in me (as doctoral researcher) and my study. Following are ways in which I built researcher credibility to encourage participants to remain engaged with the research throughout data collection and analysis processes:

- i. I asked healthcare and aged care gatekeepers (i.e., nurse managers; IQN representatives within nursing organisations) to promote my study to IQN colleagues.
- ii. I conducted phone-based or face-to-face pre-recruitment meetings with potential participants and/or healthcare employers.
- iii. I managed potential conflicts of interest, per Bogdan and Biklen's (2007) recommendations, by choosing neutral settings for research conversations (e.g., cafes, private meeting rooms).

I also selected participants who were unknown to me prior to the study. Although I did offer gift cards and refreshments to IQN participants, I found that the most effective participant recruitment strategy was the *koha* of my attention to addressing the needs and interests of potential participants.

In addition, I sought to understand the key factors that might encourage an IQN to participate in the study by consulting with nurses and nursing lecturers who were IQNs themselves. It was clear from my consultants' feedback that IQNs wanted to understand their own workplace interactions in their nursing context. They also desired to help their fellow nurses within the local and wider healthcare sectors. According to Kate, my study would likely be attractive to IQNs as it was important for the wider nursing community to understand where IQNs come from. This might lead to more two-way understanding, and valuing, of IQNs' overseas nursing experience. Kate observed that IQNs can be judged by other nurses, who ask, "What is [IQNs'] experience?" (Kate, personal communication, July 6, 2020).

3.4.5.1.1 *Recruitment Channels.*

Key sociocultural considerations for recruiting IQNs included building and maintaining mutual trust and rapport with participants who came from a range of cultural, ethnic, and language backgrounds (Kelly & Howie, 2007). Following are the channels I used to uphold researcher credibility in recruiting IQN participants for this longitudinal study:

- *Website*—In line with Addor et al. (2015), I developed a website (www.tinyurl.com/DanaTaylorPhDProject) using the WIX.com website builder to advertise my research study. This website provided information about the study's purpose and intended participants, as well as my professional background. I also set up a designated email address, danataylorphdproject@gmail.com hosted by Gmail, a free email service within the Google Suite of software applications. Both the website and Gmail address allowed potential participants to contact me to ask questions and/or register their interest. Researcher details were made available to potential participants whether or not they decided to participate in the study.
- *Printed flyers and cards*—I followed Berry and Bass's (2012) advice to use printed flyers and cards for advertising the study to members of the healthcare community, as well as to the public. I designed a professionally printed card (see Figure 3) and flyer (see Figure 4) with matching images and fonts, as McCullagh et al. (2014) recommended, to be pinned on notice boards in hospitals, community centres, and other public locations. After reading the recruitment card or flyer, potential participants and/or their friends or colleagues could then contact me via email, phone (voicemail or text), or website to express their interest in finding out more about the study.

Dana Taylor | PhD candidate
 Researching the professional identity of internationally qualified nurses (IQNs) in New Zealand healthcare settings

Are you an IQN who has worked in New Zealand for three to five years?
 I'd love to hear from you!

Find out more and get in touch
www.tinyurl.com/DanaTaylorPhDProject



Figure 3. Participant recruitment card



Research participants wanted
 Are you—or is someone you know—an internationally qualified nurse (IQN) who has been working in New Zealand healthcare settings for at least three years?

I will be exploring the professional identity of IQNs as they reflect on their interactions with colleagues within New Zealand healthcare settings.

*My supervisors are Ute Walker, PhD (U.Walker@massey.ac.nz), Franco Vaccarino, PhD (F.A.Vaccarino@massey.ac.nz), and Wendy Holley-Boen, PhD (W.Holley-Boen@massey.ac.nz).
 Project approved by the Massey University Human Ethics Committee: Northern, Application NOR 19/29.*

Please contact me to find out more or register your interest:
www.tinyurl.com/DanaTaylorPhDProject
 Ph. (021) 187 0331

Figure 4. Participant recruitment flyer

- *Professional networking*—I liaised with my contacts at the local public hospital, the nursing department at a local tertiary provider, the Manawatū Multicultural Council, and the Network of Skilled Migrants Manawatū. I arranged pre-recruitment meetings with my contacts and their nurse colleagues to present and discuss my study. During these meetings, I explained the aim and nature of my study, how research findings may help migrant nurses, and the potential benefits to the wider nursing and migrant communities. A nursing lecturer gave me the contact details of a nurse educator who works with IQNs, which subsequently led me to recruit three IQNs in aged care facilities. Indeed, Mary (pseudonym of the registered migrant nurse with whom I piloted my materials) advised that the majority of IQNs are employed by aged care facilities locally (Mary, personal communication, June 19, 2020). I asked my nursing educator contacts to disseminate recruitment flyers and cards and act as a contact for potential participant IQNs.

It was my hope to encourage my contacts to become my ‘champions’, promoting the benefits—to IQNs themselves and the wider nursing community—and requirements of this study with potential participants who fit my inclusion criteria (Broyles et al., 2011). I also wrote to managers at the Palmerston North hospital (for which I had received ethics approval to recruit IQNs for my research), healthcare providers, and rest home facilities seeking permission to post recruitment flyers on staff notice boards and/or speak to staff about the study’s aims and expectations. Liaising directly with potential participants either in person or via telephone or email provided a personalised recruitment approach (Eide & Allen, 2005). I was able to: (i) give prospective participants the details included on the recruitment flyer and/or information sheet; (ii) ease IQNs’ minds that this study was unrelated to their employment or professional practice (i.e., IQNs were not being observed in relation to their visa status); and (iii) encourage them to contact me by phone, via email, or through my website, www.tinyurl.com/DanaTaylorPhDProject.

- *Article in Kai Tiaki Nursing New Zealand*—My nursing consultant Kate suggested I write a letter to the editor of the professional nursing journal Kai Tiaki Nursing New Zealand to invite IQNs to join my study. After speaking with the journal editor, I proposed writing a short article discussing emerging themes from my research. This article was published in the November 2020 issue of Kai Tiaki Nursing New Zealand. See https://issuu.com/kaitiaki/docs/kai_tiaki_november_2020. My article attracted the attention of Jessie (pseudonym), an IQN who subsequently participated in my study, owing to the benefits she felt my research would have for migrant nurses in New Zealand (Jessie, personal communication, July 21, 2022).
- *Facebook posts by NZNO*—An IQN nursing contact from Internationally Qualified Nurses Aotearoa recommended I email the New Zealand Nurses Organisation (NZNO) to ask if I could promote my project to IQNs through the NZNO Facebook page. In March 2021, the NZNO kindly posted my blurb comprising the following wording:

Overseas-trained nurses wanted for a PhD research project

Are you an overseas-trained nurse who has been working in New Zealand for at least three years? I'd love for you to join my PhD project researching migrant nurses' [workplace interactions] and professional identity in New Zealand healthcare settings. Every three months over a 12-month period, we'll meet online via Zoom (or similar) for a 50-minute conversation about a challenging and/or positive workplace interaction you may have had with your colleagues.

I'll also invite you to participate in two focus group Zoom meetings with other nurse participants. During each meeting, participants will have the opportunity to share, and reflect on, their [workplace interactions] with colleagues and the impacts of these experiences upon their sense of professional identity. Want to know more? Please phone/text [phone number] or email danataylorphdproject@gmail.com,

or visit <http://www.tinyurl.com/danataylorphdproject>

(Massey University human ethics approval: NOR 19/29)

As a result of the NZNO Facebook post, I recruited two IQNs working in mental health and dementia care. Since the New Zealand nurses' union—that is, NZNO—had endorsed my research study by promoting it, in line with Bonisteel et al. (2021), this Facebook post enhanced the study's credibility.

3.4.5.1.2 Pre-Recruitment Meetings.

Prior to beginning the participant selection phase, I held a pre-study information session via a phone call to each IQN who expressed interest in my research project. This enabled further discussion of the nature and expectations of the research study with potential participants. My goal was to elicit IQNs' interest in the research aims and consent to participating in the study (Kaba & Beran, 2014). During the phone call, I explained the purpose, frequency, and format of our research conversations. I also advised that IQNs would be invited to talk about both challenging and positive interactions they had experienced with colleagues in their New Zealand healthcare workplace. This was because I intended to follow the narrative interviewing technique recommended by Lewis (2014) whereby often-marginalised participants engage in “the telling of their own stories” (p. 6).

3.4.5.2 Participant Selection.

Although I had originally intended to recruit six IQNs for this study, I followed Bankhead et al.'s (2017) advice to increase the number of participants to eight participants. This was to minimise the risk of participant attrition, owing to personal issues caused by “intolerable adverse events” (ibid, ¶ 2), such as COVID-19. The eight IQN participants were over the age of 18 years, had the capacity to give their consent, and volunteered to be part of the research project. All participants had been working in New Zealand healthcare settings for at least three years after obtaining their New Zealand registration. IQN participants were working either full- or part-time for a public or private healthcare provider. IQNs came from diverse ethnic and language backgrounds, and English was either their first or additional language. As they were New Zealand-registered nurses, I considered that participants for whom English was an additional language had a minimum English language proficiency of

IELTS Band 7. All eight IQN participants indicated their willingness to participate in a 14-month study, understanding that they were free to leave the study at any time.

This study required participants to demonstrate a range of perspectives and experiences. I therefore conducted purposive sampling to ensure that the participant cohort in the study phase reflected demographic diversity. I recruited IQN participants from a variety of home countries, covering Asia, Africa, and Europe. Two were from the Philippines, two from India, one from South Africa, one from Malaysia, and two from Great Britain. (For ethical reasons, I am not identifying each participant's home country.) Three of my participants were recruited via my professional contacts in aged care facilities. One IQN was recruited from a recruitment flyer in a medical centre and personal introduction. Two IQNs were recruited from my Kai Tiaki Nursing Research article, and two IQNs were recruited from NZNO's Facebook post.

3.4.6 Research Framework

3.4.6.1 Theoretical Framework.

I have selected positioning theory as the theoretical framework that constructs and uncovers the meaning of IQNs' social interactions, locating IQNs' identity within social, cultural, and professional discourses (Riessman, 2005, 2008). Extending Foucault's (1972) concepts of subject positions and discourses, positioning theory was developed by Davies and Harré (1990) to examine how people locate 'self' and 'other' within a physical and/or temporal space during a social interaction (Tirado & Gálvez, 2007).

3.4.6.1.1 Overview of Positioning Theory.

When people co-construct stories about social episodes in the past, they take on a character through which they can engage in interactive positioning (i.e., positioning others) and reflexive positioning (i.e., positioning themselves) (Jones, 2012).

Positioning exists in conversation, which is "a structured set of speech-acts" (Davies & Harré, 1990, p.45). Consequently, researchers (e.g., Bamberg, 1997, 2003, 2011; Bamberg & Georgakopoulou, 2008; Dayter, 2015; Georgakopoulou, 2006, 2007) have analysed people's 'small stories' (i.e., recounts of common social interactions) to discern positioning strategies resulting in moral positions and identity claims.

According to McVee (2011) and van Langenhove and Harré (1999), the three main concepts of positioning theory are position, speech and other acts, and storyline:

- i. *Position* denotes the rights and duties that a person has to speak and act within a social episode.
- ii. *Speech and other acts* are a person's actions that have been considered meaningful by interlocutors within a social setting. Positions can be interpreted and established by self and others by meaningful acts.
- iii. *Storylines* frame the moral context of position and acts within a social episode. They shape what one is expected to say, do, and be during a meaningful interaction.

Groleau et al. (2006) contend that stories concerning specific events and people are filtered, revised, and censored by participants to fit the objectives of their personal narratives. Social constructionist perspectives of identity, wherein aspects of identity are revealed via “talk-in-interaction” (De Fina, 2013, p. 3), incorporate the flexible components of positioning theory and the spatial constructs of sociolinguistic views of identity (Dong & Blommaert, 2009). For instance, De Fina's (2013) narrative inquiry study found that the stories migrants told about the communication challenges they faced within social settings (‘small-d’ discourses) and the wider community's socio-political environment (‘capital-D’ discourses) showed negative impacts upon their identity construction as participants in English-speaking social contexts.

Positioning theory is the most appropriate theoretical and analytical framework for this study because it responds to the dynamics of identity. That is, one's sense of self is fluid, rather than static and categorised, particularly in organisational contexts (Iversen, 2019). In their stories about workplace interactions with colleagues, storytellers are likely to position themselves and others within a storyline based on their own subjective experiences. This positioning can be accepted, modified, or rejected by a colleague via co-construction of shared meaning and negotiation of professional relationships (Boston, 2015). In Phillips and Hayes's (2006) study, for instance, positioning theory was used to analyse nurse participants' stories of workplace interactions, and the role that language played in these interactions, to

understand their professional identity. This is in line with my study's constructionist perspective, which focuses on the ways that storytellers see their world and express aspects of their professional identity.

Possible shortcomings of positioning theory, though, are its immanentist view (Anderson, 2009); that is, where a storyteller's identity positioning is determined via a single story. According to Davies and Harré (1990) and McVee et al. (2018), identity positions are flexible, situated, and immanent, signifying a person's access to, and negotiation of, "a cluster of rights and duties to perform certain actions" (Harré & Moghaddam, 2003, p. 5). An immanentist view is criticised for not allowing for people's "positioning repertoires" across interactions (Anderson, 2009, p. 292; McVee et al., 2018). Other criticisms of positioning theory are that it:

- i. fails to reflect the cultural and organisational settings in which social episodes occur (Christensen et al., 2017); and
- ii. does not consider the linguistic backgrounds of the storytellers, particularly in detecting and interpreting their use of metaphorical expressions (Kupferberg, 2014).

This study mitigated these potential risks of positioning theory, by not relying on a single story to generate data and by using multiple data sources situated within a range of healthcare settings (e.g., aged care facilities, private clinics, nursing education providers). Furthermore, the key strength of my research was that it allowed for IQN participants to tell their own stories in their own words, using their own linguistic (literal and non-literal) and paralinguistic (visual) devices. According to De Costa et al. (2021), narrative research can be conceptualised as "social practice [that] focuses on the contexts in which narratives take place as well as their constitution and performance" (p. 4).

3.4.6.2 Analytical Framework.

3.4.6.2.1 Case Study.

Case study research is a qualitative method used to answer 'how' and 'why' research questions in realistic settings (Yin, 2009). Single or multiple cases describe bounded systems, which are situated within a specific period and subject area. Case studies in nursing research incorporate human participants, symbolic and documentary

resources, and geographic locations to produce descriptive data. Such data are used to deepen understanding of multiple realities, consider alternative perspectives, and/or improve nursing practice (Heale & Twycross, 2018). Consistent with Sunday et al. (2020), I selected the interlinked qualitative methodologies of narrative hermeneutics, case study research, and narrative inquiry for this study. Case study helped me explore the multi-layered professional context within which IQNs interact, whilst narrative inquiry allowed for the investigation of IQNs' discursive identity positioning. According to Yin (2009) and Hetherington (2013), case studies are suitable for describing social phenomena (a process known as thick description) and presenting data in a user-friendly format.

3.4.6.2.2 *Thematic Analysis.*

I used reflexive thematic analysis, as outlined by Braun and Clarke (2006, 2022), as the first stage of my data analysis process. SLC and ZPS transcripts were coded for meaning units, before undergoing higher levels of abstraction to construct themes and subthemes from the codes grounded in the data (cf. Davis, 2020). Below are the steps I followed in the thematic analysis procedure:

1. SLC and ZPS transcripts were stored and coded using the 2020 version of the NVivo software package (QSR International, 2021). I selected NVivo software to assist me in managing my textual and visual data and supporting my data analysis processes (Zamawe, 2015).
2. I followed Braun and Clarke's (2006) and Byrne's (2022) advice by first familiarising myself with my data by reading and re-reading the SLC and ZPS transcripts and noting my thoughts of possible thematic areas.
3. I coded the transcripts—both my own utterances and those of my participants—for meaning. This involved using the highlighting function in NVivo to select the section of narrative data and labelling it with a gerund or imperative phrase to describe the meaning of the selected utterance(s).
4. I used participants' own words through in vivo coding (Glaser & Strauss, 1999).
5. The following example demonstrates my thematic coding and categorisation in NVivo:

Exemplar:

TA - Challenging - Overcoming misunderstanding and miscommunication by sharing knowledge with colleagues and asking questions to avoid being ‘passive’ and ‘stuck’

Key:

- TA = Thematic Analysis
 - Challenging = ‘Story of a Challenging Workplace Interaction’
 - The label description begins with a gerund per grounded theory coding protocol.
 - NVivo coding is represented by participants’ words and phrases within inverted commas.
6. Grounded in the data, these codes were assigned to a thematic area (e.g., ‘Workplace Culture’), from which subthemes were constructed. Subtheme labels were modified throughout the thematic analysis process as more codes were assigned to each label. I intended this analytical process to remain sufficiently open, inductive, and reflexive to allow me to refine category names, thereby leading to greater research credibility and transparency (Gale et al., 2013). Chapter Five will present these themes and subthemes with selected examples in detail to show how they respond to Research Question 3.

3.4.6.2.3 *Creating Codes and Categories.*

Qualitative research focuses on deciphering and interpreting meaningful concepts by constructing codes and categories grounded—or tied closely to—the data (Charmaz, 2008; Davis, 2020). In line with Hsieh and Shannon (2005), as a qualitative researcher, I aimed to uphold validity during data analysis by specifying my analytical processes and rationales. This was because efficient coding and categorising would help me generate themes and subthemes in a straightforward way. After transcribing a research conversation with one participant (Story-Led Conversation) or with two participants (Zoom Pair Share), I read and re-read the transcript for indications of the participant’s overt and covert meaning when (re)telling stories of their workplace interactions with colleagues.

I also recorded my subjective reflection on any underlying emotions and perspectives the participant may have evidenced during the conversation. There were three key questions I asked myself when (re)reading the transcript:

1. What kind of language (e.g., informal (idiomatic, metaphorical) or formal (professional, technical)) does the participant use to express their storied experiences of challenging and positive workplace interactions?
2. How and why are such linguistic features used in the participant's storytelling?
3. What aspects of the participant's storied experience and discursive positioning are most noticeable during initial data analysis?

Following Erlingsson and Brysiewicz's (2017) exemplar of qualitative content analysis, I condensed each utterance produced by the participant into a short meaning unit that was close to the original text. My own utterances were usually only analysed as part of meaningful researcher-participant exchanges per the social constructionist approach to grounded theory. That is, I would not analyse my questions to a participant, but I might analyse my responses or personal observations in relation to a participant's story. This was particularly important if such comments added to the joint construction of meaning within the conversation.

While saving the codes into groups of similar meaning units to generate subthemes, I could see where I needed to split subthemes. I purposefully took a subjective, interpretivist perspective and the social constructionist approach of letting my data "speak" to me (Campbell, 2020, p.4). As a narrative researcher, I participated in the co-creation of meaning attributed to participants' stories and storyworlds (Barkhuizen, 2011). This meaning-making allowed me to construct the themes and subthemes from my narrative data per Braun and Clarke's (2006, 2021) thematic analysis protocol. Figure 5 shows a sample of codes related to IQN participants' recognising the need to be professional and proactive in healthcare workplaces.

TA – Challenging – Recognising that asking about offering in-patient clinics over Christmas out of goodness of heart ‘came back to bite IQN on the bum’
TA – Challenging – Showing proof of a medication mistake to a nurse colleague and receiving agreement
TA – Challenging – Understanding that socialised people act and talk appropriately
TA – Challenging – Unwittingly contradicting a doctor’s decision in front of patient to keep patient at home rather than in respite care
TA – Positive – Appreciating colleagues’ sharing of training expertise and resources to IQNs who are new to New Zealand
TA – Positive – Being seen to be thorough and accurate with nursing documentation
TA – Positive – Putting up professional boundaries with new manager who was a team member
TA – Positive – Receiving nursing colleagues’ praise and appreciation for proactively arranging for RNs to attend nursing conferences regularly for professional learning and networking opportunities
TA – Positive – Responding to staff needs promptly and resolving their problems quickly because staff are IQN manager’s ‘work family’
TA – Positive – Working as a team to solve communication and technology problems in the team

Figure 5. Sample of codes: Thematic analysis of participants’ stories of challenging and positive workplace interactions

3.4.6.2.4 Contemporary Analytical Frameworks for Identity Positioning.

Two contemporary analytical frameworks—critical discourse analysis and narrative analysis—are often used in narrative research to explore aspects of participants’ professional identity. This section considers the extent to which each framework might help me analyse IQNs’ sense of self via their storied experiences of interactions within professional contexts. The next section introduces a third approach (multimodal positioning analysis) that extends Bamberg’s (1997, 2003, 2020) positioning analysis to provide a deeper analysis of participants’ discursive identity positioning.

- i. *Critical discourse analysis*: Critical discourse analysis has been used by New Zealand researchers (e.g., Holmes, 2015; Holmes & Schnurr, 2006) when investigating the gendered, hierarchical nature of workplace interactions, particularly for professionals joining an established community of practice (Lave & Wenger, 1991). Critical discourse analysis investigates cultural behaviours and norms (e.g., saving face, navigating power distance, and using politeness strategies) that are situated in wider language and social contexts. Nevertheless, to answer my research questions, I needed an approach to analysing narrative data that would provide deeper insight into professionals' identity positioning of self and others (Watson, 2007). This is because, as Norton (2000) proposed, one's sense of self is dynamic, flexible, and linguistically constructed.

- ii. *Narrative analysis*: Narrative analysis focuses on people's use of storytelling to convey their interpretation of events, emotions, and actions in which human beings have active roles as characters or actors (Bruner, 1990). A narrative is a storied representation of a person's perspective of an event—or series of events—that occurred in the past. It comprises a plot wherein actions are performed by characters, leading to a learning point—or moral of the story. The events in the story may be real, but because the narrative is told from the viewpoint of the storyteller, the actions and characters may be embellished or fictionalised (Gubrium & Holstein, 2009).

Warden and Logan (2017), for instance, liken IQNs' gaining nursing registration in the host country and reconstructing their professional identity to an archetypal hero's quest which represents international nurses' career experiences:

Initially the individual leaves the known world to enter unknown territory [...] Although the adventurer meets helpers and a mentor along the way, there is inevitably a low point termed "the abyss" which reflects a crisis point or extreme difficulty. This forges painful growth and transformation and is followed by [...] the gift of new knowledge and expanded perspective (pp. E350–E351).

Narrative analysis, according to Riessman (2008), implements a qualitative approach, using semi-structured interviews that encourage the participants to tell and co-construct their story. Storytellers use ‘emplotment’ (Ricoeur, 1984) and a progressive story structure to organise and (re)frame their memories and beliefs about events they have experienced (Frank, 2012). Narrative analysis in nursing research involves transforming participants’ narrative data that include features of emplotment into structured stories that may be further analysed for themes and subthemes (Lewis, 2018; Petty et al., 2018). Nonetheless, participants’ sense of self revealed through their language use can be lost when the researcher reconfigures their contextual narrative data into a formal story structure per Riessman’s (1993) seminal description of narrative analysis.

3.4.6.3 Multimodal Positioning Analysis.

3.4.6.3.1 Designing the Multimodal Positioning Analysis Model.

After assessing the appropriacy of critical discourse analysis and narrative analysis in helping me understand IQNs’ identity positioning, I determined that a different analytical framework was needed. This was because I sought to investigate IQNs’ use of language to position themselves and others within their nursing community and thus respond to IQNs’ beliefs about their social world. The thematic analysis of my narrative data from SLCs and ZPSs as described above was a bottom-up analytical process. The second stage of data analysis, though, was a top-down approach to answering my research questions. In line with De Fina and Georgakopoulou’s (2020) observation that contemporary narrative research was incorporating multiple modalities, I drew on positioning theory concepts to devise a multimodal analytical approach, which I called multimodal positioning analysis (MPA). My MPA model (see Figure 6) focuses on analysing the textual data from SLC and ZPS transcripts and the visual data from the Flower Diagrams.

I designed the MPA model with the view to analysing and interpreting the ways in which participants’ storied representations of being an IQN in their own local context fit within, and contribute to, the wider nursing community. Consistent with Lakoff and Johnson (1980, 2003), Ruiz de Mendoza Ibáñez and Hernández (2011), and Steger (2007), IQNs may use literal and non-literal language as expressive and interpretive tools to conceptualise and (re)tell stories of complex or emotionally

laden workplace interactions. When people tell stories about their lived experience, they position themselves and others via a range of linguistic devices, including emotive, humorous, questioning, indexical (i.e., referring to concrete events in place and time), and metaphorical expressions (De Fina & Georgakopoulou, 2008; Delfino & Manca, 2009; Jovchelovitch & Bauer, 2000). Lakoff (1994) and Lakoff and Johnson (2003) contend that people use metaphorical language, for instance, to link concepts with others to understand and talk about physical, emotional, and spiritual phenomena.

My MPA model was based on Bamberg's (1997, 2003, 2020) positioning analysis framework, Davies and Harré's (1990) and Harré and van Langenhove's (1999) positioning theory, Kayi-Aydar's (2021) work on positioning and emotionality, and Silverstein's (2003) work on indexicality. This top-down analytical framework was created to analyse participants' discursive positioning at Levels 1, 2, and 3 within Bamberg's (2003, 2020) positioning analysis framework. Barkhuizen (2010) notes that, at Level 1, the researcher examines story content, characters, and their relationships within a specific context. At Level 2, the researcher focuses on considering how the storyteller positions self in relation to the listener(s) and vice versa. At Level 3, wider discourses indicated by the story characters and context are analysed to determine "the broader ideological context, within which the characters agentively position themselves and by which they are positioned" (Barkhuizen, 2010, p. 284).

Following are descriptions of each level in the context of my research:

Level 1 refers to the storyteller's interactional representation of storyworld characters.

- i. Who am I, and who are they, as healthcare professionals in this story?
- ii. Why are we positioned this way?

Level 2 refers to the storyteller's interactional representation of self in relation to the listener.

- i. How do I present myself as a healthcare professional?
- ii. Why am I conveying the story (elements) this way?
- iii. How is story meaning being co-constructed?

Level 3 refers to the storyteller's interactional representation of self within the nursing community.

- i. Who am I in the workplace / nursing context?
- ii. What is the overarching social, political, and/or cultural discourse within which IQNs are experiencing workplace interactions with colleagues?
 - a. What role does a Master Narrative play?
 - b. What role does a Counter Narrative play?

Bamberg (2005, 2020) encourages the narrative researcher to consider ways in which storytellers position themselves and their stories within master narratives (or Capital D discourses) and/or counter narratives at Level 3 of his positioning analysis framework. Master narratives reflect a community's norms and mores; that is, the "cultural standards against which community members feel compelled to position their personal experience" (Thorne & McLean, 2003, p. 171). According to Hyvärinen (2007), counter narratives oppose the tenets of master narratives and seek to reframe, reshape, or remove cultural scripts within wider community discourses.

3.4.6.3.2 Rationale for Adapting the Positioning Analysis Framework.

Using positioning theory as an analytical strategy has been criticised for not explaining the specific ways in which storytellers position self and others in narrative data (Vågan, 2011). I adapted Bamberg's (1997, 2003, 2020) positioning analysis framework because I was reading the work of researchers (e.g., Bamberg, *ibid*; Barkhuizen, 2010; De Fina, 2013; McVee, 2011) in interpreting small stories and the ways in which they revealed aspects of the storytellers' identity positioning. I was attracted to positioning analysis as it allowed me to contextualise and relate the storytellers and the storyworld within wider discourses. However, I realised I needed a focused model that would be time effective as I knew I would have a lot of narrative data to analyse and interpret in order to answer my research questions. I therefore took a cogent stance in constructing the MPA model. Adapting positioning analysis allowed me to construct an analytical framework that suited my research context and my participants' needs. That is, participants were primed to tell and retell stories of their challenging and positive workplace interactions. They chose the most salient, relevant, and personal stories to share with me and, during Zoom Pair Shares, their co-participant. Developed over three years with several draft versions, the MPA

model was applied to narrative data whilst I was transcribing, reading, and coding research conversations.

3.4.6.3.3 Description of the MPA Model.

I devised the MPA model to set out clearly how a storyteller—in this study, each IQN participant—uses positioning to reflect aspects of their professional identity within the following four ‘identity spaces’ (cf. Bamberg, 2020; Bamberg et al., 2011; Kayi-Aydar, 2021): positionality (agency and control; sameness and difference; temporal constancy and change); emotionality (textual—literal language, non-literal language; visual—colours, shapes); relationality (self-positioning, other-positioning, reflexive positioning); and consequentiality (moral implications, social-cognitive implications, professional reflexivity).

- i. *Positionality* is described by Holmes (2020) and McVee et al. (2011) as indicating the storyteller’s positioning that portrays their world view, beliefs, and values about a social event and its socio-political context. In MPA, positionality relates to: (i) the agency and control that participants demonstrate, or do not demonstrate, during workplace interactions; (ii) participants’ feelings of sameness and difference in relation to their colleagues; and (iii) aspects of temporal constancy and change, whereby participants’ sense of professional self may either stay the same or change over time (Bamberg, 2020; Bamberg et al., 2011).

- ii. *Emotionality* refers to the storyteller’s textual and visual representations of the emotions connected with their storied experiences. Literal and non-literal language produced during SLCs and ZPSs contribute to ascertaining the ‘who’, not the ‘what’, of identity (Thomas & Beauchamp, 2011, p.764). Researchers (e.g., Cameron, 2010; Flores & Day, 2006) have found that people use non-literal language, such as metaphorical expressions, to position themselves within their profession and make meaning of their professional role. Central to the creation of metaphorical expressions is the reference to “experience, culture, and context to shape the implied comparison between the dissimilar entities. [... and] produce rich, creative, and unique images” (Ferrante et al., 2008, p. 105). This is because metaphorical language emerges naturally from conversations about oneself

and one's emotional reactions to lived experiences (Ruiz de Mendoza Ibáñez & Hernández, 2011).

- iii. *Relationality* refers to the storyteller's self-positioning, other-positioning, and reflexive positioning (i.e., positioning others and, in turn, being positioned by others). The literal and non-literal language used by the storyteller to position themselves and others conveys an evaluation of their own and others' speech and social acts, as well as demonstrate the "affective, cognitive, socio-cultural, and behavioural dimensions of the self" (Kupferberg & Green, 2005, p. 28).
- iv. *Consequentiality* is a construct I have devised to relate to the 'so what?' or 'what next?' aspects of identity positioning. This identity space would allow me to answer Research Question 3, which related to how participants' identity positioning and insights upon their workplace interactions within New Zealand healthcare settings may benefit the wider nursing community. In telling their story of a challenging or positive workplace interaction with a colleague, IQN participants—whether directly or indirectly—indicate their beliefs about the moral (i.e., how one ought to act morally as a nurse), social-cognitive (i.e., how one is expected to be and think as a nurse), and/or professional reflexivity (i.e., how one should reflect on one's own and others' professional practice in order to improve nursing outcomes) implications of a workplace interaction. The storyteller is thus linking their co-constructed storied experience with wider discourses (De Fina & Georgakopoulou, 2020; van Langenhove, 2017). This construct heeds Schegloff's (1997) advice for the researcher to show how a storyteller indexes—that is, creates meaning through literal and non-literal language (Silverstein, 2003)—their contextual communication within a professional community. This helps ensure that critical analysis is grounded in data and applicable to real-world contexts.

MULTIMODAL POSITIONING ANALYSIS MODEL FOR A PARTICIPANT'S STORY OF A CHALLENGING / POSITIVE WORKPLACE INTERACTION

MULTIMODAL POSITIONING ANALYSIS MODEL

Four identity spaces ⇒		Positionality ¹	Emotionality ²	Relationality	Consequentiality
Positioning level ↓					
ANALYTIC	<p>Level 1³ (L1) Interactional representation of storyworld characters:</p> <ul style="list-style-type: none"> Who am I, and who are they, as healthcare professionals in this story? Why are we positioned this way? 				
	<p>Level 2⁴ (L2) Interactional representation of the storyteller:</p> <ul style="list-style-type: none"> How do I present myself as a healthcare professional? Why am I conveying the story (elements) this way? How is story meaning being co-constructed? 				

¹ cf. Bamberg's (2020) and Bamberg, De Fina & Schiffrin's (2011) identity dilemmas

² cf. Kayi-Aydar's (2021) emotionality

³ cf. Bamberg's (2003, 2020) Level 1 positioning

⁴ cf. Bamberg's (2003, 2020) Level 2 positioning

I N T E R P R E T I V E	<p>Level 3⁵ (L3) Interactional representation of the storyteller within the nursing community:</p> <ul style="list-style-type: none"> • <i>Who am I in the workplace / nursing context?</i> • <i>What role does a Master Narrative play?</i> • <i>What role does a Counter Narrative play?</i> 				
<p>Research problem and questions (as an aide memoire) In what ways do IQNs use discursive positioning to express aspects of their professional identity when reflecting upon their interactions with colleagues in New Zealand healthcare workplaces? To investigate this research problem, I have devised the following three research questions:</p> <p><i>Research Question 1:</i> How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings? ↳ LEVEL 1 POSITIONING</p> <p><i>Research Question 2:</i> How does IQNs' use of discursive positioning jointly construct aspects of their professional identity? ↳ LEVEL 2 POSITIONING</p> <p><i>Research Question 3:</i> What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community? ↳ LEVEL 3 POSITIONING [AND LINKS TO THEMES IDENTIFIED DURING THEMATIC / TEMPLATE ANALYSIS]</p>					

Analytical model for an IQN participant's Story of a Challenging / Positive Workplace Interaction based (and expanded) on Davies and Harré (1990), Bamberg (1997, 2003, 2020), Kayi-Aydar (2021), and Silverstein (2003)

Figure 6. Multimodal positioning analysis (MPA) model

⁵ cf. Bamberg's (2003, 2020) Level 3 positioning

3.4.6.3.4 Process of Multimodal Positioning Analysis.

The process of applying the MPA model to narrative data was highly procedural. I asked my supervisors to review and provide feedback on how I used my systematic MPA model to code a participant's story of a workplace interaction with a colleague. This validation of the following five-step analytical process gave the MPA model credence and allowed me to find the limits of the model for its further adaptation:

1. The first step in multimodal positioning analysis was to read each transcript and select a 'chunk' of meaningful text related to one identity space within the MPA model; e.g., positionality, emotionality, relationality, or consequentiality.
2. I then ascertained which of the identity space's three elements was relevant for this chunk of text.
3. Next, I determined whether the participant was positioning self and/or others at Level 1, Level 2, or Level 3 of the MPA model as described above.
4. I took a grounded approach to coding narrative data in NVivo (QSR International, 2021) by labelling each chunk of text in the following way: 'A-MP_[P]_[T]_[LP]_[IS]_[Label description in gerund form]' where A-MP = Analysis – Multimodal Positioning, P = Initial of participant's pseudonym, T = Transcript reference (e.g., S1 = Story-Led Conversation 1; Z1 = Zoom Pair Share 1), LP = Level of positioning (e.g., L2 = Level 2), and IS = Identity space (e.g., R-SP = Relationality – Social-cognitive). The label description began with a gerund per grounded theory coding protocol, and in vivo coding in the description was represented by participants' words within inverted commas (Glaser & Strauss, 1999). I recognised that my findings would be written in narrative form, hence the comprehensive summary of the chunk of text selected for analysis.
5. I finally created static sets in NVivo for each participant to save codes evidencing their use of positioning at Level 1, Level 2, and Level 3. Categorising codes in static sets for each participant allowed me to organise my analysis in a streamlined way to help me later write my Findings and Discussion chapters. For instance, I realised I would discuss aspects of IQNs' professional identity revealed at Level 1 (Research Question 1), Level 2 (Research Question 2), and Level 3 (Research Question 3) in Chapter Five (Findings from multimodal positioning analysis), before interpreting my

findings vis-à-vis those within the wider literature in Chapter Six (Discussion).

As I have described above, multimodal positioning analysis answers each of my research questions. The first two research questions distinguish between the storyworld of interactions in healthcare settings and the storytelling context of data collection. That is, participants engage in discursive positioning of self and others when telling and retelling stories of their workplace interactions with colleagues (Research Question 1). In positioning themselves vis-à-vis their listener(s), oftentimes with the active involvement and input from the researcher and/or their co-participants, IQNs jointly construct meaning from their story. Such co-construction of meaning may result in IQN participants' mutual understanding and benefit, including professional support as peer IQNs (Research Question 2). Research Question 3 is specifically answered by aspects of thematic analysis and Level 3 positioning within my MPA model. Considering the 'so what' question and its implications, Research Question 3 is focused on the benefit of understanding and responding to IQNs' storied experiences for the nurses themselves and the wider nursing community. So, in my research conversations with participants, I always asked IQN participants either "What advice do you have for an IQN in this situation?" or "What advice would you have for management to support IQNs in this situation?"

3.4.7 Upholding Data Rigour and Quality

3.4.7.1 Trustworthiness.

Golafshani (2003) and Guba and Lincoln (1994) state that trustworthiness of findings is determined through maintaining the dependability of results (Zhang & Wildemuth, n.d.). As Cho and Trent (2006) suggest, I used the following approaches to maximise trustworthiness in this study:

- i. I purposefully applied thick description and abstraction when coding and analysing my narrative data. Research findings are not statistically generalisable, though, owing to the small-scale, qualitative nature of this study (Zucker, 2009).
- ii. Throughout data collection and data analysis stages, I employed the praxis/social change approach of member checking. Following Cho and

Trent's (2006) advice, I involved my IQN participants in the research process not only to uphold the study's trustworthiness in their eyes but also to co-construct knowledge through checking how they and their stories were presented and understood. I invited participants to engage in member checking to confirm whether the themes and subthemes I constructed from codes grounded in data were appropriate in line with their knowledge and experience (Fraenkel et al., 2012).

- iii. Remaining critically reflective, I sought alternative explanations and explored unexpected findings to gain greater understanding of the rich data that were brought to light in my research (Pine, 2009). I minimised potential researcher bias when interpreting data sourced from research conversations to respond to my research questions by asking my doctoral supervisors to moderate my initial data analysis procedures (Baxter & Jack, 2008).
- iv. I considered trustworthiness to tie into *Te Ara Tika* (i.e., guidelines for Māori research), which encompasses the *tikanga Māori* values of care, precision, robust discussion, appropriacy, and understanding in relation to research ethics (Hudson et al., 2010). As my participants may interact with Māori colleagues, I was keen to obtain advice on issues that may arise concerning *tikanga Māori*. I consequently met with my institution's cultural advisor, *kaumatua* (tribal elder) Mr Anaru Himiona in July 2019 to discuss Māori perspectives on the following aspects of research ethics:
 - *Whakapapa* (relationships): In what ways are relationships being established, developed, and maintained with *iwi* (tribe), *hapu* (subtribe), *whānau* and Māori communities?
 - *Tika* (purposefulness): Can the research achieve its aims? In what ways will it impact on Māori?
 - *Manaakitanga* (cultural and social responsibility): Does the research treat people with cultural sensitivity?
 - *Mana* (justice and equity): To what extent will the benefits and burdens of this research be fairly distributed?

I concur with Yin (2003) that recording all research procedures in this chapter will allow for study replication and thus greater reliability. This study's methodological,

data, and technique triangulation (e.g., through SLC and ZPS transcripts for textual data and Flower Diagrams for visual and textual data) is likely to enhance validity and trustworthiness (Baxter & Jack, 2008). Figure 7 shows the connections within and between the multiple approaches used in this study to enhance trustworthiness and procedural validity.

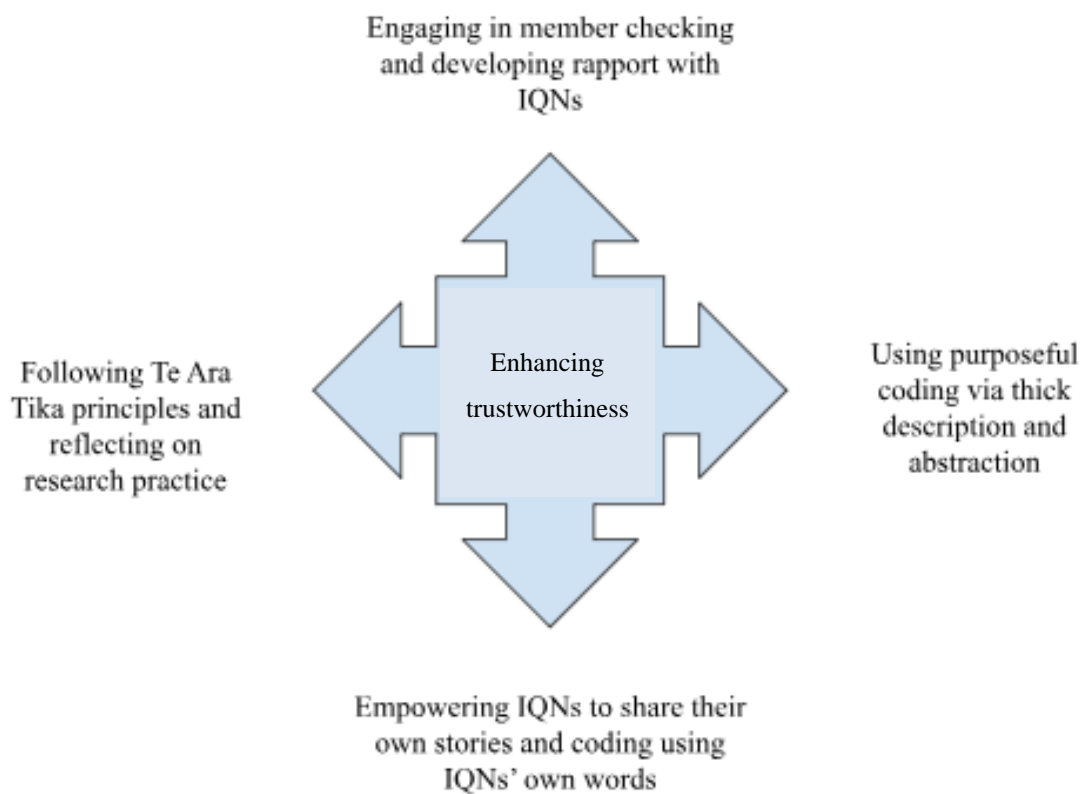


Figure 7. Multiple approaches of enhancing this study's trustworthiness (cf. Cho & Trent, 2006)

3.4.7.2 Integrity and Consistency.

As Miles and Huberman (1994) assert, research propositions for professional and educational settings are linked to relevant theoretical frameworks that correlate with data sources, research methodology and design, and empirical findings. The researcher's notetaking needs to be accurate to ensure memoing is suitably interpretive, descriptive, and reflective during data analysis and interpretation. Compiling a comprehensive database of notes also creates a chain of evidence for categorising, tabulating, and evaluating data, thereby maintaining credibility. I therefore sought to ensure my writing and compiling of notes was accurate so that memoing would be interpretive, descriptive, and reflective during data analysis and interpretation to maintain credibility (Miles & Huberman, 1994). Doing my own

transcription involved intellectual effort as I listened and processed the participants' utterances. I also engaged in constant member checking by emailing interview transcripts to participants within 10 days following each research conversation for their review and feedback on accuracy. In addition, I coded all my own data, including utterances that would ultimately be quotes. Data handling and analysis were supported by using software, such as NVivo, given the complexity of the data (Creswell, 2012; Leech & Onwuegbuzie, 2011).

After constructing themes and subthemes from participants' stories of challenging and positive workplace interactions, I held a voluntary Capstone Conversation (CC) with four IQN participants. (The remaining participants were unable to attend, owing to health issues, family commitments, and work obligations.) Each Capstone Conversation was about 30 – 35 minutes for member checking. During the CC, I shared my findings from thematic analysis for participants' observations, reflections, and recommendations. This form of member checking outlined by Birt et al. (2016) is a way to close the research circle because I was eliciting from participants as a cohort their feedback about how I had interpreted meaning from their stories. I also asked them to answer the 'so what' question related to Research Question 3: *Where to from here? What can we do with this knowledge of IQNs' workplace interactions with colleagues in healthcare settings?* These questions sought to elicit their further insights into new data and input into future research outputs to benefit the wider nursing community.

3.4.7.3 Confirmability and Dependability.

It is essential for qualitative studies to uphold credibility, transferability, dependability, and confirmability—equating to internal and external validity, reliability, and objectivity in quantitative research—to ensure adequate rigour (Anney, 2014; Golafshani, 2003). I thus collected and analysed narrative data (i.e., stories) from naturalistic settings to infer meaning and develop concepts of IQNs' positioning and identity (Barkhuizen, 2015; Onwuegbuzie & Leech, 2007). This may result in generalising participants' utterances to "the population of words/observations (i.e., the 'truth space') representing the underlying context" (Onwuegbuzie, 2003, p. 400).

This narrative study demonstrates ecological validity in line with Andrade (2018) because, although the aim was not quantitative validity, its continuous interpretative process contributed to greater reliability. I followed Barkhuizen's (2015) recommendation to confirm my findings and interpretations with participants prior to analysing and communicating results. I also invited participants to review transcripts and thematic findings to suggest information to be added, modified, or redacted, prior to writing up the research (Fraenkel et al., 2012; Stake, 1995). Furthermore, as Harper and Cole (2012) proposed, I engaged in member checking during data collection (i.e., presenting emerging findings in ZPS research conversations) and after thematic analysis (i.e., conducting Capstone Conversations with participants).

3.5 Ethical Considerations

3.5.1 Upholding Ethical Principles

Prior to collecting data, I sought ethics approval from the Human Ethics Committees of Massey University and the MidCentral District Health Board, by confirming that the study's procedures and methodology met their ethical requirements for low-risk studies (Burns, 2000). This doctoral research study received Massey University Human Ethics Committee approval on 5 September 2019 (see Appendix F). MidCentral District Health Board (MDHB) approved the ethics of the study on 9 September 2020 (see Appendix G).

3.5.1.1 Data Management Protocols.

All research data and consent forms were kept in secure storage at a Massey University campus and/or my residence. My personal computer was accessed via password and kept in my home. As the sole researcher, I alone have access to the consent forms. My supervisors and I will have access to the data during a five-year storage period, after which my supervisor(s) and I will dispose of all data. I saved SLC and ZPS transcriptions on three USB sticks and on Google Drive and Apple's iCloud Drive platforms. I also compiled all transcriptions by each IQN participant (for SLCs) and by IQN pairs (for ZPSs) to help with data analysis on NVivo. I shared in a Google Drive folder with my three supervisors all participant data, along with transcript compilations of the SLC transcripts and the ZPS transcripts. These

safekeeping processes were in line with my MUHEC application and ethics responsibilities.

3.5.1.2 Ethical Risks and Benefits.

The key ethical issues I identified during the planning stages of this project were maintaining participants' confidentiality and upholding their emotional wellbeing. IQNs' disclosure of personal information and insights could put them at risk of breach of confidentiality, particularly in a Zoom Pair Share research conversation. Participants might have felt as though they were being observed or evaluated for institutional reporting purposes (e.g., performance appraisal). There was also a risk that participants might experience personal discomfort during this research. This was because during research conversations and whilst writing self-reflective journals, participants might discuss difficult situations and interactions they experienced at work. Consequently, I was aware that they might become upset when reliving these challenging scenarios.

I duly mitigated these risks in the following ways:

- Participants were made aware via focus group consent forms and information sheets that they must not divulge co-participants' information. My priority was to safeguard participants' anonymity by keeping data (field text) secure, using pseudonyms, and treating all information with respect and discretion.
- I followed Oranje and Feryok's (2013) recommendations to apply pseudonyms to participants, stakeholders, and institutions when coding data and communicating results.
- To minimise the risk of participants' becoming emotionally distressed, I always prioritised mutual sensitivity during my conversations with participants. I particularly focused on ending each research conversation in an affirming way; for example, by acknowledging a story that had inspired me and/or a co-participant.
- Research conversations centred on IQNs' agency. I let participants decide what, and how much, to tell me and edited the transcripts afterwards to ensure identifying information was masked or redacted.

- Per my Nursing Consultant Mary's recommendation, I provided the contact details of EAP Counselling's support services on the participant information sheet.

I felt that participants would potentially benefit from the narrative inquiry processes of storytelling, though. Through sharing their storied experiences of challenging and positive workplace interactions with colleagues, participants' professional realities were explored and co-constructed. Consistent with Wang and Geale (2015), it transpired that, in telling stories of these workplace interactions, IQN participants were able to better understand their feelings and sense of professional self resulting from these workplace interactions.

3.5.1.3 Ethnicity Data Analysis.

This study was not focused on one ethnic or social group. However, those participants who expressed interest in my research and accepted my invitation to participate came from a range of continents or regions. This consequently ensured (to a somewhat limited degree) the diversity of IQN participants' language and cultural backgrounds. Ethnicity data were collected to ensure I covered a range of language and cultural backgrounds. In this study, I interviewed IQNs to find out how their stories of challenging and positive workplace interactions with colleagues revealed aspects of their professional identity. Participants were asked to reflect upon their own experiences interacting with colleagues who may have belonged to another cultural or social group. Central to their stories—and to their professional identity—might have been the challenges they faced when positioning themselves as qualified and experienced registered nurses within New Zealand healthcare settings.

Participants' stories may have been shaped by their experiences and perceptions within different cultural settings. Cultural elements (i.e., cultural issues, practices, and beliefs forming participants' identity) were therefore included in the context of participants' stories but were not the focus of this research.

My research methodology consisted of discussing and interpreting the themes and subthemes constructed from, and the elements of multimodal positioning identified in, rich narrative data generated by IQN participants' research conversations, Flower Diagrams, and Optional Reflections. To uphold participants' privacy and anonymity, I therefore masked information related to IQNs' ethnicity or home country, without

compromising the story's relevance. There was, however, a risk of identifying specific participants if their ethnic or regional backgrounds were mentioned. Although I removed or adapted any identifiable aspects of participants' stories, ownership of privacy issues nevertheless belonged to all participants during the member-checking process (Birt et al., 2016). All transcribed elements that participants used in their stories were checked and verified with participants.

3.5.1.4 Upholding Participants' Confidentiality.

I maintained confidentiality of IQN participants' identities in data treatment and analysis processes by:

- i. using a pseudonym for each participant;
- ii. not disclosing participants' nationality (I referred only to their region; e.g., South-East Asian), language background, and institution;
- iii. using study codes on data documents (e.g., Optional Reflections) instead of recording identifying information; and
- iv. removing face sheets containing identifiers (e.g., names and addresses) from instruments containing data after receiving from study participants.

All identifying information was removed or modified in transcripts through using square brackets. Moreover, upon the advice of MUHEC, I did not reveal the location of the participants in this thesis and transcripts, using 'North Island city' or 'South Island city' and similar descriptors within square brackets.

I also followed Allen and Wiles's (2016) advice to ask my participants to choose their own pseudonym. The only request I had was for them to select a pseudonym starting with the first letter of their real name. This naming protocol linked with Allen and Wiles's (2016) findings that participants benefit from choosing their own pseudonym based on personal and cultural factors. For instance, Lilly chose her pseudonym because her mother's name was Lilly. If participants did not have a preference, I suggested a pseudonym. For example, I suggested 'Carmel' to a participant who liked this name, particularly due to her Catholic background.

3.5.2 Upholding Te Tiriti o Waitangi (Treaty of Waitangi) Principles

Narrative inquiry's ethical research focus and collaborative practice meet the principles of cultural self-determination and equality upheld in Te Tiriti o Waitangi

(Treaty of Waitangi) (Houkamau & Sibley, 2010). During the ethics approval process, MUHEC encouraged me to consult with a cultural advisor to discuss my research study's obligations to Māori communities. I subsequently met *kaumatua* (tribal elder) Anaru Himiona on 25 July 2019 to consider matters relating to *tikanga Māori* in my research.

3.5.2.1 Offering Hospitality and Koha (Gift).

To reduce possible burdens on participants, Anaru advised giving participants a *koha* (gift or donation), a beverage or refreshment, and an opportunity to provide feedback on transcripts. According to Anaru, *koha* is a gesture of friendship and appreciation to a participant (e.g., a petrol voucher for transport to the interview). He recommended providing refreshments for participants, quoting the Māori proverb *He marae kai puehu*, which means 'the only food that the *marae* has to eat is dust'. That is, the *marae* (meeting house) does not provide adequate hospitality for visitors. As a researcher, I aimed to be a good host and offered my participants refreshments in person, or a voucher from a supermarket, café, or department store, as a gesture of appreciation. Anaru's suggestion to give transcripts to IQNs to comment on aligned with Hagens et al.'s (2009) findings that participants' reviews of transcripts further enhance researcher-participant rapport, as well as participants' commitment to the study. This also demonstrates the *koha* of honouring participants' stories by creating space for IQNs to share their experiences and paying full attention to their words and meanings.

3.5.2.2 Storytelling in Tikanga Māori.

Storytelling in my research is important to Māori for the passing on of knowledge (Jones et al., 2006). My study would allow for *kōrero* (discussion) between the participant and the researcher as part of the review process of notes, transcriptions, and findings. This protocol was supported by Moyle (2014), who encouraged researchers to value participants' lived experience: "Participants [become] the teachers who are gifting their stories, without which the research would not be research" (p. 31). According to Anaru, "*Kōrero* safeguards knowledge and allows people to share what, and how much, they know." Anaru also liked my 'Story of a Workplace Interaction' Flower Diagram, telling me that when he speaks on the *marae*, he looks at carvings to help him remember stories: "The image releases the

memory. [...] Imagery in carvings connects many ideas.” Storytelling can be a valuable data collection tool for studies in both Māori and non-Māori contexts, as Moyle (2014) attests.

3.5.3 Researcher Positioning and Reflexivity

The study was guided by relational ethics, which is the cornerstone of narrative inquiry because it focuses on the participants’ and researcher’s ethical action and interdependence (Clandinin et al., 2018). I understood the need to uphold IQN participants’ equitable power roles and self-expressive social identities, as promoted by Te Tiriti o Waitangi (Treaty of Waitangi) in New Zealand cultural contexts (Houkamau & Sibley, 2010). Consistent with Upasen (2017), an ethical approach to a researcher-participant interpersonal relationship was appropriate for my study situated within a healthcare setting. I aimed to empower participants in sharing their storied experiences, following guidance from the literature, in an open and flexible manner. I spent time and effort in building rapport with participants, strengthening our personal connection and professional relationship. In line with Andrade (2018), I frequently sent participants transcripts, emails, and texts so they felt they were contributing to the research, as opposed to just being ‘study subjects.’ Doing this research in pandemic conditions was only possible through building my researcher-participant relationships.

3.6 Strengths and Limitations of the Study Design

3.6.1 Strengths

3.6.1.1 Developing Rapport with Participants.

Lewis (2014) recommends that narrative inquiry researchers develop rapport with participants prior to data collection. Rapport in our researcher-participant relationship comprised mutual trust throughout data collection. I intended the SLCs, ZPSs, Flower Diagrams, and Optional Reflections to be both beneficial and safe forums for participants to convey their storied experiences. Furthermore, such rapport added credibility to my narrative research study, which is people centred not data centred (Broyles et al., 2011; Clandinin, 2013). Both my participants and I agreed that our research conversations did not feel like formal interviews, in which I asked questions and expected to ‘get’ information back from interviewees. An SLC

instead resulted in triggering participants' ideas, memories, and emotions for our co-construction of knowledge. Moreover, the Flower Diagram allowed IQN participants to re-experience the workplace interaction as they remembered, relived, and reflected upon the workplace interaction and the emotions and learnings involved in the communication process (Clandinin, 2006).

3.6.1.2 Videoconferencing Technology to Overcome COVID-19 Pandemic Restrictions.

I would not have been able to conduct this research without video conferencing technology like Zoom. Having access to a Zoom Pro subscription through my workplace was valuable because there was no time or participant limit for our call. This meant that, for ZPSs and SLCs (with out-of-town participants or during COVID-19 pandemic restrictions), we were able to meet at our mutual convenience. Participants advised that they enjoyed our research conversations via Zoom. Jessie (pseudonym) confessed, though, that she—along with her nurse educator colleagues—were suffering from 'Zoom fatigue'. That is, they found it difficult working online all the time because of the health issues related to extensive screen time. According to Elbogen et al. (2022), Zoom fatigue during COVID-19 lockdowns and pandemic restrictions was an occupational health and safety issue that needed to be managed in healthcare workplaces to ensure remote work did not have a longstanding negative impact on workers' mental health.

3.6.2 Limitations

3.6.2.1 Recruiting IQN participants.

Similar to what Namageyo-Funa et al. (2014) found, my printed recruitment tools (i.e., recruitment card and flyer) were not only costly but ineffective in attracting the attention of IQNs working in healthcare and aged care facilities. I overcame these challenges by developing connections with professional organisational and community groups which could provide access to potential IQN participants. Community-based networking helped me build professional relationships with contact people from specific sociocultural groups (Patel et al., 2003). The contact person (e.g., the Chairperson of a local multicultural community centre) then promoted the study within their community via email, phone call, or social media (e.g., NZNO's Facebook post to members). This boosted the study's credibility—and

popularity—with prospective participants from diverse language, ethnic, and cultural backgrounds (Eide, 2008).

Whilst all eight of my IQN participants were female, this is largely representative of the field. Mao et al. (2021) notes that women make up the majority of nursing professionals worldwide, despite the increasing number of male nurses over the past fifty years. Two male IQNs did express an interest in finding out more about participating in my study. However, they were unable to commit to this longitudinal research project, owing to study commitments and work pressures. (One IQN was doing his master's degree, and the other had changed jobs to a busy hospital setting.) The narrative data sourced from my IQN participants thus comprise solely female-centric experiences and perspectives. I recognise that the female-skewed gender imbalance, which Polit and Beck (2021) also found in nursing research studies, may suggest limitations in terms of the study's findings.

3.6.2.2 Withdrawal of a Participant.

Owing to the withdrawal of one participant (Carmel) in July 2021, I invited Mons and Rose to participate in Lilly's second Zoom Pair Share. Mons agreed as she was in aged care like Lilly and was free to participate in a Zoom call during work hours. In line with Hadidi et al. (2013), I experienced great stress when my hitherto engaged and enthusiastic participant withdrew from my study. With guidance from my supervisors and support from my other participants, though, I was able to carefully consider—and respond to—the ethical repercussions of Carmel's withdrawal. I had obtained plenty of textual and visual data from Carmel's three research conversations and her one Zoom Pair Share with her co-participant Lilly. However, I needed to ensure that Lilly, Carmel's co-participant in the second Zoom Pair Share, had the opportunity to share with another IQN their stories of positive workplace interaction with colleagues in aged care facilities.

3.7 Chapter Summary

Taking a social constructionist perspective, this study employed narrative inquiry to empower IQNs to voice their storied experiences of workplace interactions with colleagues. In this chapter, I have discussed my research paradigm and research

methodology used to collect, analyse, and interpret qualitative data sourced from eight IQN participants via semi-structured interviews ('Story-Led Conversations') and peer-to-peer facilitated conversations via Zoom ('Zoom Pair Shares'). I explained how I intended to use bottom-up thematic analysis to identify themes related to IQNs' workplace interactions with colleagues. I also outlined the top-down analytical framework multimodal positioning analysis (MPA), which is based on positioning theory. The MPA model was designed to analyse participants' discursive positioning of self and others when telling their stories of workplace interactions.

In addition, I discussed how ethical considerations were managed in this study and acknowledged the strengths and limitations of my research methodology. I reflected upon how my own contribution and positioning as a person-focused researcher influenced the study's data collection and analysis processes. Chapter Four will present the findings from thematic analysis, specifically themes and subthemes related to IQNs' challenging and positive workplace interactions with other healthcare professionals. Chapter Five will then demonstrate how I applied my multimodal positioning analysis model to this study's narrative data.

Chapter 4: Findings from Thematic Analysis

4.1 Introduction

The purpose of this narrative case study was to gain a deeper understanding of the identity positioning of eight IQN participants. Aspects of IQNs' discursive positioning were revealed through their stories of conversations with colleagues in New Zealand healthcare settings. Empowering IQN participants to voice their storied experiences of challenging and positive workplace interactions gives valuable insights into migrant nurses' sense of professional self. Following are the three research questions guiding this study:

Research Question 1

How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings?

Research Question 2

How does IQNs' use of discursive positioning in their stories jointly construct aspects of their professional identity?

Research Question 3

What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?

Narrative data from participants were collected via semi-structured interviews ('Story-Led Conversations') and peer-to-peer facilitated conversations via Zoom ('Zoom Pair Shares'). This chapter outlines my participants' nursing backgrounds and involvement in this study, before presenting the thematic findings. Six themes, each comprising six subthemes, related to IQNs' workplace interactions with colleagues were constructed from the study's narrative data.

4.1.1 Participants' Nursing Background and Study Participation

4.1.1.1 Lilly.

Lilly was a registered nurse and Clinical Lead for an aged care facility in a city on the North Island of New Zealand. She and I held four research conversations

together, along with two Zoom Pair Shares with Carmel and Mons respectively, between September 2020 and August 2021.

4.1.1.2 Mons.

Mons was a registered nurse and a Facility Manager at an aged care facility in a town on the North Island of New Zealand. She and I held four research conversations together, along with two Zoom Pair Shares with Rose, between October 2020 and December 2021.

4.1.1.3 Carmel.

Carmel was a registered nurse and a Virus Control Lead at an aged care facility in a town on the North Island of New Zealand. She and I held four research conversations together, along with one Zoom Pair Share with Lilly, between October 2020 and April 2021.

4.1.1.4 Rose.

Rose was a registered nurse and nurse manager for a private healthcare provider in a city on the North Island of New Zealand. She and I held four research conversations together, along with two Zoom Pair Shares with Mons, between January 2021 and December 2021.

4.1.1.5 Jessie.

Jessie was a registered nurse and a nurse educator for a diagnostic assessment software company in a city on the North Island of New Zealand. She and I held four research conversations together, along with two Zoom Pair Shares with Nightingale, between February 2021 and December 2021.

4.1.1.6 Nightingale.

Nightingale was a registered nurse for a public healthcare provider in a city on the North Island of New Zealand. She and I held four research conversations together, along with two Zoom Pair Shares with Jessie, between March 2021 and February 2022.

4.1.1.7 Ricky.

Ricky was a registered mental health nurse for a public healthcare provider in a city on the South Island of New Zealand. She and I held four research conversations together, along with two Zoom Pair Shares with Lola, between April 2021 and January 2022.

4.1.1.8 Lola.

Lola was a registered nurse in the dementia care sector in a city on the South Island of New Zealand. She and I held four research conversations together, along with two Zoom Pair Shares with Lola, between April 2021 and January 2022.

4.1.2 IQN Participants' Data Collection Points

Table 4 shows the data collection points for each of the study's participating IQNs. Seven IQNs participated in four Story-Led Conversations (SLCs) with me and two Zoom Pair Shares (ZPSs) with me and an IQN co-participant. One IQN (Carmel) participated in three SLCs with me and one ZPS with me and an IQN co-participant. Carmel needed to withdraw from the study in August 2021.

Table 4

PhD Project Data Collection Schedule

PhD PROJECT DATA COLLECTION SCHEDULE							
Timeframe: September 2020 - February 2022							
Participant [±]	STORY-LED CONVERSATIONS (SLCs)				ZOOM PAIR SHARES (ZPSs)		
	SLC1	SLC2	SLC3	SLC4	Pair Share 1	Pair Share 2	
1 Lilly	September 2020	January 2021	May 2021	August 2021	June 2021	September 2021	
2 Mons	October 2020	February 2021	April 2021	September 2021	June 2021	December 2021	
3 Carmel	October 2020	December 2020	April 2021	--	June 2021	--	
4 Rose	January 2021	May 2021	August 2021	November 2021	June 2021	December 2021	
5 Jessie [^]	February 2021	May 2021	August 2021	November 2021	June 2021	December 2021	
6 Nightingale	March 2021	July 2021	October 2021	February 2022	June 2021	December 2021	
7 Ricky [^]	April 2021	July 2021	October 2021	January 2022	August 2021	January 2022	
8 Lola [^]	April 2021	July 2021	October 2021	December 2021	August 2021	January 2022	

* Pseudonym ^ Via Zoom

4.1.3 Overview of Themes and Subthemes

My purpose for constructing themes and subthemes from my study's narrative data was to help me understand how IQNs' experience with transitioning into their career in New Zealand might affect how they felt about staying long-term. This could then allow me to draw conclusions in support of IQNs and their prospects for choosing to develop a sustainable nursing career in New Zealand. Findings from thematic analysis would specifically help me answer Research Question 3, namely *What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?*

I used thematic analysis to determine the types of challenging and positive workplace interactions that IQN participants experienced with colleagues. NVivo software allowed me to construct codes grounded in the data. Six themes, each comprising six subthemes, were generated from the thematic analysis of the participants' interview transcripts, as shown in Table 5. The wording of the subtheme was based on the open coding used in my grounded approach to analysing the data.

The labelling of the subthemes in Table 5 changed as each subtheme was constructed and strengthened. Following data collection, I sought to receive feedback from my IQN participants during member checking via voluntary Capstone Conversations (see Section 4.8). The four participants (Jessie, Ricky, Lola, and Nightingale) with whom I held Capstone Conversations agreed with the wording of the subthemes, which encompassed their own workplace interactions or observations as IQNs. Four participants (Lilly, Mons, Carmel, and Rose) were unable to attend Capstone Conversations because of personal and professional matters.

Table 5

Themes and Subthemes

Themes	Subthemes
1. Workplace Culture	<ul style="list-style-type: none">i. Understanding and using humour in the workplaceii. Experiencing or not experiencing equitable treatment amongst colleaguesiii. Valuing professional relationships and rapport with colleaguesiv. Recognising the need to act with integrity in healthcare workplacesv. Recognising the need to be professional and proactive in healthcare workplacesvi. Working professionally within New Zealand workplace culture and power dynamics
2. Workplace Communication	<ul style="list-style-type: none">i. Giving or receiving feedback or counselii. Understanding or not understanding the Kiwi accents or idiomsiii. Experiencing understanding or misunderstanding with colleaguesiv. Recognising the need for open, authentic communication to enhance understanding

	<ul style="list-style-type: none"> v. Recognising the need for clear, person-centred communication to enhance understanding vi. Listening actively, or being listened to, for the benefit of staff or patients
3. Workplace Interactions	<ul style="list-style-type: none"> i. Being inducted or inducting others into the workplace ii. Being acknowledged for professionalism in the healthcare workplace iii. Acknowledging own or others' professionalism in the healthcare workplace iv. Showing or being shown collegiality and compassion v. Giving or being given professional support vi. Navigating misunderstandings and resolving differences to enhance teamwork.
4. IQNs' Concerns and Advice for Employers and Educators	<ul style="list-style-type: none"> i. Being concerned about bullying in New Zealand healthcare workplaces ii. Being concerned about racism in New Zealand healthcare workplaces iii. Being concerned about exploitation or favouritism in New Zealand healthcare workplaces iv. Offering advice to management v. Offering advice to nursing educators and CAP providers

	<ul style="list-style-type: none"> vi. Reflecting upon health and safety issues in New Zealand workplaces
5. IQNs' Professional Experience	<ul style="list-style-type: none"> i. Valuing or creating a connected professional community ii. Being a professional, ethical manager iii. Being a professional, ethical mentor iv. Recognising the need for IQNs' skills and experience to be valued v. Promoting own or others' professional learning or career advancement vi. Learning from collegial advice or professional self-reflection
6. IQNs' Agency	<ul style="list-style-type: none"> i. Perceiving workplace interactions as learning opportunities, however difficult ii. Being resilient in challenging workplace interactions iii. Coping with professional demands iv. Being treated unfairly or unethically by managers or peers v. Feeling self-confident or motivated in healthcare workplaces vi. Speaking up for self and colleagues

4.2 Theme One: Workplace Culture

The first theme, *Workplace Culture*, illustrates how the participants experienced cultural dynamics as registered nurses (RNs) in New Zealand healthcare settings, which included aged care, primary care, and private practice. This theme provides evidence of how IQNs understand and use humour in the workplace; experience or do not experience equitable treatment amongst colleagues; value professional

relationships and rapport with colleagues; recognise the need to act with integrity in healthcare workplaces; recognise the need to be professional and proactive in healthcare workplaces; and work professionally within New Zealand workplace culture and power dynamics.

4.2.1 Subtheme 1: Understanding and Using Humour in the Workplace

The subtheme ‘Understanding and using humour in the workplace’ reflects the ways in which IQNs shared humour with their colleagues to build relationships and develop rapport, leading to enhanced teamwork and reduced work stress. Participants reported telling funny or sardonic stories to overcome workplace misunderstandings. Mons, for instance, did this through sharing comical anecdotes, which could sometimes be “too fresh,” whilst acknowledging others’ perspectives about serious matters. When the New Zealand government introduced the COVID-19 immunisation programme in 2021, Mons attempted to counteract a staff member’s disagreement with the Pfizer vaccine. She joked that the microchip inserted into her arm was not working. “I did take off my name badge and put it against my arm, and it dropped off. [I said to the staff member,] ‘Obviously, I got the side-line dose because it didn't magnetise.’ But she didn’t find that amusing. I thought it was funny!”

IQNs also shared jokes and banter with Kiwi colleagues about accents and idioms, resulting in mutual rapport building. They were occasionally teased for being a foreigner with a different accent by colleagues with whom participants had a friendly professional relationship. For example, Ricky’s colleagues conducted a handover by mimicking her accent. (Ricky had a distinct regional accent in English, her first language.) They spent the night practising Ricky’s accent to give the handover in a humorous way. This was risky behaviour by Ricky’s colleagues, but they knew she would not take offence. In fact, Ricky felt so much part of the team because her colleagues realised they could “take the mickey out of [her].” The extent of her colleagues’ skit preparation and their mutual positive relationship and rapport gave Ricky “warm fuzzies.”

4.2.2 Subtheme 2: Experiencing, or Not Experiencing, Equitable Treatment Amongst Colleagues

Participants spoke of wanting to work in a comfortable, equitable healthcare environment. They valued having a supervisor or shift lead who managed IQNs' workload, balanced acuity amongst nurses, and took responsibility for being the "all-seeing eye on the ward" (Ricky). Nevertheless, they recognised the importance of task delegation to avoid discrimination and enhance teamwork. Nightingale explained that, in her healthcare workplace, having medical students help registered nurses as peer workers at the same level was beneficial in ensuring high levels of testing during the COVID-19 Omicron outbreak.

IQNs said they had experienced receiving both respect and disrespect from colleagues and managers at work. Ricky expressed her anger at feeling disrespected by her manager's treatment of her, although she had to remain calm and professional. This was because she did not want to project her annoyance on the floor onto patients. Rose also felt frustrated when a colleague initially requested her help, as nurse manager, at a COVID-19 immunisation event but then asked another nurse to assist instead. Nevertheless, she had been included by the practice manager in wider management planning meetings across her organisation's three sites, indicating the manager's high regard of her clinical knowledge: "She has introduced me to various [site] managers. Now I am planning things with them—how the three [sites] should look like—[so] that we are all on the same page."

According to participants, it was common for IQNs to experience organisational politics and challenging workplace policies that increased staff tensions and pressures. During the COVID-19 vaccine roll-out, Nightingale reported feeling confused by her employer's "mixed message, you know, what we actually need to do or not—specific policy, or the rules, is changing within a day." Participants noted that a collegial atmosphere supported equitable learning amongst team members to relieve such work pressures. According to Rose, collegiality was important because "everyone brings different kind of education, different kind of experience, from where they worked."

4.2.3 Subtheme 3: Valuing Professional Relationships and Rapport With Colleagues

Building rapport with managers and colleagues to enhance the work environment was important to participants. Lilly recognised that good teamwork and happy colleagues made for a good working environment. Indeed, IQNs valued having an intact, understanding relationship with colleagues, thereby “feeling we are all in this together all the time” (Jessie). They appreciated managers and fellow nurses taking time to develop camaraderie and collegiality, by “pulling together and supporting each other to perform better as a team” (Rose). This “positive energy” helped nursing staff cope with COVID-19 Delta pandemic restrictions in 2021. IQNs appreciated working with supportive team members and managers, whose collegiality allowed them to overcome work stressors. IQNs also enjoyed interacting with friendly colleagues from different cultures. Team members possessed mutually different but compatible personal attributes that enhanced collegial relationships.

Along with New Zealand-trained nurses, IQNs faced both personal and professional stressors during COVID-19 pandemic restrictions. These stressors, such as high workload and anxiety, impacted nurses’ morale, according to participants. When restrictions eased, participants cherished attending in-person meetings, training courses, and social events with colleagues to develop mutual understanding, boost team relationships, and “make heart connections as nurses” (Jessie). Nightingale enjoyed doing the morning trivia quiz with her peers, leading to their working as a team and reducing work stress. Lola, too, was pleased that her rapport-building with a shy teammate resulted in the staff member asking Lola about COVID-19 risks at the start of the pandemic. Lola explained that “the nurse bit kicked in” to provide clear, accurate information to her colleague, despite her own anxiety about COVID-19.

Open lines of communication with managers and colleagues were therefore essential for IQNs. Participants spoke of the need to be honest with managers and colleagues to ensure there was no unrest between nurses. They benefited from engaging in conversations with colleagues about managing work stresses and sharing professional knowledge, which led to high-trust work relationships. Rose spoke of resolving a mutual misunderstanding with an upset colleague and thereafter

developing a strong professional and personal friendship, which “was the winning point.”

4.2.4 Subtheme 4: Recognising the Need to Act With Integrity in Healthcare Workplaces

IQN participants were concerned about themselves and their peers acting with integrity in the healthcare workplace. Carmel recounted having her concerns about a nurse colleague's medication error not listened to by the Nurse Manager. She had told the Nurse Manager that her colleague was not trustworthy in administering medication, thereby compromising patient safety. Furthermore, she discovered that the Nurse Manager had removed Carmel's documentation of the medication error without advice or explanation. Carmel was told to cover up the RN's error, which was in violation of the facility's medication administration policy. Carmel felt that, as she had followed the established protocol of documenting a medication error, management should “do their part to manage the situation.” She recognised that being thorough and accurate with her nursing documentation was essential, despite the perceived favouritism that a manager was showing her colleague.

Certainly, many IQNs spoke of feeling angry or frustrated by colleagues' unprofessional behaviour. Participants expressed their desire to remain polite and objective during challenging workplace interactions. In dealing with rude or difficult colleagues, IQNs reported being “kind and smiley” (Mons), “not taking sides” (Nightingale), showing professionalism, and being open to collegial dialogue. Participants in managerial roles were keen to respond to staff members' needs promptly and resolving nurses' problems quickly because “staff are [their] work family” (Mons).

4.2.5 Subtheme 5: Recognising the Need to be Professional and Proactive in Healthcare Workplaces

The proactive sharing of knowledge with colleagues was important to IQN participants. For instance, Nightingale managed her feelings of confusion during the pandemic by finding out from a colleague about the New Zealand government's Āwhina app, through which she could learn the COVID-19 alert levels and

community case numbers. She was pleased that her colleagues were working together to discover communication and technology solutions for the benefit of the team.

Nightingale and Carmel both spoke of appreciating their colleagues taking the initiative in supporting staff and patients. They observed fellow nurses using their professional expertise and resources to develop the clinical skills and cultural awareness of IQNs who were new to New Zealand. However, when Lola proposed to a senior manager that she offer in-patient clinics over Christmas, the manager dismissed her offer outright. This resulted in Lola feeling like her offer, given “out of the goodness of her heart, came back to bite [Lola] on the bum.”

4.2.6 Subtheme 6: Working Professionally Within New Zealand Workplace Culture and Power Dynamics

IQN participants responded positively to the flatter hierarchy and informal power dynamics in New Zealand. IQNs found few differences between nursing in their home country and in New Zealand. However, they recognised that different personalities and cultures, not racism, can cause miscommunication in New Zealand healthcare settings. Participants often spoke about working calmly and professionally with a difficult colleague, with Lola observing that “nursing can be a complaining culture.”

The IQNs in this study experienced both successes and challenges navigating workplace expectations and cultural practices, particularly during COVID-19 pandemic restrictions. Jessie and Nightingale both agreed that Asian IQNs were more compliant with workplace regulations due to their cultural background. There was the potential, though, for IQNs to misunderstand COVID-19 rules for the workplace when management appeared to be changing policies and procedures (Nightingale). Mons acknowledged that “being a people-pleaser” could lead to an IQN wanting to avoid confrontational conversations with colleagues. Whilst Carmel thought her nursing colleagues communicated well to resolve misunderstandings, Rose “was not too worried about” small communication challenges with team members.

Participants appreciated being trusted by management to be professional and accept assigned tasks due to their high work ethic. Rose, though, observed workplace politics when a competent male nurse was overlooked by hiring managers in favour of “a troublemaker nurse” who had been promised a job. Participants noted that power relationships, such as between a junior doctor and a senior nurse, were more equal compared to those in their home country. For instance, IQNs reported providing learning opportunities to registrars, owing to their clinical knowledge. As a senior nurse, Lola offered her medical opinion if she was asked by senior colleagues. She did, though, refrain from contradicting consultants or registrars in front of patients, only discussing her concerns with doctors after the patients’ departure.

4.3 Theme Two: Workplace Communication

The second theme, *Workplace Communication*, demonstrates the ways in which IQN participants communicated with their colleagues in challenging and positive interactions in healthcare settings. These interactions include giving or receiving feedback or counsel; understanding or not understanding the Kiwi accents or idioms; experiencing understanding or misunderstanding with colleagues; recognising the need for open, authentic communication to enhance understanding; recognising the need for clear, person-centred communication to enhance understanding; and listening actively, or being listened to, for the benefit of staff or patients.

4.3.1 Subtheme 1: Giving or Receiving Feedback or Counsel

It was important for IQN participants to choose their words carefully to provide constructive support and advice to colleagues. This was because IQNs found it difficult knowing how to approach fellow healthcare workers and managers when they had concerns about their professional practice. Ricky, for instance, felt awkward when a shift lead did not appreciate her complaint about unfair caseloads between IQNs and New Zealand nurses: “It has to be shared equally. The nurse took it badly—like I was attacking her.” Furthermore, participants acknowledged that it was difficult to convince colleagues and managers to act upon collegial advice and learn from their mistakes. Carmel bravely told her Nurse Manager that a fellow nurse was not trustworthy in administering medication, which was compromising patient safety.

However, her advice to manage this nurse's administration protocols was not followed by management.

IQNs in supervisory positions also needed to counsel a team member who made a mistake in their professional practice. Rose recalled counselling a colleague for a lack of ethics in not communicating their upset to an IQN in private. Likewise, Lilly dealt with the difficulty of giving correction to a caregiver for making an error when administering medication to a resident by offering him privacy. She experienced his negative reaction, including closed body language showing his anger and unhappiness to being counselled. Lilly also reprimanded a staff member who was blaming others for her mistake dispensing medication. Nevertheless, upon giving correction to both team members, Lilly felt she had resolved the challenging conversations, so she "left the matter alone" with no further issues.

IQN participants received critique and constructive feedback from their colleagues and managers as well. As a Practice Manager, Rose invited new RNs being inducted at her medical centre to give feedback on what could be changed to improve work practices at the centre. Jessie saw the encouraging support and feedback from her manager as a professional learning opportunity. This motivated her to keep developing her skills as a nurse educator: "I want to learn how she can deliver a message that is very soft." Conversely, several participants were counselled by their manager for improperly following workplace protocols. Nightingale reported being wrongly chastised by a colleague for "doing the wrong thing." Jessie was reproached by her manager about not following work processes when scheduling a personal appointment during work hours.

4.3.2 Subtheme 2: Understanding or Not Understanding the Kiwi Accents or Idioms

For IQN participants, understanding Kiwi (i.e., from New Zealand) English accents and idioms proved problematic. IQNs explained that they did not understand many words and phrases in the New Zealand English accent. They often needed to ask for clarification, especially during a telephone conversation. Carmel felt she had grown professionally, having learnt about New Zealand English colloquialisms and slang.

Lola and Ricky did, though, enjoy humorous banter with Kiwi colleagues about their accent and idioms, resulting in mutual rapport building. Ricky recounted her embarrassment when she used a common idiom from her home country (i.e., ‘rooting around’—a New Zealand vulgarism referring to promiscuous behaviour) when talking about her weekend leisure activities. Wondering why her colleagues no longer invited her to social events, Ricky was “mortified” to learn from a senior IQN colleague that she had gained a bad reputation with colleagues. This was simply because she had used an idiom with negative connotations in New Zealand: “It wasn’t really the best [experience] in a new workplace, in a new country.” It was a relief to have her professional reputation restored once her colleague explained the idiom used in Ricky’s home country to New Zealand nurses at a staff meeting. As a result, Ricky and her colleagues could share a joke about the perceived vulgarism and its misunderstood meaning.

4.3.3 Subtheme 3: Experiencing Understanding or Misunderstanding With Colleagues

IQN participants experienced both understanding and misunderstanding with colleagues and managers, such as language barriers and cultural differences in the workplace. Jessie was upset about her misunderstanding with a respected manager over scheduling a personal appointment. Still, participants sought to understand their colleagues when engaging in challenging conversations. Rose and Lilly both felt motivated and happy when their respective colleagues demonstrated understanding after being counselled or receiving constructive criticism. According to Lilly, “conflict with someone—you don't feel good. But after the conversation, I was also happy. She was also happy.”

4.3.4 Subtheme 4: Recognising the Need for Open, Authentic Communication to Enhance Understanding

IQN participants used open communication to bridge gaps of understanding with colleagues and managers to have effective, solution-focused conversations and manage their work responsibilities. They observed that personality differences influence how colleagues communicate with each other in either a supportive or aggressive way. For example, Jessie noticed her manager used open body language

and appeared interested in learning about another clinical perspective: “She was open. It’s not like crossed [arms]. [...She] was thinking, but she doesn’t appear that she was cross.” As a nurse educator, Jessie liked her trainees’ being open about their learning struggles so she could meet their learning needs productively. Lola, too, appreciated her senior nurse colleague encouraging open communication amongst senior managers, middle managers, and nursing staff.

In addition, IQN participants recognised the value of being an authentic communicator in healthcare workplaces. Mons, Lilly, and Carmel found, though, that conveying difficult managerial decisions or workplace protocols to staff was challenging. According to Mons, “Working for a company, it’s not just my decision. So, you have that blanket of protection, you know. So, it’s not just me working independently, making decisions on my own, which is really good. I’m supported. So, I was more the messenger.” Lilly and Carmel spoke of their difficulties confronting an RN colleague and Nurse Manager respectively when the organisation’s medication administration policy was not followed. In both cases a medication error was made, potentially risking residents’ safety. Jessie felt punished for being honest with her manager about scheduling personal tasks alongside her job responsibilities during the workday and being criticised for her honesty.

4.3.5 Subtheme 5: Recognising the Need for Clear, Person-Centred Communication to Enhance Understanding

Engaging in clear communication with colleagues in the workplace was important to IQN participants. This was especially crucial during the rollout of the COVID-19 vaccine in 2021. Since communication of the immunisation programme was “not well organised by the central Ministry of Health,” Nightingale said she received unclear policy directives from management. This left her struggling to understand what was expected of staff and, as a casual staff member, feeling stressed by hearing different news and rules for the COVID-19 vaccine rollout. For example, Nightingale reported instances of miscommunication when Standard Operating Procedures for infection control were changed, but the new rule was not passed on. This created issues in understanding for healthcare workers. She felt that senior management were

not communicating regulations between themselves, causing staff to be unsure whether to follow management instructions or Ministry of Health directives.

According to participants, person-centred communication helped IQNs have problem-solving conversations with colleagues. They acknowledged the importance of being diplomatic when giving difficult messages to senior and junior nurse colleagues. Thinking carefully about how to create and communicate a message to colleagues was crucial. Examples of person-centred conversations included negotiating the sharing of tasks and scheduling breaks with team members (Nightingale); talking calmly to a shift lead when recommending that caseloads be more equal to help IQNs cope with high acuity and caseloads (Ricky); discussing pros and cons of COVID-19 vaccination with colleagues to educate and convince family, friends, and patients to be immunised (Mons); and using calming body language to reduce colleagues' anxiety when presenting uncertain or difficult messages to colleagues (Lola).

4.3.6 Subtheme 6: Listening Actively, or Being Listened to, for the Benefit of Staff or Patients

IQN participants appreciated the active listening used by themselves and their colleagues to enhance the welfare of staff and patients. They focused on listening actively so that workplace protocols were followed and organisational goals met. Jessie explained that she needed to bring nurses' attention to remaining alert during their training sessions held via teleconferencing, despite their mutual 'Zoom fatigue'. She also stayed silent when frustrated trainees were ranting. This was so "they realised they were over-talking", softened their voices, and calmed down.

Rose valued having her advice about patient communication listened to and acted upon by a junior nurse, whilst Jessie appreciated having a manager who "picked up on staff problems." Both Lilly and Carmel acknowledged that team members and managers will sometimes listen to, but may equally not listen to, IQNs' instructions or advice. After emailing management about medication errors made by a fellow nurse, Carmel was pleased that her criticisms were "communicated higher [to senior management]." Carmel's concerns and recommendations for medication

administration safety became a professional learning opportunity at a nurses' staff meeting. IQNs did express feelings of awkwardness and upset, though, when a manager rejected a proactive offer of providing patient clinics over Christmas (Lola); took a complaint about unfair caseloads between IQNs and New Zealand nurses badly (Ricky); and dismissed a participant's concerns about not having the skills and knowledge to care for a complex social work patient, saying that she could do the job (Lola).

4.4 Theme Three: Workplace Interactions

The third theme, *Workplace Interactions*, expands the previous themes' focus on elements of culture and language relevant to IQNs' conversations with colleagues. It further identifies the nature and contexts of these workplace interactions. Subthemes include being inducted or inducting others into the workplace; being acknowledged for professionalism in the healthcare workplace; acknowledging own or others' professionalism in the healthcare workplace; showing or being shown collegiality and compassion; giving or being given professional support; and navigating misunderstandings and resolving differences to enhance teamwork.

4.4.1 Subtheme 1: Being Inducted or Inducting Others Into the Workplace

For IQNs, inducting others into the workplace involved making new nurses feel comfortable in the team and giving them freedom of choice in learning and practising work tasks. Participants overcame colleagues' resistance to inducting IQNs in their new role, owing to time and other resourcing costs, by seeking induction support informally from a range of healthcare colleagues. Rose, for example, was responsible for inducting new RNs into the medical practice. Her aim was helping new nurses to get to "know the place and how things are" and to build graduate nurses' confidence in assisting doctors with minor surgeries. Although participants found it challenging to adjust to team members who did not know the nursing routine (Rose) or who spoke negatively about colleagues (Nightingale), they still valued building collegial relationships with new staff for the benefit of the team.

4.4.2 Subtheme 2: Being Acknowledged for Professionalism in the Healthcare Workplace

IQN participants reported being acknowledged for their professional skills, attitude, and knowledge by their colleagues and their managers in their healthcare workplaces. Lola, for instance, was complimented by a doctor for helping a patient understand and accept the benefits of respite care. This led to the doctor saying she would use Lola's phrases in her own challenging conversations with patients. Ricky's IQN colleague expressed her gratitude for having her caseload reduced as a result of Ricky's supportive complaint about unfair caseload distribution. Rose, too, was shown appreciation from management and fellow nurses for working hard for the medical centre. She was recognised for: organising supplies; diligently giving and documenting flu vaccinations; showing new graduate RNs how to take bloods; and proactively arranging for nurses to attend nursing conferences regularly for professional learning and networking opportunities.

Being acknowledged by managers boosted IQNs' self-confidence in being a nurse in New Zealand. Mons told of receiving appreciation from the CEO for her "hands-on, on-the-ground work." Lola said she was initially embarrassed at being congratulated by a senior manager for her hard work and "a job well done," upon receiving a certificate of accreditation for a care project. Nevertheless, she was "very chuffed to be appreciated" by leadership for "being a doer and squirrelling away at stuff." Mons, too, was nominated for a staff award and valued being appreciated by the organisation for her dedication to staff and residents. Both Jessie and Carmel were commended by their respective managers for being conscientious in giving person-centred feedback to colleagues and keeping detailed nursing notes to uphold quality in nursing education and patient care. Receiving positive compliments about her professionalism from two managers helped Ricky feel she was supported by management and recognised as capable of dealing with difficult patients.

Participants said they felt highly valued when being recognised by management for their professionalism and person-centredness. Ricky did acknowledge that it is difficult for IQNs to accept compliments from colleagues because "in New Zealand [one] doesn't big other people up." Being praised by a senior manager for her hard work in receiving accreditation pleased Lola, but she self-consciously redirected the

manager's compliments to her working group instead of herself. Nonetheless, receiving a compliment from a colleague "hits the heart in a good way," so Lola reflected that she needed to accept praise for teamwork graciously because it indicated "shared collegiality." Carmel, too, felt inspired and motivated to do her nursing and infection control job by being shown appreciation by management for her work and dedication.

4.4.3 Subtheme 3: Acknowledging Own or Others' Professionalism in the Workplace

IQN participants reported the giving and receiving of acknowledgement for their own and their colleagues' professionalism in both formal and informal ways. Nightingale appreciated her co-ordinator's good efforts in improving communication during COVID-19 vaccine policy changes by starting a weekly staff newsletter, whilst Lilly valued the dedication of a caregiver who came into work on her off day. Rose and Nightingale recognised younger nurses' and medical students' positive attitude and their good understanding of digital technology used in healthcare, which they were willing to share with colleagues. Rose also felt proud of herself for giving advice and clinical assistance to senior RNs, who were thankful for their "irreplaceable" IQN colleague. As a manager, Mons enjoyed giving out certificates to staff nominated for awards as she believed in thanking staff for being an integrated part of the team: "Recognising that being nominated for a staff award and having the nomination story printed on a certificate is really special to the nominee."

4.4.4 Subtheme 4: Showing or Being Shown Collegiality and Compassion

IQN participants recounted their experiences offering and receiving collegial support to enhance their professional practice and boost their colleagues' morale. Indeed, having mutually supportive collegial relationships and kind, trusting managers was important to participants. Rose and Nightingale spoke of the reciprocal benefits from teammates sharing each other's burden of appointments, which "always creates a positive atmosphere at work" (Rose). Likewise, an understanding colleague told Lola that her "patients were lucky to have her" to give Lola a positive boost when making potentially difficult conversations with distressed patients during COVID-19 pandemic restrictions.

In addition, participants expressed their feelings of loyalty towards their employer for supportive management and teamwork during COVID-19 pandemic restrictions. Jessie appreciated the personal texts of personal and workload support she received from colleagues during the “stressful period” of the New Zealand COVID-19 Delta lockdown of late 2021. She felt that managers cared about staff by checking on nurse educators’ wellbeing and offering counselling and workload support. Rose also valued her manager’s support and sensitivity during COVID-19 Delta restrictions. She was given time off to take care of family responsibilities, after having moved into an unfinished and unheated home just before the August 2021 lockdown.

4.4.5 Subtheme 5: Giving or Being Given Professional Support

New Zealand healthcare workplaces provided IQN participants with opportunities to give and receive professional support and encouragement for the benefit of staff and patients. Nightingale said she was motivated by “loving her job and being touched” by receiving help from her colleagues. According to Rose, it is important that IQNs feel supported by fellow IQNs, as well as New Zealand nurses, so “they will really flourish.” When providing training support to RNs, Jessie understood the challenges nurses were facing. She therefore gave trainees “that space to just vent and vent and lash out,” whilst she just “absorbed all the energy.”

Participants—like Carmel, Ricky, and Lola—felt their morale and confidence were boosted by receiving professional learning support, advice, and validation from their managers. Jessie’s experience of benefiting from a “smiling, helpful” manager who coached and encouraged staff, resulted in “a win-win situation and a positive atmosphere for all the team.” Rose, as a nurse manager, encouraged a trainee nurse to enrol in training to gain transferable skills and continuing education hours for her nursing competency practice. Rose was also asked for support by a junior nurse. When offering help to a student nurse to triage patients, though, she received an angry response.

4.4.6 Subtheme 6: Navigating Misunderstandings and Resolving Differences to Enhance Teamwork

IQN participants explained that navigating misunderstandings and resolving differences allowed them to develop team relationships. Following are examples of collegial differences:

- i. disagreeing with a manager about aspects of job performance (Jessie);
- ii. responding to administration and communication challenges caused by colleagues' different perspectives during COVID-19 Delta restrictions (Mons);
- iii. misunderstanding workplace protocols regarding scheduling personal appointments during work hours (Jessie);
- iv. noticing workplace miscommunication when older staff felt disrespected by a younger colleague, who did not listen to their professional guidance (Nightingale); and
- v. experiencing colleagues' not wanting to discuss or learn from their unprofessional communication (Lilly, Rose).

These workplace disagreements were overcome by IQNs through sharing knowledge with colleagues, seeking advice from management, showing professionalism, and being open to professional dialogue to proactively develop strong work relationships. According to Nightingale, her colleagues engaged in effective communication with each other to resolve misunderstandings and work as a team. She noticed that her colleagues showed kindness and understanding in considering each other's views to talk about problems and avoid conflict. Lilly reported feeling happy that a misunderstanding with a healthcare assistant about a medication administration error turned into a positive conversation, with a learning opportunity for the assistant. Rose was also pleased when she received her colleague's "heartfelt hug" and apology for giving Rose the silent treatment after a misunderstanding. Indeed, the nurse's expression of regret led to their reconciliation and long-term friendship.

4.5 Theme Four: IQNs' Concerns and Advice for Employers and Educators

The fourth theme, *IQNs' Concerns and Advice for Employers and Educators*, refers to the experiences that IQN participants reflected upon that linked with bullying, racism, exploitation, and favouritism in New Zealand healthcare workplaces.

Participants offered their recommendations to managers, CAP course providers, and nursing education providers to improve the wellbeing of IQNs. In providing advice to employers and educators, IQN participants aimed to balance the organisational needs of healthcare providers with the health and safety needs of patients and healthcare professionals.

4.5.1 Subtheme 1: Being Concerned About Bullying in New Zealand Healthcare Workplaces

Several IQN participants reported having experienced bullying themselves and observing bullying to others in their healthcare workplaces. Ricky described “being set up for failure” by a bullying colleague from the same region in Ricky’s home country. Carmel documented, and notified management of, the intimidating speech and treatment she received from a nurse colleague who refuted Carmel’s claim of bullying. This led to confrontations with the colleague, which were “a disaster because you cannot work harmoniously in your workplace if you have a misunderstanding.” Carmel recognised, though, that she did not want to go to work when colleagues mocked her: “Is she really an RN? Does she really know what she’s doing? I think what I learned on that experience is to speak up for myself.”

Still, participants conceded that nurse colleagues’ bullying behaviour happened to other nurses, not just IQNs. Mons recounted instances of resolving bullying situations for staff members, expressing her empathy for staff who were bullied. She was tasked with managing a bullying situation where a caregiver was bullying a manager: “So, the one bullied [a manager], saying she’s racist and all this, [but] when I confronted her, she said, “Well, I was just angry because she cancelled my leave.” Moreover, Ricky was unhappy that she had been unfairly accused of bullying by a colleague who had been acting unprofessionally: “I confronted her and asked

her what was going on and then she was accusing me of bullying her. And I ended up having to document everything and take it to management.”

4.5.2 Subtheme 2: Being Concerned About Racism in New Zealand Healthcare Workplaces

Racism was experienced by IQN participants who had English as an additional language and observed by participants who had English as their first language. Ricky—whose first language is English—noticed that competent Filipino and Indian IQN colleagues were not treated with the same “fairness and dignity” as white, European IQNs who spoke English fluently. It was also upsetting to Ricky that an Asian IQN colleague was given a patient “who hated Asians” by an unsympathetic shift lead. Mons and Nightingale, however, recognised that it was different personalities and cultures, not necessarily racism, that could cause miscommunication in the New Zealand workplace.

4.5.3 Subtheme 3: Being Concerned About Exploitation or Favouritism in New Zealand Healthcare Workplaces

Experiencing exploitation and favouritism was another discouraging experience for IQN participants working in New Zealand hospitals, aged care facilities, and medical clinics. Participants felt especially demoralised by not receiving support from management and seeing negative reinforcement of workplace abuse (Carmel, Ricky) or favouritism (Rose, Carmel). For example, Ricky was told by her manager—an IQN herself—to “put up and shut up” on her first day of work. This happened after Ricky expressed concerns about being unable to monitor and care for 11 high-needs mental health patients. She decided to go to the nursing union to complain about being directed to work in unsafe conditions as she was a new graduate nurse and a new arrival to New Zealand. Rose felt “bothered” by the unfair hiring process of a “troublemaker” female nurse instead of a better male nurse candidate. She believed that the female nurse was being “pampered” and “pandered to” by nurse managers because of her reputation for laying complaints with the health authorities.

4.5.4 Subtheme 4: Offering Advice to Management

IQN participants offered advice to management of private and public healthcare providers and aged care facilities in the areas of hiring and inducting IQNs, developing and supporting IQNs, and managing IQNs. According to participants, it is important for managers to prepare New Zealand healthcare staff for the arrival of IQNs from different countries. Employers should also consider providing a three-month orientation period so that IQNs receive sufficient induction support. During induction, it is beneficial for supervisors to encourage IQNs to “be vocal of their feelings” and know that managers “are not condemning [but] are here to help” (Carmel) when they make a mistake. This is so they “take ownership and responsibility” for their mistakes and receive the help they need (Mons).

Rose and Mons both recommended that management assist IQNs during their career by promoting their professional development. This might include clinical training and leadership mentoring (for IQN supervisors) from a sympathetic senior colleague. The mentor should ensure IQNs understand their responsibility to patient safety by not being “a little bit slack” in completing medication administration documentation (Mons). Most importantly, managers should help IQNs set professional goals (Rose) and “change their mindset” that they should not question managers (Mons). In fact, Mons confirmed it was “okay and constructive” to challenge senior colleagues: “It’s not, like, disrespectful in any way or form. If they know that, then their inside voice seems to come out a bit, which is good.”

Participants advised that IQNs benefit from managers’ listening to their needs and perspectives. Jessie’s recommendation was for managers to “listen to nurses and nurse educators and allow their input about organisational changes so they can feel valued.” According to Mons, many people have misconceptions about IQNs’ intelligence and abilities because of language and cultural differences. Managers, then, who know how to communicate with IQNs in a multicultural environment are, in Mons’s view, people-focused leaders, for whom IQNs “will want to do well.” Furthermore, Lola suggested that managers “get out of the ivory tower and onto the coalface” to “find out what IQNs have to say about their various roles so you can help them support patients and colleagues better.” Being available to work with staff

on the floor makes IQNs feel supported because, as Mons declared, “staff need to know [managers are] not sitting up on top of a high rock barking down at staff.”

4.5.5 Subtheme 5: Offering Advice to Nursing Educators and CAP Providers

IQN participants recommended that nursing educators and CAP course providers focus on being encouraging, positive, and patient when training, placing, and mentoring newly arrived IQNs in New Zealand healthcare settings. Ricky suggested that nursing educators help IQNs see the value in respecting *tangata whenua* (translated as ‘people of the land’, the Māori people) and following Te Tiriti o Waitangi (Treaty of Waitangi) principles. It was useful, she said, for IQNs to understand the importance of *karakia* (incantation) and making connections with colleagues, managers, and patients to bridge cultural gaps. Both Ricky and Lola felt that newly arrived IQNs would benefit from receiving a glossary of New Zealand English idioms, slang words, and colloquialisms. Jessie recommended tutors use plain English, though, and avoid using idioms that IQNs may not understand. To check IQNs’ understanding and stimulate critical thinking, Jessie believed tutors and preceptors should use questioning techniques and provide contextual examples as a learning opportunity.

In addition, in supporting IQNs on their nursing placement during the CAP course, Rose advised tutors to inform IQNs about the nursing responsibilities, open communication, and teamwork required in the placement. They needed to know, too, that their preceptor nurse on placement was there to support and guide them. They should therefore be confident to ask questions and say no if they are not feeling comfortable in a nursing situation. According to Rose, “The best thing is communication skills. Always. And working within the nursing boundaries, which is very, very crucial.” Mons and Lilly thought it would also be beneficial for IQNs to have plenty of time for mentoring or induction with a healthcare manager who was an IQN as well. This could comprise a three-month orientation and access to websites, nursing mentors, and placement opportunities. “Otherwise, they will not be aware of all these differences between the organisations,” as Lilly pointed out.

4.5.6 Subtheme 6: Reflecting Upon Health and Safety Issues in New Zealand

Workplaces

IQN participants were concerned about health and safety issues in their nursing contexts as workplace safety incidents are a significant risk for nurses and other healthcare professionals. They recommended that nurse managers or shift leads take health and safety issues seriously when assigning workload to staff. This is because nurses allocated a high caseload or acuity may not have time to take rest, meal, or toilet breaks. Ricky was concerned that such workplace pressures negatively impact nurses' wellbeing and increase the risks to patients: "How can you fully look after somebody when you're not looking after yourself?" Ricky also explained that IQNs are experiencing work stress in the New Zealand mental health sector because of "revolving door patients." This means that mental health nurses "can't do the therapy work they want...because of the pressure on beds all the time and it's just getting worse" (Ricky).

Carmel acknowledged the importance, too, of having a quality assurance manager provide support and training to help both domestic and international nurses follow medication administration protocol to uphold patient/resident safety. This is in line with Lilly's observation that IQNs should receive continuing professional learning of clinical skills and New Zealand healthcare workplace regulations, like the Health and Safety in the Workplace Act 2015 and the Privacy Act 2020. Lilly also believed that staff members should have a feeling they are being observed as that would make them make fewer medication mistakes and be more vigilant with following health and safety protocols. If the wrong medicine, or too much medication, were given, Lilly considered such an error to be "a disaster. It's a big event or accident; it's not supposed to happen." Consequently, Lilly and Carmel both recommended the auditing of the administration of medications by nurses for the safety of patients and resident. Auditing would lead to the ongoing preservation of safe clinical practice in line with Nursing Council regulations and government legislation.

There were certainly health and safety issues for IQNs during the COVID-19 Alpha (2020) and Delta (2021) outbreaks. Mons noted that IQNs were expected as nurses to work with people who may not want to have a COVID-19 vaccination or who may have been infected with the coronavirus and not want to be tested. Lilly was

concerned about managing staffing for workplace safety during COVID-19 pandemic restrictions and lockdowns, too. She felt frustrated when staff called in sick and “it was hard to find cover to keep the floor running safely.” This put pressure on Lilly’s whole team and endangered patient wellbeing.

According to Rose, IQNs ought to take a self-directed approach to their professional learning. They do this by observing, practising, assisting, learning, and—for new IQNs—recording notes in a diary “because professional and cultural expectations of safe nursing practice are different in New Zealand.” Mons, Carmel, and Ricky advised IQNs to ask for help if they did not possess the skills or resources to complete a task but also to stand up for themselves. This is because, as Lola indicated, if nurses do something wrong, they risk patient safety. Plus, they could lose their healthcare career, nursing registration, and professional reputation.

4.6 Theme Five: IQNs’ Professional Experience

The fifth theme, *IQNs’ Professional Experience*, includes subthemes that demonstrate IQNs’ valuing or creating a connected professional community; being a professional, ethical manager; being a professional, ethical mentor; recognising the need for IQNs’ skills and experience to be valued; promoting their own or others’ professional learning or career advancement; and learning from collegial advice or professional self-reflection.

4.6.1 Subtheme 1: Valuing or Creating a Connected Professional Community

IQN participants valued being part of a connected professional community, as well as creating learning networks with their colleagues. They appreciated the communication of professional skills, experience, and knowledge between colleagues because, according to Nightingale, “sharing is caring.” Valuing a collegial atmosphere at work, IQNs benefited from team members’ different kinds of experiences and education, leading to their own professional learning. Jessie recognised that her manager’s different clinical background and strengths resulted in her seeing clinical problems differently to Jessie. Rose, Ricky, and Lola enjoyed working with a highly experienced colleague who was encouraging and willing to impart knowledge and help with nursing tasks. Participating in enthusiastic and

supportive nurses' meetings boosted team relationships and contributed to a positive workplace environment for IQNs, acknowledged Rose and Nightingale.

It was invaluable for IQN participants to create a connected professional community. Mons revealed that IQNs might experience having their ideas to enhance the work environment rejected by management. Yet, Lilly and Nightingale recounted instances when nurses and healthcare professionals worked together without supervisors' direction to solve communication problems and proactively achieve tasks as a team. All participants were motivated to support their colleagues, including junior nurses, caregivers, and medical students, to build their morale and confidence. Nightingale wanted to "make the work environment calm and comfortable" by guiding students in their ongoing learning. Mons, as a manager, recognised staff burnout and worked to minimise work stressors by holding a monthly facility-wide staff dress-up day. Working closely with colleagues who were as enthusiastically and actively involved in the nursing work they were both doing was motivating for IQN participants.

4.6.2 Subtheme 2: Being a Professional, Ethical Manager

Being a professional manager was important to IQNs who were either a manager themselves or who had experienced working with a manager who demonstrated these qualities. Mons conceded that feeling attached to staff and "knowing the ins and outs of their personal lives" made dealing with staff disciplinary matters difficult, but "at management level, you cannot be people's friend." As Clinical Lead, Lilly considered how best to give constructive criticism or advice to her staff as she did not "want to give anyone a bad day by telling them they made a mistake." Mons agreed with Lilly's person-centred approach, saying, "You have to mark your words carefully to come across as helpful and not hurtful."

Overall, IQNs valued managers who focused their leadership style on "working alongside people rather than above them" (Mons) and who understood the importance of delegation and collaboration for effective teamwork (Lilly, Nightingale, and Ricky). Mons described herself as "a switched-on manager," who was receptive to staff needs "with the office door open for staff questions" because staff were her "work family." Nevertheless, she upheld her professionalism by

responding to staff members' protests against the COVID-19 immunisation programme by stating that "management is following Ministry guidelines, full stop."

IQN participants considered upholding professional ethics as a manager to be crucial during COVID-19 pandemic restrictions. Several of Mons's team protested receiving COVID-19 immunisation because their views of the vaccine were informed by social media. One staff member chose to opt out of being vaccinated because it went against her beliefs, despite the risk of losing her job. Mons duly advised staff members who were against the vaccine not to resign "as they wouldn't get another healthcare job." (In late 2021 and early 2022, most New Zealand workplaces required staff to be vaccinated to work on site, which was essential for healthcare workers.) She also "gave staff a treat" by distributing a gingerbread man along with a motivational quote to thank them for working through the 2021 COVID-19 Delta lockdown. Lilly, too, prioritised residents' safety during COVID-19 lockdowns in 2020 and 2021 by only hiring staff known to follow virus infection control protocols.

4.6.3 Subtheme 3: Being a Professional, Ethical Mentor

Most IQN participants took on the role of being a professional mentor in their healthcare workplace. Rose and Jessie, for example, acknowledged that adult teaching involves coaching not lecturing trainees. Rose spoke of guiding a "problematic" student nurse, and seeing her gradual improvement, through a placement. She supported the student by asking her to complete Nursing Council competencies, despite the student's initially negative response to such experiential learning. Rose's spending time with the student, and talking to her in a friendly way, resulted in the student transforming into "a chirpy, talkative person." Rose felt she was appreciated by new graduate RNs for her support, encouragement, advice, and proactive hard work to junior staff and the wider nursing team.

For Nightingale and Rose, being an ethical mentor entailed making new colleagues feel comfortable in the team and giving them "freedom of choice" (Nightingale) in learning and practising work tasks. Rose advised her RN colleague who had a falling-out with her preceptor nurse to overcome negative feelings by moving forward with positive thoughts: "Negative feelings are like boulders. You can't walk with boulders tied to your ankle, can you? You need to unlock those and then move

forward with a positive thought.” Lola wanted to provide professional development to a fellow RN in a careful, courteous way so as not to cause offence to a highly knowledgeable albeit “scratchy” practice nurse: “I didn’t want to upset her because she is a very experienced nurse. And she’s very, very competent and professional... But the reason she has done so well in primary care is that she is that personality where she is very confident.”

4.6.4 Subtheme 4: Recognising the Need for IQNs’ Skills and Experience to be Valued

Participants expressed their desire for IQNs’ skills and experience to be valued by colleagues and managers. Many employers appreciated IQNs’ knowledge, professional contacts, and ability to complete tasks. Carmel, for example, had her professional expertise recognised and was promoted to Virus Control Lead in her aged care facility. Experienced with running music therapy classes for mental health patients, Ricky developed great rapport with a high-needs patient, owing to their shared musical appreciation, which surprised her colleagues. Nightingale hoped to contribute her transferable and clinical skills and nursing knowledge within the wider nursing community after her contract with a COVID-19 healthcare provider came to an end.

However, there were times when IQNs’ expertise was not valued in healthcare workplaces. Rose thought that a nurse colleague felt threatened by her knowledge as a practice manager. Ricky and Lola explained, though, that IQNs can sometimes be perceived as less educated. They both had their nursing qualifications from their shared home country overlooked or disrespected by employers. Lola and Mons noted that IQNs for whom English is an additional language may not have their language ability valued by colleagues.

4.6.5 Subtheme 5: Promoting Own or Others’ Professional Learning or Career Advancement

IQN participants actively and enthusiastically promoted their own or others’ professional learning. They valued both in-house and external continuing education for RNs. For instance, Nightingale completed her required competency assessments

and professional development hours for her Annual Practising Certificate. Rose encouraged IQNs to do postgraduate studies in order to progress their nursing career. Mons enjoyed doing online study at work for her own professional practice as well. Seeing her new Virus Control Lead role as an “exciting, confidence-building learning opportunity,” Carmel felt happy about attending a conference to learn more about the role and broaden her network. Indeed, she considered her promotion to be “a big step in achieving [her] career goal of working in leadership as a nurse manager.”

Promoting others’ professional learning was also important to IQN participants because they were glad to help their colleagues develop clinical skills. Rose advised a junior nurse colleague of the need to continue with her professional development and on-the-job learning as an RN. Rose and Lola provided learning opportunities to student and graduate nurses and registrars respectively. Rose prepared a study plan for a student nurse who resisted her teaching, while Lola showed a junior doctor how to have a needs-based conversation with a patient. According to Lilly and Carmel, it is essential for nurses to learn from their medication errors to prevent reoccurrence and uphold patient safety. They were glad about the positive learning outcomes resulting from the mishandling of documented medication errors, leading to staff training meetings and new protocols for documenting incidents. As nurse educators, Lola and Jessie felt happy when RN trainees expressed their feelings of struggling with professional development so that educators could respond to their learning needs productively. Jessie, for instance, received thanks from trainees for her needs-based training and personalised support that “helped them cope with technology” and “learn better during their learning journey.”

4.6.6 Subtheme 6: Learning from Collegial Advice or Professional Self-Reflection

Learning from collegial advice and professional self-reflection was a common occurrence for IQN participants. They explained that being open to sharing knowledge and receiving constructive advice was essential in their roles. IQNs learn from their colleagues (Nightingale, Jessie), particularly when observing and reflecting upon other people’s mistakes (Mons). For example, Jessie valued a conversation about her job performance with her manager, considering it a mutual

learning opportunity to discuss techniques for giving “softer and lighter” constructive feedback to trainees.

Seeing challenging situations at work as opportunities for self-reflection, self-learning, and points of difference to be resolved, IQNs gained workplace experience through communicating with colleagues. Jessie had learnt from reflecting upon a mistake she made with her manager that clear communication was crucial for mutual understanding. She asserted that she had overcome her habit of saying yes to a manager by learning to say no and explaining her professional position. Participants also saw the need for IQNs to engage in self-reflection and self-learning for personal and professional growth. Mons and Rose, for instance, reflected on their experience in dealing with staff and supporting colleagues in helping staff reduce stress or anxiety.

Participants recognised that the emotion of a challenging situation at work added to IQNs’ mental pressure after hours, too. Mons advised, “If you add emotion to your workload, you’re just increasing your time. The workload after hours. The thinking. The going over and over it again. But if you just stick to the black and white [...and] the pure factual, then it just simplifies it.” To manage her stress, Mons “lived off proverbs,” which she liked to share with staff members. Proverbs and quotations helped Mons reflect on her professional life to stay positive and learn from her mistakes.

4.7 Theme Six: IQNs’ Agency

The sixth theme, *IQNs’ Agency*, includes subthemes related to perceiving workplace interactions as learning opportunities, however difficult; being resilient in challenging workplace interactions; coping with professional demands; being treated unfairly or unethically by managers or peers; feeling self-confident or motivated in healthcare workplaces; and speaking up for self and colleagues.

4.7.1 Subtheme 1: Perceiving Workplace Interactions as Learning Opportunities, However Difficult

IQN participants spoke of overcoming many communication challenges and not being affected professionally by challenging interactions with their colleagues. Lola revealed that she had learnt the importance of making an appointment to have a challenging conversation with a manager “at a good time and in the right environment.” This was after an “awkward and uncomfortable” off-the-cuff interaction with her manager. Lola was accused of “making a fuss over nothing” when management decided not to offer in-patient clinics over a holiday period. Ricky found, too, that she needed to talk with a shift lead colleague about IQNs’ unfair caseload distribution “in private to uphold comfort for everyone.” Recognising that bolstering professional relationships was an ongoing process of mutual understanding and negotiation, Mons admitted that “it sometimes takes a hard experience to pull through, to get that common ground. And it makes us stronger.”

4.7.2 Subtheme 2: Being Resilient in Challenging Workplace Interactions

Experiencing a colleague’s anger or rudeness at work led to heightened negative emotions for IQN participants, requiring their resilience and self-reflection after such challenging workplace interactions. Participants explained that they needed to work professionally with difficult colleagues. For instance, Lola bore the brunt of her manager’s anger for not challenging other colleagues’ concerns about staff members’ health status (i.e., whether or not they had been vaccinated against COVID-19) being checked by management. Lola was frustrated by her manager’s tirade, which she found “confrontational and not helpful during a stressful work week.” Lola noted that her own hand was shaking “as if [she] was about to explode.” Mons had to deal calmly with a rude union representative during a staff termination. Moreover, Rose was tasked with mentoring a nurse who demonstrated challenging communication behaviours, like “throwing a tantrum” and not listening or talking to colleagues.

IQN participants reported that working with strong-willed or impatient colleagues could be stressful. Rose recounted her difficult interactions with an upset, aggressive colleague who was stressed by personal difficulties. Ricky received a threatening response from a shift lead who took her suggestion for more equitable nursing

caseloads as “a direct personal attack.” Nightingale, though, was accepting of difficult team members’ personalities and chose not to make herself stressed when working with challenging colleagues. Interacting with colleagues who demonstrated demanding behaviours could “start bothering you,” according to Mons. This could result in “overthinking” and regretting things one had said (Mons). Still, participants acknowledged their resilience and strength to maintain professional relationships (Ricky, Nightingale) and not be underestimated in the workplace (Rose, Carmel).

4.7.3 Subtheme 3: Coping With Professional Demands

There were myriad professional demands made upon IQN participants in healthcare workplaces, particularly during COVID-19 pandemic restrictions. Participants spoke of their difficulties balancing personal and work commitments, managing stress, being overworked, or not being supported by colleagues or managers. They faced sudden new tasks arising during COVID-19 Delta restrictions and the rising number of community cases. Coping with ‘Zoom fatigue’ during COVID-19 left Jessie not wanting to attend virtual team meetings. This was because she was feeling exhausted by “constant Zoom training sessions that hurt [nurse educators’] eyes.”

IQN participants experienced tension when balancing their own, their colleagues’, and their patients’ needs in the pandemic. Jessie felt there was a negative mental health impact during the 2021 Delta lockdown, and Lola experienced anxiety along with her colleagues about the lockdown and restrictions. Similarly, Nightingale and her colleagues were “crazy busy and physically stretched” by having to administer high numbers of COVID-19 Omicron tests. Ricky admitted to feeling unsafe in the workplace when her manager insisted that she be sole charge nurse for a high number of mental health patients. The manager failed to follow safety procedures, causing Ricky to complain to the New Zealand Nurses Organisation (NZNO).

Even so, there were many instances where participants acknowledged feeling supported in their work by their colleagues or organisation. Nightingale expressed her happiness about working in a positive workplace with a supportive team that helped her overcome work stressors and physical challenges. Rose and Lola also enjoyed having conversations with colleagues about managing work pressures by

delegating decision-making and sharing nursing knowledge and technical skills. Recognising the challenge of putting a staff member in a job with a huge workload, Mons split job responsibilities with her new co-leader. Rose divulged that she and a senior nurse colleague were not thinking about difficulties during COVID-19 pandemic restrictions. Instead, they focused on smiling during busy or difficult times to work happily as a team: “2021 will be a year of smiles. We’re not going to think anything. We’ll just smile. And even if there is something going on, then we will always smile.”

4.7.4 Subtheme 4: Being Treated Unfairly and Unethically by Managers or Peers

Despite many positive experiences demonstrating their professional agency, IQN participants reported experiencing unfair or unethical treatment by colleagues in New Zealand healthcare workplaces. Jessie described “being lashed out at by a demotivated and frustrated RN trainee,” who had been “forced to attend” Jessie’s training session by management. Jessie said she was used to being verbally attacked by trainees, despite her offering pre-training support. She always responded in a kind, understanding way to trainees’ negative reactions to the training, though. Lilly was unfairly chastised by a nurse who took offence at Lilly’s request for a medical certificate for sick leave when she knew the nurse had gone to a concert. Likewise, Carmel was wrongly blamed by a nurse colleague for not checking a patient during her shift. Following management’s decision not to offer in-patient clinics over a holiday break, Lola felt her doctor colleagues were unfairly critical of her professionalism. Rose, though, valued receiving a nurse colleague’s heartfelt hug to acknowledge reconciliation after the nurse’s unfair and unprofessional behaviour towards Rose.

IQN participants noted that unethical treatment from colleagues and managers involved their not being supported when dealing with difficult patients or unprofessional colleagues. According to Rose, when individual managers discover staff backgrounds, personal issues, and family support, they can treat staff badly: “The main bosses get to know your background as well, financial stability, your knowledge, your support with the family, which they lack. So, there is the way to put you down if they don’t have that.” Ricky and Carmel both felt demoralised by not

receiving professional backing from management and seeing negative reinforcement of perceived workplace abuses. Recognising that two managers had been unhappy and unimpressed with her complaints about IQNs' unfair caseloads, Ricky believed management expectations for IQNs to care for more high-needs patients were "culturally insensitive, inhumane, and inconsiderate." Likewise, Carmel was unhappy that managers with different opinions about a nurse's removal of documented medication errors failed to back Carmel's claim of fraudulent and unfair treatment towards an IQN.

4.7.5 Subtheme 5: Feeling Self-Confident or Motivated in Healthcare Workplaces

IQN participants expressed their feelings of self-confidence and motivation in their healthcare roles. Their morale and confidence were boosted by receiving professional support and validation from managers and colleagues. Describing herself as someone who is "tiny, but she knows what she's doing and cannot be argued with," Carmel had added confidence from accepting a Virus Control Lead role. During a weekend shift, Carmel was advised by her supervisor to ring the hospice for a resident's pain relief. She later acknowledged her own RN status and ultimately "decided not to give morphine to a resident who was asleep and comfortable." Reflecting on her own nursing expertise, Lola said she "received a big boost" to her self-confidence by receiving appreciation for her professionalism from management. Nightingale and Rose also felt more confident that they were following good nursing practice by being able to support their nurse colleagues and giving advice and help to senior RNs.

In addition, participants were motivated by positive feedback from colleagues and managers. Nightingale recognised that not being motivated "resulted in staff feeling down and not wanting to work with their colleagues." She felt excited about going to work and working with "new and different" teammates, especially because of the workplace's positive energy, supportive colleagues, and open communication. Jessie, too, voiced her happiness and motivation to "come to work with a manager who was good at handling team members." Mons, Lola, and Ricky all felt inspired in their jobs by being shown informal and formal appreciation by management and "built up and valued" (Ricky).

4.7.6 Subtheme 6: Speaking Up for Self and Colleagues

It was important for IQN participants that they spoke up for themselves and for their colleagues. Plus, they advised fellow IQNs to develop confidence in working calmly and professionally with difficult colleagues by asking questions, standing up for themselves, and “not taking things personally” (Nightingale). Carmel explained that after telling her manager of her patient observation notes being changed by a colleague, the nurse’s challenging behaviour lessened. Ricky’s experience of talking to a shift lead about a fellow IQN’s high caseload because she was concerned about the IQN’s ability to complete all required tasks resulted in the shift lead telling her to “keep her nose out.” Ricky had protested that her IQN colleague’s overly high and unfair caseload could negatively affect other staff and patients. Noticing that the shift lead had “a hierarchy of ethnic backgrounds” of IQNs, indicating who would receive higher or lower patient caseloads, Ricky recognised that some Asian IQNs accepted high caseloads. This was because “they didn’t want to make any waves.” However, she spoke calmly to the shift lead when recommending that caseloads be more equal so IQNs struggled less with high-needs patients. Ricky wanted to help her IQN colleague speak up about overly high acuity, owing to her own beliefs about fairness and her refusal to “put up and shut up” with unfair caseloads.

4.8 ‘Closing the Circle’: Capstone Conversations

I wanted to receive feedback from my IQN participants during member checking via Capstone Conversations, wherein participants had the opportunity to comment on the wording of the subthemes and how they felt about the subthemes. Six months after our final conversation, I invited participants to attend a Capstone Conversation in person or via Zoom so we could discuss the themes and subthemes. Six out of eight participants had expressed interest in attending a Capstone Conversation. However, I was unable to meet with two of the six interested participants, owing to their personal circumstances. In July and September 2022, I held Capstone Conversations with four of my participants. These informal conversations were held via Zoom (for Jessie, Lola, and Ricky) and in person with Nightingale. My rationale for Capstone Conversations was to give weight to the perspectives of participants, as well as for us to make sense of the thematic findings together. Each conversation enhanced the

study's internal consistency as I was reporting to, and discussing with, participants the thematic findings from IQNs' stories, from which we had jointly made meaning.

Furthermore, Capstone Conversations allowed me to link the narrative data with their implications; that is, looking into the future to think about 'where to from here'. I felt that I would be 'closing the circle' not just with individual participants but also 'telling the bigger story' of IQNs' storied experiences within their cohort of peers. Seeking additional validation and clarification from my participants helped ensure that I understood and contextualised their perspectives. It also allowed participants to feel they were more than just respondents who held valuable views about workplace interactions in nursing contexts. As a researcher, I was being responsive and sensitive to their communication situations and needs. Following are the observations and reflections from Jessie, Lola, Ricky, and Nightingale on the study's six themes and their respective subthemes.

4.8.1 Theme One: Workplace Culture

I outlined the subthemes related to the *Workplace Culture* theme: understanding and using humour in the work; experiencing or not experiencing equitable treatment; valuing professional relationships and rapport with colleagues; recognising the need to act with integrity in healthcare workplaces; recognising the need to be professional and proactive in healthcare workplaces; and working professionally within the New Zealand workplace culture and power dynamics. The participants agreed with the wording of these subthemes, saying that it was not surprising that acting with integrity was important for nurses (Ricky). Nightingale said to me, "Yes, this is what we are dealing with here in New Zealand." Indeed, Nightingale confirmed that there was a strong team dynamic at her workplace. Although there might be time and work pressures, Nightingale and her colleagues worked together as a team, sharing jokes, laughing together, and seeking mutual understanding.

4.8.2 Theme Two: Workplace Communication

I explained to participants that the subthemes comprised giving or receiving feedback or counsel; understanding or not understanding the Kiwi accents or idioms; experiencing understanding or misunderstanding with colleagues; recognising the

need for open, authentic communication to enhance understanding; recognising the need for clear, person-centred communication to enhance understanding; and listening actively, or being listened to, for the benefit of staff or patients.

As Jessie observed, “Sometimes you can be open or authentic with your colleague, but maybe you don’t express yourself as clearly as you would like to and vice versa. You may want to be kind to a colleague, but maybe you’re not being as authentic as you could be.” She could see why these two subthemes were separated. She also thought that listening actively was important because sometimes others were passively listening or not listening at all: “[They] were just saying, ‘Yeah, yeah, yeah,’ but they were actually not wanting to benefit others.” Nightingale agreed that listening actively could help IQNs in the workplace. If nurses were unsure of the language used by a colleague or their speed or accent, they could listen actively and use nonverbal cues. They could ask lots of questions to check their understanding in the busy healthcare workplace, too.

Ricky and Lola concurred that recognising the need for authentic and clear, person-centred communication made sense, with Ricky stating that she would “just assume that everyone would do that.” Believing that person-centred communication enhanced IQNs’ mutual understanding, especially by being considerate, compassionate, and collegial, Nightingale reiterated the importance of IQNs speaking up for themselves and their colleagues. Nevertheless, Lola noted that the interactional features of nursing communication were central to successful workplace relationships:

It’s somewhat surprising because the Nursing Council put so much effort in making sure we can all communicate with good English reading, writing, and speaking. This is obviously very important, but they’re not looking at the other aspects of communication. It’s really good that [these subthemes] highlighted the fact that, like communication, even if you’re speaking the same language, it can be different in different cultures.

Nightingale had experienced times herself when colleagues would use slang and she did not understand what they meant. She also agreed with other IQN participants that it was important for IQNs to ask questions to check their understanding. This helped with overcoming miscommunication and misunderstanding in the workplace.

4.8.3 Theme Three: Workplace Interactions

This third theme, I explained to my participants, encompassed the use of culture and language; that is, focusing on the nature of IQNs' workplace interactions. Subthemes included being inducted or inducting others into the workplace; being acknowledged in the healthcare workplace; acknowledging IQNs' own or others' professionalism in the healthcare workplace; showing or being shown collegiality and compassion; giving or being given professional support; and navigating misunderstandings and resolving differences to enhance teamwork. Jessie thought these subthemes were "perfectly worded, like 'showing and being shown', 'giving and being given'. The highlight of everything is [...] how do we find resolution to our misunderstandings or differences."

Lola considered this theme to be well linked with the second theme, *Workplace Communication*:

They feed into each other—that it's having those communications and feeling part of the team and not feeling different. The communication and the interactions are feeding into each other. You can be acknowledged, but if you don't feel that you're being acknowledged, it's just words. You don't hear the words. You want to feel that it's how people communicate in that sense that you get when people are communicating with you.

Agreeing with Lola, Ricky added that this theme and its subthemes were expected within a healthcare setting: "It's basically like being acknowledged for professionalism in the healthcare workplace. It's being respected, isn't it? Being respected for what you know, what you bring."

Ricky did feel, though, that giving or being given professional support in the healthcare workplace was uncommon:

It'd be brilliant if it was given. Sadly, sometimes I got the impression that some people wanted me there, other people didn't. And on one occasion I heard someone say to someone else, "Well, she's taken a Kiwi's job." And it's like, oh, well, I'm the only one on shift that's foreign, so it must be me. I go into defensive attack. How many Kiwis are in [Ricky's home country], you know? If we all stayed in our own countries, what would that look like [for nursing]?

Nightingale held similar views about collegial support as Ricky, saying that "when a colleague needs help, [you go] out of your way to support your colleague and vice versa. A good manager as well [will] come out of the office and help nurses where there is a need."

To Nightingale, being inducted into the workplace was a high priority for all nurses because "one ward is not like another ward. New nurses need an understanding of people working there as well." Nightingale observed that, in the hospital setting, when there was a nurse short, the shift supervisor or the clinical lead would call for an agency nurse or a nurse from the casual pool. If that nurse had worked at the facility before, they would understand the culture. If they were brand new to the facility, however, they might struggle with their shift—not just practising as a nurse but caring for patients and working with staff in line with expected norms. According to Nightingale, misunderstandings are common in healthcare workplaces where there are differences in cultural expectations and language differences. These can be navigated by being supportive and being open with communication.

4.8.4 Theme Four: IQNs' Concerns and Advice for Employers and Educators

The highly practical fourth theme incorporated IQNs' concerns about bullying, unjust racial or ethnic mistreatment, and exploitation or favouritism, as well as their advice for nursing managers and educators. Jessie told me, "You've chosen the right words. We are concerned that maybe colleagues are experiencing bullying, which is kind of different [from] racism." Lola thought this theme was "very sad, but it's a very accurate representation of being an IQN in New Zealand. It's something I've experienced with other nurses that have gone through this from nurses and

managers.” Jessie, Lola, and Ricky agreed that the possibility for IQNs to be exploited was serious because IQNs are on work visas: “They feel they don’t have that voice. I felt less of that because I had a residency visa, but it’s very sad. It’s something that does need to be acknowledged” (Lola). Admitting that there was “a lot of [bullying] in nursing,” Ricky thought this theme was “bang on [as] the phrase that comes to my mind is like a ‘rite of passage’ [...Nurses] grow into their careers, and then they start doing the same [bullying] because it’s been done to them.”

Nightingale was grateful that she was not working in a hospital setting as she recognised the pressures that hospital nurses face that can impact upon their emotional wellbeing. For instance, she told me that, while working in a hospital overseas, she was managing a ward of 30 patients as sole charge nurse at night. One of the patients died on her shift from kidney failure. Even though she was not responsible, Nightingale still felt a sense of guilt. She and I discussed Ricky’s story of being put in sole charge of a ward of 22 high-needs patients and the resulting health and safety risks for patients. Participants (Nightingale and Ricky) recognised that patient care was compromised when nurses were overburdened with high acuity patient numbers and little management support.

4.8.5 Theme Five: IQNs’ Professional Experience

The subthemes for Theme Five included valuing or creating a connected professional community; being a professional, ethical manager; being a professional, ethical mentor; recognising the need for IQNs’ skills and experience to be valued; promoting own or others’ professional learning or career advancement; and learning from collegial advice or professional self-reflection. Jessie pointed out, and many of the IQNs told me, “We come with such experience.” IQNs wanted to feel like their professional advice and experience was valued by their colleagues. Reflecting upon giving advice to colleagues, though, Ricky said, “I can think of examples where colleagues are giving me advice and [saying], ‘Maybe try this approach.’” She noted that it was important to be professional when receiving and conveying advice to colleagues: “It’s not just how you take [advice, it’s] how you come across.”

Lola and I talked about the tall poppy syndrome that is “rife in New Zealand.” She indicated that, as an IQN, wanting to be recognised was not “just trying to show off. I’m just explaining what I know and what I can do so you have a little recognition.” Nightingale also agreed with the subtheme of valuing IQNs’ qualifications and experience. When she started nursing in Australia, she received a salary and position commensurate with her qualification and experience as an RN. The CAP course Nightingale attended in Australia was shorter and included two placements, so she felt very supported in beginning her nursing career in Australia. We discussed Lola’s and Ricky’s experiences of not having their nursing qualifications and transcripts immediately recognised by the Nursing Council in New Zealand. Nightingale advised that streamlining of the validation process of international nursing qualifications would be useful for IQNs.

4.8.6 Theme Six: IQNs’ Agency

This was a strong theme, comprising IQN participants’ perceptions, coping mechanisms, and sensations or feelings related to professional learning, resilience, self-management, self-confidence, and motivation. Subthemes included perceiving workplace interactions as learning opportunities, however difficult; being resilient in challenging workplace interactions; coping with professional demands; being treated unfairly or unethically by managers or peers; feeling self-confident or motivated and healthcare workplaces; and speaking up for self and colleagues. Jessie agreed with all of these subthemes: “I’m very happy with my colleagues. I’ve built a relationship with them. You’ve been through the highlights and happy moments. Now [we] can understand any challenges that come our way.”

Moreover, Lola said that this theme was the “universal dichotomy of being a nurse,” whether an IQN or a New Zealand-trained nurse:

These are all reflections that most nurses have, but because of the previous themes, that can make this harder, so all nurses are coping with challenging workplaces. IQNs have been resilient, and we’re trying to have positive learning opportunities. Most nurses, at some point, have [experienced being] treated unfairly,

or not feeling confident, or having to, or wanting to, speak up for themselves and for colleagues, so it's a universal theme.

Ricky observed, too, that nurses might cope with professional demands by reflecting on, and learning from, their strengths and shortcomings:

It's also realising your limitations and perceiving workplace interactions as learning opportunities. I think that's fantastic. Although, at the time, you might not be able to because it's really hard to go through those times. But once you go through it and you look back, then you see how resilient you are and how much you've learned from it. And if you were ever faced with that kind of situation again, what would you do differently?

4.9 Chapter Summary

This chapter presented the findings from applying thematic analysis to IQN participants' narrative (textual and visual) data. Participants' storied experiences of their challenging and positive workplace interactions with colleagues were analysed to construct six themes, each comprising six subthemes, in order to answer this study's third research question. The next chapter describes aspects of participants' discursive positioning found through my application of multimodal positioning analysis to the textual and visual data. This will help me respond to the three research questions that guide this study.

Chapter 5: Findings from Multimodal Positioning Analysis

5.1 Introduction

In this doctoral study, I employed narrative inquiry to empower IQNs to voice their storied experiences of challenging and positive workplace interactions via semi-structured interviews ('Story-Led Conversations') and peer-to-peer facilitated conversations using Zoom ('Zoom Pair Shares'). I have sought to answer my three research questions by implementing a social constructionist research methodology. Chapter Four applied thematic analysis to my narrative data to help me respond to Research Question 3. Chapter Five presents the findings from multimodal positioning analysis (MPA) of the narrative data that allow me to investigate aspects of IQN participants' professional identity, thereby answering all three research questions.

In this chapter, I demonstrate how the four MPA criteria (i.e., positionality, emotionality, relationality, and consequentiality) were applied to the narrative (textual and visual) data. I then describe the IQN participants' positioning at the following three positioning levels:

Level 1 to respond to Research Question 1; that is, *How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings?*

Level 2 to respond to Research Question 2; that is, *How does IQNs' use of discursive positioning in their stories jointly construct aspects of their professional identity?*

Level 3 to respond to Research Question 3; that is, *What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?*

Presenting evidence of participants' positioning within the MPA model's four criteria and at each of its three levels is crucial in this chapter. I have sought to demonstrate how I applied the MPA model to my narrative data in order to analyse

and interpret IQNs' storied experiences. Chapter Five concludes with an overview of the MPA findings' key linkages with the findings from thematic analysis.

5.1.1 Summary of Multimodal Positioning Analysis

In line with Davies and Harré (1990), I have chosen positioning theory as a framework to frame and analyse storied experiences of IQNs interacting with their colleagues in New Zealand healthcare settings. Positioning theory focuses on how one uses language to locate self and others within the storyline of a meaningful conversation. Multimodal positioning analysis is based on Bamberg's (1997, 2003) positioning analysis, whereby:

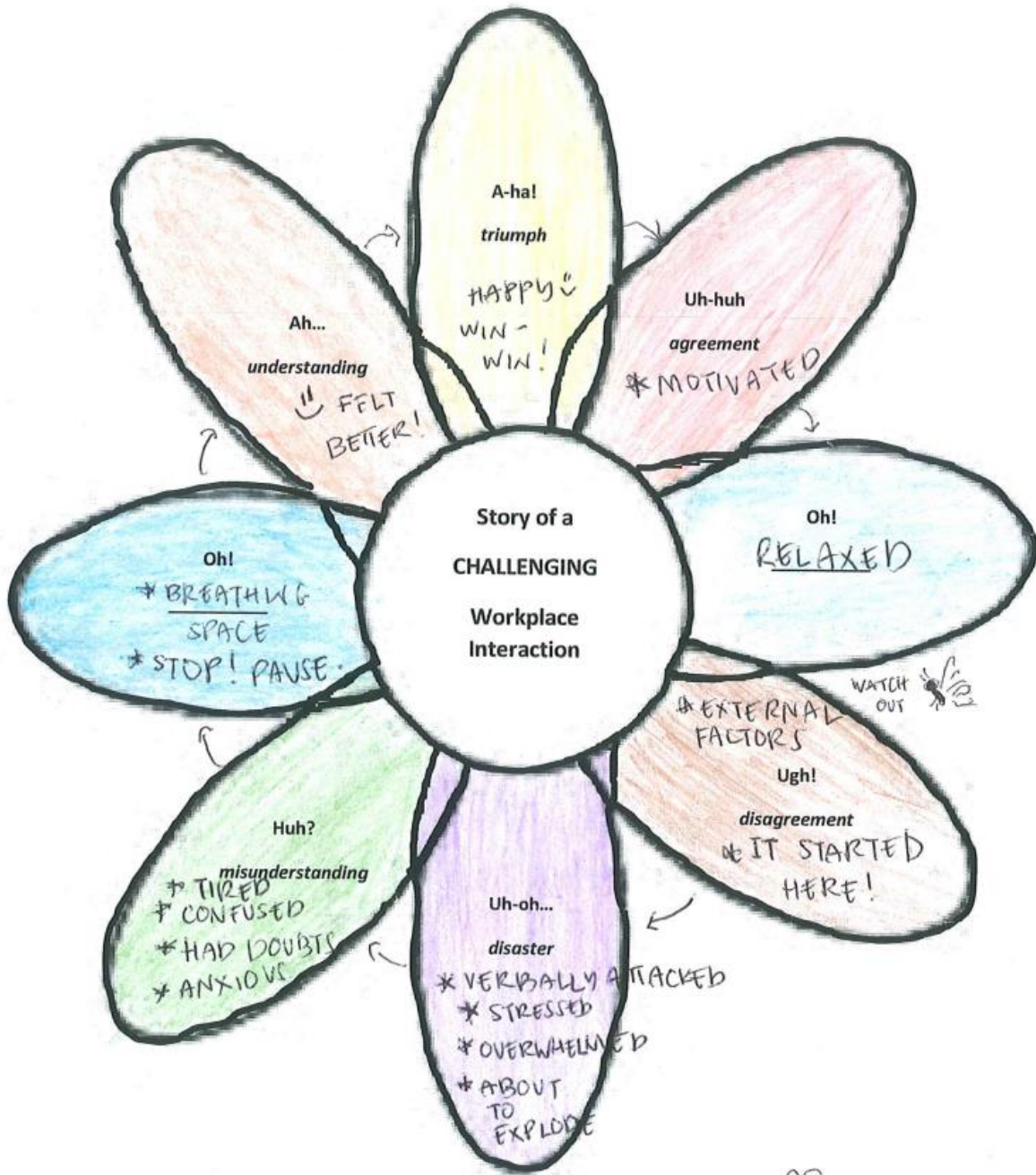
Level 1 refers to the interactional representation of storyworld characters; that is, *Who am I, and who are they, as healthcare professionals in this story?*

Level 2 refers to the interactional representation of the storyteller vis-à-vis the listener(s); that is, *How do I present myself as a healthcare professional?*

Level 3 refers to the interactional representation of the storyteller within the nursing community; that is, *Who am I in the workplace/nursing context? What role does a master or counter narrative play?*

The MPA model (see Figure 6 presented in Chapter Three) shows the three levels of positioning on the left-hand side and these four identity spaces across the top:

1. *Positionality* relates to: (i) the sense of agency and control participants had, or did not have, during workplace interactions; (ii) participants' feelings of sameness and difference compared to their colleagues; and (iii) aspects of temporal constancy and change, whereby participants' sense of professional self either stayed the same or changed over time.
2. *Emotionality* refers to participants' use of discursive language (i.e., literal and non-literal phrases) and visual language (i.e., colours, shapes, and/or words used on Flower Diagrams). See Figure 8 for a Flower Diagram completed by Jessie to represent her feelings when talking about a challenging workplace interaction.
3. *Relationality* denotes IQNs' self-positioning, other-positioning, and reflexive positioning (i.e., how they positioned others and were positioned by others).
4. *Consequentiality* considers the implications and reflections of participants' stories for wider nursing communities and discourses.



Upon reflection, I realised that my story is like a flower 🌸. The petals (my feelings, thoughts, and behaviour) are interconnected. They make up the core of ^{the flower} my challenging workplace story. 😊

5

Figure 8. 'Story of a Challenging Flower Diagram' - Jessie, Story-Led Conversation 1, 10 February 2021

5.1.2 Summary of MPA Findings

Although this is a qualitative narrative research study, it is interesting to note the elements of participants' discursive positioning as analysed by the MPA model as numerical data. Table 6 shows the number of participants who demonstrated specific criteria within the four identity spaces.

Table 6

Summary of MPA Findings

LEVEL	POSITIONALITY			EMOTIONALITY		RELATIONALITY			CONSEQUENTIALITY		
	Agency & Control	Sameness & Difference	Temporal Constancy & Change	Discursive Language	Visual Language	Self-Positioning	Other-Positioning	Reflexive Positioning	Social-cognitive Implications	Moral Implications	Professional Reflection
1	7	6	2	4	6	3	3	5	1	2	2
2	5	4	0	6	8	7	4	5	3	4	4
3	3	2	0	3	0	0	0	2	8	6	3

5.1.3 Aide-Memoire Summary of IQN Participants

1. Lilly was an RN and Clinical Lead for an aged care facility.
2. Mons was an RN and a manager at an aged care facility.
3. Carmel was an RN and Virus Control Lead at an aged care facility.
4. Rose was an RN and nurse manager for a private healthcare provider.
5. Jessie was an RN and a nurse educator for a medical software provider.
6. Nightingale was an RN for a public healthcare provider.
7. Ricky was a registered mental health nurse for a public healthcare provider.
8. Lola was an RN in the dementia care sector.

5.2 Level 1 Positioning

5.2.1 Positionality

5.2.1.1 Evidence of agency and Control.

At Level 1, seven participants (Lilly, Carmel, Rose, Jessie, Nightingale, Ricky, and Lola) showed varying levels of agency and control as nurses and/or nurse managers in their respective healthcare settings.

- 1) Demonstrating her professional agency, Lilly asked a senior caregiver why she was not toileting a resident, but she lacked control of the caregiver's timely response. The caregiver did not follow Lilly's instructions to complete the urgent task of caring for the resident's ablutions and angrily challenged Lilly's authority. As a Clinical Lead, Lilly knew she had the authority to ask a senior care staff member to complete a job-related task; that is, toileting a resident. She was therefore justified in being "not happy" when her instructions were not followed immediately.

Lilly also expressed her agency as Clinical Lead as being responsible for staff performance. She gave training and clarification in a private area to a caregiver who made a medication administration mistake. Lilly wanted to "give a reflection" to the staff member so he would avoid future mistakes and keep patients safe. Nevertheless, she did not have control of the caregiver's unhappy and "stubborn" response to receiving counsel and correction to improve his performance. Lilly showed, too, that she possessed authority to ask a staff member, who had called in sick, for a medical certificate. This was because Lilly expected to receive acknowledgement from her staff member that, as a manager, Lilly had the right to follow policy if the reason given for sick leave did not appear to be genuine. Lilly was unable to control her staff member's unhappy response and argumentative reaction for being asked for a medical certificate, though.

- 2) Carmel displayed her professional agency by responding proactively and confidently to medication errors. She showed initiative by emailing the facility manager to ask why she "wasn't doing anything" about another nurse's frequent medication error. Carmel told the manager that she was unhappy and concerned about residents' safety. However, Carmel did not have the control of the manager's response to her email as the manager had removed Carmel's record of the nurse's error. The manager refused to explain to Carmel why she removed the documented error and said that "it's not a medication error."
- 3) Rose revealed her sense of agency to communicate her expectations for professional practice and teamwork "in a very nice, healthy, friendly

manner.” For instance, Rose told her colleagues that all nurses and nurse managers needed to help each other to “leave the treatment room spick and span with everything in order.” Although Rose had the authority to give directions to a student nurse, she did not have direct control of the student’s supervision. This was because the student was being “pampered” by the clinic’s managers, who had “heard that [the student was] a woman who would put up a complaint to the [District Health Board].” Indeed, not only did the student nurse not follow Rose’s instructions, but the doctors interfered with Rose’s request for the student to help clean up the treatment room. They informed Rose, “No, she has got so many other things to do. You nurses can do them,” which Rose felt was “not right.”

- 4) Jessie had the agency to provide support and encouragement to a trainee who was resistant to attending a training course led by Jessie. She demonstrated her control of the challenging conversation by speaking to the trainee calmly in a learner-centred way:

She [the trainee] was just frustrated at work, unable to cope, but then she saw the positive side of persevering, you know, and completed the course. [...] Yeah, despite the fact that she just didn’t want to continue anymore. But I tried my best to let her know that it would still be professional development hours that she can have additional credential on her end.

- 5) Demonstrating her professionalism, Nightingale had the agency to adjust her work practices and communicate clearly and confidently with her peers. For example, Nightingale lacked access to wider information about COVID-19 community cases because of not watching or listening to news. After following a colleague’s recommendation to download the Āwhina app “to get the [COVID-19] communication better,” she gained control of access to vital information about case numbers. Neither did Nightingale have control of the dissemination of messages amongst staff related to new COVID-19 rules and procedures. This led to miscommunication amongst staff from different shifts—an issue which was solved by implementing a communication book to

explain the new rules to staff. Nightingale explained that she and her colleagues “had to read [this book] every day and [attend] a briefing before and after work,” which “had really helped” understanding amongst staff.

Teamwork was key to Nightingale’s sense of professional agency and authority. As there was no coordinator to arrange meal breaks, Nightingale and her teammates had the collective control to discuss work break times and the needs of the team: “We would say, ‘Hey, Team A, you go on a break first, OK, and when you finish and come back, then Team B go have a break.’” This resulted in a positive conversation since, “instead of being bossy to each other,” they worked as a team to ensure that everybody took a meal break because the clinic was “crazy busy.” Furthermore, Nightingale had the agency to “challenge back” a nurse colleague who criticised her for not acting professionally, despite not providing evidence of what Nightingale had done wrong. Nightingale expressed her self-control in not being manipulated by unfounded critique from “an older, more senior” RN. She defended her actions, which the other nurse had seen, because “the evidence says differently” than what the RN had told her. Nightingale “managed to bring herself back up,” refuting the RN’s accusation. This resulted in the nurse initially not being happy but then, after working with Nightingale for more shifts, feeling “okay.”

- 6) Ricky displayed her agency and control of challenging workplace interactions, as well as more person-centred conversations, with colleagues in her mental healthcare facility. Firstly, Ricky had the agency to walk off the floor and meet with the service manager to complain about the “inhumane” caseload she was assigned. Her “really rude” nurse manager had told Ricky to “put up and shut up” after she refused to care for more patients than was safe for a new nurse. Taking control of the formal union complaint process, Ricky went immediately to the NZNO union representative for support, explaining that she was dealing with an unfair caseload: “I’ve just basically been told by my manager that as I’m [an overseas-] trained nurse, [...] I should know what I’m doing. And I’m a human being—I’ve got my limitations.”

Ricky also had the agency to “have a word” with a shift lead on behalf of a fellow IQN who had an overly high caseload of high-needs patients. Ricky thought this was unfair, especially as New Zealand nurses’ caseload was “not as hard” as the IQNs from India and other Asian countries. Although Ricky’s caseload had been “pretty hard,” she had control of her own caseload because she was “vocal.” Ricky counselled her IQN colleague that it was important for her to speak to the shift leader and not “set a precedent now,” otherwise she would “burn out.”

- 7) Lola possessed professional agency to propose clinical suggestions to patients and colleagues without contradicting a doctor’s advice. She did not always have control of colleagues’ reactions to her recommendations, though. Lola took responsibility for what she did as a nurse to suggest to a patient, in a situation in which Lola did not “feel particularly confident and competent at,” that a social worker would be more appropriate to visit her at home. Lola’s suggestion was “not necessarily to contradict” the doctor who had “dropped Lola in it” by volunteering her to visit the patient. Lola knew that refusing was unprofessional and “would undermine the doctor and [Lola].” Instead, she explained to the patient what support she could give, and she could refer a social worker for additional assistance.

After disagreeing with a registrar colleague about the care plan for a patient needing respite care at a facility, Lola demonstrated her agency by asking a consultant doctor to settle the difference in professional opinion. The consultant listened to Lola and the registrar express their respective reasons why respite was and was not appropriate. He duly agreed with Lola’s recommendation, confirming that “it was in the best interest of the patient to go into respite.” Lola then took control of the professional conversation by demonstrating her nursing experience and ability “to explain to [the patient and her family member] why they need these services.” To the registrar’s surprise, the patient accepted this proposal as Lola had presented the pros and cons of in-patient respite care “without bullying but showing benefits.”

5.2.1.2 Evidence of Sameness and Difference.

There was strong evidence that IQNs possessed similarities and differences with their nursing colleagues, as demonstrated by six participants' (Lilly, Mons, Carmel, Rose, Ricky, and Lola) stories of workplace interactions.

- 1) Lilly positioned herself as the same as one of her staff, a senior caregiver, as they were both healthcare workers. However, she positioned herself as different from the caregiver because their priorities for caring for the resident were not aligned. The caregiver did not understand the urgency of the task as she was too busy with making a personal phone call, which Lilly felt was inappropriate during work hours.
- 2) Mons demonstrated her feelings of sameness and difference in relation to her colleague, the Assistant Manager at their aged care facility. She positioned her colleague as similar to herself because they “gel [as colleagues]” and “she’s never rude.” Yet, Mons felt she was different to her colleague as she was “a hugger,” whereas her fellow nurse manager “did not show affection,” “liked her space,” and was “not a huggy, kissy person.”
- 3) Carmel positioned herself as having the same level of competence as a nurse from the District Health Board (DHB) who made a medication error because both were RNs and were used to following medication administration protocols. She felt she and her colleague were different, though, because the RN followed a DHB process in administering medication as “that’s what they do” in the DHB, whereas Carmel believed that “she should follow the [rest home] policy.”
- 4) Feeling she shared similarities with a new graduate nurse as both were “mature nurses,” Rose outlined their similar primary care nursing experience. They had similar experience using the medical computer programme Medtech32 programme and understanding of “exactly what is expected” at the clinic. Conversely, Rose positioned the graduate nurse as being different as she did not have Rose’s knowledge of the patient population, workplace environment, and clinical processes. Rose conducted patient consultations and medical procedures such as punch biopsies and suturing, for example,

without anxiety because of her surgical background. The new nurse was apprehensive about such procedures, finding them “overwhelming.”

- 5) Expressing similarities and differences with her colleagues, Ricky valued their shared professional backgrounds and dedication, despite the challenges of being “under the pump” with work pressures. The nurse manager who assigned her an unfair caseload was an IQN, so Ricky could not understand why the manager “had obviously lost the ability to reflect back on how she found things” when she arrived in New Zealand. In addition, a GP who was from the same country as Ricky did not want to help Ricky in her role. Whereas Ricky enjoyed helping her colleagues and valuing them as “resources,” the GP told her, “We haven't got time to help,” which Ricky felt made the doctor “really miserable as a person.”

- 6) Lola positioned herself as the same as her registrar colleague in believing “the main focus of working within the older person’s health community teams is keeping people in the community.” They both sought to reassure patients that their medical team was “not going to put them straight in a home.” In contrast to the registrar, Lola felt that in this case the patient was depressed and needed respite because “there are times when you need to just give people a break, [...] and this was completely against [the registrar’s] thinking.” Lola positioned herself as being “a strong advocate for patients,” so she was “a bit of a pain” about promoting her recommendation to the consultant.

5.2.1.3 Evidence of Temporal Constancy and Change.

Two participants (Ricky and Lola) experienced aspects of temporal constancy and change, which impacted their sense of professional self. These were related to using idiomatic language and engaging in potentially difficult conversations with colleagues.

- 1) Ricky felt “mortified” after three months of using the phrase ‘rooting around’ when telling her colleagues about her weekends spent exploring the local area. However, “nobody said a damn thing” about this slang term, until an

IQN colleague from Ricky's home country explained the meaning of the phrase. This clarified why Ricky "had been hit on by quite a few male RNs." Ricky then realised she had a reputation for "getting about a bit with the opposite sex," which "wasn't the best" in a new workplace.

- 2) Lola experienced transformation in her identity positioning over time when checking a fellow nurse's cognitive assessment of a dementia care patient. Recognising the necessity to phone an "exceptionally experienced practice nurse" to advise her of her error in the cognitive assessment, Lola needed encouragement from colleagues to make the phone call. Her colleagues advised Lola that she "really should tell [the practice nurse] because if it was them, they'd want to know" about the error. After a period of procrastination where Lola "just avoided and avoided it," fearing she "might upset her." Lola finally rang the nurse who checked the assessment on her screen and said, "Oh, I made a mistake." This was a "way better" conversation than Lola had expected:

I felt very relieved. And my colleagues who were listening to the phone calls said, "See, see." [...] It's like if, you know, if I'd just rung her on the day that I noticed it... [But] maybe if I'd rung as soon as I'd marked it, it wouldn't have been the right time for me either because I may have been more irritable, and I would have been more fraught [...] and so a bit of time is good.

5.2.2 Emotionality

5.2.2.1 Evidence of Discursive Language.

The literal and non-literal language used by four participants (Lilly, Jessie, Ricky, and Lola) showed the emotions they felt about both challenging and positive interactions with their healthcare colleagues.

- 1) Lilly's use of literal and non-literal language revealed her feelings about herself and others within her stories of challenging and positive workplace interactions in her aged care facility. She expressed feelings of happiness, motivation, and unhappiness when engaging in work-related conversations

with her team members. Lilly was “very happy” that an “angry” caregiver who had made a medication administration error said sorry, leading Lilly to consider the caregiver’s apology “a victory” because he agreed with her counsel. Lilly also felt motivated because the caregiver was glad to hear her share her story of making mistakes at work and then learning from them for her professional development. Lilly was “not happy,” though, by a caregiver ignoring Lilly’s request to toilet a resident and responding angrily to Lilly’s questioning her on why she wasn’t performing the task promptly. She was also unhappy with a cleaning staff member for responding in a negative way to being asked to clean a resident’s room. However, after the staff member apologised, Lilly was satisfied with her apology and the “all good” situation.

- 2) Jessie’s literal and non-literal language revealed her feelings of disquiet when responding in a professional way to a resistant trainee who needed “space to just vent and lash out.” As a result, the trainee “calmed down” after listening to Jessie’s offer of providing learning support prior to the scheduled training course.
- 3) Ricky’s use of literal language indicated her emotions towards difficult and uplifting workplace interactions with her colleagues. Firstly, after being “hugely disrespected” by a nurse manager, Ricky was “so angry” about being told to “get back on the floor” after being assigned an unfair caseload. Secondly, Ricky had “a good laugh” with a senior RN when she found out the meaning in New Zealand of the idiom ‘rooting around’. This led to a sense of camaraderie with her colleague, who told Ricky he thought clarification was “better coming from somebody from her country.” He then “reported back in handover to all [their colleagues] that Ricky wasn’t loose,” restoring Ricky’s reputation after she had been “lost in communication badly.”
- 4) Lola used literal phrases related to distress in describing her feelings about having a difficult workplace interaction with a senior manager. Lola admitted to feeling uncomfortable during a conversation with a senior manager when she requested permission to see her elderly patients during Christmas closedown, which the manager refused to consider. According to Lola, this

conversation “may have looked a little confrontational, rather than a relaxed colleague-to-colleague conversation” since both the manager and Lola were “flustered.” Lola recognised afterwards that she had chosen the wrong time to make the request, as the manager was busy and “didn’t have time for this conversation.”

5.2.2.2 Evidence of Visual Language.

At Level 1, six participants (Lilly, Mons, Carmel, Rose, Nightingale, and Ricky) used a variety of colours, words, and shapes in their Flower Diagrams to reflect their feelings about their conversations with colleagues.

- 1) Lilly’s selection of colours and words for her Flower Diagrams demonstrated her emotions in reaction to both challenging and positive workplace interactions. To reflect her difficulty in convincing a staff member of the reason for management’s decision not to hire agency staff during the COVID-19 lockdown in 2021, Lilly coloured the ‘Disaster’ petal black. This was because black “is not a good emotion, not a good colour.” She also selected an orange colour for the ‘Misunderstanding’ petal. Orange “is a bright colour,” reflecting a staff member’s initially not understanding the reason for management’s decision not to hire agency staff. This decision was due to the safety risks for residents and staff, and the staff member later expressed her understanding of the rationale. In addition, Lilly coloured the ‘Triumph’ and ‘Agreement’ petals yellow because “it’s a bright and positive colour,” signifying staff members’ taking Lilly’s advice and making a plan to divide their tasks. This helped them lighten their workload and work as a team. According to Lilly, yellow is “a good sign, a positive feeling” and “a happy, sunny colour” that represents teamwork.

Expressing her gratitude towards a staff member who came into work to help the healthcare team on her day off, Lilly chose a green colour for the ‘Oh!’ petal, in which she wrote the word “happy.” She also selected a pink colour for the ‘Triumph’ petal and a “bright and positive” yellow colour for the ‘Understanding’ petal to represent “a kind of victory” for their mutual happiness and appreciation. The pink colour symbolised the surprise on the staff member’s part for being thanked by Lilly, who was grateful for her staff

member's selfless help. COVID-19 pandemic restrictions meant that the team was short-staffed, so "on the day, without her, we won't be able to do it."

Lilly also used a bright red colour for the 'Oh!' petal, in which she wrote "teamwork," to represent the collegial support the staff member gave to Lilly and the team.

- 2) Selecting a red colour for the "Disaster" petal, Mons explained that red represented the "underlying love and the disaster" of providing information about the COVID-19 vaccine to staff who were against government-mandated vaccination. Mons said she did understand "what anti-vaccine staff are feeling" and shared a staff member's "good feeling" of having "God on your side."
- 3) Carmel represented her feelings towards her challenging interactions with a nurse who exhibited bullying tactics by selecting a pale red colour for the 'Misunderstanding' petal. Red indicated Carmel's lack of motivation because of being treated badly by her peer: "I [didn't] want to work anymore [or] work with this colleague anymore."
- 4) Rose selected bright colours for petals on her Flower Diagrams to represent her positive feelings towards offering collegiality and mentorship to fellow nurses. She coloured in the 'Understanding' petal red because it was a "passionate, very alarming" colour. Red signified her desire for a graduate nurse to share professional understanding, humorous workplace anecdotes, and clinical knowledge with her mentors and peers. Rose also chose a green colour for the 'Triumph' petal because green was "nice and refreshing" and indicated her support of a nurse colleague who had been experiencing "sorrow and sad-ism." Rose noted that her colleague had "become more confident," helping Rose to check medical equipment, clean tables, prepare patients to be seen, and see patients herself. This was a result of the nurse's working with Rose and talking with her, despite being "an introvert and not very friendly."

- 5) Nightingale used literal language and colours in her Flower Diagrams to demonstrate her positive emotions about teamwork in her healthcare workplace. Feeling that team members could get “tired or stressed” at work, she encouraged staff to do exercise together, which “everybody loved.” They enjoyed having “a good laugh” as well because “when you have a good team that you work nicely [with], it [does] bring positive energy.” Good humour and teamwork helped Nightingale “not to feel as tired, not to feel stressful,” despite “standing for long hours and then feeling cold, numb, frozen.” Nightingale selected a light blue colour for the ‘Oh!’ petal, writing in the word “energy” to show that she and her colleagues felt “glad we look after each other and that gives more spirit, or energy, or motivation.” They prioritised teamwork “to look up to each other and bring the energy,” which she felt was needed in a busy work environment.
- 6) Selecting a red colour for the ‘Disaster’ petal, because red signified “embarrassment,” Ricky had wanted “the ground to swallow her up—wholly, not partially—and never to release [her] from the ground again.” This was after Ricky discovered the New Zealand meaning of the phrase ‘rooting around’. She had wondered why colleagues were not inviting her to social events, and “even managers were looking at [Ricky] a bit funny.” However, after her colleague explained Ricky’s use of the idiom to staff, “the invites started again, and they thought [Ricky was] actually okay.” Ricky thus chose a pale blue colour for the ‘Understanding’ petal because “it’s calming.” This referred to her sense of calm when a senior colleague explained that Ricky’s meaning of the term ‘rooting around’ was innocent and a genuine miscommunication. Once her colleagues realised that she was not what her reputation had mistakenly suggested, Ricky developed a warm rapport with the senior RN, who “turned into a mentor.”

While Ricky experienced unhappy conversations with supervisors at times, she appreciated supportive interactions with her colleagues, too. She selected a brown colour for the ‘Misunderstanding’ petal because “it’s not a very happy colour [and it] dampens the mood.” This indicated Ricky’s sense of the “pooey atmosphere” with a shift lead nurse who was giving IQNs heavier caseloads “like IQNs were pack horses.” The shift lead was

“dismissive” of Ricky’s concerns about IQNs’ work pressures, despite being “normally fairer [and] delegating tasks evenly.” Colouring in the ‘Understanding’ petal yellow because it was a “calm colour...and soothing,” Ricky appreciated the service manager who “actively listened” to Ricky’s complaint about being allocated an overly high caseload on her first day of work. The service manager “validated” Ricky’s angry response, telling the nurse manager, “Go easy. You were a foreigner here once for the first time.” This dressing-down “probably wrecked” Ricky’s relationship with the nurse manager, but she “felt okay” about that outcome. There was agreement, though, between Ricky and her colleagues, who could see how a high-needs patient was benefiting from Ricky’s care. His rapport with Ricky was evident in the humour, such as jokes and their “own little handshakes,” that he shared with Ricky. Ricky chose a pink colour for the ‘Agreement’ petal because pink was a “nice light colour [that was] pleasant to look at.” Pink indicated that Ricky “was relieved” her motivation style was seen as meeting vocational needs.

5.2.3 Relationality

5.2.3.1 Evidence of Self-Positioning.

Positioning themselves as professional and collegial nurses and nurse managers, three participants (Lilly, Mons, and Nightingale) gave strong evidence of valuing ethical, team-focused work relationships.

- 1) Lilly positioned herself as a leader responsible for managing staff performance and professional development. She also revealed herself to be a mentor to colleagues and staff members. For example, Lilly advised a caregiver who made a medication administration error that “mistakes can happen” and are “quite common—even I [have] done lots of [mistakes].” She told him that realising and correcting mistakes gives a person strength. Furthermore, Lilly positioned herself as a professional manager by calmly offering a staff member counsel in private as she “did not want to make him uncomfortable.”

- 2) Mons positioned herself as having a collegial yet fun relationship with her fellow manager, with whom she “bounced ideas off.” This was epitomised by Mons suggesting the manager take leave for her birthday so she could go away for a much-needed long weekend. As a light-hearted birthday prank, Mons dressed up the manager’s car with balloons, which she knew her colleague would enjoy.

- 3) Nightingale positioned herself and her colleagues as having close rapport, despite her working with a couple of difficult individuals. Positioning herself as “professional,” Nightingale also described herself as “crazy” because she had “a sense of humour or something that breaks up the silence.” Nightingale’s self-positioning was supported by her colleagues’ joyful welcome when she returned to work from sick leave. She explained that her teammates greeted her enthusiastically because they were “happy to see her.” Nightingale’s colleagues said that her “being there gives a different atmosphere, a different vibe,” and they appreciated the “nice atmosphere” in the workplace when she was working.

5.2.3.2 Evidence of Other-Positioning.

In their stories of workplace interactions, three participants (Lilly, Carmel, and Lola) positioned their colleagues as either showing unprofessional and dismissive attitudes or being open to learning and supporting their team members.

- 1) In her stories of staff members responding in positive and negative ways to counsel, Lilly positioned her colleagues as professional and unprofessional. She positioned a caregiver as professional, for example, for apologising for his disagreeable mood and attitude and for showing his understanding and agreement with Lilly’s counsel. Conversely, another caregiver was positioned as unprofessional because of his negative response to Lilly’s guidance about his needing to be careful with administering medication. As the caregiver was “not happy” about receiving correction, Lilly had difficulty convincing him to recognise and learn from his medication administration error. In addition, when Lilly asked a nurse for a medical certificate for seemingly inauthentic sick leave, she faced having “a hard conversation” with the nurse. Lilly

considered the nurse's response to her request to be unprofessional since she was "not talking and hiding her unhappy and non-smiling face."

- 2) Positioning a nurse manager as not appreciative of the hard work that caregivers and RNs were doing, Carmel expressed her own appreciation of staff who were "extending [and] doing their best when they're short staffed." Carmel positioned several of her nurse colleagues as being difficult to work with, too. For instance, a nurse colleague blamed Carmel for not checking a resident for a fever, despite not being on shift with Carmel at the time, "so how [would] she know?" Another nurse colleague was held accountable by Carmel for her bullying and untruthful behaviour, which involved changing Carmel's first-hand observation notes about a resident's movement in bed. The nurse had accused Carmel of not having done "the right nursing intervention." This was because Carmel wrote in her notes that the resident moved well in bed, whereas the nurse thought the resident was unable to move and needed to be repositioned.

- 3) Lola reported having her professional thoughts and feelings dismissed by management and consultant doctors, after which her "little heart sank." Firstly, Lola positioned a senior manager as being unsupportive by "shooting down completely" Lola's suggestion to balance the hospital's enforced Christmas closedown with her seeing elderly patients struggling during the "tricky, tricky time" of COVID-19 pandemic restrictions. The manager positioned Lola as being difficult and "making so much fuss" about the need to open the clinic. Because the hospital was always closed over Christmas, the manager "didn't know why they were having this conversation." Secondly, Lola's feelings of being "a little bit out of her depth" visiting a patient at home were dismissed by a consultant doctor. He expressed his confidence in Lola's ability to care for "a complicated patient" and "sort out all the issues." Positioning the consultant as "not having any doubts that [Lola] wouldn't be fantastically persuasive," Lola did appreciate the "good relationship" she had with the doctor.

5.2.3.3 Evidence of Reflexive Positioning.

Five participants (Lilly, Mons, Jessie, Ricky, and Lola) demonstrated their reflexive positioning when positioning, and being positioned by, their colleagues as being, at times, caring and professional and, at others, unsympathetic and difficult.

- 1) Lilly used reflexive positioning to position herself and her colleagues as demonstrating mutual appreciation and—conversely—disappointment. She positioned a staff member as being “very helpful” for coming to work on her day off so as not to let the team down when they were short staffed. In turn, Lilly was positioned by the caregiver as being a grateful manager, leading to their mutual feelings of happiness and respect. While Lilly positioned a nursing colleague as being unhappy and upset with her workload during the 2021 COVID-19 lockdown, she was positioned by the RN as an inconsiderate manager for overburdening staff. This was because Lilly was not authorised by senior management to hire external agency nurses due to safety concerns.
- 2) Mons positioned herself as being supportive with staff who would not get the COVID-19 vaccine. She counselled her staff not to resign because of the ‘no vaccine, no job’ policy in the New Zealand aged care sector in 2021. Mons was, however, positioned by anti-vaccine staff as representing management that was uncaring in requiring staff to have a vaccine that “was rolled out too quickly” and was “actually quite dangerous.” Positioning herself as wanting to address staff members’ concerns about having the COVID-19 vaccine in a caring, non-threatening way, Mons shared information about governments combating pandemics with vaccines since the Spanish flu. Still, she was positioned as not having credible evidence to change the disbelieving staff member’s mind. Mons determined the staff member to be “closed [and] blocked” towards having the vaccine. This left Mons feeling frustrated that her staff member’s career was in jeopardy, owing to her mindset that “would not budge.”
- 3) Although Jessie was obliged to work with frustrated trainees who “couldn’t tell their manager” that they did not want to attend training, she felt supported by her team lead whom she respected. Jessie positioned a trainee as unmotivated and not committed to being trained by Jessie because “she was

just forced by the manager” and felt “sandwiched.” The trainee was not receptive to Jessie’s encouragement to do the training, positioning Jessie as “an easy target to dump all her frustrations.” Jessie’s highly qualified team lead, who she “liked so much,” positioned Jessie as needing her workload protected and work tasks supported. Jessie was, though, “putting [up a] boundary” with her manager because they already had “an overfamiliar relationship” as former team members.

- 4) Ricky’s colleagues were positioned as being at times unsympathetic and at other times supportive. Ricky positioned her nurse manager as acting in a “really culturally insensitive” way by demanding Ricky care for 11 patients instead of “the maximum of [...] five or six at a push.” Ricky protested that she was “not comfortable” and “frightened things [were] going to happen” because she was unable to monitor all patients. Being positioned by the manager as having no right to complain about her caseload, Ricky was told to “get back on the floor.” This was a positioning that Ricky rejected outright because she would not allow this precedent for a new nurse to be “expected to have whatever [caseload] is given.” After their confronting disagreement over Ricky’s “inhumane” caseload, Ricky positioned the nurse manager as “steering clear” of Ricky and her attempts to discuss “how things were for her when she first came over” to New Zealand. She instead only spoke to Ricky “in a professional capacity” about work tasks but in a “abrupt, even rude” manner. Nevertheless, Ricky preferred the nurse manager’s “cold” demeanour compared with the “unsafe” attitude she had previously displayed to Ricky.

Furthermore, Ricky positioned a shift lead who was not distributing caseloads equitably amongst New Zealand and IQN nurses as being “unfair” in overloading IQNs with high-needs patients. This could lead to IQNs’ possible burnout, especially as IQNs may demonstrate a “suck it up, buttercup” attitude because of “not wanting to make waves” about their caseload. Ricky, though, was positioned by the shift lead as being difficult and “attacking her management style,” telling Ricky to “keep her nose out as it was “nothing to do with her.” This resulted in Ricky’s explaining to the

shift lead that she was not being “awkward” but was upholding her belief that caseloads had to “be shared equally.”

Ricky positioned, and was positioned by, her colleagues as giving “good banter,” which was “part of being a team.” Ricky was thrilled with her teammates doing handover in Ricky’s native accent. Her colleagues had researched Ricky’s accent online, so she appreciated that they had “gone out of their way” to build team rapport and humour. Ricky positioned her colleagues as “looking like they were really getting into” the handover’s funny accent, which “gave her warm fuzzies.” In turn, she was positioned by the senior RN who led the handover as brave to “be so far away from home and on her own.” This left Ricky feeling thankful for her colleagues making her “feel like she is home.” Her colleagues positioned Ricky as appreciating “banter” because she would “give the mickey back.” They knew she would “really enjoy this handover,” which was correct because Ricky “cried laughing.”

Moreover, Ricky was “grateful” that it was a senior RN telling her of the workplace misunderstanding that resulted from her use of the phrase ‘rooting around’ when describing her weekend activities. He realised Ricky had made a “genuine mistake” because she was “not to know” that in New Zealand this phrase refers to licentious behaviour. Positioning her colleague as always finding “the right words to use [to not] inflame anything or make you feel bad,” Ricky was positioned by the RN as not being “that type of [promiscuous] person.”

- 5) Lola’s reflexive positioning of her colleagues and herself demonstrated aspects of her professional identity as an experienced nurse and educator. Lola reflexively positioned herself and her colleagues in diverse ways to represent her sense of professional self in challenging and positive workplace interactions. She positioned her colleagues in responding in “not a particularly helpful” way when Lola offered advice and feedback to overcome workplace challenges. Positioning a registrar as disbelieving Lola’s ability to persuade a patient to go into respite care, Lola noted the doctor was “sitting there waiting for it all to go wrong.” However, when Lola told the patient and her family the benefits of respite care, the registrar was thankful

for Lola's "amazing" conversation, which "was really good to see and hear" for her medical practice. She positioned Lola as an experienced clinician and patient advisor, owing to her ability to soothe the patient. The registrar expressed her intention to use Lola's calming phrases and manner in her job when explaining clinical services. Furthermore, Lola positioned her line manager as being unusually angry and confrontational when responding to Lola's feedback that nurses were concerned about health details, like BMI, being collected during the COVID-19 lockdown. Although the manager criticised Lola for not challenging her colleagues' convictions about the COVID-19 vaccine, Lola felt that it "wasn't her place," suggesting to the manager that "people are entitled to their thoughts." This resulted in the manager launching into "a tirade about anti-vaxxers and [...nurses] not being allowed [their] own thoughts."

Lola did enjoy several positive workplace interactions with colleagues that boosted her confidence in her professionalism. She positioned a cleaning staff member as "very, very quiet and very reserved" around doctors and nurses, wanting to avoid Lola when she was working late. At the start of the COVID-19 lockdown in 2020, the cleaner was worried about the risks of working at a hospital. She sought Lola's advice about COVID-19, which Lola "was really, really pleased" about as the cleaner saw her as friendly and knowledgeable. Recognising that her "smiling and waving was really good" in helping the cleaner feel confident in seeking her medical knowledge, Lola gave the cleaner "as much information as [she] could." Lola was also positioned by an "enthusiastic" and "very helpful" nurse colleague, who was "good at her job," as being organised at a meeting. This compliment made Lola feel "very chuffed," although she "wasn't feeling very organised" at the time. Lola appreciated receiving praise because "it always seems so effortless for her [colleague]."

5.2.4 Consequentiality

5.2.4.1 Evidence of Social-Cognitive Implications.

The key social-cognitive implications at Level 1 were related to organisational communication processes experienced by one participant (Nightingale), particularly during the 2021 COVID-19 pandemic restrictions.

- 1) Nightingale recognised that unclear communication, involving language and cultural barriers, meant that workplace messages were not conveyed to relevant staff. This led to miscommunication hindering Nightingale's and her colleagues' understanding of COVID-19 rules and procedures at their workplace. Nightingale believed that having a mix of cultures in a healthcare workplace could result in staff who had problems with colleagues "trying to be manipulative, trying to give a [reputation] that's no good, just judging by one occasion." Instead, she recommended her colleagues should talk to the person with whom they had a personal problem or talk to a manager. This was so they could solve the problem "the right way" as there were "different personalities, character, culture" in workplace settings.

5.2.4.2 Evidence of Moral Implications.

There were moral implications of the workplace interactions that two participants (Rose and Nightingale) experienced with their colleagues.

- 1) Rose noted the importance of showing care and compassion to difficult colleagues. For instance, Rose gave support to a student nurse when she discovered her "big fallout with the preceptor." Talking to the student in a friendly manner, Rose advised, "These are all negative feelings you're carrying like boulders tied to your ankles, which you need to unlock. [You can] then move forward with a positive thought." Rose's compassionate guidance led to a surprising turnaround two weeks later when the student was "a changed person completely—so chirpy, very talkative." Nonetheless, Rose knew she needed "to inculcate some nursing responsibilities on her" to increase the student nurse's professionalism.
- 2) Nightingale reflected upon the benefits she had seen from staff being heard by management. She and her colleagues were invited to give mutual feedback about "what went well, what didn't, and how to improve" to solve problems. Nightingale recognised the need for nurses to be "as a team, be together as one voice, one vision, one mission [...and] not going to the different direction." Therefore, encouragement from management for nurses to provide input would help ensure the team followed mutually understood processes.

5.2.4.3 Evidence of Professional Reflection.

Two participants (Jessie and Ricky) reflected on the importance of giving in-person feedback or critique to a colleague.

- 1) Jessie recognised the benefit of speaking directly to trainees since it motivated people to “push through the training and learn new skills.” This was because a face-to-face interaction made both trainer and trainee feel “connected from the heart as nurses,” leading to mutual understanding. In addition, Jessie valued receiving constructive feedback from her manager on her comments to a trainee. She was “delighted with the manager’s support and feedback” as they discussed “different techniques on how to make comments to a trainee softer and lighter.” Their discussion resulted in a boost to Jessie’s confidence and her feelings of validation.

- 2) According to Ricky, it was important to speak to a shift lead in private about the unfair caseload and overburdening of IQNs. This was because having such an awkward conversation in front of colleagues would be “so uncomfortable for everyone,” particularly since Ricky had “had it done” to her. The shift lead tended “to give the bulk of the work to Asian, Indian, and then UK nurses...in hierarchical order,” and Ricky felt that this was not “fair play.” In confronting the shift lead, Ricky was “not making it personal, not being racist” but instead showing her that she was “picking on us [IQNs].” In Ricky’s view, nurses needed a balance of high and lesser acuity, so Ricky explained to the shift lead that with such a high caseload she would “be struggling.” The shift lead “was not impressed” with Ricky’s advice, though, and “would not speak to [her] for a while.”

5.3 Level 2 Positioning

5.3.1 Positionality

5.3.1.1 Evidence of Agency and Control.

At Level 2, five participants (Lilly, Carmel, Jessie, Nightingale, and Lola) displayed differing levels of agency and control as nurses and/or nurse managers in the healthcare workplace.

- 1) Lilly acknowledged her authority as a Clinical Lead to take corrective action with a caregiver who needed to be counselled for making a medication administration error. She recognised her job responsibility to give counsel, despite it being “not a nice or good feeling,” saying that as a manager “you have to do it.” Nevertheless, Lilly experienced “no negative effect” one week later upon the professional relationship she had with the caregiver. This was because after Lilly’s correction, the disagreement was resolved.
- 2) Carmel displayed her authority to advise staff of infection control measures in her new role as Virus Control Lead. She was feeling “all right” about the role, despite not being able to control staff members’ responses to her guidance. According to Carmel, “sometimes caregivers will listen, sometimes not,” so she needed to be confident in her ability to provide infection control support to staff and residents.
- 3) Jessie had the agency to make personal appointments during work hours if she followed the expected process of notifying her manager in advance. Emailing her manager prior to the appointment about needing time off was “a better approach because it was not an emergency.” Admitting there was “miscommunication at her end,” Jessie understood that she “could have talked to [her] manager [about the] personal appointment.” Jessie duly made a “genuine” apology to her manager. However, she argued that normally, if Jessie knew she was right, she would “not keep on apologising,” otherwise management “will step on you because you’ll just follow control.”
- 4) Nightingale had the agency to determine whose instructions to follow. These were either the Ministry of Health’s orders on their website for the healthcare sector or the directions from “one specific person just giving the order, but he’s not the boss.” Nevertheless, she lacked control of the communication processes implemented by top-level management who were “not communicating well themselves.” Nightingale was concerned that staff were put in “the awkward position” of wondering “who to follow....the manager, the coordinator, or the director of nursing.” This was because the directives

did not clarify who staff were obliged to listen to and they “can’t just listen to anyone.”

- 5) Lola had the agency to make home visits during the enforced Christmas closedown at her healthcare workplace. She considered these home visits to provide benefits to patients. Lola was “cross” that visiting patients was not seen to be crucial to assist those who were struggling due to “tricky” Covid restrictions. However, she did not have control of the response from her senior manager, who failed to provide support in keeping the clinic open for enforced holiday time. Lola felt she was following an “inflexible system,” resulting in her patients’ needs not being met. This was despite the doctors having to do home visits and doing “as best that they could.”

5.3.1.2 Evidence of Sameness and Difference.

IQN participants demonstrated similarities and differences with their nursing colleagues as seen by four participants’ (Mons, Rose, Jessie, and Nightingale) stories of workplace interactions.

- 1) Mons felt that she was different to other managers at her facility who displayed a more formal managerial style: “I do have quite a big mix of our managers that are strictly policy and procedure. [...] Others are borderline, depending on who they’re mixing with. And then they have me. I’m more the relaxed, the other side. Compassionate.” Secondly, positioning herself as the same as her fellow manager because they “laugh about the same things” and are “upset about the same things,” Mons said their collegial relationship was like being in “a work marriage.” While Mons acknowledged that she and her colleague were different to each other as they were “normally the opposite a little bit,” they were able to “bounce off each other [and] get on so well.” According to Mons, their positive relationship was “a nice place to be,” and she appreciated the change in their relationship over the year. Her second-in-command used to not initiate hugs, but she recently gave Mons a hug. This was “like getting affection,” which Mons felt was rewarding.
- 2) Rose positioned herself as the same as nurses from other disciplines because “there’s nothing a nurse should not know what to do—it’s all part of the

nursing thing.” She did observe her different clinical background compared to more specialist nurses: “The only thing I would struggle with [would be] oncology. I’ve never worked in oncology, but the rest of it...I’ve worked everywhere.”

- 3) Jessie positioned herself as aligned with her manager and colleagues in being “open to learning” and enjoying “intact and [...] really close relationships” but having different clinical backgrounds and professional strengths. As her team leader saw clinical problems differently, Jessie carefully considered how to explain a patient’s clinical condition to her manager without offending or undermining her. Jessie also positioned herself and her colleagues as being “there for each other and [to] back up each other.” She did feel dissimilar to her fellow nurse educators in other offices, who she believed were treated differently by management compared to Jessie and her other remote workers.
- 4) Nightingale positioned herself as being the same as her colleagues because they were all at the same level. Stating that she did not have any problems with fellow nurses or medical students, Nightingale was “not taking any side.” Still, she positioned herself as different from her fellow nurse colleagues because she did not know why they saw medical students as “snobby.” Nightingale believed that judging students or assuming snobbiness was unnecessary. As medical students needed “to learn, it’s not necessary to judge. Everything takes time until they adjust and know everything.” Wanting to make the work environment calm and comfortable for her colleagues, Nightingale preferred to “wait and see what experience she would have with new colleagues,” rather than prejudging people.

5.3.2 *Emotionality*

5.3.2.1 Evidence of Discursive Language.

There was strong evidence that six participants’ (Lilly, Mons, Carmel, Jessie, Ricky, and Lola) literal and non-literal language showed the range of emotions they felt about their workplace interactions with healthcare colleagues.

- 1) Lilly expressed her feelings of frustration and happiness using both literal and non-literal language when talking about her workplace interactions with colleagues. She said she was “initially angry” when a caregiver did not accept Lilly’s correction for his mistake or see it as positive. However, she later felt happy when the caregiver tried to understand Lilly’s advice. Lilly felt “shocked” upon seeing the wrong medication had been administered to a resident, saying she was “sad and sorry for the resident who had the wrong medicine.” She did feel “happy,” though, that staff members agreed with Lilly’s rationale for not hiring agency staff during COVID-19 restrictions. This contributed to a mutual resolution of their feelings of upset, as Lilly was “not feeling good after the conflict.”

Lilly was also pleased that staff members understood her explanation of health and safety requirements during COVID-19 restrictions despite their extra workload. In fact, staff were happy to make a plan to divide their tasks: “They were like a team, and they [did] share their work, and they [were] all happy.” Lilly used the metaphor of “achieving a victory” when describing her happiness and pride at managing a corrective conversation with a caregiver who made a medication error because “we made it.” She recognised, too, that nurses need “lots of boosting up” to maintain their confidence when they make a mistake. This is because RNs benefit from professional reflection as “they’re alone” in learning from their own errors.

- 2) Mons’s literal and non-literal language demonstrated her dichotomous feelings of upset and wellbeing when engaging in professional interactions with her colleagues. Mons expressed her feelings of being attacked by a terminated employee’s union representative, who was impatient, rude, and “just a very mean person.” “Biting [her] tongue” during the employee’s disciplinary meeting, Mons politely accommodated the representative’s demands with composure. This was because her aim was not to “fall for the bait” but instead “kill people by kindness.” Mons also felt “torn” about dealing with a colleague’s unprofessional response to a stressful workplace situation. Wanting to hide her angry emotions, Mons responded by “putting her thinking hat on” to find a mutually acceptable solution for her colleague’s work stress. Conversely, Mons felt “really good” about being “close” with

her fellow manager “to support each other strongly.” She recognised that, as managers, “the higher you are, the lonelier.” Their shared maxim of “united we stand” was “nice in a workplace when you’re the manager” who had to make difficult staffing decisions.

- 3) Carmel’s use of literal language revealed her feelings of both disappointment and satisfaction in communicating her professionalism to colleagues. Carmel felt disappointed by the Nurse Manager being “biased” in “justifying the wrong actions” of the RN who made medication errors. She was also “uncomfortable” when a fellow RN called in sick, leaving Carmel in sole charge over the weekend with no support from her manager. Although Carmel felt “okay working alone” with the caregivers, she felt disheartened thinking that the RN would not thank her colleagues for their hard work or give them “a pat on the back.” Carmel did feel happy, though, about making “an action,” emailing her concerns about frequent medication errors to management. Her complaint was later upheld by management via professional learning at a staff meeting. Carmel was “glad that there’s a positive outcome on that negative situation” of having her queries about the removal of medication errors by the Nurse Manager rebuffed. Furthermore, Carmel was satisfied about winning the staff member of the month award. After receiving a voucher and a card from management, Carmel said she felt appreciated for “everything she [was] doing.”
- 4) Jessie felt “touched” by her colleagues who telephoned her during the COVID-19 lockdown in 2021 to ask if she needed support. Jessie appreciated how, as a team of nurse educators, they looked after each other. In fact, her colleagues were “the reason why [Jessie was] staying, apart from loving the job, when [feeling] frustrated about management.”
- 5) Ricky had “a good laugh” with a senior RN from Ricky’s home country, after finding out the meaning in New Zealand of the idiom ‘rooting around’. Ricky felt a sense of camaraderie with her nurse colleague, who explained the misunderstanding to Ricky’s colleagues so “it turned into a joke.” Suggesting the need for “a rulebook,” Ricky co-constructed with her listener that a

glossary of Kiwi English slang would help IQNs in New Zealand avoid using innocent expressions that “could mean something so different.”

- 6) Lola used literal and non-literal language to depict her positive and negative feelings about interacting with colleagues and managers. She was surprised at being congratulated by a senior manager for her contribution to a working party that “managed to [gain] accreditation in the field of dementia.” Lola positioned herself as “a doer,” so she felt “very chuffed to be appreciated.” Since Lola did not know if the manager recognised her, she felt very embarrassed at first because she “doesn’t like attention.” Yet, it was “nice to be acknowledged” by the manager, and the praise was “a nice reward for all her hard work.” Although feeling “really good” about being congratulated, Lola was “not good at accepting praise,” so she kept turning it back to the team’s hard work. She later realised she should have been “gracious” and simply thanked the manager. Lola was also embarrassed by her colleague saying to her, “Your patients were lucky to have you.” Lola told herself to accept the compliment: “Don’t argue. Just say, ‘Thank you very much.’”

Working in a light-hearted workplace, Lola was teased for “being the foreigner in the office and team.” Lola shared great rapport with her colleagues and felt “very blessed” to work with “fabulous nurses, [who were] very supportive, very caring, very skilled, very competent.” When a doctor colleague called Lola “a miracle worker” in taking care of a patient, Lola thought his praise was “nice in a way.” Nonetheless, she did feel “frustrated” by the doctor’s overestimation of her ability in caring for a high-needs patient. This was because his evaluation was “fairly unrealistic and set [her] up to fail with this patient,” leading to Lola being “miffed that [she] got put in a tricky situation.”

5.3.2.2 Evidence of Visual Language.

At Level 2, all eight IQN participants (Lilly, Mons, Carmel, Rose, Jessie, Nightingale, Lola, and Ricky) used diverse colours, words, and shapes in their Flower Diagrams to reflect their feelings about their conversations with colleagues.

- 1) Lilly selected red, ash brown, black, and orange for Flower Diagrams related to her challenging workplace interactions. She coloured in the ‘Disagreement’ petal red as it represented “danger” and feeling “not happy” about a caregiver who recognised a medication administration mistake but disagreeing with, and resisting, Lilly’s correction. Selecting an ash brown colour for the ‘Misunderstanding’ petal, Lilly explained she was concerned that her RN colleague was “not aware” of her medication error and the potential serious outcomes of the mistake. This aligned with her selection of a red colour for the ‘Disaster’ petal indicating “an accident,” “a stop sign,” and “an alert” because “medication errors can kill someone,” which is “not supposed to happen.”

- 2) Mons used bright colours in her Flower Diagrams to represent her feelings of collegial adoration, understanding, and unity. Selecting a teal colour and drawing a love heart in the ‘Triumph’ petal, Mons expressed her happiness about sharing such close rapport with her fellow manager, whom she called “my love” and “my butterfly girl.” She also chose a pink colour for the ‘Triumph’ and ‘Understanding’ petals to reflect Mons’s feelings of pride towards her team members. Mons called them her “work family” and her “babies” because they were “so sweet” and made her both smile and cry. Mons explained that she loved her work, and when she did not “feel pink,” she would “pluck the challenging petal off and a new one [would] grow” for “everything [to be] nice.” The ‘Agreement’ and ‘Understanding’ petals were coloured pink, which represented Mons’s appreciation of team unity. Her job satisfaction benefited from Mons’s expectations for staff members to tell her if she was “above the line—happy—and below the line—grumpy.”

- 3) Carmel used colours and shapes in her Flower Diagrams to reveal aspects of her sense of professional self in challenging and positive workplace interactions. Carmel selected a yellow gold for the ‘Triumph’ petal and drew a star in the petal because she was “shining like a star.” She was feeling “recognised and appreciated” and growing in confidence in her role of Virus Control Lead. Selecting a “nice grass green” colour for the ‘Triumph’ petal, Carmel explained that green represented the “beginning,” “spring,” and

“growth” of her accepting the role. The word ‘A-ha’ indicated Carmel’s feeling of “achievement” that her manager “trusted her” and saw her “as an asset in the workplace.” Carmel also chose a dark green colour for the ‘Understanding’ petal to signify “growth and positivity.” This was because she was “the one on the go because green means go. I’m the one in control. I am the captain of the ship.” Conversely, Carmel coloured in the ‘Disaster’ petal red, black, and green because of her misunderstanding with a bullying nurse colleague and “the way she talked, the way she treated” Carmel. Red referred to the nurse’s unethical behaviour, like changing Carmel’s observation notes. Black showed “problems,” and green represented Carmel “trying to correct and trying to tell.”

- 4) Rose used various colours on her Flower Diagrams to represent her emotions about challenging and positive conversations with her colleagues. She coloured the ‘Misunderstanding’ petal the “very aggravating” colour red to indicate her feeling “incomplete” at not being able to explain why she had come to observe her colleague checking the cold chain fridge after a power cut. Rose’s appearance resulted in the nurse becoming irate and refusing to listen to Rose. Selecting orange for the ‘Triumph’ petal because “it brightens your mood; it uplifts you,” Rose showed she valued the rapport she later created with the RN, who had apologised to Rose for her unprofessional response.

Rose explained that she worked to develop agreement and understanding with her team of nurses: “We always think that we won the battle.” Selecting a green colour for the ‘Triumph’ petal because green is “very cool,” Rose believed she was developing a close relationship with her colleagues and graduate nurses. She also chose a blue colour for the ‘Triumph’ and ‘Agreement’ petals to signify the sky. According to Rose, “you’ve got to spread your wings wider” and enhance collegial relationships since “there’s no limit to confidence building.” Rose chose a blue colour and a light green colour for the ‘Understanding’ petal to represent her rapport with her senior RN colleague and with a new graduate nurse respectively. This was because “blue is calm” and “green is soothing for the eye, for the mind. It’s always a positive thing.”

- 5) Collegiality was an important feature of Jessie's satisfaction with her work team. Selecting a teal colour for the 'Triumph' petal and the overlapping petals of 'Understanding' and 'Agreement', Jessie explained that "if you understand each other, you agree with each other, and that's a triumph." Teal signified Jessie's feeling of "being relaxed and being in the clouds" because despite "the lockdown and poor communications with management, colleagues make you feel relaxed."

When reflecting on her challenging interaction with a resistant trainee, Jessie selected a red colour for the 'Oh!' petal, writing "Oh! Why are you so mad" in the petal. To Jessie, red denoted anger or aggression from the manager who did not want to have training. The manager's wrath left Jessie feeling "affected" and "taken aback." She experienced "a [hot] flash," noting that "when you're taken aback, all your senses are active; you turn red as well." Jessie also chose a violet colour for the 'Disaster' petal because "this was the last straw when she lashed out at me." Violet represented the disaster that "led to peace" between Jessie and the trainee. Their conversation involved the trainee going "on and on with the verbal lashing out." According to Jessie, "it ended well" because she spoke calmly with the trainee, "just explaining things and understanding where she's coming from." Jessie believed that all petals representing the conversation with a resistant trainee were interconnected: "We had a disagreement. We didn't understand each other. That led to a disaster. And 'A-ha!' We've resolved the conflict." The 'Oh!' petal was "a space to remember—to reflect and understand that [this] was not really a disagreement or disaster, but a reactive misunderstanding."

Conversely, Jessie coloured in the 'Triumph' petal pink and yellow to represent her positive emotions when helping a trainee and receiving supportive feedback from her manager. She selected a pink colour for the 'Triumph' petal and the 'Oh!' petal. Writing "OK" in the 'Oh!' petal, Jessie said that her feelings towards an anxious trainee were "Oh, how can I help you with this?" The trainee was "willing to learn and listen" to Jessie, who felt she wanted "to help her succeed in the technology and navigate software." This resulted in "a very positive, encouraging" interaction because the trainee was happy with achieving her competency. Jessie chose a yellow

colour for the 'Triumph' petal as well, explaining that yellow was "like the sun is out; it's smiling; it's a happy colour." Jessie expressed her satisfaction with helping a trainee achieve competency. She was glad to see a colleague feel "positive and happy with the learning journey" and have "those a-ha moments" when developing new skills.

Colouring a yellow colour in the 'Triumph' petal, along with the overlapping parts of the 'Understanding' and 'Agreement' petals, Jessie also described her emotions as "shining bright as the sun." These colours represented her happiness when she received "validation" from her manager that she was safe in her practice and "doing it right." Jessie noted that her new team leader was the team's "sunshine now," clarifying that "sunshine yellow is something light. When you wake up and you see the sunshine, it's like there's a hope for today, and it's sunny [and] nice." The rapport that Jessie had with her team lead was "an a-ha!" because "even if you don't say anything, she's already picked up your problem."

- 6) Nightingale used diverse colours to represent her emotions related to sharing professional knowledge and rapport. She selected a purple colour for the 'Misunderstanding' petal because it signified Nightingale having doubt in herself. Indeed, Nightingale was questioning whether she was "the only one who misunderstands" because English was not her first language. She observed that some people in her workplace used different words and intonation. They went "around, around, around the circle to get to the point," which created the issue of others misinterpreting the message. Nightingale also chose a bright orange colour for the 'Understanding' petal. Orange signified her "waking up from the darkness, from being black or brown and then suddenly 'Ah! I understand,' brightening up your mind." IQNs needed to develop their understanding about the health system in New Zealand, since "countries are different. So, for somebody to share knowledge about the system, it gives IQNs more understanding." For instance, Nightingale coloured in the 'Oh!' petal a red colour and wrote in the petal "supportive" to indicate the credibility of the Āwhina app. This app gave healthcare workers important COVID-19 information to "extend [nursing] knowledge beyond [their] own capability." Admitting that she was "not a technology person,"

Nightingale said she was “always willing to learn something new.” If a colleague helped her, she felt “encouraged, supported.”

Reflecting her feelings towards working during the COVID-19 pandemic restrictions, Nightingale selected a blue colour for the ‘Understanding’ petal, which Nightingale linked to “blue sky thinking” and having hope. She noted that “hope is always there” when interacting with colleagues who may not understand COVID-19 vaccine regulations in New Zealand. She also chose a brown colour for the ‘Oh!’ petal, writing in the words “positive energy.” This was because brown is “kind of like energy from the soil,” connecting to the team with positive energy. Despite the COVID-19 restrictions in place at the time, Nightingale felt she had the energy to enjoy coming to work with her colleagues, with whom she valued having “a good laugh.”

A peaceful work environment was important to Nightingale. This was seen in her selecting the ‘Triumph’ and ‘Understanding’ petals to depict several positive workplace interactions. Nightingale chose a yellow colour for the ‘Triumph’ petal because “triumph is kind of like you waking up” and “yellow is part of [bringing] up the energy—positive energy—and it’s peaceful as well.” She wrote the word “peaceful” in the ‘Oh!’ petal to signify the need for a work environment to be peaceable: “You can’t have tension all the time with your work colleague.” Team members should have fun together, since “the workplace becomes a hell” if workers are tense. Selecting a purple colour for the ‘Understanding’ petal, Nightingale wanted to understand her RN colleague “as a person as well as to understand more if she does have more knowledge.” Nurses benefit from sharing clinical skills or knowledge, so “purple is a peaceful colour,” even though the way the RN talked to her left Nightingale feeling “scared or frightened.” However, Nightingale did not feel angry but “kind of like hurting,” so “solving [the issue], understanding it more, [leads to...] relief and you become peaceful.”

- 7) Ricky selected a red colour for the ‘Disaster’ petal since red represented Ricky’s “embarrassment” that turned her face red when she found out that the common phrase ‘rooting around’ in her home country was a vulgar term in New Zealand. Ricky acknowledged that she was “catastrophising” her use of

the term as “it was like an absolute disaster.” She coloured in the ‘Understanding’ petal pink, since her face was “pink because [Ricky] was still slightly embarrassed,” even after her mentor explained Ricky’s meaning to colleagues. Although they now understood that she meant she had been looking around her new town on her days off, Ricky was “a bit flushed.” Yet, in Ricky’s view, it was good that “people actually gave [her] another chance.” This was co-constructed with Ricky’s listener as being a relief to be told of the faux pas, despite her embarrassment.

When reflecting on the nurse manager who was “surprised that Ricky had the guts to report” her unfair caseload to the nursing union, Ricky chose “the deepest red” colour for the ‘Disaster’ petal, in which she wrote the word “understanding.” This was because red indicated “danger” and “high alert” in nursing that something catastrophic was happening. According to Ricky, “red is for ‘stop’,” although she believed it would be unlikely other nurses from other cultures would have reported the “inhumane” treatment. Certainly, Ricky felt she was “standing up for all nurses.” Ricky also selected a red colour for the ‘Disagreement’ petal because red signified the “fiery atmosphere” she experienced with a shift lead after her protest at IQNs’ unfair caseloads. This led to a “very awkward [atmosphere] you could cut with a knife.”

Nevertheless, Ricky valued the warm professional relationships she had with her colleagues. She chose a yellow colour for the ‘Triumph’ petal because “yellow is nice, like a hug in a colour,” which was Ricky’s experience of her team’s rapport during a humorous handover meeting. She felt she was “on the right path” with the way she was interacting with her teammates, with whom she could be serious about work but also “have some zest”—“How can you not embrace the love there?” Ricky also appreciated the senior RN in her team who “had a warm, lovely heart,” and she “found it hard to leave” her nurse colleague to move to another workplace.

Ricky selected the “nice, happy, bright” colour yellow for the ‘Triumph’ petal to symbolise the collegiality she enjoyed with her former manager. Although being like “an old-style matron,” she would assist Ricky when the “serious stuff” was happening with challenging patients on the ward. This was co-constructed with Ricky’s listener as signifying the need for

managers to continue “having nursing in their veins” to provide clinical support. Such support is essential “if there is any drama or conflict.” Therefore, managers should not just “sit in their ivory tower and not come down to see what happens on the units and wards.”

Ricky appreciated the “release valve of humour and funny support and taking the mickey” she received from her colleagues to cope with work pressures. After receiving a supportive email from a senior manager who praised Ricky for her professionalism, Ricky selected a yellow colour for the ‘Oh!’ petal because “it’s a nice, bright, vibrant colour—a bit loud [like Ricky].” She wrote the words “I’m back!” in the petal to represent her feelings of being valued as a nurse and professional. Consequently, Ricky would always let new staff “know they’re not alone” through “sharing meals and having a laugh” as a team. This was because she remembered what it was like being new and uncertain in a nursing role.

- 8) Lola chose a range of colours and shapes for her Flower Diagram to represent her emotions connected with challenging and supportive conversations with her colleagues. She selected a red colour for the ‘Disagreement’ petal because “red is an argumentative colour” to depict a senior manager not understanding why Lola wanted to offer clinics over Christmas. Co-constructing with the listener her sense of a lack of reconciliation and her reduced agency, Lola wrote the words “upset,” “withdrawal,” and “frustration” in the ‘Disagreement’ petal. These words indicated that the senior manager “wasn’t hearing” Lola’s perspective and did not agree with what Lola “was trying to put across.” Lola chose a red colour for the ‘Disagreement’ petal as well. Red signified the colour of her face when Lola found she had “been dropped in it” by her colleague, who had volunteered her to care for a patient. It also indicated Lola’s annoyance that this proposal was not what she and the doctor had discussed, co-constructed with the listener as Lola having to “keep that professional face to bottle up upsets.”

Selecting a light pink colour and a red colour for the ‘Oh!’ petal, Lola wrote the words “Oh, dear!” in the petal to show her reaction to looking at a highly experienced nurse’s cognitive assessment scoring. Lola was thinking ‘Oh, dear’ as she knew she had to phone the nurse to advise her of the

mistake. The red signified “all the worry” Lola felt about the possibly “disastrous phone call,” in which she was “going to upset [the nurse].” This was co-constructed with her listener as representing Lola’s working that anxiety up in her head “bigger than big.” To represent her feelings after having phoned the nurse, Lola chose a light blue colour for the ‘Understanding’ petal and a dark blue for the ‘Triumph’ petal. Lola recognised that she had overcome her anxiety, moving from “red, which is hot and flustered to blue that was cool.” Blue indicated that everything “was good, so woo hoo!” After the phone call, Lola’s colleagues reminded her, “The next time you do that, it will be easy.” Still, Lola recognised her propensity for “working up” in her head the possibility of having “tricky conversations” on the phone, which was common for both Lola and her listener.

Lola selected bright colours for her positive feelings of being appreciated by her managers and colleagues. She coloured in the ‘Oh!’ petal a pink colour as it signified “the nice shade” Lola went due to “the panic” she felt upon realising that senior managers wanted to congratulate her on attaining accreditation. Being acknowledged by a senior manager for her and her team’s hard work was “really, really nice” and “a real triumph.” Lola represented her feelings of accomplishment by colouring in the ‘Triumph’ petal a purple colour. In addition, Lola chose a yellow colour for the ‘Triumph’ petal because yellow signified the “sunny, happy and cheerful, and woo hoo” emotions she felt when her colleague complimented her nursing skills and caring attitude. Reflecting that in “stressful times, it’s always nice to have a colleague acknowledge what you do,” Lola appreciated being told “how fabulous” she was. This aligned with Lola’s sense that her colleagues saw her as “kind” and “a little soft,” believing she “really does have a big heart and cares a lot about [her] patients.” Lola selected a yellow colour for the ‘Understanding’ petal and orange for the ‘Triumph’ petal when reflecting on providing advice about COVID-19 to a cleaning staff member. According to Lola, yellow was a “happy, happy colour,” signifying the cleaner’s developing understanding of the coronavirus. The “nice, warm, huggy colour” orange reflected “that warmth” both she and the cleaner felt after their collegial conversation.

5.3.3 *Relationality*

5.3.3.1 **Evidence of Self-Positioning.**

Positioning themselves as supportive and confident nursing professionals, seven participants (Lilly, Mons, Carmel, Rose, Nightingale, Ricky, and Lola) demonstrated their commitment to collegial working relationships.

- 1) Lilly positioned herself vis-à-vis the listener as a kind and compassionate leader and colleague, who did not want “to give anybody a bad day.”
Positioning herself as a confident user of the telephone by having practised taking phone calls, Lilly confirmed that she used telephone strategies, such as speaking clearly and slowly and breaking instructions down, to understand others and be understood by them. Lilly said she was “the one who [answered] all the [phone] calls here in terms of nursing enquiries.”
- 2) Positioning herself as a “people pleaser” without an ego, Mons also demonstrated her willingness to stand up for staff when they had been bullied by a family member who complained about the food served in their aged care facility. Mons had wanted to confront the family member about the way she treated staff members because “there should be some boundaries” to protect staff. Mons explained that she was “an open communicator,” who believed such bullying behaviour was unacceptable. Furthermore, Mons positioned herself and her fellow manager as a team who have “pulled through a hard experience to get that common ground and become stronger.”
- 3) Carmel positioned herself as being “already more on the leadership side of being an RN and managing people.” She was looking forward to being in a managerial role, wanting “to manage people, to influence people.”
Positioning herself, too, as confident in making clinical decisions, Carmel wanted to be seen as an RN whose experience and self-belief showed that “you cannot argue with that lady. She’s small but terrible.”
- 4) Positioning herself as an ethical nurse and encouraging colleague, Rose wanted to uphold her principles of equity: “Am I [being] fair? Am I doing the right thing?” She recognised that having specialist clinical knowledge, strong

family support, and secure financial background meant that management might “put you down if they don’t have that. And [if] they have got a [managerial] position, they know how to step onto your feet.” In addition, Rose indicated that she was a caring and non-judgemental mentor and team manager. Helping with patient clinics to reduce less-experienced nurses’ anxiety and completing clinical tasks if nurses were busy was important to Rose. Called a “brilliant” nurse by her colleagues, Rose declared, “I do not say no. And they’re really very appreciative of what I do for them.” Although Rose positioned herself as an efficient nurse, she admitted that she was “just a human” nurse, who “can be wrong,” so she welcomed criticism of her clinical practice.

- 5) Coping well with work problems was important to Nightingale, who positioned herself as “finding a balance” between small issues she could deal with and big issues that she needed to ask a colleague about. She felt confident in asking questions to management when there was an “issue, a big deal,” about which Nightingale believed she was not informed. Nightingale was open to learning because if a nurse wanted “to be there or get there” in their nursing career, “you have to ask questions if you don’t know, otherwise you’re [...] being passive.” She recognised that she was “not that type of person” because she took an active role in her professional learning.
- 6) Ricky positioned herself as feeling “calm” and “full of hope” about a new job in general practice as she had colleagues whose contacts were happy doing similar jobs. She admitted that she knew “how to be with people.” Even if she could “not be expected to have all the answers,” she could “listen and help advise” patients and colleagues in her nursing advisory role.
- 7) Lola valued having developed professional rapport with a cleaning staff member, positioning herself as having a helpful nature, such as always offering to move when the cleaner needed to work in her office. Noting that “nurses had limited information” in the early months of the COVID-19 pandemic,” Lola confessed to being “a little bit on the histrionic side at times” when feeling anxious. Yet, when responding to the cleaner’s shy

questioning, “the nurse bit rather than the ‘[Lola]’ bit kicked in.” Lola positioned herself as putting her own anxiety about COVID-19 aside when passing on “accurate [coronavirus] information at the right level” to the cleaner. Their previous positive interactions, Lola believed, had encouraged the cleaner to approach her for COVID-19 advice. Lola was then “able to soothe” her colleague because she recognised that the cleaner “liked to be as invisible as possible.” This might have resulted from the cleaner’s “negative experiences [...] where people have shouted at her.”

Lola’s co-constructed self-positioning with her IQN co-participant reflected her feeling disorganised and thinking that others could perform work tasks more easily. Thus, Lola agreed with her co-participant’s observation that getting a compliment from an admired colleague “hits you in the heart in a good way.” Since colleagues do not give much praise as “they just expect [work tasks] to be done,” Lola and her IQN co-participant acknowledged that receiving a compliment could be hard for nurses because in healthcare “you do the job of three.”

5.3.3.2 Evidence of Other-Positioning.

In their stories of workplace interactions, four participants (Lilly, Jessie, Nightingale, and Lola) positioned their colleagues as showing professional and positive attitudes towards team members.

- 1) Lilly’s colleagues were positioned as professional workers who, despite some resistance to her instructions, were able to reflect upon their mistakes and learn from them. For instance, Lilly positioned a caregiver as having “a good attitude” for apologising for her previous angry outburst. She had responded irritably after Lilly asked her to toilet a resident when she had been on a phone call.
- 2) Jessie positioned her competency manager as “very soft spoken, very encouraging,” who knew how to deliver critique that is “very soft [and] nice.” Having “butterflies and hearts” on her face when reflecting upon her relationship with her manager, Jessie felt “like you want to be coached by her because she’s very encouraging.”

- 3) Nightingale positioned her colleagues as giving positive energy. This made her feel excited about coming to work to have positive workplace interactions. For example, she enjoyed talking about topics she could only discuss with medical people and doing the trivia morning quiz to “have a good laugh” and “work together as a team.”
- 4) Positioning herself as feeling anxious about phoning a “very experienced, very knowledgeable” practice nurse, clinician, and coordinator about her cognitive assessment error, Lola saw the nurse as an expert in her area of practice. Lola was also seen as an expert and an educator in her area of practice. However, she did not want to upset such a very competent and professional nurse who could be “scratchy.” Lola recognised that the head practice nurse had “done so well in primary care because [of being] very confident, very assured of her actions.”

5.3.3.3 Evidence of Reflexive Positioning.

Five participants (Lilly, Mons, Carmel, Rose, and Jessie) demonstrated their reflexive positioning when positioning, and being positioned by, their colleagues as strong, ethical, and caring.

- 1) Lilly positioned herself as being calm and silent in response to a cleaning staff member’s being “not in a happy mood” when asked to clean a room before a new resident’s arrival. At the same time, Lilly was positioned by the team member as a manager who expected cleaning staff to “do a beautiful job” when preparing residents’ rooms.
- 2) Positioning her fellow manager as “a hundredfold stronger” than Mons with “a steel backbone,” Mons was positioned by herself and her listener as “mushy” and “all soft inside.” Whilst wanting “to kiss and make up,” she also showed her backbone through standing up for her staff. Her manager colleague in turn positioned Mons as being “funny.” Indeed, she laughed at Mons’s comments about their professional challenges, namely “what doesn’t kill us makes us stronger.”

Mons expressed her desire to be fair-minded towards all staff as “everyone deserves a chance,” despite having been disappointed by unprofessional or unethical staff in the past. She was positioned by a colleague as being “a wuss” who “just liked everybody,” although Mons was not ready “to change her true self.” Mons positioned her relationship with the aged care provider’s CEO as being one of cooperation, too. She felt that he was “very [realistic], hands on, [and] on the ground” in conducting “plenty of Head Office visits” with Mons and the staff at their aged care facility. She relished being positioned by the CEO as a valued staff member, revealing that it was “lovely that you get acknowledged.”

- 3) Carmel positioned her clinical leader and manager as supportive and not blaming staff during challenging clinical situations involving residents’ families. Carmel felt motivated “to work more.” She said she had “the presence of mind” to “do the right thing” with confidence and without regret, thereby gaining managers’ support.
- 4) Rose was positioned by the practice manager, who was “kind of harsh but otherwise very friendly,” as being a nurse manager who took care of her RNs and planned weekly tasks in a strategic, business-oriented manner. Rose enjoyed discussing work matters with the practice manager every week to “see how nurses were doing.” Although a student nurse showed a “fighting attitude” to being given guidance, Rose advised the nurse that she was conveying the Nursing Council’s expectations for nursing competencies. Rose, who was “never a short-tempered person,” guided the nurse “with perseverance, with love, [and] with communication” to help her develop nursing confidence and competence.
- 5) Jessie positioned her colleagues as caring towards her during a stressful time moving house and working from home during the COVID-19 lockdown in 2021. They asked Jessie how she was feeling and offered her training assistance if she needed it. Her colleagues positioned Jessie as a valuable team member needing their collegial support as she “was in a difficult position,” owing to stress in her work and personal life. Positioning her

trainees as being thankful for gaining understanding of their own learning needs, Jessie valued her many positive interactions with trainees. For instance, competency conversations were constructive and motivating, which made Jessie feel “so happy.” Her trainees appreciated Jessie’s spending extra time giving them verbal feedback “to make sure they understand the concept.”

5.3.4 Consequentiality

5.3.4.1 Evidence of Social-Cognitive Implications.

The key social-cognitive implications at Level 2 were related to organisational communication and professional learning processes experienced by three participants (Lilly, Rose, and Jessie).

- 1) Recognising that, in a manager’s absence, she was responsible for staff performance, Lilly understood she had to clearly explain medication administration errors to her colleagues for their reflection and professional learning.
- 2) Rose recommended that supervisors encourage new nurses to always ask if they did not understand. This was because senior RNs were “there for helping; there to support” as nurses developed their confidence. She advised new RNs to be honest about needing guidance to fill their knowledge gaps and “work within nursing boundaries, which is very crucial.”
- 3) There were social-cognitive implications of Jessie’s desire to be a “bridge to learning” for her manager and trainees. Jessie focused on “putting [her] health team member hat on” to patiently communicate clinical information to a colleague from a non-nursing background so she understood a patient’s medical condition. This was a teaching strategy Jessie said she could use with her trainees as “an added approach.” Jessie recommended that management be flexible with employees’ training needs, which was co-constructed with her listener that “everything is fixed with communication.”

5.3.4.2 Evidence of Moral Implications.

There were moral implications of the workplace interactions that four participants (Mons, Carmel, Rose, and Nightingale) experienced with their colleagues.

- 1) Mons asserted that she would “always be honest” when giving a reference for staff who had been dismissed. Still, she did want to support terminated employees, as well as current staff, by suggesting options for their further training. This was because Mons believed that people deserve second chances as they “grow and change through time.”
- 2) According to Carmel’s stories, there were moral implications of her conversations with colleagues. She did not trust an RN who said she had administered medication, but when Carmel checked, the medication was still there. Carmel told herself, though, to have integrity and “continue doing what is right even if nobody’s looking” to protect residents’ safety.
- 3) Rose suggested that nurse managers seek to understand team members’ personal and health needs: “Ask them what exactly is going on in their life [because] communication is a must...[without] being inquisitive, making fun, or being harsh or aggressive.” The onus was on management to help new nurses and IQNs “come out of that anxiety” and have “two-way communication for everyone’s benefit.”
- 4) There were similar moral implications of working with a difficult colleague since Nightingale believed that, instead of “making an enemy” of a teammate, “you got to be even closer to that person.” Nightingale acknowledged that a disagreeable colleague may be having trouble in her personal life: “She wants to have a friend, but she just doesn’t know—it’s her personality.” Therefore, it was important to “accept the way we are with other people and how we’re handling [challenging interactions].” This might bring relief, rather than stress, so “you just have to make the best out of the time” working with different personalities in the workplace.

5.3.4.3 Evidence of Professional Reflection.

Four participants (Lilly, Mons, Ricky, and Lola) reflected on the importance of following protocols, working as a team, maintaining a safe workplace, and engaging in person-centred communication.

- 1) Lilly reflected upon her own managerial response to a staff member's non-genuine sick leave, identifying her own authority to follow policy. It was important for her as Clinical Lead to request a medical certificate, even if the staff member was unhappy and argumentative.
- 2) Mons reflected on the value of being part of an organisation that looked after staff. In return, Mons and her staff gave the company loyalty because they recognised the benefit of "getting in the canoe and paddling together" towards the company's goals.
- 3) Ricky reflected that her negotiating IQNs' caseloads with a shift lead was "not being nasty or obstructive" or intending "to make a colleague feel bad." Instead, Ricky was "protecting herself" and her fellow IQNs as she "just wants fairness so that everyone is safe" in the workplace.
- 4) Lola engaged in professional reflection when planning her phone call to an experienced practice nurse who had made an error on her cognitive assessment. Firstly, she recognised the benefit of being encouraged by her colleagues "on a daily basis" to phone the busy practice nurse. They reminded Lola that providing feedback to the nurse was part of her role, telling Lola, "You don't want to [phone the nurse], but you need to." After the successful phone call, her colleagues implied Lola should have "just rung [the nurse] on the day she noticed the error." Although Lola believed the time delay was good, she knew that procrastination had set in. Lola recognised that she had wanted to avoid any confrontation with the nurse as she was a "people pleaser," who liked to have "good, positive conversations" with colleagues. She had wanted to "set the scene better" for a potentially "trickier" conversation with the nurse about an assessment error, after reflecting upon her awkward meeting with a senior manager about offering clinics over Christmas. This was because "when you're ringing someone up

who is very busy, there are lots of environmental and timing things you can't change." Lola managed her apprehension by ensuring the practice nurse "had some time to talk" and doing "a little bit of the pleasantries beforehand, rather than launching straight into what [Lola] wanted."

5.4 Level 3 Positioning

5.4.1 Positionality

5.4.1.1 Evidence of Agency and Control.

At Level 3, three participants (Lilly, Mons, and Carmel) demonstrated degrees of agency and control as nurses and/or nurse managers within healthcare settings.

- 1) Lilly acknowledged that IQN managers' agency is necessary for supervising and interacting with team members. Lilly noted that being a nurse manager required her to maintain balance between being friendly and serious to optimise staff performance. As an IQN, she believed that some colleagues did not acknowledge or accept Lilly's authority to give instructions and advice. Neither did they want to listen to her counsel, indicating their "kind of inferiority or superiority complex still there."

- 2) Mons positioned herself as having agency and independence as a manager based on her role and because of working with a people-focused senior manager. Firstly, Mons had the authority to be "the messenger from head-office" when terminating an employee. This was "more like the crappy job," although Mons did have control of employment-related management processes in her facility. Secondly, Mons reported having previously experienced "five years of hell" working for a results-driven regional manager. She was now working for a staff-focused manager who wanted his team to be happy and do the best they could. This was "a nice little bit of support" and "so different" to her previous manager. Mons confessed that she would not want to work with such a demanding manager again because "who you're reporting to can make all the difference."

- 3) Carmel had the agency to "speak up for herself," despite being new in a foreign country, but she did not have control of others' perceptions of her.

She believed that colleagues might wonder if she, as an IQN, “knew what she was doing,” leading to feelings of uncertainty and unmotivation. Nonetheless, Carmel had the authority as an experienced RN with the medical knowledge to tell herself to “be strong enough to face” a decision by using her medical knowledge and asking for help from colleagues.

5.4.1.2 Evidence of Sameness and Difference.

Two IQN participants (Lilly and Nightingale) expressed their similarities and differences with their nursing colleagues when telling stories of their workplace interactions within the healthcare workplace.

- 1) Lilly positioned herself as a manager who was similar to staff members in needing compassion and reflection time when being asked to complete a job task. This was because responding in an argumentative way to a colleague’s request was ineffectual because “we have to think from their side.” Nevertheless, she considered herself to be different to her staff because caregivers and cleaning staff had more physically demanding jobs with different task pressures.

- 2) Nightingale positioned herself as being the same as nurses who supported the COVID-19 vaccination because they “have the knowledge of what this vaccination [is] for, what is a side effect, what is the benefit.” She was prepared to talk about the vaccine’s pros and cons, whereas colleagues who did not support the COVID-19 vaccine were concerned about not having sufficient evidence of what might happen, or not happen, after the vaccination. Nightingale considered rumours about the vaccine to be a risk for nurses’ safety. She argued that the biggest challenge during COVID-19 pandemic restrictions was convincing people in a democratic country to accept a new vaccine. Certainly, Nightingale positioned her colleagues who were against the vaccine as not listening to all facts about COVID-19 vaccination: “We let them know, but then if they don’t want to do it, then that’s the risk for the community.”

5.4.2 *Emotionality*

5.4.2.1 **Evidence of Discursive Language.**

The literal and non-literal language used by three participants (Mons, Carmel, and Rose) showed emotional reactions to solving problems and being promoted in the healthcare workplace.

- 1) Mons's use of non-literal language revealed her feelings of emotional burden as a manager of an aged care facility who needed to solve problems for staff, residents, and their families. She felt "drained and very lonely" and unable to share her feelings with her colleagues, confessing that it was "lonely at the top" as a senior manager.

But you can juggle 20 things that don't even take all that strain. When it comes to your emotions, it does increase the workload. If you add emotion to your workload, you're just increasing your time. The workload after hours. The thinking. The going over and over [challenging conversations] again. [...] Yeah, it's really hard not to be emotional. It's like a hammer: Knock [the challenge] down, knock it down! Put that [problem-solving] hat on.

- 2) Carmel's positive emotions about being promoted to Virus Control Lead were revealed through her expressions of happiness. She felt "very happy" about her new role. To Carmel, being sent to an infection control conference was "a new adventure" to "make friends" and "broaden [her] network."
- 3) Rose used non-literal language to remind IQNs of the importance of speaking up and sharing their feelings about a difficult workplace situation. They needed to "wait for the clouds to get over and wait for the sunshine" because with clear communication people can reconcile for "a happy ending."

5.4.3 Relationality

5.4.3.1 Evidence of Reflexive Positioning.

Two participants (Mons and Carmel) showed evidence of reflexive positioning when positioning, and being positioned by, their colleagues as having diverse skills, emotional attributes, and cultural backgrounds.

- 1) Mons agreed with her colleagues' positioning of a nurse as being a "jack of all trades." Being a nurse was, to Mons, like being a "clinical hairdresser," who was "a social worker," "advisor," and "everything." Mons concurred with her listener's co-construction of a nurse manager being "human." Mons did acknowledge her personal attachment to staff: "I know all the ins and outs. I know a lot about their personal lives."

- 2) Positioning management as being supportive and understanding of IQNs' cultural differences, Carmel encouraged IQNs to "tell what you want; be vocal of your feelings" because management was "not condemning" IQNs. Yet, Carmel was positioned, along with fellow IQNs, as "sometimes shy to speak out and be heard." She recognised that "good communication is key," so IQNs needed to be open about their suggestions and feelings.

5.4.4 Consequentiality

5.4.4.1 Evidence of Social-Cognitive Implications.

There were strong social-cognitive implications at Level 3. All eight IQN participants (Lilly, Mons, Carmel, Rose, Jessie, Nightingale, Ricky, and Lola) expressed their perspectives on cross-cultural and organisational communication, professional learning opportunities, and resolving differences or misunderstandings.

- 1) Recognising the social-cognitive implication of cross-cultural communication being "the big issue," Lilly admitted that an IQN's linguistic meaning is not always taken as expected. This is a problem for IQNs who "do not know Kiwi slang and sarcasm or humour as they were not born in New Zealand." Lilly recommended that IQNs, particularly those for whom English is an additional language, manage communication challenges on the telephone by listening to others' use of English, speaking clearly and carefully, and practising pronunciation to avoid misunderstanding. She noted that IQNs'

shyness and lack of confidence might be overcome by writing down what they wanted to say, using simple and substitute words, before making a phone call.

- 2) When responding to challenging staff issues, such as the reasons employees gave for sick leave or resignation, Mons believed that being a manager required “juggling personal opinion against evidence.” It was important for managers to put in “a bit of empathy [to] spice it up a bit” when staff were “going through their own issues.” Therefore, “being yourself in management” called for compassion and “not sitting up on some high rocky thing and barking down at [staff].”
- 3) Carmel recommended that IQNs in a position to delegate tasks “show that they are the authority.” This was especially crucial for Asian RNs who were petite as they were not always seen as having authority and experience by staff. Recognising the importance of “expressing oneself well, telling the truth, being transparent, and doing one’s job well,” Carmel sought to resolve misunderstandings and avoid “made up stories” in the workplace. In addition, she recommended that nursing management “listen to what the staff are saying and [...] to work on the floor when there’s nobody else to work.”
- 4) According to Rose, the social-cognitive implications of nurses’ professional learning opportunities were that IQNs had to “keep nursing skills up [so they can] be an example to all the other nurses.” She valued nursing education for IQNs’ ongoing knowledge, confidence, and self-encouragement. This was so IQNs could “keep the fight up,” enhance teamwork, and develop strong communication skills. Rose likened IQNs’ developing nursing competencies to planting a tree:

Like when you plant a tree, you don’t get a fruit straight away. You’ve got to water it with your hard work. And then once the fruit is there, you will flourish. You’re nurturing with education to bring out new leaves, and you’ll have fruit, birds, flowers...and that’s the outcome of a very qualified nurse.

Moreover, Rose reflected on the importance of IQNs' suggestions to make positive changes in the healthcare workplace. She noted that "everyone brings a different kind of education, different kind of experience from where they worked." IQNs, along with new nurses, "kind of amalgamate themselves," hence the need for nursing colleagues to sustain a positive atmosphere in the workplace.

- 5) Within the wider nursing community, Jessie indicated the social-cognitive implications of providing learning opportunities to colleagues. Giving feedback to a colleague required "widening our perspective, looking [through] a different lens." This is because "anything we encounter with other team members is an opportunity to learn." Jessie quoted Stephen Covey's book 'The 7 Habits of Highly Effective People' by saying, "Seek first to understand, then to be understood." In other words, it was important to think of the listener when communicating a message in a way that is understandable by a person with a different set of perspectives.

Recommending that nurses and nurse educators "be open to learning," Jessie explained that accepting critique from colleagues, such as during a competency review, necessitated "an open, positive mind that anything will be given to you—negative or positive." She encouraged IQNs to "take everything as a learning opportunity for nurses to grow and develop and to keep us safer in our practice." Moreover, Jessie advised management to listen to employee feedback and "allow staff input so we can also feel valued." According to Jessie, this would help raise positivity amongst team members because "when [nurses are] together, we can achieve more success and manage problems before they even occur."

Jessie had several suggestions for IQNs in developing their nursing competence and confidence in New Zealand healthcare settings. IQNs who felt they lacked professional skills and knowledge were advised by Jessie to "help themselves" and build their confidence, especially if they were "still adjusting to [their] new country." When IQNs are new to the country and the workplace, they are "testing water," but once they "develop that backbone, [they] start to speak up." Plus, as many IQNs are bilingual, they can be shy because they are translating words in their mind: "The moment the word

comes out, they have lost their train of thought [and they] don't want to say it anymore." This is why written feedback between a migrant nurse and a manager or trainer is useful because IQNs "have time to process their thoughts."

Recommending that IQNs develop resilience, Jessie opined that migrant nurses whose manager is demanding, unsympathetic, or exploitative need to make sure they are "safe in [their] practice, no matter what." If managers' directions cross their professional boundaries, IQNs must "stand up for self." That is, they should "follow [their] clinical judgement," or "if no longer safe, leave that facility for peace of mind." Yet, if the manager is "strict, demanding but fair, it's a learning opportunity," so resilience is crucial for migrant nurses in New Zealand.

- 6) Nightingale advised IQNs to "take time to sit down and really talk about [a misunderstanding] to clarify the situation." This is because if IQNs misunderstand colleagues, teamwork suffers, but "being a nurse, it's important to work as a team." She recommended that an IQN should "never be afraid to speak up for [one's] own opinion [... or] be afraid to ask," since colleagues would "never eat you" if an IQN shared their thoughts. Still, IQNs needed to consider diverse personality types when communicating with colleagues:

If you're dealing with somebody who's quiet, who doesn't want to speak, talk, ask questions, then no matter how much advice you give, they are probably reluctant to do it. [This is] because in [their] cultural background, they are not going to ask a question to their boss in case they are seen as stupid or not knowing anything. That's back to personality, back to the individual—whether you want to be communicative, open, active.

Nightingale was excited about passing on knowledge and skills to help other nurses. As a result, she recommended that IQNs pass on new information to colleagues and show them how to access resources. It was important, though, for IQNs to observe colleagues as to whether they were "approachable" or "a snob," before offering a colleague advice or guidance.

She noted that “not everybody would like to be told, even if with a nice, good intention.” They might take the advice wrong, thinking “Why is [my colleague] so bossy, always telling me that?” Therefore, advice had to be considerate and communicated carefully.

- 7) Ricky recommended that IQNs “not be frightened” of talking to a senior manager to get support in an unfair, unsafe workplace situation. IQNs were advised by Ricky to go to management with a positive, rather than a negative, attitude. She explained that the focus should be on taking care of patients’ needs, rather than IQNs’ own needs. Ricky also acknowledged that IQNs could expect to misunderstand idioms and slang. She explained that IQNs “will come across some terms in a different light to what [they] think...and it’s okay.” Meaning could be “lost in translation” for IQNs when interacting with colleagues in New Zealand, even though they were speaking the same language, because of the different slang expressions. If in doubt, they should ask colleagues to explain their meaning, and “if people are looking perplexed, then use other words to describe your meaning.” This advice was affirmed by Ricky’s listener, who suggested IQNs consider “buddying up with someone” to ask for the meaning of misunderstood phrases. This might avoid their feeling “mortified” and isolated from professional and social interactions.

- 8) Lola recommended that IQNs manage having challenging telephone conversations by writing scripts, including “soothing phrases, because when you’re stressed or you’re busy, things can be misconstrued.” According to Lola, scripts help IQNs “say what [they] want to say so it doesn’t come across [as] critical.” IQNs with English as an additional language may not be accepted by colleagues, who may give IQNs “the rolling eyes,” even though they are competent nurses. Fellow healthcare professionals may also “make judgement calls about IQNs when they speak to them on the phone,” owing to their different accents. Lola noted, though, that she was “not treated the same way as [...her] Filipino or Indian nurse friends” since English was her first language.

In Lola’s view, IQNs can manage power dynamics in the healthcare workplace by being “calm and [explaining] articulately [why] their decisions

are correct.” They should have confidence to stick by their convictions because, as a nurse, “you believe your decision is right for a patient.” IQNs must “stick to their guns,” use “calm communication,” and “ask for help, if need be.” Lola recognised, though, that proactive communication is “really hard because health is so hierarchical.” The New Zealand workplace culture of “strong, autonomous practitioners” may be different from that in IQNs’ own country. Therefore, migrant nurses can “find it difficult to express [themselves] if they feel that something is wrong.”

5.4.4.2 Evidence of Moral Implications.

At Level 3, the moral implications of six participants’ (Lilly, Mons, Carmel, Nightingale, Ricky, and Lola) workplace interactions in healthcare workplaces related to counselling colleagues, recognising team members’ achievements, and demonstrating ethical and safe nursing practice.

- 1) In Lilly’s view, moral implications for nurse managers were to provide counsel to colleagues who made mistakes in a professional manner. This would oblige managers to maintain privacy and comfort to staff, stay calm and quiet during difficult conversations, and offer mental support so colleagues “do not feel inferior.” She advised nurse managers to show gratitude to staff who “work hard on the floor,” saying managers should “listen to staff, understand their problem, and try to be extra supportive.” It was crucial for managers to show healthcare workers the importance of teamwork for the benefit of staff and patients/residents.
- 2) Mons felt that managers needed to give staff recognition, “like a small voucher to say thank you [...to bring] the team together.” Mons’s organisation gave out certificates for Staff Member of the Month, recognising nominees who were “an integrated part of the team.” To Mons, this showed staff they were “special” and valued. This would then boost team members’ intrinsic motivation and give them “a reason to get up in the morning.”
- 3) To Carmel, “doing what is right” involved following nursing policy and practice ethically and correctly. She advised IQNs that, if there was a clinical

error, they should take evidence of the error to management “so if the Nursing Council comes in, you’re safe. You have all the documentation and know your licence is safe” because “you’re doing your job well.” Carmel stated that nurses “just want to deliver quality [...] because we’re dealing with people’s lives.” Consequently, IQNs should not be shy to ask questions because “understanding is key to nursing.” They must also “be mindful, be humble, [...]and] be well socialised with other RNs and healthcare professionals to keep learning,” thereby enhancing their nursing practice and professional relationships.

- 4) According to Nightingale, there were moral implications of engaging in conversations with difficult colleagues. Nightingale recommended that IQNs “make friends out of your enemy.” This was because she had experienced teammates at first talking behind her back, but then they “suddenly turn back.” Therefore, it was important to think positively and “take any challenge as an experience.” Nightingale’s aim was to create a “harmonious atmosphere” for her colleagues, in which one was not afraid to ask questions or stand up for oneself. She reflected on the need for nurses to “put aside [one’s] own personal emotion” and “show sympathy or empathy” to colleagues.

To Nightingale, nurses “are supposed to show our care to people. This is the most important part of the job of being a nurse.” Nightingale did believe that being a caring person was a challenge, since “not everybody has the personality to show the care.” Furthermore, balancing work demands and nursing demands might mean IQNs “don’t really think about the care anymore, but they just want to do things, especially with the paperwork they need to do.” It was crucial for IQNs to care for, and listen to, patients and teammates, although “your [nursing] experiences teach you how to care.”

- 5) Ricky advised IQNs to “not feel pressured to do what you’re told when something seems wrong” because the onus was on “protecting the patients.” They should not feel like they were “making waves, causing problems by defending themselves, [or] sticking up for themselves.” Ricky emphasised the need to prevent harm to patients and staff, asking “What if a medication error

happens?” Furthermore, those IQNs whose caseloads are overly high, unfair, and unsafe must “nip [unethical caseload management] in the bud.” This is because if management set a precedent, they may “think that it’s okay to just give [an IQN] a heavier load every single shift.” It would be worthwhile, though, for an IQN who sensed they were “getting an attitude from a colleague,” such as when discussing workloads, to “take a step back and breathe” as that person “might be having personal stuff go on.” It was better for an IQN to avoid going “down that rabbit hole of, ‘It’s me—I’m not a good nurse.’” To Ricky, this would “catastrophise” the situation and likely lead to professional upset.

- 6) Acknowledging the moral and professional implications involved in safeguarding patient safety, Lola recommended that IQNs stand up for themselves and each other. IQNs should endeavour to say no to, or seek assistance for, tasks that were outside their qualifications, expertise, and professional practice and registration. Lola advised IQNs, “If you can’t do it, you have to say no because if you end up doing it wrong and you end up in a court of law, no one’s going to be behind you supporting you.” However, IQNs may not refuse a task if they feel their visa is at risk. They should “have the courage to speak out,” though, even if “they feel they haven’t got a voice.”

5.4.4.3 Evidence of Professional Reflection.

Three participants (Lilly, Mons, and Lola) reflected on the importance of maintaining workplace relationships, undertaking professional development, and engaging in person-centred communication.

- 1) Feeling happy and proud about doing “a great job” in resolving collegial disagreements, Lilly reflected that she had achieved a victory when a staff member realised he had made a mistake: “We made it. We [have] done it together.” She also considered it essential that IQNs continue their professional learning of workplace regulations and nursing practice. To Lilly, IQNs need to exhibit professional behaviour towards patients and fellow healthcare workers.

- 2) Mons reflected that having collegial relationships and listening to staff were crucial for nurse managers. Working with a fellow manager who had a different personality, Mons benefited from their strong professional association, which was “like a work marriage.” She advised that nurses in management roles needed to “gel, [...] be strong, [...] and] on the same page and the same bus,” otherwise “the whole lot—[the] relationship—will collapse.” In addition, Mons recommended that management listen to the challenges that nurses talk about and “find something you can fix.” IQN managers “work harder than everyone else to make [their] mark,” especially managers who have English as an additional language. If senior managers suppress IQNs’ ideas, this “breaks [a nurse manager’s] confidence,” according to Mons.

- 3) Lola’s professional reflection on her “tricky conversation” with a senior manager about supporting elderly patients during the Christmas closedown led her to regret not setting a time to talk with the manager. Next time, she would “maybe not ambush the manager,” which Lola reflected “wasn’t one of [her] smartest moves.” Lola noted that some managers “respond very well to an IQN saying, ‘Tell me the answer now.’” Still, she advised IQNs to allocate “more planning, more thought, more time” when seeking to have a work-related discussion with a busy manager.

5.4.5 Links to Findings From Thematic Analysis

MPA findings at Level 3 can be linked to the findings from thematic analysis. This is because both sets of findings respond to Research Question 3, namely *What are the implications of understanding, and responding to, participants’ stories for the IQNs themselves and the wider nursing community?* In this section, I demonstrate how the four MPA criteria (i.e., positionality, emotionality, relationality, and consequentiality) at Level 3 align with the six themes presented in Chapter Four.

5.4.5.1 Workplace Culture

The first theme, *Workplace Culture*, included the subthemes of understanding and using humour; experiencing or not experiencing equitable treatment amongst colleagues; valuing professional relationships and rapport with colleagues; recognising the need to act with integrity in healthcare workplaces; recognising the need to be professional and proactive in healthcare workplaces; and working professionally within New Zealand workplace culture and power dynamics. IQN participants noted that, as IQNs and new nurses are integrating into the healthcare workplace, they benefit from a positive work environment. This would require management to be supportive and understanding of IQNs' cultural differences, feelings, and perspectives. To manage power dynamics in the healthcare workplace, IQNs were advised to demonstrate their expertise by expressing their viewpoints clearly and confidently.

5.4.5.2 Workplace Communication

The second theme, *Workplace Communication*, comprised the subthemes of giving or receiving feedback or counsel; understanding or not understanding the Kiwi accents or idioms; experiencing understanding or misunderstanding with colleagues; recognising the need for open, authentic communication to enhance understanding; recognising the need for clear, person-centred communication to enhance understanding; and listening actively, or being listened to, for the benefit of staff or patients.

At Level 3, the implications of workplace communication in healthcare workplaces were related to overcoming misunderstandings, sharing medical knowledge and skills, engaging in person-centred communication, and developing nursing confidence. IQNs' linguistic meaning can sometimes be misconstrued by conversation partners. This is because IQNs may not understand local accents, slang and idioms, and humour that can be "lost in translation," even when speaking a common language. Migrant EAL nurses can minimise potential miscommunication by attending to their own and others' use of spoken English, asking for written feedback, and managing their tone or emotions over the telephone by rehearsing their message beforehand.

Being open or authentic with colleagues and listening to colleagues is invaluable, according to participants. IQNs were advised to share their suggestions and feelings in a truthful and transparent way. Honesty and collegiality are crucial for resolving misunderstandings. Focusing on the listener's personality and communication needs can also help an IQN clarify the situation and convey their message in a way that is correctly understood by a colleague. This is because miscommunication amongst colleagues can hinder teamwork and problem-solving, which are central to effective nursing.

5.4.5.3 Workplace Interactions

The third theme, *Workplace Interactions*, involved IQNs' understanding and application of culture and language to their workplace interactions with colleagues. It included the subthemes of being inducted or inducting others into the workplace; being acknowledged in the healthcare workplace; acknowledging own or others' professionalism in the healthcare workplace; showing or being shown collegiality and compassion; giving or being given professional support; and navigating misunderstandings and resolving differences to enhance teamwork. IQN participants positioned themselves as being open to sharing their clinical understanding of the COVID-19 vaccine. They were aware of its pros and cons, despite some colleagues' resistance to the New Zealand-wide immunisation programme. IQNs who were experiencing challenging interactions with colleagues, particularly those giving "attitude" during caseload or work task discussions, were advised to focus on collegiality and compassion. Some IQN managers faced the emotional burdens, though, of managing staff members' task resistance or vaccine hesitancy. Mons, for example, felt that being a senior manager was a "very lonely" position to be in because managers need to be problem solvers and keep their feelings to themselves.

5.4.5.4 IQNs' Concerns and Advice for Employers and Educators

The fourth theme, *IQNs' Concerns and Advice for Employers and Educators*, presented the concerns that IQN participants wished to convey to employers and educators. These were related to bullying, racism, exploitation or favouritism, and other health and safety issues in New Zealand healthcare workplaces. IQNs advised

nursing management to listen to employee feedback, respond to staff input, and assist on the ward so that nurses feel valued. This would develop positive workplace relationships and greater collegiality amongst healthcare workers, too. In addition, participants encouraged managers to focus on solving nurses' problems and providing constructive counsel in a private and confidential manner to enhance IQNs' wellbeing and sense of professional self. Showing gratitude to nurses who, according to Lilly, "work hard on the floor," contributes to teamwork, group responsibility, and professional support in healthcare settings.

5.4.5.5 IQNs' Professional Experience

The fifth theme, *IQNs' Professional Experience*, incorporated the subthemes of valuing or creating a connected professional community; being a professional, ethical manager; being a professional, ethical mentor; recognising the need for IQNs' skills and experience to be valued; promoting one's own or others' professional learning or career advancement; and learning from collegial advice or professional self-reflection. While participants recognised their own agency as IQNs and authority as nurse managers, they sometimes felt uncertain or unmotivated when colleagues did not acknowledge their clinical knowledge and experience. Ongoing nursing education was seen as essential for IQNs' career sustainability, though. This was because IQNs need to continue their professional learning of workplace regulations and nursing practice to provide quality care to patients and professional support to fellow healthcare workers. Attending training courses and conferences broadens IQNs' knowledge, confidence, and self-motivation to enhance their teamwork, peer-learning, and open communication skills within nursing contexts. Furthermore, IQN participants valued working for staff-focused, rather than target-focused, managers who were empathetic and offered balanced opinions.

5.4.5.6 IQNs' Agency

The sixth theme, *IQNs' Agency*, demonstrated that IQNs expressed their agency by perceiving workplace interactions as learning opportunities, however difficult; being resilient in challenging workplace interactions; coping with professional demands (e.g., finding work-life balance); being treated unfairly or unethically by managers or peers; feeling self-confident or motivated in healthcare workplaces; and speaking up

for self and colleagues. Balancing nursing tasks and nursing administration might diminish IQNs' passion for patient-focused nursing, owing to the amount of paperwork they needed to do. To Carmel, IQNs do well to be "mindful" and "humble" in "doing what is right" in following nursing protocols in an ethical and appropriate way. Nurses benefit from peer learning opportunities, such as sharing advice and perspectives with colleagues and providing suggestions and feedback to managers, to make positive changes in the healthcare workplace. Nightingale recommended that IQNs create a "harmonious atmosphere" for their fellow healthcare workers, although they should not be afraid to ask questions or stand up for themselves.

Building resilience is crucial for migrant nurses in New Zealand. Ricky recommended that IQNs seek support from management if they are faced with an unfair, unsafe workplace environment. Participants observed that nurses should think positively and see challenging interactions as learning experiences, though. It was important, in Lola's view, for IQNs to "stick to their guns," communicate clearly, and request assistance when needed. However, communicating proactively in hierarchical healthcare contexts can be difficult for IQNs.

According to IQN participants, there are moral and professional implications and responsibilities involved in safeguarding patient safety. If IQNs are given overly high, unfair, and unsafe caseloads, they need to stand up for themselves and colleagues by refusing or negotiating the assigned caseload. They should also ask for help with general or specialty nursing tasks that do not align with their qualifications and/or clinical experience. It was pointed out, though, that IQNs who fear for their visa may feel they do not have "a voice" to reject nursing tasks or caseloads. Recommending that IQNs develop resilience and courage, Jessie considered it essential for IQNs to "stay safe in their practice" if their manager was demanding or exploitative.

5.5 Chapter Summary

This chapter presented the findings from applying multimodal positioning analysis to IQN participants' narrative (textual and visual) data. Positioning theory was used to

conceptualise the four positioning criteria (i.e., positionality, emotionality, relationality, and consequentiality) at Level 1, Level 2, and Level 3 respectively. Participants' storied experiences of their challenging and positive workplace interactions with colleagues were analysed to reveal aspects of IQNs' discursive positioning to answer this study's research questions. I also showed how the four MPA criteria at Level 3 align with the six themes presented in Chapter Four. The next chapter situates the findings from thematic analysis and multimodal positioning analysis within the research literature surrounding IQNs' collegial workplace interactions and identity positioning in healthcare workplaces.

Chapter 6: Discussion

6.1 Introduction

Chapter Six discusses my interpretation of this study's findings in line with research findings from the nursing and applied linguistics literature. In Chapter Four, I set the scene for the reader to understand the participants and the contexts in which they are working. Thematic findings gave a sense of IQN participants' workplace contexts; i.e., the settings, tensions, issues, and positive aspects of their workplaces and workplace interactions. In Chapter Five, I presented the multimodal positioning analysis (MPA) findings. I showed how participants discursively positioned self and others at the three levels of positioning of the MPA model, which was inspired by Bamberg's (1997) positioning analysis framework. The levels of positioning in the MPA model responded to my three respective research questions. RQ1 and RQ2 considered how IQN participants positioned themselves and others within their storyworld and discursively constructed their identity vis-à-vis their listener; that is, the research and/or a co-participant during a Zoom Pair Share. RQ3 considered how IQN participants positioned their workplace interactions within the wider nursing and allied healthcare discourse communities.

My research aim was to investigate the professional identity positioning of internationally qualified nurses through their stories of participating in challenging and positive workplace interactions with colleagues in New Zealand healthcare settings. During the Capstone Conversations, my participants concurred that there was a need to develop new nursing knowledge about IQNs' professional identity in New Zealand nursing contexts. This knowledge might support IQNs in their choice to live and work in New Zealand—to want to stay, want to grow, and want to develop personally and professionally. My participants were a team of healthcare experts, whose stories of challenging and positive workplace interactions have the potential to offer valuable insights into migrant nurses' sense of professional self. The original contribution my study thus makes to the scholarly literature is providing a channel for IQNs' relational and interactional workplace interactions that have been impacted by contextual tensions (COVID-19 pandemic restrictions and the New Zealand nursing shortage, for example) to be understood for the benefit of the wider

nursing community. In this chapter, I begin by discussing the participants' professional context (that is, their healthcare settings, issues, and tensions). I then interpret aspects of participants' identity positioning with reference to the existing literature to answer this study's three research questions.

6.2 IQNs' Professional Context

Chapter Four presented the thematic analysis of the study's narrative data to identify the types of challenging and positive workplace interactions that IQNs experienced with colleagues. I used NVivo to construct codes grounded in the data, which were then categorised into six thematic areas. During Capstone Conversations, I received feedback from four IQN participants (see Chapter Four) that the themes and subthemes encompassed their own workplace interactions or observations as IQNs. In this section, I evaluate the IQN participants' professional context in light of the literature discussed in Chapter Two.

6.2.1 Theme One: Workplace Culture

The flatter hierarchy and informal power dynamics in New Zealand healthcare workplaces were certainly embraced by IQN participants. Researchers (e.g., Nørgaard, 2011; Philip et al., 2019; Roth et al., 2021) found that IQNs acculturate more easily to the host country's workforce when they feel they are accepted within their nursing team. IQNs' acculturation is also optimised when they work effectively and optimistically with their colleagues and managers. For instance, humour is one area which can help or hinder workplace integration in some cultures. Using humour in the healthcare workplace helps decrease nurses' stress (Haavisto, 2014). IQN participants enjoyed having "a good laugh" with colleagues (Nightingale), especially in a supportive workplace environment that gave team members "warm fuzzies" (Ricky). According to Philip et al. (2015), humorous and light-hearted banter contributes to IQNs' sense of feeling close rapport with their colleagues. Engaging in humour-filled conversation is an uncommon communicative practice for IQNs who have not yet found a sense of belonging within their healthcare workplace (Philip et al., 2015). This may be because some come from cultural contexts where humorous interactions in the workplace would be frowned upon. IQN participants focused on building rapport with their colleagues and managers to contribute to a motivating,

affirming work environment and open communication channels. According to Nightingale and Lola, a collegial atmosphere in healthcare settings helped relieve the personal and professional pressures that, according to Seymour (2020) and Manchester (2020), nurses faced during COVID-19 pandemic restrictions.

Moreover, IQN participants recognised the need for healthcare workers to receive equitable treatment in the workplace. Participants valued the opportunities to participate in equitable learning opportunities, such as in-person meetings, training courses, and social events. This was so they could work more closely with colleagues to ensure their mutual understanding and to “make heart connections as nurses” (Jessie). Ricky, though, reported and escalated her complaint of IQNs’ not receiving professional respect or equitable treatment when, on separate occasions, she and a fellow IQN were given a higher caseload.

It was important for IQN participants to act with integrity within their healthcare team, despite their concerns of colleagues’ behaving unprofessionally. In dealing with rude or difficult colleagues, IQNs reported showing professionalism and being open to collegial dialogue. This was evidenced by Mons being “kind and smiley” and Nightingale “not taking sides” when facing disharmony in the workplace. IQNs in New Zealand understand the value of communicating in a fair-minded manner with healthcare colleagues (Choi et al., 2019). Kamau et al.’s (2022) findings showed, for example, that IQNs who acted with integrity and collegiality were accepted within their healthcare team, thus helping them overcome workplace challenges. In line with Block (2007), IQNs are more easily accepted within their nursing community of practice through their sharing of professional ideas. Participants expressed their enthusiasm for sharing nursing knowledge with team members. Nightingale and Carmel both spoke of appreciating their colleagues taking the initiative in supporting staff and patients.

Participants valued the trust they received from management to complete their assigned work tasks in a professional and ethical manner, especially during COVID-19 pandemic restrictions. IQNs from Asian countries are influenced by their cultural backgrounds to comply fully with workplace regulations, according to Jessie and Nightingale. As Choi et al. (2019) found, IQNs with more nursing experience in the

host country understand the need to interact as equals with their colleagues, even if they come from hierarchical nursing backgrounds. When IQNs feel appreciated by their manager, they are better able to overcome workplace challenges (Gao et al., 2015). In this study, participants' experiences of dealing with workplace issues and tensions are evidence of the cultural indicators that encompass healthcare providers' organisational culture (Mannion & Davies, 2018).

6.2.2 Theme Two: Workplace Communication

IQN participants revealed that they often needed to give advice or counsel to healthcare workers, despite sometimes receiving negative reactions from staff after giving advice. Lilly and Ricky, for instance, focused on providing constructive guidance to team members, although they expressed feelings of awkwardness when colleagues “took it badly—like I was attacking [them]” (Ricky). They also found it difficult responding to advice, counsel, or guidance from their colleagues or senior managers. Aggar et al. (2020) contended that the guidance IQNs received from managers would help them develop nursing skills and knowledge. It was beneficial for IQNs to have a positive relationship with an encouraging manager who responded to their professional development needs, even if such support might not boost IQNs' job satisfaction (Aloisio et al., 2021).

IQNs' ability to understand and use local accents and colloquialisms may boost their confidence as active, equal participants in their healthcare team (Gu & Shah, 2019; O'Daniel & Rosenstein, 2008). Since “miscommunication [in nursing contexts] can lead to severe harm or death” (Nursing Council of New Zealand, 2022, p. 1), seeking clarification during telephone or face-to-face conversations was a key communication strategy for participants. This helped IQNs minimise their difficulties understanding or using New Zealand English phrases. IQN participants' experiences of understanding and misunderstanding with colleagues and managers resulted from language barriers, communication styles, and cultural differences. To generate shared meanings with their colleagues, IQNs needed to apply effective, person-centred communication skills and strategies in healthcare settings (Brunton et al., 2019; Muntasir & Nurviani, 2020).

O'Daniel and Rosenstein (2008) recommend that IQNs use inclusive communication processes with their colleagues to feel confident as a member of their healthcare team. Such processes accord with the principles and elements of cultural safety, such as mutual respect, trust, and acceptance, as promoted by Nuku (2020). Whilst this gives migrant nurses agency in influencing the group dynamic, the onus placed on IQN participants to bridge communication gaps by having solution-focused conversations with colleagues was somewhat unfair. Despite personality differences influencing how team members communicated with each other, participants valued engaging in authentic workplace interactions in nursing contexts. IQNs are often perceived by fellow nurses as being empathetic and culturally sensitive, so positive experiences of team communication and collaboration enhance IQNs' sense of belonging in their workplace (Kaihlanen et al., 2019; Schilgen et al., 2019).

Clear workplace communication processes were valued by IQN participants, especially during the challenges caused by the COVID-19 pandemic restrictions and immunisation roll-out in 2020 and 2021 (NZNO, 2020; Turgut et al., 2022). As Burden et al. (2021) explained, this was because “over and above the scale and urgency of the endeavour, [the government's challenge was] to promote vaccine confidence and acceptance against a background of misinformation and mistrust” (p. e-16). Participants valued their colleagues' perspectives towards the COVID-19 vaccine, which aligned with Burden et al.'s (2021) recommendation for nurses to use open communication to encourage others' vaccine confidence. Yet, Nightingale expressed feelings of confusion and stress when immunisation policy directives from the central Ministry of Health “were not well organised” and seemed to convey differing rules. Eriksson and Engström (2018) found that IQNs benefited from receiving timely guidance from management. However, during the global pandemic, nurses reported experiencing emotional distress, owing to the uncertainty brought about by the constantly changing healthcare policies and protocols (Longmore, 2021; Sarabia-Cobo et al., 2021).

In line with Riddell et al. (2022), participants engaged in open communication, collaborative teamwork, and flexible learning processes to manage healthcare challenges during COVID-19 restrictions. When participants used open communication in their problem-solving conversations, they were able to be

diplomatic and careful when conveying sometimes difficult messages to colleagues. To maintain the welfare of staff and patients, IQN participants used active listening strategies to follow workplace protocols and meet organisational goals. Eriksson et al. (2018) and Schilgen et al. (2019) found that IQNs who felt they were listened to by managers and colleagues considered themselves to have integrated into the host country's nursing community. Participants conveyed their feelings of disquiet, though, when IQNs' proactive offers of support or quality-focused complaints were rejected by colleagues or managers. This was concerning, as nurses in New Zealand are expected to uphold *tikanga Māori* and *Te Whare Tapa Whā* values in their workplace interactions with colleagues to support team members' wellbeing and cultural safety (Brunton et al., 2020).

6.2.3 Theme Three: Workplace Interactions

According to the literature (e.g., Aggar et al., 2021; Ghazal et al., 2020), skills training opportunities, like staff induction, assist IQNs in applying intentionality, goal setting, and self-regulation to their nursing practice in new workplaces. IQNs' goal-orientedness and job commitment may increase when they feel supported by their manager during nursing induction and skills training. IQN participants reported having experience inducting others into the workplace to welcome new nurses into the team and provide guidance in their professional learning and practice. They recognised the value of developing rapport with newly hired staff to benefit team relationships and task management.

It was also notable that IQN participants expressed appreciation for their colleagues' professionalism in communicating with team members (Nightingale), relieving staff pressures during COVID-19 pandemic restrictions (Lilly), and showing a team-focused attitude (Mons). The positive recognition that participants gave to their colleagues' contribution to the workplace aligns with Aggar et al.'s (2021) research into IQNs' appreciation of their colleagues' nursing practice and clinical skills development. Furthermore, the participants' team members and managers expressed their own admiration of IQNs' nursing skills, attitude, and knowledge, which enhanced IQNs' nursing self-confidence. Such recognition from their colleagues led to participants feeling confident in their nursing skills and valued for their

professionalism and person-centredness. Still, there is a need for further research into the impact that employers' appreciation of their nursing expertise has upon IQNs and their retention (Walker & Clendon, 2012).

Barton and Wilson (2008) noted that the values of *awhi* (i.e., 'to embrace' or 'to cherish') in *tikanga Māori* are applied by IQNs to care for, and provide soft support to, their colleagues. Participants in this study valued giving or receiving collegial support as an opportunity to enhance their nursing skills and team morale. A strong example of this was during New Zealand COVID-19 Delta lockdown of late 2021. Jessie and Rose appreciated their managers' demonstrating care and concern for staff by offering counselling and workload assistance (Jessie) and additional leave to cope with family pressures (Rose). Indeed, IQNs in New Zealand have reported the emotional and professional benefits from their supportive conversations with colleagues and managers (Brunton et al., 2020).

In line with Nørgaard (2011), when IQN participants considered their workplace environment to be positive and inspiring, they felt encouraged to support their colleagues for both team members' and patients' wellbeing. Findings from nursing researchers (e.g., Ohr et al., 2016; Roth et al., 2021) identified migrant nurses' experiences of engaging in effective teamwork and professional support as potentially contributing to their feeling valued within nursing contexts. Participants' rapport with their colleagues was boosted by resolving misunderstandings and differences through exchanging professional knowledge and demonstrating professional behaviours and attitudes. This finding was similar to Kalisch's (2011) study, which found that, despite experiencing conflict and exclusion, IQNs benefited from collaborative relationships within healthcare teams. Peer relationships allowed IQNs to develop the communication and teamwork skills that supported quality patient care.

6.2.4 Theme Four: IQNs' Concerns and Advice for Employers and Educators

King-Dejardin (2019) found that, compared with New Zealand-trained nurses, IQNs may be more prone to being bullied or harassed in the healthcare workplace. IQN participants spoke of their experiences of bullying—either to themselves or their

peers—in New Zealand healthcare settings. Participants did note, though, that New Zealand-trained nurses also experienced bullying from other RNs. IQNs’ negative experiences of being bullied or harassed may lead to their feeling excluded from the nursing community and dissatisfied in their nursing career (Cheung et al., 2018; Chun Tie et al., 2018). Participants also expressed their feelings of discomfort when interacting cross-culturally with colleagues and sensing elements of racism. Whether English was their first language or additional language, racism was either experienced or observed by IQN participants. Nursing researchers (e.g., Choi et al., 2019; Dahl et al., 2017; Gillespie et al. 2017) have determined that IQNs’ experiences of racism, prejudice, and cultural ‘othering’ negatively impact their sense of self as qualified and experienced RNs. Such harmful experiences destabilise IQNs’ efforts to integrate into the nursing community.

In addition, IQN participants reported their sense of exploitation, such as feeling sidelined from being involved in professional discussions with colleagues, or feeling they were not receiving professional respect or courtesy. The lack of support from management or negative reinforcement from management of exploitation or favouritism led to Rose, Carmel, and Ricky feeling demoralised in their healthcare settings, for example. IQNs reflected that their New Zealand colleagues appeared to receive more favourable treatment, thus contributing to IQNs’ feeling exploited. Ricky recognised, too, that many IQNs, especially those from Asia and other countries where the power distance is such that you do not question a manager, do just “put up and shut up.” IQN participants’ experiences of exploitation and inequality align with King-Dejardin’s (2019) and Smith et al.’s (2020) findings that IQNs are susceptible to being allocated a large caseload or high patient acuity (i.e., requirements for nursing care per Jennings’s (2008) definition). IQNs may reduce the workplace stress and feelings of alienation resulting from others’ prejudices through building professional relationships and engaging in mutually respectful communication with colleagues and managers (Ghazal et al., 2020; Schilgen et al., 2019).

IQNs’ sense of career fulfilment and workplace collegiality may support their sociocultural and professional adaptation in the host country’s nursing community (Zanjani et al., 2021). Therefore, when healthcare organisations focus on reducing

the potential for IQNs to experience burnout, IQNs' career sustainability in New Zealand may be enhanced (Roth et al., 2021). Participants in this study acknowledged that managers need to help healthcare staff understand how best to work with IQNs prior to their arrival in New Zealand. Rose and Mons suggested managers promote IQNs' professional development, including providing clinical training and reciprocal mentoring opportunities, which Kakyō et al. (2022) also recommended for nurses' career progression. In addition, Jessie advised managers to "listen to nurses [...] and allow their input about organisational changes so they can feel valued." Participants' recognition of the need for IQNs to engage in professional development and open communication to boost their self-confidence and collegiality is reflected by the NZNO's (2018) expectation for nurses to "work respectfully with colleagues to best meet patient needs" (p. 16).

IQNs develop skills and confidence during a CAP course in applying *tikanga Māori* and Te Tiriti o Waitangi (Treaty of Waitangi) principles to nursing practice so that the wellbeing and cultural safety of staff and patients are maintained (Brunton et al., 2020; McBride-Henry et al., 2022; Nursing Council of New Zealand, 2022). Nursing educators and CAP course providers were thus advised by IQN participants to be encouraging, positive, and patient to support IQNs' integration into New Zealand healthcare settings. Participants recommended that nursing educators help IQNs develop their understanding of Te Tiriti o Waitangi (Treaty of Waitangi) principles so they were better able to respect *tangata whenua* (Māori people) in their nursing practice. Another priority, according to participants, was the teaching and encouragement of open communication and teamwork skills that IQNs would need in their New Zealand nursing roles. As Philip et al. (2015) and Kaihlanen et al. (2019) observed, newly arrived IQNs should be reminded that it is acceptable for them to speak up and interact professionally with doctors. This is an aspect of cultural awareness that may support their integration into the nursing community host country's nursing workforce.

New Zealand organisations are obliged by the Health and Safety at Work Act 2015 to maintain a healthy and safe workplace. Wellbeing in the workplace also entails workers not being exploited, harassed, or discriminated against based on their racial or cultural background (New Zealand Government, 2023). It is worth noting, though,

that this Act depends on: (i) employers' being sensitive to workplace harassment or exploitation; and (ii) IQNs' standing up for themselves, both of which do not consistently occur in New Zealand healthcare settings. Consequently, IQN participants advised nurse managers to prioritise health and safety when distributing caseloads amongst nurses so that staff had time to take rest and comfort breaks. IQNs' allocation of large caseloads or high acuity may be commonplace in the healthcare sector (Smith et al., 2020). To Ricky, high acuity posed a risk to staff and patient wellbeing because nurses cannot "fully look after somebody when [they're] not looking after [themselves]."

Furthermore, it was important to participants that managers provide training on following medication administration processes to ensure patient safety. IQNs may find it difficult to ask questions, which is a crucial skill in nursing to understand clinical directions or explanations and keep patients safe (Brunton & Cook, 2018; Buchanan, 1990). Taking responsibility for their clinical practice would help IQNs uphold patients' welfare, as well as safeguard their nursing registration and professional reputation. Participants thus emphasised the need for IQNs to stand up for themselves and ask for help with tasks if they lacked specific skills. This recommendation from IQN participants aligns with the World Health Organization and International Labour Organization's (2022) advice for a healthcare workplace's culture and practices to support the physical and psychosocial welfare of staff. Such a recommendation seems to place the onus for fixing a structural problem onto individual IQNs with limited power, though.

6.2.5 Theme Five: IQNs' Professional Experience

Zacharias (2010) observed that IQNs develop their communicative competence in healthcare settings through acculturating to New Zealand workplace environments and cultural practices. IQN participants appreciated having the opportunity to create learning networks so that professional skills, experience, and knowledge could be shared with their nurse colleagues to form a connected professional community. When IQNs become more confident and competent in their interpersonal and cross-cultural interactions, they may demonstrate the cultural awareness and team collaboration skills that support their integration into a healthcare organisation

(Kaihlanen et al., 2019; Myles, 2009). In line with Ghazal et al. (2020), participants were motivated to engage in nursing skills training with colleagues, which would help them develop goal-orientedness and self-efficacy. Professional learning opportunities may also support IQNs' understanding of aspects of workplace language and culture that Olajoke (2013) notes are central to healthcare providers' organisational communication.

According to Balante et al. (2021) and Brunton and Cook (2018), IQNs are better able to overcome workplace challenges when they use effective interpersonal and cross-cultural communication skills. IQN participants who were nurse managers themselves, or who had a manager who demonstrated professionalism in the workplace, endorsed an ethical and staff-focused leadership style that supported teamwork. Participants also valued their colleagues' collaboration skills that focused on building rapport and collegiality. This accords with Gao et al.'s (2015) research in which nurses coped better with work pressures when they felt appreciated and supported in their healthcare team. In line with the perspectives of Harding and Mawson (2017) and Skår (2010), participants viewed mentoring as a mutual exchange of nursing knowledge via coaching or professional inquiry, rather than simply lecturing colleagues or trainees. When mentors encourage IQN colleagues to share their nursing knowledge and experiences, it may be easier for IQNs to be accepted within their nursing community of practice via their legitimate peripheral participation (Block, 2007; Hanks, 1991; Wenger, 2006).

It was important to participants that IQNs' clinical skills and experience be recognised by their colleagues and managers. They noted that many healthcare employers in New Zealand did appreciate IQNs' knowledge and competencies in completing nursing tasks. Nonetheless, there were several instances when IQN participants reported feeling demeaned as a professional when their nursing expertise was not recognised. This aligns with findings from the nursing literature (e.g., Roth et al., 2021; Smith et al., 2022; Walker & Clendon, 2012), which show that local nurses may not respect IQNs' nursing qualifications or clinical experience. Such professional disparagement may potentially contribute to IQNs' deskilling, career dissatisfaction, and attrition (Roth et al., 2021). IQN participants were enthusiastic proponents of in-house and external professional learning opportunities for IQNs and

New Zealand-trained nurses alike. IQN participants' positive career development and professional learning experiences in New Zealand contrasted with Gotehus's (2022) study participants, whose colleagues did not value IQNs' specialist and generalist training, as well as their clinical skills.

Learning from collegial advice and professional self-reflection was also important to IQN participants. This was because they considered it essential for IQNs to be open to learning from their colleagues' constructive feedback and their own experiences. The nursing literature (e.g., Brunton & Cook, 2018; Philip et al., 2015; Wright, 2012) emphasises the importance of IQNs' self-reflection and sharing of professional knowledge to determine the extent to which their verbal and non-verbal communication meets team members' needs. IQNs' self-efficacy may increase when they adjust their cognitive and behavioural processes to continue making progress towards their professional goals (Bandura, 2006). Despite the onus on individual IQNs to reflect upon workplace interactions to consider what they would do or say differently in future, participants' reflections on their communication skills served to enhance their nursing practice.

6.2.6 Theme Six: IQNs' Agency

Despite experiencing communication challenges in their New Zealand healthcare workplace, IQNs admitted to not feeling affected professionally by difficult interactions with colleagues. For participants, developing professional relationships required them to engage in an ongoing process of collaboration and negotiation. They reported experiencing miscommunication in the workplace because of ineffective interpersonal skills, though. The nursing literature (e.g., Balante et al., 2021; Ghazal et al., 2020; Javanmard et al., 2017; Philip et al., 2015) has found that IQNs' workplace conversations with colleagues can result in mutual misunderstanding and miscommunication, potentially hindering IQNs' acculturation in healthcare workplaces. It is evident that IQNs benefit from using appropriate verbal and non-verbal communication skills to reach mutual understanding with colleagues (Manankil-Rankin et al., 2022; Philip et al., 2015; Pressley et al., 2022).

IQN participants' challenging workplace interactions led to their experiencing heightened negative emotions. This required participants to demonstrate resilience and self-reflection when focusing on working calmly and professionally with difficult colleagues. As Candlin and Crichton (2011) note, migrant EAL nurses who are effective communicators demonstrate the sociolinguistic and sociopragmatic competencies that help them feel more at ease in healthcare environments. According to participants, it could be stressful working with strong-willed or impatient colleagues, especially during COVID-19 pandemic restrictions. Their difficulty in dealing with colleagues' negative reactions to these restrictions belie Killeen and Saewert's (2007) findings that nursing's core norms of collegiality, loyalty, and compassion are central to a nurse's professional identity and practice. Aggar et al. (2021) found that personality differences amongst healthcare team members can lead to IQNs' experiencing communication challenges. Nightingale, though, was accepting of her team members' different personalities, so she chose not to become stressed when interacting with difficult colleagues. IQN participants demonstrated their commitment to maintaining collegial relationships by staying optimistic albeit assertive in the face of challenges (Block, 2007; Nørgaard, 2011).

IQN participants reported having professional demands made upon them in their healthcare workplaces during COVID-19 pandemic restrictions. New Zealand was suffering a nursing shortage in 2020 and 2021 because of the government's initial policy of eliminating the coronavirus that resulted in COVID-19 immigration restrictions (Alexander, 2022; Jefferies et al., 2020). Despite being recruited to enjoy their New Zealand lifestyle, IQNs experienced pressures such as balancing their personal and work commitments, managing stress and work expectations, and not receiving collegial support from colleagues or managers. IQNs' work pressures risked their wellbeing, which Lovelock et al. (2017) warned could result in staff burnout. The IQNs in this study revealed that they felt supported in their nursing roles by their colleagues or organisation, despite the professional demands caused by the COVID-19 pandemic. Participants' sharing of their experiences during COVID-19 pandemic restrictions enhanced their own and their colleagues' ability to understand workplace pressures and make informed decisions (Harding & Mawson, 2017).

Participants in this study talked about the challenges they faced when their managers or colleagues treated them unfairly. Such unethical treatment appears to contradict Johnson et al.'s (2012) observation that nurses align their personal ethics with their nursing profession's expectation for care and compassion. In addition, IQN participants did not always receive support from their managers when interacting with challenging patients or colleagues. Participants' experiences of criticism or exploitation contrasted with research (e.g., Dörnyei, 2003; Pung & Goh, 2017; Smith et al., 2020; Teo et al., 2013), which indicated that IQNs' self-efficacy helped them overcome workplace pressures. Positive feedback from colleagues and managers led to participants' feeling more motivated in their work. This aligns with research by Dörnyei (2003), Gao et al. (2015), and Johnson et al. (2012), whereby IQNs' motivation and self-esteem arose from their feeling valued and agentic in overcoming, and learning from, workplace challenges. This then contributed to participants' feelings of success in their nursing role. Nightingale pointed out, though, that the lack of motivation in healthcare workplaces "resulted in staff feeling down and not wanting to work with their colleagues." Consequently, it behoves healthcare employers to show they value and support IQNs in their nursing roles in order for migrant nurses' motivation, organisational commitment, and career sustainability to be maximised (Spoonley, 2014; Walker & Clendon, 2012).

In this study, participants recognised the need for IQNs to speak up for themselves and for their colleagues to develop their confidence in working calmly and professionally with difficult colleagues. Nursing researchers (e.g., Brunton & Cook, 2018; Chun Tie et al., 2019; Lum et al., 2014) have found that, whether English is their first or additional language, IQNs may experience discomfort when interacting with their colleagues in healthcare settings. This may be owing to differences in culturally-bound communication and nursing practices. It was thus important for IQN participants to seek clarification, be assertive, and focus on "not taking things personally" (Nightingale). Furthermore, Ricky's storied experiences of bullying and exploitation in nursing contexts echo Smith et al.'s (2020) observation that healthcare employers may not be responding appropriately to IQNs' concerns about discrimination in the workplace.

6.3 IQNs' Sense of Professional Self

The study set out to answer the following two research questions in relation to IQNs' sense of professional self:

Research Question 1

How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings?

Research Question 2

How does IQNs' use of discursive positioning in their stories jointly construct aspects of their professional identity?

I used positioning theory (Davies & Harré, 1990; Harré & van Langenhove, 1999) as my overarching theoretical and analytical framework in the research design to understand how IQN participants revealed aspects of their professional identity as they shared their storied experiences of workplace interactions with colleagues. Data sourced from research conversations with eight IQN participants were analysed via a two-stage process, demonstrating how positioning analysis can be applied to qualitative coding procedures. A social constructivist approach to grounded theory (Charmaz, 2008, 2014) informed my initial treatment of transcript data to produce codes, categories, and themes.

Bamberg's (1997, 2003) positioning analysis formed the basis of my second-stage analytical procedure, namely multimodal positioning analysis (MPA). RQ1 sought to discover how IQNs positioned themselves and others as they told and retold stories of participating in workplace interactions with colleagues in New Zealand healthcare settings. RQ2 considered the ways in which IQN participants jointly constructed aspects of their professional identity via discursive positioning in their stories.

Whilst researchers (e.g., Bamberg, 2011; De Fina, 2008) usually conduct positioning analysis via conversation analysis of participants' 'talk-in-interaction', I did not follow this approach when devising and applying the MPA model to my narrative data. Instead, I solely transcribed participants' spoken and written (i.e., text on Flower Diagrams) words. Through multimodal positional analysis, I analysed the ways in which IQNs used positionality, emotionality, relationality, and consequentiality when making sense of, and reflecting upon, their storied

experiences to reveal aspects of their professional identity. In this section the study's key findings in relation to each of these questions are interpreted and discussed in connection with previous research.

6.3.1 Aspects of Multimodal Positioning at Level 1

At Level 1, IQN participants displayed agency in their stories of responding professionally and proactively to colleagues who they felt were not following correct protocol. They often maintained control of difficult conversations by speaking calmly and compassionately. For example, as Clinical Lead, Lilly gave counsel in private to a caregiver who made a medication administration mistake. As Ohr et al. (2016) point out, IQNs appreciate being able to support their colleagues in developing clinical skills and knowledge. Participants expressed the value they gained from sharing similar nursing experience and professional backgrounds with their colleagues. Enjoying their professional relationships, participants were keen to mentor and support their colleagues in a mutually beneficial way. This is also seen in Brunton et al.'s (2020) research, which found that IQNs benefited from engaging in supportive conversations with their peers, especially when IQNs' individual perspectives and experiences were respected. Participants noted, though, that they were expected to work in healthcare teams whose members possessed different personalities, which could impact their nursing practice. As Aggar et al. (2021) observed in that regard, IQNs may experience challenging workplace interactions when there are personality differences between IQNs and their colleagues.

Aspects of temporal constancy and change in IQNs' identity positioning were indicated through participants understanding how professional learning occurred in challenging ways but allowed them to develop confidence as nurses and team members. For instance, Ricky developed a mentoring relationship with a senior nurse colleague. This concurs with Harding and Mawson's (2017) research, wherein professional mentoring helped IQNs become more confident and committed to their healthcare workplace. Lola's experience of being encouraged by her colleagues to have a potentially difficult conversation with another nurse aligned with Zhang et al. (2014), who noted that nurses benefit from working in healthcare settings in which values of mutual respect and professional empowerment are upheld.

In this study, IQN participants used discursive language (e.g., literal and non-literal expressions) to reveal their emotions within their storied experiences. That is, figurative language played a role in showing how nurses conceptualised their emotions discursively and made sense of their workplace experiences, which Froggat (1998) observed as well. In addition, IQNs' used visual language in selecting colours and shapes to indicate their feelings surrounding misunderstanding, collegiality, and communication within healthcare teams. Nurses' emotions in response to their workplace interactions influence their sense of agency, leading them to experience and express feelings of professional stress or support (Lapum et al., 2021). IQNs also face challenges to their sense of agency when managing discordant and inequitable team relationships (Kalisch, 2011). When talking about informing staff about the COVID-19 vaccine, Mons used the colour red to represent the "underlying love and the disaster" of coming up against resistance from those who were against the vaccine. Ricky coloured in the 'Understanding' petal a blue colour when describing how her mentor's solution to a communication breakdown filled her with "a sense of calm." When IQNs feel positively motivated by their work as a nurse, their feelings of self-efficacy and self-management may likewise increase (Dörnyei, 2003; Johnson et al., 2012).

The findings of this study revealed the importance of IQNs' self-positioning in the professional areas of managing or mentoring staff and being a collegial team member. Kamau et al.'s (2022) research supports this study's finding that Lilly's self-positioning reflected her feelings of satisfaction in her managerial role. Lilly demonstrated confidence and compassion in being a manager, helping staff understand, and learn from, their mistakes in a comfortable way. Participants' appreciation of their positive workplace relationships aligns with Noguchi-Watanabe et al.'s (2016) and Winkelmann-Gleed and Seeley's (2005) findings that IQNs' career sustainability is enhanced by collegial interactions and others' recognition of their nursing skills.

During their stories of workplace conversations with fellow healthcare workers, participants positioned their colleagues as being both professional and unprofessional in turn. Staff members who apologised for their mistakes and responded positively to

counsel were considered by Lilly to be upholding professional attitudes. This is in line with Kamau et al. (2022) and Choi et al. (2019), who found that IQNs focused on communicating with integrity, collegiality, and equity within healthcare teams to enhance their feelings of team membership. Conversely, in Lilly's, Carmel's and Lola's respective stories, colleagues who either refused to follow directions and clinical observations or were unappreciative, untruthful, or dismissive of IQNs' perspectives were positioned as unprofessional in their clinical and managerial roles. In similar research contexts, nursing researchers (e.g., Noguchi-Watanabe et al., 2016; Walker & Clendon, 2012) have found the IQNs may not obtain timely clinical information from managers to support their nursing, decision-making, and reporting processes. IQNs may also not receive acknowledgement of their professional skills and experience from colleagues.

As Lovelock et al. (2017) reported, front-line staff in New Zealand healthcare settings were stressed by the time pressures and resource shortages that negatively impacted employees' retention, emotional wellbeing, and organisational loyalty. Several participants positioned, and were positioned by, their colleagues as acting unprofessionally, particularly because of staffing pressures. For instance, whilst she was confident in resisting a shift lead's efforts to give IQNs a higher number of patients than local nurses, Ricky was concerned that other IQNs might burn out because of their "not wanting to make waves" about an overly high caseload. Ricky's concerns for, and support of, her IQN colleagues align with Smith et al.'s (2020) finding that IQNs' workplace exploitation and bullying are evidenced by their being given high acuity, for which IQNs are ill prepared.

Cheung et al. (2018) and Chun Tie et al. (2018) reported that IQNs' experiences of bullying, racism, or exploitation, and the lack of management support, led to their feeling dissatisfied with their nursing role. Nevertheless, IQNs in this study did position themselves and their fellow nurses as being appreciative and experienced healthcare professionals, who focused on motivating and supporting their colleagues. IQNs' positioning of themselves, and their positioning by others, as collegial nurses aligns with Thompson and McNamara's (2022) findings that nurses seek to "find their voice [to] move away from the ingrained 'handmaiden' identity" (p. 2350). In potential conflict situations, such as workplace bullying, Noguchi-Watanabe et al.

(2016) recommend nurse managers keep open channels of communication so that relationships with staff members are boosted by reciprocal, meaning-focused conversations.

The positive support that Jessie received from her manager in response to her trainee's rejection of the professional learning opportunity aligns with findings from both empirical studies of IQNs (Eriksson et al., 2018; Timilsina Bhandari et al., 2015), as well as reviews of qualitative research on IQNs' workplace interactions (Viken et al., 2018). That is, colleagues who listen to, and respect, IQNs' perspectives and expertise, helping them to feel included in the healthcare workplace, contribute to IQNs' career sustainability (Viken et al., 2018). When their thoughts and feelings about workplace interactions were listened to by their colleagues, IQNs gained an increased sense of being valued in their healthcare setting, which Eriksson et al. (2018) also found. Still, as Lola experienced, IQNs may sense a lack of agency when wanting to balance their workplace obligations with patient or colleague needs. Lola's "little heart sank" when a senior manager dismissed her suggestion to visit elderly patients during COVID-19 pandemic restrictions. This was because she was unable to use self-efficacy and forethought to manage her own nursing practice and support the wellbeing of her patients and colleagues, a dilemma also identified by Brunton et al. (2020), as well as Ryan and Deci (2000).

Similar to Roth et al.'s (2021) research, IQN participants valued productive and amicable teamwork processes. Collegial interactions in which mutual humour and recognition help IQNs feel supported in their nursing role (Caza et al., 2018; Philip et al., 2019). Participants were positioned by their colleagues in communicating effectively using person-centred verbal and non-verbal communication. In contrast with Bland and Woolbridge's (2011) findings that IQNs are challenged by communicating clinical information to service users, Lola was positioned by a registrar as an experienced nurse because she used soothing phrases when explaining medical services to a patient. IQNs' use of verbal and non-verbal communication that is appropriate to healthcare contexts contributes to high standards of patient care (Xu et al., 2012).

The social-cognitive implications of IQNs' stories of collegial interactions at Level 1 related to migrant nurses with English as an additional language having limited confidence in clarifying workplace instructions or explanations, which is in line with Buchanan (1990). In Nightingale's workplace, for instance, there were instances when COVID-19 rules and procedures were not effectively conveyed to staff, leading to their misunderstanding of key messages that would impact their work. Noguchi-Watanabe et al. (2016) indicated that irregular or insufficient information from management led to the affective implication of IQNs feeling frustrated that they were unable to fully participate in workplace decision-making, reporting, and resourcing processes. There were also moral implications of participants' showing compassion to difficult colleagues and receiving acknowledgement of their concerns, which demonstrate nurses' desire for caring patient and staff relationships (Barton & Wilson, 2008). Noguchi-Watanabe et al. (2016) recommend that nursing leadership encourages reciprocal communication processes so that staff-supervisor and team relationships are strengthened. IQNs' self-confidence may be boosted by supportive workplace relationships and interactions with healthcare professionals (Roth et al., 2021). IQN participants reflected that giving feedback to colleagues and managers in person and in private was crucial in reducing IQNs' work pressures.

6.3.2 Aspects of Multimodal Positioning at Level 2

At Level 2, I examined what Barkhuizen (2010) termed "the performance aspect of the story" (p. 289); that is, the interactional nature of a participant's presentation of: (i) self as storyteller; and (ii) story components in relation to the listener(s) (Bamberg, 2004). Following Barkhuizen's (2010) and Chase's (2003, 2005) advice, I asked IQN participants to share a story of a challenging or positive workplace interaction they had with their colleague(s). My open questions (e.g., "Tell me more about...", "What advice would you have for another IQN who had a similar experience?", or "What would a fly on the wall notice on your/their face during the conversation?") aimed to elicit reflective responses from participants, as Nardon et al. (2021) suggested. Our story-led conversations comprised rich narrative data through which IQN participants' identity positioning might be better understood. Participants' stories were further enriched by prompts, feedback, and input from their listeners (i.e., me as researcher and their IQN co-participant during Zoom Pair

Shares), resulting in mutual relationship building and co-constructed story meaning. In this section, I discuss participants' demonstration of positionality, emotionality, relationality, and consequentiality in their stories of workplace interactions that reveal aspects of their professional identity at Level 2 of the MPA model in relation to relevant literature.

As nursing researchers (e.g., Balante et al., 2021; Javanmard et al. 2017; Philip et al., 2015) have found, IQNs and their colleagues may experience mutual miscommunication, owing to cultural and language differences. IQN participants demonstrated their sense of agency and control in their stories of advising colleagues, acting independently, and following directions in healthcare settings. For example, Jessie recognised that she had the agency not to keep apologising for a perceived mistake if she was in the right. Otherwise, according to Jessie, management would “step on you because you’ll just follow control,” so IQNs needed to be confident in their professional abilities.

Participants also expressed their feelings of sameness and difference with their colleagues by positioning themselves as sharing similar nursing experience, being open to learning, and valuing close professional relationships. Rose and Jessie positioned themselves as the same as nurses who had different specialist training. This contrasts with Choi et al.'s (2019) findings whereby specialty-trained IQNs, who were either unable to apply their specialist nursing skills in the workplace or were required to complete generalist nursing, felt discouraged in their role. Jessie positioned herself as sharing a love of professional learning with her managers as well, valuing “intact and [...] really close relationships.” Whilst IQNs may find it difficult to join the host country's nursing community of practice (Wenger, 1998, 2006), this study aligns with Zhang's (2014) advice for healthcare providers to ensure nurses are shown professional respect. This involves giving IQNs ample opportunities to further their career and increase their job satisfaction.

Furthermore, IQNs who demonstrate integrity and collegiality are more likely to be accepted within the healthcare team, even if team members possess diverse cultural and professional backgrounds (Kamau et al., 2022). This was seen by the contrasting leadership styles of Mons and her fellow managers. Mons's recognition of her

“compassionate” leadership style, compared with other managers’ formality, is in line with research by Dörnyei (2003) and Johnson et al. (2012), wherein IQNs’ high levels of self-efficacy, self-motivation, and self-esteem helped them manage their own and others’ job performance.

Aspects of IQNs’ professional identity were revealed in their stories of giving advice, being a professional manager and nurse, appreciating collegiality, being acknowledged by colleagues, and showing rapport and collegiality. Although Lilly was “initially angry” when her correction to a caregiver was rejected, she was happy when he tried to understand Lilly’s advice later. The metaphor of ‘achieving a victory’ was used by Lilly to indicate her happiness and pride at reaching agreement with her team member. Lilly’s use of this metaphor also revealed her sense of struggle and conflict during the disagreement. This was subsequently vanquished through mutually overcoming this challenge to their workplace relationship. Collegial relationships were found by Thistlethwaite (2015) to be central to IQNs’ team participation and job satisfaction. Mons, for instance, coped with challenging conversations with colleagues by staying calm and finding mutually beneficial solutions. As a manager, Mons felt that “the higher you are, the lonelier,” so she valued her rapport with her fellow manager in helping her lead the team. Engaging in constructive and collaborative workplace interactions has been found to increase IQNs’ self-confidence in their nursing role (O’Daniel & Rosenstein, 2008).

This study’s findings at Level 2 indicated that, as Killeen and Saewert (2007) observed, IQNs’ professional identity and clinical practices are influenced by the nursing community’s values of equity, collegiality, loyalty, and compassion. After feeling disappointed by a “biased” nurse manager who was “justifying the wrong actions” of an RN who made mistakes in administering medication, Carmel was happy to make “an action” by emailing managers with her concerns. According to Johnson et al. (2012), nurses unite their sense of personal and professional self by aligning their personal ethics and personal characteristics with the expectations and norms of their nursing role. Lola was “very chuffed to be appreciated” by a senior manager for her work in gaining accreditation in the field of dementia. However, a doctor’s overestimation of her ability in caring for a patient left Lola feeling “frustrated” by the doctor’s “fairly unrealistic” evaluation of her nursing skills.

Receiving recognition for her loyalty and expertise from her manager and colleague did indicate Lola's supportive workplace relationships.

Certainly, IQNs benefit from engaging in compassionate interactions with their colleagues, which are crucial for nurse retention (Harding & Mawson, 2017). When Jessie's colleagues telephoned her during the COVID-19 lockdown in 2021 to offer support, Jessie felt "touched" by their kindness. This aligns with Lola's experience of sharing harmonious relationships with her team members: She enjoyed being teased and working in a light-hearted way with "fabulous nurses, [who were] very supportive, very caring, very skilled, very competent." Nonetheless, IQN participants' familiarity and rapport contrasted with Brunton and Cook's (2018) research that humour and collegiality in the healthcare workplace could be misconstrued by IQNs.

IQNs used visual language in their Flower Diagrams when sharing their storied experiences of: (i) having or not having their advice accepted or understood; (ii) experiencing colleagues' anger; and (iii) sharing rapport and unity with colleagues. Having noticed that IQNs were given unfair caseloads, Ricky coloured the 'Disaster' petal red, indicating her awareness of the "danger" and the "fiery atmosphere" with the shift lead after her protest at IQNs' exploitation. The high rates of migrant nurses' attrition are influenced by the exploitation and bullying they face, as evidenced by their being given a large caseload or high acuity (Smith et al., 2020). Lola chose a light pink colour and a red colour for the 'Oh!' petal, in which she wrote the words "Oh, dear!" Lola had been anxious about telephoning an experienced nurse about a mistake she had made in a cognitive assessment scoring. Lola's subsequent positive experience with offering guidance to her colleague contrasted with Lilly's, who was frustrated at having her expertise dismissed. Lilly's frustration was similar to the exasperation felt by IQNs in Walker and Clendon's (2012) study.

When IQN participants did experience their colleagues' anger, they worked to overcome these negative emotions in the healthcare workplace. When Jessie and her trainee reached an understanding, she picked a violet colour for the "disaster" that turned into peaceful relations. In the 'Disagreement' petal, Lola used a red colour for

the manager not wishing to discuss Lola's proposal to offer clinics over Christmas because "red is an argumentative colour." This study extends Philip et al.'s (2019) findings that IQNs found it difficult to respond assertively to a colleague's inappropriate or angry interactions. Lola's storied experience demonstrated the powerlessness she felt in being unable to negotiate with her manager.

Moreover, IQNs valued the rapport, agreement, understanding, and unity they experienced with their colleagues. Mons coloured in the 'Triumph', 'Agreement', and 'Understanding' petals a pink colour when talking about her fellow manager, whom she called "my little flower girl," owing to their close professional relationship. Rose chose green and blue for the 'Triumph' petal to represent her "cool" and "unlimited" team rapport respectively. These examples of collegiality in the healthcare workplace link with Schilgen et al.'s (2019) and Gao et al.'s (2015) findings that IQNs benefit from feeling supported by their colleagues when engaging in teamwork.

IQNs who participate in mutually supportive relationships within healthcare teams may experience a boost to their professional self-confidence (Ohr et al., 2016). Both Carmel and Lola expressed their positive feelings about being appreciated and growing in confidence as experienced migrant nurses. Carmel drew a yellow gold star in the 'Triumph' petal because she felt she was "shining like a star" in her nursing career. Lola chose pink to signify the "panic" and purple for the "triumph" she felt when a senior manager congratulated her for attaining accreditation. She also coloured in the 'Triumph' petal yellow as it signified the "sunny, happy and cheerful, and woo hoo" emotions she felt upon receiving professional recognition during the "stressful" COVID-19 pandemic restrictions. Carmel's and Lola's strong sense of being a career- and person-oriented nurse may have led to their feeling satisfied in their jobs. Participants' job satisfaction may not only have enhanced their retention and supported their professional development but also reduced their risk of burnout, as Rasmussen et al. (2021) found. Still, their positive experiences with providing clinical support to colleagues during the pandemic contrasted with participants in Lapum et al.'s (2021), who felt burnt out and stressed by the nursing challenges brought about by COVID-19.

As Nørgaard (2011) points out, in building collegial relationships, the clinical skills and professional attributes of IQNs and their managers are enhanced to support the wellbeing of team members. Jessie also felt a sense of triumph when she received supportive feedback from her colleagues. After Jessie's manager said she was "doing it right," Jessie felt emotions that were "shining bright as the sun," leading her to select yellow in the 'Triumph' petal. It is notable that the Flower Diagram was a powerful channel and catalyst for participants to volunteer such evocative descriptions. Where Ohr et al. (2016) considered team relationships amongst nurses as boosts to their self-confidence, this study has given participants ways to share storied experiences of self-confidence through metaphor and other expressive language.

Having hope and connecting positively with colleagues was important for IQN participants during the uncertainty brought about by COVID-19. Indeed, IQNs' career sustainability is enhanced by workplace collegiality and teamwork (Schilgen et al., 2019; Thistlethwaite, 2015). Nightingale said she enjoyed going into her workplace as a nurse during COVID-19 pandemic restrictions. She coloured in the 'Oh!' petal brown and wrote in the words "positive energy" to represent her appreciation of the rapport she felt with her colleagues. This is in line with nursing researchers (e.g., Pung & Goh, 2017, Javanmard et al., 2017; Schilgen et al., 2019) who found that IQNs' collegial relationships supported their acculturation and wellbeing. Selecting a yellow colour for the 'Triumph' petal because it gives "positive energy—and it's peaceful as well," Nightingale stressed the importance of a peaceable and fun workplace environment. Indeed, healthcare employers have the responsibility for prioritising IQNs' emotional wellbeing in the workplace (Roth et al., 2021).

Being an ethical and collegial team member was also important to IQN participants. Lilly and Rose positioned themselves as being kind, caring, and non-judgemental nurse leaders, who never wanted "to give anybody a bad day" (Lilly). Sharing "positive energy" and humour with her teammates, Nightingale positioned her colleagues as being a source of her job motivation. Findings from the literature (e.g., Bennett, 2003; Haavisto, 2014; Lewis, 2011) are in line with IQN participants' reports of engaging in co-operative, humorous, and motivating conversations with

colleagues to manage workplace pressures. In addition, Lola positioned herself as being helpful to her team members and “able to soothe” their anxiety to develop rapport. This was particularly crucial during COVID-19 pandemic restrictions when anxiety amongst healthcare workers was high and staffing resources were low (Seymour, 2020; Witton, 2022).

Smith et al. (2022) found that migrant nurses’ communication efforts with their colleagues were not always accepted nor understood by other healthcare workers. Brunton and Cook (2018), Buttigieg et al. (2018), and Pung and Goh (2017) have noted that idioms can lead to communication challenges for IQNs. These language barriers may be overcome through colleagues’ advice and correction, though. According to Roth et al. (2021) and Schilgen et al. (2019), IQNs’ self-confidence when participating in interpersonal and cross-cultural communication is further enhanced by collaborative and constructive workplace relationships. When IQNs enjoy close rapport with their colleagues and managers, they may be better able to cope with any prejudice or harassment they may face in the healthcare workplace. Although Lola felt disorganised, despite her colleague’s compliments on her apparent organisation skills, other IQNs positioned themselves as being a confident decision-maker (Carmel) and an efficient nurse (Rose).

IQN participants’ sense of agency and initiative links with the work of Ryan and Deci (2000) and Rasmussen et al. (2021) as they used self-efficacy in their nursing practice and communication to enhance their wellbeing and career sustainability. Participants’ other-positioning related to their colleagues being professional and open to learning from their mistakes (Lilly) and their manager being encouraging and constructive in giving supportive feedback (Jessie). Positioning her colleagues as being experts and mentors in their area of practice, Lola respected a senior nurse for having “done so well in primary care because [of being] very confident, very assured of her actions.” In line with participants’ positioning of their colleagues and managers as being professional and supportive, IQNs’ other-positioning in the wider literature (e.g., Eriksson et al., 2018; Timilsina Bhandari et al., 2015) included peers’ respecting IQNs’ expertise, supporting their career goals, and valuing their perspectives.

My findings aligned with those of nursing researchers (e.g., Aggar et al., 2021; Barton & Wilson, 2008; Brunton et al., 2020), whereby participants sought to nurture professional relationships and develop their peers' clinical skills by having encouraging conversations with their colleagues and managers. As managers, Lilly, Mons, and Rose positioned themselves as staying calm and compassionate when giving directions to staff, who they positioned as working hard to “do a beautiful job” (Lilly) and be strong professionals (Mons). They were in turn positioned by their staff as having high standards (Lilly), using humour to cope with struggles (Mons), and being person-centred and equitable as nurse managers and mentors (Mons and Rose). IQN participants' sense of moral community within healthcare settings is a central characteristic of their professional identity (Liaschenko & Peter, 2016).

There were several social-cognitive implications related to IQNs' providing professional learning to colleagues. Lilly presented herself as being confident when giving counsel as a Clinical Lead, clearly explaining medication errors to her colleagues so they could learn from their mistakes. Rose saw the value in advising the senior RNs on her team to support new nurses in their development of nursing competencies. Jessie, too, insisted that colleagues from a non-nursing background should have clinical information explained to them in a patient and clear way so that it became a teachable moment for both nurses. The implications of IQN participants' commitment to, and delivery of, professional learning to their peers are linked with Johnson et al.'s (2012) findings that IQNs' motivation, self-esteem, and confidence in their nursing role are increased by working with skilled and supportive colleagues. Still, opportunities for professional learning in the healthcare workplace may be limited by time constraints, nurse shortages, psychosocial factors such as staff burnout and cultural or language prejudices, all of which may be present in an IQN's fast-paced healthcare workplace (Brunton & Cook, 2018; Lovelock et al., 2017).

The moral implications of IQNs' workplace interactions with their colleagues encompassed the need for IQNs to support team members' professional development, act ethically to develop others' competencies, and enhance collegial relationships. Mons focused on supporting her staff members by suggesting options for their further training. Rose and Nightingale both sought to understand their team

members' personal and health needs to boost mutual rapport and teamwork. Wishing to protect residents' safety, Carmel upheld the value of nurses having integrity and "doing what is right even if nobody's looking." Her actions exemplified those of registered nurses, both in New Zealand and overseas, who are required to demonstrate nursing competencies, such as legal and ethical responsibility, interpersonal and cross-cultural communication skills, and reflective practice for professional learning. Therefore, it is crucial for IQNs to engage in collaborative workplace relationships to develop their clinical expertise, build rapport in healthcare teams, and maximise patient care outcomes (NEJM Catalyst, 2017; Nursing Council of New Zealand, 2022).

Agentic nurses in this study had "the power to originate action" (Bandura, 2001, p. 3) to manage their own and others' professional practice and interpersonal communication (Ryan & Deci, 2000). Findings from this study may enhance what is already known about agency by showing, for instance, IQN participants' self-efficacy and initiative when negotiating challenging workplace situations. Their agentic actions contrasted with Kalisch's (2011) findings that IQNs may lack the ability to manage conflict, participate in decision-making within nursing contexts, or demonstrate agency. Lilly and Ricky acknowledged the agency that an IQN exhibits when following nursing and HR policy to manage staff (Lilly) and protect IQNs from exploitation. Ricky noted that upholding "fairness so that everyone is safe" was crucial for supporting IQNs in the workplace (Ricky). According to Chun Tie et al. (2018), IQNs facing workplace prejudice or exploitation were not always given management support, though.

Moreover, participants' collaborative team relationships and staff-focused managers helped them cope with multiple nursing duties and workplace pressures in healthcare contexts, as Viken et al. (2018) and Schilgen et al. (2019) found. IQN participants reflected upon the importance of showing mutual appreciation, loyalty, and encouragement and engaging in task management and planning. Mons expressed her and her team's sense of loyalty to their organisation because they were all "getting in the canoe and paddling together" to achieve organisational objectives. Timilsina Bhandari et al. (2015) and Eriksson et al. (2018) found that IQNs who expressed a

sense of fulfilment in their nursing career in the host country felt they were respected by managers and colleagues for their nursing skills and perspectives.

6.4 IQNs' Sense of Professional Community

The study set out to answer the following research question in relation to IQNs' sense of professional community:

Research Question 3

What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?

I analysed the narrative data to identify the wider discourses indexed by the story characters and context in light of the IQN participants' use of positionality, emotionality, relationality, and consequentiality at Level 3 of the MPA model. In this section, I respond to RQ3 by discussing the MPA findings at Level 3 in line with relevant literature. I will also consider the ways in which participants positioned themselves and their stories within master narratives (or Capital D discourses) and/or counter narratives.

6.4.1 Aspects of Multimodal Positioning at Level 3

At Level 3, IQN participants revealed aspects of agency and control in their storied experiences of being independent and assertive nursing professionals. Nurses' professional agency and professional identity are connected, and both are needed for a sense of moral community within nursing contexts (Liaschenko & Peter, 2016). Lilly and Mons recognised that being an agentic IQN manager required them to be both friendly and serious with team members, who might not always accept an IQN manager's authority. Carmel felt she had the agency to "speak up for [her]self" as an IQN, despite being new to New Zealand and having her colleagues question her nursing expertise. This is in line with New Zealand research studies (e.g., Bland and Woolbridge, 2011; Smith et al., 2022; Walker & Clendon, 2012) that New Zealand-trained nurses critiqued IQNs' proficiency, owing to differences in nursing norms and practices. In contrast with Philip et al.'s (2015) findings, Carmel's desire to keep working in New Zealand was not hindered by her colleagues' dismissive attitude to her overseas nursing experience. Lilly and Nightingale considered themselves to be similar to their colleagues in appreciating opportunities for: (i) reflecting on task

performance (Lilly); and (ii) sharing clinical knowledge “of what this [COVID-19] vaccination for, what is a side effect, what is the benefit” (Nightingale). IQNs in this study aligned their values of compassion and understanding with the World Health Organization and International Labour Organization’s (2022) advice for the workplace culture in healthcare settings to enhance nurses’ physical and emotional welfare.

IQN participants’ discursive language showed their positive and negative feelings about being in leadership. Carmel was “very happy” about her promotion to Virus Control Lead, which entailed her attending a nursing conference to “broaden her [professional] network.” In contrast, Mons said she felt “drained and very lonely” as a senior manager because she could not express her emotions with colleagues. Carmel’s and Mons’s need for collegial support in supervisory roles aligns with findings by Philip et al. (2019) and Song and McDonald (2021) that IQNs value an inclusive nursing community. Such a professional community recognises IQNs’ professional skills and emotional needs. Moreover, IQNs who have access to inclusive communication processes in nursing contexts are better able to manage emotional pressures (Ghazal et al., 2020). Using the metaphor of IQNs’ needing to “wait for the clouds to get over and wait for the sunshine,” Rose advised IQNs to use clear communication with colleagues when sharing their concerns about difficult healthcare situations. As Gao et al. (2015) found, IQNs may overcome workplace challenges when they feel supported by team members in performing nursing tasks.

Liaschenko and Peter (2016) consider nurses’ identities to be “shaped by a complex interaction of how nurses see themselves, how others see them, and the culturally authorised identity of ‘nurse’” (p. S19). IQN participants used reflexive positioning to position themselves and their colleagues as being multiskilled and encouraging healthcare professionals. Positioning nurses as being a “jack of all trades,” “clinical hairdresser,” and “a social worker,” Mons co-constructed the positioning of herself and her fellow IQNs and nurse managers as being open to sharing personal and professional experiences with colleagues. Conversely, Carmel positioned herself and other IQNs as needing to be more open in conveying their ideas and feelings, especially since management was positioned as being receptive towards IQNs’ cultural perspectives. Carmel’s reflexive positioning accords with nursing

researchers (e.g., Smith et al., 2022; Walker & Clendon, 2012), who found that IQNs who had difficulties communicating with colleagues because of cultural factors, such as displaying deference to doctors, were encouraged by fellow nurses to be assertive in their workplace interactions.

The social-cognitive implications of IQNs' workplace interactions with colleagues at Level 3 involved elements of professional communication, community building, and nursing skills development. Recognising that cross-cultural communication was "the big issue" for IQNs (Lilly), participants acknowledged that IQN managers needed to be fair-minded and empathic to support staff "going through their own issues" (Mons). It is their diverse cultural and language backgrounds that may contribute to IQNs' communication breakdowns with colleagues and managers. These communication issues might impact IQNs' sense of professional self (Walker, 2008; Walker & Clendon, 2012). COVID-19 pandemic restrictions resulted in high levels of fatigue and stress for nurses in New Zealand, when it was "all hands on deck, among radically changing policies and clinical care requirements" (Seymour, 2020, p. 11). Ricky recommended that IQNs seek support from a people-focused manager if they were expected to work in an unfair, unsafe workplace. A supportive manager might help IQNs overcome work stressors and build team relationships to increase their job satisfaction, as revealed by studies into nurses' workplace challenges (e.g., NZNO, 2018; Pung & Goh, 2017; Smith et al., 2020; Teo et al., 2013).

In accordance with Brunton and Cook (2018), DiCerbo et al. (2014); and Levis (2011), participants suggested that IQNs use spoken and written communication strategies (e.g., checking their understanding of colloquialisms and idioms, writing down informal and health-related language in a notebook) to improve their professional interactions with colleagues. According to Lola and Nightingale, IQNs benefit from writing scripts, clarifying misunderstandings, using calm communication, and asking for help when engaging in potentially difficult workplace conversations because "things can be misconstrued" (Lola). Lola also recognised that IQNs may struggle with their colleagues' and managers' expectations to be proactive communicators and "strong, autonomous practitioners" as these cultural norms may be different to those in IQNs' home countries. Furthermore, Jessie believed that IQNs should focus on building resilience because IQNs must stay "safe in [their]

practice, no matter what,” especially when working with demanding or uncaring colleagues. Lola’s and Jessie’s observations reflected those of nursing researchers (e.g., Choi et al., 2019; Chun Tie et al., 2018; Kamau et al., 2022; Nørgaard, 2011), who found that it was beneficial for healthcare workers to assist IQNs in becoming more confident and cordial in their workplace interactions. This is because IQNs’ effective communication skills may help them overcome exploitation or prejudice and be accepted into the nursing team.

IQN participants’ experiences engaging in teamwork and cross-cultural communication with colleagues and managers in healthcare settings influenced their feelings of job satisfaction, which Kamau et al. (2022) also found. Nevertheless, IQNs may have difficulty communicating clearly and openly with fellow healthcare workers from different language or cultural backgrounds (Brunton & Cook, 2018). Rose therefore valued continuing nursing education to help IQNs develop their confidence to “keep the fight up” and boost their teamwork and communication skills. Jessie and Nightingale encouraged IQNs to share professional feedback and information with colleagues, thereby participating in informal learning opportunities to build their nursing skills and confidence. Participants’ zeal for ongoing professional learning is consistent with Aggar et al.’s (2020) and Noguchi-Watanabe et al.’s (2016) advice for managers to advocate for nurses in developing and sharing their clinical knowledge to boost team members’ nursing skills, team relationships, and open communication processes.

There were moral implications in Lilly’s and Carmel’s providing professional guidance to colleagues to help them recognise correct nursing protocols and learn from their mistakes. Carmel advised IQNs to take evidence of clinical errors to management “so if the Nursing Council comes in, you’re safe.” Having to balance their work demands and nursing demands may reduce IQNs’ standards of quality care, though. This is because, in Nightingale’s view, “[nurses] just want to do things, especially with the paperwork they need to do.” Ricky and Lola considered it essential for IQNs to refuse, or seek assistance for, tasks that were beyond their professional training and registration to stay safe in their practice.

IQNs' stories of counselling their colleagues and reporting administration errors align with Walker and Clendon's (2012) findings that IQNs need to be team-focused, proactive, and assertive in their workplace interactions to maintain high-quality care to patients. In the literature (e.g., Chun Tie et al., 2018; Gao et al., 2015), IQNs felt less stressed and more rewarded by their nursing role through engaging in supportive conversations with their managers and colleagues. Mons and Nightingale valued opportunities to show appreciation to staff to boost their intrinsic motivation (Mons) and create a "harmonious atmosphere" in the team (Nightingale). Certainly, team collaboration and support are key factors in IQNs' feeling better able to cope with work pressures (Schilgen et al., 2019). Brunton and Cook (2018) also noted that IQNs would benefit from being mentored by New Zealand nurses to enhance professional understanding, thereby contributing to patient safety.

In telling stories of their challenging and positive workplace conversations, participants demonstrated characteristics similar to those of IQNs in Ghazal et al.'s (2020) study. That is, they were able to reflect on the extent to which they used inclusive communication strategies to interact, and build rapport, with team members. IQNs are expected to reflect upon their nursing practice and workplace interactions to determine the communication skills and strategies that may contribute to their professional success within healthcare teams (Philip et al., 2019). IQN participants expressed their satisfaction in resolving collegial disagreements and participating in open, person-centred communication. They reflected on the importance for IQNs to build collegial relationships and be professional in their workplace communication. For instance, Lola regretted her "ambushing" a busy manager when she wanted to have a task-focused conversation. She thus advised IQNs to give "more thought, more time" into preparing for workplace interactions with managers. IQNs who are accepted by their team demonstrate the professionalism and sense of self that align with nursing's common values of competence, collegiality, and compassion, despite differences in language and culture (Ghazal et al., 2020; Johnson et al., 2012; Killeen & Saewert, 2007).

6.4.2 Master Narratives and Counter Narratives

At Level 3, I have followed Bamberg's (2005, 2020) recommendation for narrative researchers to consider ways in which storytellers position themselves and their stories within master narratives (or Capital D discourses) and/or counter narratives. According to Bamberg (2005), "The term 'master narrative' has been extended to all sorts of legitimisation strategies for the preservation of status quo with regard to power relations and difference in general" (p. 287). Liaschenko and Peter (2016) define master narratives as denoting common beliefs about what it is to be a member of a certain group—in this study, a nurse or nurse manager. Counter narratives oppose the tenets of master, dominant, or hegemonic narratives and cultural expectations (Hyvärinen, 2007). There is a risk, though, for master narratives and counter narratives to "make nurses particularly vulnerable to the development of damaged moral identities when these narratives are overly sentimentalised and do not adequately portray nurses as knowledgeable and skilled" (Liaschenko & Peter, 2016, p. S19). The master narrative of migrant nurses of simply following doctors' orders and not demonstrating decision-making skills, for instance, could impact IQNs' professional identity if it were to become a prescriptive way of working for IQNs (Choi et al., 2019; Liaschenko & Peter, 2016). Table 7 outlines a brief selection of master narratives and counter narratives that appear in nursing discourses and link with the thematic findings and Level 3 positioning findings in this study.

Another frequently heard master narrative is that nurses make a difference to people's lives (Peter et al., 2016). However, Ricky used its counter narrative, 'Nurses eat their young', in our Capstone Conversation on August 13, 2022. This phrase refers to bullying in the nursing profession around the world (Gillespie et al., 2017).

In my case, there were 22 patients, and I was [a new nurse]. There were three supposed to be on duty and only two turned up. So, I was told [by my manager] to put up and shut up. And I'm just supposed to accept it. And herself—she was an IQN. How can she not realise what she's doing here? [...] She's probably undergone something similar when she came over, but—rather than break that cycle—lets it continue. It's like, "Well, I had to suffer, so you will too." And there's a lot of that in nursing. There's a phrase that gets bandied around which I absolutely detest—and

it's very rare I detest anything—but it's [the phrase,] 'Nurses eat their young'. Because as nurses, new nurses get bullied in everything and get treated really unfairly. They grow into their careers, and then they start doing the same, because it's been done to them, rather than looking objectively and thinking, *this needs to stop*.

Table 7

Sample of Master and Counter Narratives in Nursing

Citation	Master Narrative	Counter Narrative
Peter et al. (2016)	<i>Nurses make a difference to people's lives.</i>	<i>Nurses "eat their young" (i.e., bully newly registered nurses).</i>
Gillespie et al. (2017)	Participants expressed their feelings of satisfaction when helping their colleagues, especially during COVID-19 pandemic restrictions. At the start of Covid 2020 lockdown, Lola's colleague was worried about the risks of working at a hospital so she asked Lola for advice.	Ricky aimed to help her IQN colleagues speak up about overly high caseloads and acuity, owing to her strong beliefs about equity in the healthcare workplace. This meant that Ricky refused to "put up and shut up" about IQNs' being allocated unfair caseloads by shift leads and nurse managers.
Peter et al. (2016)	<i>Nurses follow orders.</i> Rose was happy when a junior nurse listened to, and acted upon, her advice about patient communication.	<i>Nurses find solutions.</i> Lola was complimented by a medical colleague in helping a patient understand and accept the benefits of respite care through her patient-centred communication skills.

Mohammed et al. (2021)	<i>Nurses are heroes.</i>	<i>Nurses are battle axes.</i>
Jinks & Bradley (2004)	Nightingale and Carmel both spoke of appreciating their colleagues taking the initiative in supporting staff and patients during COVID-19 pandemic restrictions.	Although it was “not a nice or good feeling,” Lilly knew that it was her job as a manager to counsel staff. As an IQN, Ricky viewed her assertiveness as crucial for preventing the exploitation of migrant nurses.
Peter et al. (2016)	<i>Nursing is a process.</i>	<i>Nursing is an art.</i>
	Lilly and Carmel recommended nurses receive adequate guidance and counsel to ensure they follow medication administration processes to keep patients safe.	Expressing self-confidence and morale in their healthcare roles, participants felt supported by the professional validation they received from managers and colleagues.
Liaschenko & Peter (2016)	<i>Nursing is valued moral work.</i>	<i>Nursing is undervalued and underpaid.</i>
Roth et al. (2021)	In being promoted to a management role, participants (Lilly, Carmel, Mons, and Rose) were acknowledged for their clinical and relationship-building skills.	Ricky and Lola admitted that New Zealand-trained nurses can perceive IQNs as being less qualified or experienced. This can potentially contribute to IQNs’ deskilling, career dissatisfaction, and attrition (Roth et al., 2021).
Smith et al. (2022)		
Kosiba & Tooker (2002)	<i>Nursing is a vocation.</i>	<i>Nursing is a commodity.</i>

	Carmel and Rose upheld the importance of IQNs’ participation in team collaboration and decision making to make positive changes within the healthcare workplace and the wider nursing community.	Nightingale and her colleagues were required to administer high numbers of COVID-19 Omicron tests, leaving them feeling “crazy busy and physically stretched.”
Aiken (2008)	<i>Nursing is an essential profession.</i>	<i>Nursing is an under-resourced profession.</i>
McClure (2023)	Nightingale, Rose, and Lola were happy about working in a positive, collegial workplace, in which team members collaborated to manage nursing tasks and overcome work pressures during COVID-19 pandemic restrictions.	Jessie and Lola expressed IQNs’ negative mental health impacts, such as stress and anxiety, resulting from the COVID-19 pandemic restrictions and the 2021 Delta lockdown in New Zealand.

6.5 Implications of Research Findings

Following are the key implications for the research findings at Levels 1, 2, and 3 of the MPA model. The key implications at Level 1 were that IQNs needed to be confident when clarifying workplace directions or explanations, show compassion to difficult colleagues, and receive managers’ acknowledgement of their professional concerns and feedback. It was notable that, at Level 2, IQN participants admitted feeling frustrated when they experienced miscommunication or challenging conversations with colleagues. This led to IQN participants’ expressing their desire for migrant nurses to be protected from exploitation, treated equitably, and shown appreciation and encouragement. At Level 3, IQN participants positioned themselves and their fellow migrant nurses as experienced, well trained healthcare professionals.

IQNs' expertise and clinical skills were viewed as valuable, and their perspectives and advice worthy of consideration, within the wider nursing community.

6.5.1 Level 1 of the MPA Model

At Level 1, IQN participants demonstrated their feelings of agency when providing counsel and advice to their peers in healthcare settings. Participants showed a strong appreciation of working with colleagues who shared similar nursing qualifications and background, despite personality differences. They recognised the value of IQNs participating in professional learning opportunities to help them develop clinical skills and confidence over time. IQN participants also used discursive positioning to represent their negative and positive emotions related to aspects of misunderstanding, collegiality, and interpersonal communication they experienced within their healthcare teams. Furthermore, participants' self- and other-positioning when recounting their workplace interactions showed that being an encouraging nurse mentor, collegial team member, and a reflective, quality-focused practitioner was important to IQNs.

6.5.2 Level 2 of the MPA Model

At Level 2, IQN participants presented their positionality to their listener(s) in terms of recognising their duty to counsel staff, being a proactive nurse and nurse manager, and understanding and following management directives in healthcare workplaces. Participants felt they were similar to their nursing colleagues by enjoying their shared clinical backgrounds, professional learning opportunities, and team relationships. Aspects of IQNs' professional identity were revealed in their use of discursive language when sharing stories of giving advice, being a professional manager and nurse, appreciating team relationships and collegiality, and being acknowledged by colleagues. IQNs' Flower Diagrams were kinaesthetic and visual representations of their feelings about having or not having their advice accepted, experiencing their colleagues' ire, and valuing team rapport, particularly during COVID-19 pandemic restrictions.

Positioning themselves as caring, non-judgemental, decisive, and ethical nurses, participants saw their colleagues as being professional, reflective, and supportive.

The social-cognitive implications at Level 2 related to IQNs' placing value on providing professional learning and guidance to colleagues in formal and informal settings. It appeared that the moral implications of participants' stories pointed to the need for healthcare workers' professional learning opportunities, clinical competencies, and collegial relationships to be supported by nurses and nurse managers alike. Participants reflected that IQNs should be fully included in clinical management processes to uphold health and safety within healthcare settings.

6.5.3 Level 3 of the MPA Model

At Level 3, participants demonstrated their sense of agency as independent and assertive nurses, whilst using discursive language that emphasised the positive and challenging emotional impacts that leadership and team communications have upon IQNs. Participants positioned themselves and their fellow healthcare workers as highly experienced and supportive professionals who benefited from engaging in open communication to ensure their perspectives were listened to by colleagues and managers. There were strong links between master narratives and counter narratives in the nursing literature with those I found in my narrative data at Level 3. One counter narrative used by Ricky (i.e., 'Nurses eat their young') reflected the harmful impact that bullying, exclusion, and exploitation have upon the nursing community.

6.6 Chapter Summary

The aim of this research was to investigate the professional identity positioning of IQNs through their stories of participating in challenging and positive workplace interactions with colleagues in New Zealand healthcare settings for the benefit of IQNs and the wider nursing community. Chapter Six presented my interpretations of the narrative data obtained via research conversations with IQN participants. I have situated thematic and MPA findings within the literature to show how my research is making an original contribution to existing research. Applying thematic analysis and multimodal positioning analysis to narrative data sourced from IQN participants' stories of workplace interactions with colleagues allowed me to obtain insights into IQNs' identity positioning. These insights have been interpreted in light of the relevant nursing and applied linguistics literature to help me answer my three research questions. In this chapter, I discussed IQN participants' discursive

positioning of themselves and their colleagues in their stories of workplace interactions in relation to the nursing literature. Chapter Seven concludes this thesis by discussing the implications of thematic and multimodal positioning findings, providing recommendations for nursing practice, research, and policy, and outlining the future research outputs to support IQNs' career sustainability.

Chapter 7: Conclusion

7.1 Introduction

My doctoral research study examined the discursive positioning of internationally qualified nurses revealed in their storied experiences of workplace interactions with colleagues in New Zealand healthcare settings. This study makes an original contribution to knowledge through the research findings and the innovative data collection (Flower Diagrams, Zoom Pair Shares) and data analysis (multimodal positioning analysis) procedures. Taking a social constructionist perspective, this study empowered IQNs to participate in Story-Led Conversations and Zoom Pair Shares to share their stories of challenging and positive conversations with healthcare colleagues. This study was a model of relational research in terms of what I asked and how I asked it. In spite of difficult circumstances for IQN participants during the COVID-19 pandemic restrictions, there was little attrition. Indeed, the timing of my research inadvertently spotlighted a group of essential workers (i.e., migrant nurses) at a time when they were not only the most essential but the hardest to recruit.

I followed Haydon et al.'s (2018) advice to take a social constructionist perspective in understanding how IQNs' stories reflected aspects of their professional identity within their nursing community of practice. From those migrant nurses who responded to recruitment materials (e.g., recruitment card and/or flyer) and word-of-mouth advertising, eight IQNs with at least three years' New Zealand nursing experience were selected to participate in this 14-month study. Data from IQN participants, for whom English was either their first or additional language, were collected via Story-Led Conversations with me (as researcher), Zoom Pair Shares with me and an IQN co-participant, and Optional Reflections (i.e., self-reflective journal notes).

As recommended by Davies and Harré (1990), Bamberg (1997, 2011), and De Fina (2013), positioning theory was used to analyse participants' positioning of self and others when sharing stories of their challenging and positive workplace interactions with colleagues (i.e., doctors, fellow nurses, and healthcare administrators). Particular attention was given to ways in which participants framed their experience

and unveiled aspects of discursive positioning through their use of positionality, emotionality, relationality, and consequentiality within the multimodal positioning analysis (MPA) framework. The MPA model that I designed and used to conduct top-down data analysis was inspired by the work of Bamberg (1997, 2003, 2020), Davies and Harré (1990), Harré and Langenhove (1999), Kayi-Aydar (2021) and Silverstein (2003). The study's findings indicated that IQN participants' stories of challenging and positive workplace interactions reinforce Winkelmann-Gleed and Seeley's (2005) findings that IQNs' collegial conversations impact upon their professional identity positioning. In line with Johnson et al. (2012), this research into overseas-trained nurses' workplace interactions and professional identity may have constructive outcomes for IQNs' career pathways and healthcare facilities' operational processes.

This thesis began by introducing the study, including scoping and framing my research and reviewing the relevant literature, before developing my research methodology and research design. I then presented my findings from thematic analysis and multimodal positioning analysis of participants' stories of challenging and positive workplace interactions to answer my three research questions. In Chapter Six, I situated my research findings within the literature with the view to interpreting the findings in line with the research questions. This allowed me to draw meaningful conclusions from my thematic and multimodal positioning analysis findings for the potential benefit of IQNs and their colleagues within New Zealand healthcare settings. Chapter Seven concludes the thesis by reiterating the research findings and outlining my research reflexivity throughout data collection and data analysis procedures. Next, I evaluate the data collection and data analysis procedures and consider the significance of the study. Finally, I present my recommendations for future practice, policy, and research within New Zealand healthcare and migrant worker sectors.

7.2 Responding to the Research Questions

The New Zealand Nurses Organisation (NZNO, 2017) acknowledges that IQNs are valued by New Zealand healthcare providers as competent nursing professionals. Still, as Walker and Clendon (2012) point out, whilst IQNs may have extensive

experience in their home countries, they are obliged to transform their communication style to integrate into the New Zealand workplace culture. This is an issue because IQNs' pre-existing professional identity may be tested when they face challenges becoming members of their nursing team.

7.2.1 The Need for This Research Study

Through my examination of the nursing literature, I identified the need for a study into IQNs' storied experiences of their workplace interactions with colleagues to help migrant nurses make sense of workplace interactions that impact their identity. This is significant because a strong professional identity is central to IQNs' wellbeing and career sustainability, as well as their capacity to align to the norms and practices of the nursing profession. The New Zealand Nurses Organisation (NZNO, 2018) seeks to attract, recruit, and retain migrant nurses by encouraging employers to demonstrate their support of IQNs as they adjust to working in the New Zealand healthcare sector. Therefore, the aim of this research was to investigate the professional identity positioning of internationally qualified nurses through their stories of participating in challenging and positive workplace interactions with colleagues in New Zealand healthcare settings. Through this research, I sought to create new and relevant knowledge for the benefit of IQNs and their colleagues within the wider nursing community.

7.2.2 The Study's Research Questions

Following are the three research questions that guided this study:

Research Question 1

How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings?

Research Question 2

How does IQNs' use of discursive positioning in their stories jointly construct aspects of their professional identity?

Research Question 3

What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?

7.2.3 Implications of the Research Findings

Findings from analysis of my study's narrative data have allowed me to reach conclusions about implications for IQNs and for wider nursing and healthcare communities, which is the basis for my third research question. The key implications for the wider nursing community are that IQNs' interpersonal communication skills, protection from bullying and exploitation, teamwork and relationship building, and nursing skills development need to be promoted by healthcare employers and managers. Participants recommended that IQNs be encouraged to help colleagues follow nursing protocols correctly to avoid repeating clinical errors. Resolving disagreements and communicating clearly with their colleagues were factors that supported IQNs' positive feelings about their team relationships within healthcare work environments.

Bullying in nursing was a strong theme in my research. Either my participants had experienced bullying or had noticed it being experienced by their IQN colleagues. Consistent with Jenkins and Huntington (2016), IQNs' reporting of harassment is an individual burden resulting from a systemic problem. The counter narrative 'Nurses eat their young' indicated that IQNs are negatively affected by bullying, exclusion, and exploitation in New Zealand healthcare workplaces. Ricky's first- and second-hand encounters of bullying and exploitation echo Gillespie et al.'s (2017) findings that over 70% of nurses with less than three years' nursing experience had been bullied. Bullying behaviours that are learnt and replicated within the nursing profession have been compared to a virus whose transmission risks the wellbeing of current and future nurses (Hutchinson, 2013). Addressing this issue led to participants' offering advice to employers about health and safety in nursing.

In addition, workplace exploitation of IQNs, whereby IQNs are given higher patient acuity or caseloads, has the potential to harm patient and worker safety (Schilgen et al., 2019). Palmer et al. (2021) found that IQNs who are awaiting a visa for registration and employment are particularly vulnerable to workplace exploitation, owing to their low sense of job security. IQNs who feel empowered in their nursing role may respond assertively in countering potential bullying, racism, or exploitation

(Edmonson & Zelonka, 2019; Eriksson & Engström, 2018). We saw this in Ricky's stories of standing up for her IQN colleagues who were concerned about being given unfair case numbers but did not want to speak up to protect their employment status.

As Weston and Longmore (2020) have observed, the New Zealand nursing sector is struggling to attract, train, and retain nurses in the global nursing shortage. Therefore, key implications from this research are for employers to ensure IQNs are safeguarded from bullying, racism, and exploitation for their own wellbeing and identity as valued registered nurses. CAP education providers, too, need to understand the professional and emotional pressures that IQNs face. By giving IQNs training in soft communication skills and ensuring healthcare providers understand their mandate to identify and counteract incidents of bullying, educators may help IQNs feel confident responding assertively to exploitative workplace conditions. Insights from this research provide the impetus for employers and educators to make IQNs feel more welcome, more empowered, and more prepared to go into the workforce, which will mean that they will stay working in New Zealand.

7.3 Significance of the Study

After conducting my review of the literature, I identified the need to develop new nursing knowledge about IQNs' discursive identity positioning in New Zealand nursing contexts. This study is significant because it employed narrative inquiry to explore professional identity in a New Zealand nursing context through empowering participants to voice their storied experiences of positive and challenging workplace interactions (Wang, 2017; Wang & Geale, 2015). The innovative design and use of research tools have assisted in the co-construction of new knowledge about IQNs' professional identity in New Zealand healthcare settings. This study also makes an original contribution to knowledge by using positioning theory, along with the conversational and generative style of narrative inquiry, to analyse participants' stories of their workplace interactions with colleagues. I created the MPA model to analyse how IQN participants use positioning to reflect aspects of their professional identity within four 'identity spaces' (cf. Bamberg, 2020; Bamberg et al., 2011; Kayi-Aydar, 2021). There is also potential for my research to make further contributions to the wider nursing and healthcare communities in terms of:

- i. providing practical recommendations for workplace communication and wellbeing support systems for IQNs;
- ii. empowering individuals in less powerful positions within healthcare settings; and
- iii. enabling IQNs' storied experiences to be heard, particularly during COVID-19 pandemic restrictions, demonstrating how responsive and resilient migrant nurses are in the face of unexpected challenges.

7.3.1 Original Data Collection and Analysis Methods

Migrant nurses' professional identity and discursive positioning were explored by their sharing stories of challenging and positive workplace interactions with their colleagues. The original research methods in this study are both transparent and replicable. I have demonstrated the nature of my data collection processes (see Appendices H and I) and data analysis procedures (see Appendix J) to enhance research validity.

7.3.1.1 Flower Diagram.

The findings of Kalaja et al.'s (2013) study that used participants' drawings as symbolic representations of identity supports Carmel's modification of the Flower Diagram (see Figures 9 and 10) to portray her feelings about a workplace interaction with a clinical nurse manager. Carmel's selection of colours, visual designs, and descriptive text linked to her identity positioning as an autonomous IQN engaged in professional discourse impacted by internal emotions and external stressors (Li et al., 2014). As a research conversation (either a Story-Led Conversation or a Zoom Pair Share) was not conducted as a formal interview, its focus was on triggering IQN participants' ideas, memories, and emotions. I noticed during research conversations that when participants were colouring in the petal(s) and retelling their story of a challenging or positive workplace interaction, it appeared to be cathartic for the participants. The action of colouring in petals on a Flower Diagram was a catalyst for participants' recollection of their workplace interactions, giving another layer of data. Indeed, Ricky observed in a research conversation that she enjoyed colouring in Flower Diagram and "reflecting on good times as a nurse that can sometimes be

forgotten.” Colouring in was more culturally attuned, too, as it removed participants’ feelings of pressure when engaging in a one-to-one research conversation.

7.3.1.2 Zoom Pair Share.

Created as a response to COVID-19 pandemic restrictions, Zoom Pair Shares allowed participants to tell or retell stories of their challenging or positive workplace interaction with their co-participants. This was a notable example of relationship-building over Zoom, which prior to the pandemic was considered a barrier to collegial communication (AICPA, 2020). My participants expressed their feelings of excitement towards engaging in Zoom Pair Shares and hearing about other IQNs’ experiences in their healthcare setting. During each Zoom Pair Share, co-participants shared their current feelings about their workplace interactions and reflected upon their subsequent interactions linked to this workplace interaction. They then engaged in conversation with fellow IQNs, who might have experienced similar interactions and had their own observations and reflections to share. Participants’ retelling of stories previously conveyed to me in a research conversation addressed Anderson’s (2009) recommendation for acts of positioning to be associated within and across social interactions. Owing to IQNs’ emerging positioning repertoires and cross-cultural communication practices, “what a successful [IQN] looks like [is related to how their] battery of positions [is] oriented to over time and across multiple, interrelated contexts and perceived social boundaries” (Anderson, 2009, p. 293).

7.3.1.3 Multimodal Positioning Analysis (MPA).

I created a data analysis framework to investigate participants’ discursive identity positioning, which I termed ‘multimodal positioning analysis (MPA)’. The focus of MPA was on analysing the textual data from research conversation transcripts and participants’ Optional Reflections and the textual and visual data from Flower Diagrams. Whilst thematic analysis is a bottom-up approach to analysing narrative data (Braun & Clarke, 2006, 2021; Byrne, 2022), I considered multimodal positioning analysis to be a top-down approach to answering my research questions. The MPA model has made a distinct contribution to Bamberg’s (1997, 2003) positioning analysis framework based on my findings. It is notable that the fourth identity space, Consequentiality, allowed me to answer Research Question 3 at the

three positioning levels. Consequentiality refers to ways in which participants' identity positioning and insights upon their workplace interactions within New Zealand healthcare settings may benefit the wider nursing community. Certainly, the three positioning levels aligned well with my research questions. I reported upon aspects of IQNs' professional identity revealed at Level 1 (RQ1), Level 2 (RQ2), and Level 3 (RQ3) in Chapter Five. I then discussed and interpreted my findings vis-à-vis those within the wider literature in the Discussion chapter, leading to recommendations for nursing practice, policy, and research and practice in this chapter.

7.4 Recommendations for Practice

Following are recommendations for nursing practice based on findings from my thematic analysis and multimodal positioning analysis of IQNs' storied experiences. In answering RQ3, I have considered the benefits of understanding and responding to IQNs' storied experiences and the participants' advice for IQNs, healthcare managers, and nursing education providers. When I presented my thematic findings to New Zealand nurse educators at a training seminar and to New Zealand Nursing Council researchers in April 2022, they were particularly interested in how my future research outputs might inform nursing education providers and healthcare policymakers in New Zealand. Two key recommendations are for teaching strategies and mentoring strategies for pre-registration CAP placements of migrant nurses in New Zealand.

7.4.1 Teaching Strategies for CAP Providers

The key challenges migrant nurses face are acculturating to New Zealand healthcare workplaces, understanding and using New Zealand slang, and following Te Tiriti o Waitangi (Treaty of Waitangi) principles in their nursing placements. Firstly, New Zealand nursing contexts can have an informal workplace culture that IQNs may not be accustomed to. Migrant nurses may be hierarchy oriented, owing to their cultural background which upholds deference and respect for leaders (Brunton et al., 2020). Secondly, Ricky and Lola suggested in their first Zoom Pair Share that CAP tutors would assist IQNs in developing their understanding of New Zealand slang by providing a glossary of Kiwi idioms and colloquialisms. Finally, participants

recommended that IQNs would benefit from their CAP tutors and mentors helping them see the value in respecting *tangata whenua* (Māori people) and following Te Tiriti o Waitangi (Treaty of Waitangi) principles. For instance, according to Ricky, if IQNs are placed or employed in a New Zealand region like Gisborne, Hawke's Bay, or Northland, training in Māori protocols, including cultural practices (e.g., not sitting on tables), was crucial to bridge cultural gaps.

7.4.2 Mentoring Strategies for CAP Placements

Participants recommended that IQNs be mentored throughout the process of understanding the nursing responsibilities, open communication, and teamwork required in their CAP placement. IQNs need reassurance that their preceptor nurse on placement is there to support and guide them. Being confident to ask questions and say no if they do not feel comfortable in a nursing situation is a key learning objective. Participants also pointed out that, prior to starting their CAP placement, IQNs should be reminded of the importance of “treating everybody the same” (Nightingale) and not discriminating between ethnicities or cultural backgrounds. Furthermore, participants advised nursing mentors (e.g., CAP tutors, preceptor nurses) to be encouraging, positive, and patient when giving feedback to trainees. It was important to tell trainees the truth about their nursing practice directly without offending them. This would help IQNs reflect on their developing competence and confidence in New Zealand healthcare settings.

7.5 Recommendations for Policy

Smith's (2021) study of IQNs determined a need for nursing research to inform policy to support migrant nurses' career sustainability within host countries' health settings. Now that New Zealand borders are open post COVID-19 travel restrictions, nursing migration has been impacted. There is a nursing shortage at present, so findings from this study may lead to more *mana* (prestige, authority) being given to IQNs. The two recommendations for nursing policy relate to developing IQNs' cultural awareness and communicative competence and responding to IQNs' concerns and advice to healthcare managers.

7.5.1 Intercultural Communication and Cultural Awareness Mentoring

Both IQNs and host nurses benefit from intercultural communication skills and cultural awareness mentoring and/or training. As there is less importance placed on hierarchy in New Zealand, it would be valuable for migrant nurses to be inducted by an IQN healthcare manager who could share their own professional experiences. IQNs who spend time on their CAP placement with a manager or senior RN who was also an IQN might feel more supported in their professional learning as they progressed towards registration. Nightingale suggested that IQNs could be buddied up with a nursing mentor from their own language or cultural background.

In addition, training for host nurses or preceptors in the language and cultural implications of counselling or interacting with IQNs may be needed. This is because communication with healthcare team members is crucial for maintaining staff relationships (Oldland et al., 2020). It is crucial for managers to know how to communicate with team members in a multicultural environment. Participants recommended that managers develop two-way communication with staff through understanding, making contact, and talking with workers for the whole team's benefit. For instance, Nightingale pointed out that some healthcare team members think, "Oh, I'm the doctor. You are the nurse." But, in Nightingale's view, teamwork was paramount: "We are colleagues."

7.5.2 Listening to IQNs' Concerns

Similar to findings by Edmonson and Zelonka (2019) and Head (2017), my research has found bullying, racism, and exploitation are present in healthcare settings, both in New Zealand and around the world. This is despite the Health and Safety at Work Act 2015 requiring employers to respond to complaints of bullying promptly and transparently, owing to the significant health risks posed by bullying and harassment (WorkSafe New Zealand, 2017). Mons acknowledged that some healthcare workers treat migrant nurses badly because they think that IQNs who are developing their English skills are stupid, although many are highly educated. Participants, particularly Mons, Ricky, and Lola, thereby advised nurse managers to "go out to the coalface" (Lola) and listen to IQNs' concerns and input to help them support patients and colleagues better. Conversely, IQNs appreciate receiving clear feedback on their

nursing performance and communication skills development. Carmel suggested that managers and colleagues give IQNs written feedback so they have time to translate and process messages before responding to constructive advice. To Mons, IQNs might then feel like their needs were being listened to with “just a little bit of compassion and patience.”

7.6 Recommendations for Research

7.6.1 Applying Data Collection and Analysis Processes to Future Studies

Future studies might look at applying some or all of the data collection and analysis tools and procedures from this study to support the needs of workers, managers, and/or trainers in healthcare and other professions. This study’s data collection tools (i.e., Story-Led Conversations, Zoom Pair Shares, Optional Reflections, and Flower Diagrams) and data analysis procedures (i.e., thematic analysis and multimodal positioning analysis) may help other researchers understand and address issues in another professional context. As future participants tell and retell their story of a workplace interaction, they will be able not only to relive the experience but also feel and accept the emotions it elicits. Researchers (e.g., Alberts et al., 2012; Robins et al., 2012) found that participants who fully and non-judgmentally attend to emotions arising from all aspects of workplace communication later demonstrate more self-control and self-compassion than those who avoid or suppress their emotions. IQNs in future studies may thus benefit from the acceptance-based expression and regulation of emotions evidenced by their sharing of challenging and positive interactions with colleagues via research conversations and Flower Diagrams.

7.6.2 Conducting Colour Analysis in Relation to Emotions

In this study, the codes for participants’ Flower Diagrams referred to whether petals related to a challenging or positive workplace interaction, as well as the petal name (e.g., ‘A-ha!’, ‘Triumph’) and the colour selected by the participant. The numerical data attached to these codes—number of times a colour was selected for a certain petal, for instance—could be interesting and illuminating. However, such data analysis was beyond the scope of this research, so conducting further colour analysis in relation to emotions is a recommendation for future studies. In a research conversation, for example, a participant might choose the ‘Agreement’ petal and the

colour orange. The researcher might record the number and nature of instances when a participant chose the 'Agreement' petal and if they chose the colour orange. I can see the value in analysing the narrative data concerning a specific colour being selected for a specific petal. I found in this study that, across the research conversations, yellow seemed to be a very popular colour for the 'Triumph' petal, especially in IQNs' stories of positive workplace interactions. This aligns with Alberts et al.'s (2012) and Robins et al.'s (2012) research on the benefits of attending to emotions triggered by recounting a challenging or positive workplace interaction.

7.7 Future Research Outputs

7.7.1 Practical Guidelines for IQNs and Their Managers and Employers

One future research output is the production of practical management and communication guidelines for IQNs and their managers and employers. This output is consistent with NZNO's (2017) recommendations for the creation of government policies and processes which support health industry employers in enhancing workplace wellbeing for IQNs. The purpose of this research was to enact new knowledge in relevant and applied ways for the benefit of IQNs and their colleagues within the wider nursing community. For example, it is clear from my research that bullying, racism, and exploitation are happening in New Zealand nursing contexts. The experiential evidence of my participants shows that IQNs recognise the need for resilience and standing up for themselves and their colleagues. The phrase 'stand up' (as in 'stand up for yourself', 'stand up for your colleagues', 'be strong', 'stand strong') came out strongly through the participants' voices and stories, which is in line with Edmonson and Zelonka's (2019) research. Nightingale echoed her fellow IQNs participants' desire to "help with this research and contribute to bringing a positive research outcome for the nursing community."

Following is a sample of the key advice from IQN participants that may be used to draft potential guidelines for nursing employers and educators:

7.7.1.1 Offering Advice to Management.

- i. Ask RNs and healthcare staff for suggestions on quality improvement as they have valuable patient-focused ideas.
- ii. Ask senior RN colleagues for input in policy-making.
- iii. Be a supportive, people-focused manager and your team will want to do well for you and achieve their KPIs, without compromising the site or colleagues.
- iv. Be available to support colleagues on the floor.
- v. Be balanced in communication with staff—not too friendly, not too rough.
- vi. Encourage teamwork and a team attitude to achieve success, and manage crises and problems before they occur.

7.7.1.2 Offering Advice to Nursing Educators and CAP Providers.

- i. Be encouraging, positive, and patient when giving feedback to trainees.
- ii. Give CAP participants the opportunity to spend time and have induction with a healthcare manager who is also an IQN.
- iii. Help IQNs see the value in respecting *tangata whenua* (Māori people) and following Te Tiriti o Waitangi (Treaty of Waitangi) principles.
- iv. Provide a glossary of Kiwi idioms, slang words, and colloquialisms.
- v. Use questioning techniques to check IQNs' learning and understanding and stimulate critical thinking.
- vi. Speak slowly and enunciate words because accents can be hard for IQNs to pick up.

7.7.1.3 Reflecting Upon Health and Safety Issues in New Zealand Workplaces.

- i. It is a health and safety risk in in-patient contexts for nurses to miss their breaks or not drink or eat enough all shift. Ensure rest and meal breaks are scheduled and taken by IQNs to uphold their physical and mental wellbeing.
- ii. Support IQNs in escalating concerns about medication administration errors to management as a professional learning opportunity for all team members.

- iii. IQNs should not feel pressured to complete a task if it might compromise patient care. Preventing patient harm or medication administration errors is crucial in healthcare settings.
- iv. Encourage IQNs to ‘stand up for themselves’ if they do not possess the skills and expertise to complete a task. If a nurse does something wrong, they risk patient safety. They could also lose their nursing registration and professional reputation.
- v. IQNs’ induction should comprise sufficient training and orientation to help IQNs understand clinical and cultural practices in New Zealand.
- vi. IQNs should take a self-directed approach to their professional development by observing, practising, assisting, and learning their own and others’ clinical practice.

(Appendix K presents participants’ advice in more detail.)

7.7.2 Workshops for Nurses and Managers

Nørgaard’s (2011) study of social interactions in healthcare workplaces found that nurses are expected to demonstrate confident patient- and colleague-centred communication. Still, according to Brunton et al. (2020), there are few opportunities for nurses to suggest and discuss effective ways for all team members to communicate clearly and compassionately in healthcare settings. Consequently, I determined a need for workshops for IQNs and managers of healthcare facilities to develop their mutual understanding of cross-cultural communication needs in healthcare settings. IQNs are encouraged to be independent and autonomous and “expected to speak up” (Edmonson & Zelonka, 2019, p. 278), which is especially difficult for Indian and Asian nurses, according to Ricky. This research output is linked to Research Question 3 and supported by comments by IQN participants.

7.7.2.1 Possible Topics for Workshops Based on my Findings.

7.7.2.1.1 Developing IQNs’ Awareness of Māori Views of Healthcare.

Nurses in New Zealand are trained in the Māori view of health, specifically a Māori model of healthcare—i.e., *Te Whare Tapa Whā* (Durie, 1998; Wilson et al., 2021)—that depicts the physical, emotional, social, and spiritual aspects of health. As Ricky suggested, IQNs may benefit from learning about the cultural practices and

indigenous belief systems surrounding illness that are central to Māori health practices. *Rongoā Māori*, for instance, refers to Māori naturopathic medicine (e.g., plant-based medicines and massage treatments) and wellbeing exercises, all of which aim to treat the mind, body, and spirit (Koea & Mark, 2020).

7.7.2.1.2 Developing IQNs' Self-Management and Agency.

Migrant nurses must engage with doctors and perhaps question treatment or medication because they advocate for patients and inform patients of aspects of their care. IQNs' cultural background may make it difficult for them to take responsibility for engaging in proactive or assertive communication with colleagues, especially with senior colleagues. According to my participants, IQNs have high expectations for themselves and want to please their managers and employers. Helping IQNs develop their self-management and agency may support their feelings of job satisfaction, thereby positively impacting levels of nurse retention and career sustainability.

7.7.2.1.3 Developing Migrant EAL Nurses' Communicative Skills.

Migrant EAL nurses may need to develop their competence and confidence in using written and spoken English in their workplace. IQNs often work in aged care facilities where there are multiple sensory issues for residents. It is therefore essential for migrant EAL nurses to improve their speaking and listening skills. According to Carmel, IQNs are expected to keep written records (e.g., clinical observations and concerns) regarding patients/residents. Migrant EAL nurses benefit from developing their email and telephone communication skills, especially when communicating urgent matters such as blood test results.

Lola suggested that IQNs also focus on reducing their speed of speech because their pronunciation is different. Gu and Shah (2019) found, for instance, that common communication challenges for nurses who have English as their additional language are pronunciation, tone, and/or word or sentence stress. These may lead to patches of speech that healthcare colleagues and patients find difficult to understand. A communication skills workshop might be best facilitated by a qualified and experienced English language teacher possessing an applied knowledge of healthcare

contexts and terminology. It might also be co-presented with fellow IQNs who can serve as a bridge to linguistic and contextual understanding.

7.8 Researcher Reflexivity: Data Collection and Data Analysis

This section considers the ways in which researcher reflexivity contributed to my understanding of IQNs' professional workplace interactions and identity positioning. From the beginning of my PhD, I kept a journal to record my ongoing reflections and comprehensive notes for my supervisors after every supervision meeting to guide my thought processes. My researcher reflexivity throughout this study was based upon Patnaik's (2013) reflexive self-questioning technique. During the data collection and data analysis stages, I asked myself:

- i. How is my choice of research methodology and methods influenced by my cultural, professional, and personal background?
- ii. How is my relationship with my IQN participants shaped by my cultural, professional, and personal background?
- iii. How do I feel about my interviewing (conversational) style with participants?
- iv. What am I learning about my participants as individuals? What am I learning about myself as a narrative researcher?
- v. What are my strengths and limitations as a doctoral researcher?

7.8.1 Data Collection

Similar to Davis (2020), I thought carefully about my research philosophy and methodology in the beginning stages of my doctoral project. Collecting data via research conversations with IQNs, either with individual participants (Story-Led Conversations) or with pairs of participants (Zoom Pair Shares), was a natural fit for both social constructionist narrative research and my people-oriented personality. I enjoyed my easy-going conversations with IQN participants in person, over Zoom, or by email or text message. The commonalities my participants and I shared created rapport between us, which helped to elicit rich data.

Our rapport also allowed us to develop professional knowledge and connections as colleagues. For example, I reflected in my Research Journal about the second Zoom

Pair Share I had with Ricky and Lola. Ricky had told us she was starting a healthcare role that Lola was familiar with, so she was able to calm Ricky's nerves about the career change. Ricky later emailed me on February 3, 2022, after beginning her new role:

Well, training is going well, I'm doing well...learning to use my [recent] injury as my superpower 😊😊 it's allowing me to be kinder still on myself, to slow things down while still achieving so super stoked!! The people are absolutely lovely, I feel very lucky!!

Funny story, was doing [psychology assessment tool] training the other day where I watched videos online....Lola was in all the videos....she's an absolute star, my other new colleagues commented on how soothing and grounded she was! I felt the same as well as feeling pride that I got to know her briefly. All the best to you [and I] hope you are well.

I was initially concerned how participants might feel about being interviewed by a doctoral researcher who was from a TESOL and Applied Linguistics background and not a nursing background. However, I soon realised through their warmth and openness that participants enjoyed talking with me as an educator. This was because nursing and teaching share many commonalities as they are both people-centred professions. I focused on using my ESOL teaching and mentoring skills to enhance my role as a supportive and professional interviewer. That is, I listened to my participants and responded appropriately with encouraging sounds (e.g., 'Ah ha,' 'Yes?' 'Really?') but without taking notes, which would have made the research conversation feel too much like an interview. I was also sensitive and compassionate to my participants' stories, upholding honesty, reciprocity, and trust, which are integral to qualitative data collection. These qualities also helped develop and maintain our rapport throughout the study's 14-month data collection process. For example, during COVID-19 pandemic restrictions in September 2021, Mons sent me a handmade cookie and a personal note wishing me "only the silver linings in every challenge."

During the course of my project, my research perspective and my relationships with my participants were transformed. At first, I was more inclined to follow the interview schedule I had created. As I got to know the outline of the Story-Led Conversation, each ‘interview’ became just like a conversation with my participants. My relaxed attitude and conversational style, as I noted in my Journal, allowed participants to relax, too. They all mentioned to me at the end of the study how much they enjoyed meeting me and developing a connection. Rose (personal communication, August 18, 2023) was glad to meet me for an informal chat at a local cafe 18 months after our final research conversation so she could “offload” about what had been happening at work. She also invited me to visit her at her home “any weekend so we can catch up.” In addition, my participants appreciated reading transcripts and either providing editing suggestions via email (Ricky) or acknowledging the transcripts’ reliability: “I’m not responding to the transcripts that you’re sending me. I feel like I’m just reading it, and I’m all happy with that, so that’s okay” (Jessie); “I’m really enjoying [reading the transcripts]. I love it to get the feedback. Thank you so much” (Rose).

7.8.2 Data Analysis

Using NVivo allowed me to analyse my narrative data not only to respond to my research questions but also to motivate myself in the research graft. In my May 2022 researcher journal, I noted that I was “having great success with NVivo, and I’m [...] powering away. I have open-coded six out of my eight Zoom Pair Shares. I’m kind of feeling my way with NVivo, but I’m loving it.” I found that the benefit of engaging in narrative inquiry is that a researcher is an integral part of the data collection: “I was part of the research process, the story process. I transcribed every research conversation myself and with transcription, you’re in the data.”

Nonetheless, I wrote in my research journal that I was concerned about whether I was “doing the right thing” in my data analysis procedures. This was because I did not have any formal training in using NVivo: “I read several articles and watched YouTube videos about coding in NVivo, so I just bit the bullet and went straight in.” I soon realised that there was no right way or wrong way to code narrative data. This understanding concurred with Davis’s (2020) view that socially constructed narrative

research comprises multiple realities, thereby validating a researcher's individual style of coding.

I decided to use the gerund form for codes, taking a grounded approach to open coding as recommended by Charmaz (2014), as well as Singh and Estefan (2018). My research journal showed my thought processes around coding for Research Question 3:

When I'm coding for [RQ3] advice to management, IQNs, and CAP providers, I'm using the imperative. My thoughts at this stage are to include an element of an *in vivo* quote to demonstrate a theme. When I get to categorising codes and then grouping categories into themes, that's the data that I'm going to present to the reader. I think that has made me feel a bit more confident.

When I began to open code research conversation transcripts with NVivo, I coded participants' reflections and experiences of research conversations, my own researcher memos, and all my research prompts. I noted in my researcher journal that whenever I came across a quote in a transcript that would "stop me in my tracks and go, wow, that's cool," I coded it in NVivo. When I was coding, it was as if I was back in the research conversation all over again. As I wrote in my journal, "I remember where I'm sitting, how I'm feeling, the emotions that are elicited by the research conversation. I get to relive the good times again."

7.8.3 Evaluation of Data Collection Procedures

My data collection tools and materials comprised Story-Led Conversations, Zoom Pair Shares, Flower Diagrams, and Self-Reflective Journals (later known as 'Optional Reflections'). After experiencing delays in recruiting IQN participants in the latter half of 2020, I reworded my participant information sheet to indicate interview timing was reduced from one hour to 'up to 50 minutes.' I also changed the word 'interview' itself to 'research conversation' (or 'Story-Led Conversation') throughout my participant recruitment website and information sheet. This was because 'interview' sounded overly formal and possibly too stressful for nurses. Furthermore, I decided to rename 'Self-Reflective Journal' to 'Reflections' and make them optional to minimise any perceived burden on current and potential IQN

participants. These changes to my data collection procedures allowed me to attract the eight IQN participants I had aimed to recruit in my human ethics application. The following section provides an evaluation of my data collection procedures, reflecting upon the limitations and strengths of each tool and material I used in collecting textual and visual narrative data.

7.8.3.1 Story-Led Conversations.

I scheduled a Story-Led Conversation (SLC) with each participant once every three months. Each SLC lasted around 50 minutes and was kept informal and relaxed in line with Barkhuizen's (2011) advice. These research conversations were held at the participants' workplace (e.g., in Mons's office; in a private meeting room that Lilly booked), home (e.g., Rose's house), café (e.g., a coffee shop near Nightingale's workplace), or via Zoom video-conferencing. It was especially notable that, during COVID-19 pandemic restrictions, such as lockdowns, having the flexibility to hold research conversations via videoconferencing at convenient times and days was an attractive feature when I recruited IQN participants (Archibald et al., 2019).

While SLCs yielded the kind of data that would help me answer my research questions, the open-ended nature of my interview questions meant that I needed to pay attention to the conversation's timing. I recorded in-person research conversations with the voice recorder app VoicePro, which had a basic (albeit imperfect) transcription function that required further editing and formatting. The app's MP3 file and transcription feature had a maximum recording length of 30 minutes. I consequently had to monitor the timing of the conversation so I could stop the recorder at an appropriate time and start a new recording. This was sometimes difficult with my enthusiastic IQN participants, who were great talkers with years of experience to share.

I had provided participants with a conversation outline so they could understand the data collection process. Still, apart from key questions (e.g., "What has been a challenging workplace interaction you've experienced with your colleagues at work?"), there were sometimes less essential supplementary questions that I ran out of time to ask. As I wrote in my research journal in February 2021:

My one sticking point is whether the question “What would a fly on the wall notice about the interaction?” is able to be understood and responded to by participants in data-driven ways. Will participants be able to picture what I mean by the fly on the wall (that is, taking an objective look at the interaction)—and does it even matter? Actually, I’ve now kind of modified this question, depending on the participant and the context, to “What would an observer—someone standing in the room—notice about what was happening during the interaction?”

Asking the ‘fly on the wall’ question was a form of depersonalisation as a questioning technique, which was a strength of the study. Consistent with Levin et al. (2022), there were three key benefits of depersonalising the interview prompt:

- i. broadening participants’ perspectives;
- ii. mitigating participants’ potential feelings of a story being too personal to share by telling it from a neutral perspective; and
- iii. garnering participants’ responses as IQNs felt more comfortable sharing sensitive experiences in a more detached manner.

The positioning that participants used to frame and generate meaning from workplace interactions was revealed in their stories and Flower Diagrams, as well as my follow-up questions. Participants’ answers to my question “Where to from here?” allowed for their further reflections and revelations linked to their storied experiences, for instance. (Answers to questions to find out what so-and-so said (“What did you say?” “What did he/she say?”) naturally came out of the story anyway.) As I developed more confidence as a qualitative researcher, I only asked a pre-set question if relevant storied experiences or explanations had not yet emerged. In my researcher journal I reflected, “I feel like I’m growing as a researcher because I’m responding to participants’ real-time stories and observations to support data collection.”

Furthermore, research conversations also allowed me to build rapport with my participants, owing to our mutual sharing of personal and professional experiences generated by the SLC’s topic. Berger (2015) advised that a researcher should refrain from disclosing personal information and instead present a distant albeit empathic research approach. My aim, though, was to notice, and respond to, participants’ co-

constructed meanings, as well as their emotions, within each research conversation, as Ellis and Berger (2003) recommended. For example, during a research conversation, one of my participants talked about recently losing her pet cat, which reduced us both to tears. She later brought her new kitten to ‘meet me’ on Zoom, so we laughed together as I cooed at her kitten.

7.8.3.2 Zoom Pair Shares.

Owing to the New Zealand COVID-19 pandemic restrictions in 2020 and 2021, I modified my original data collection plan from in-person focus groups to online research conversations via Zoom with two IQN co-participants (rather than IQN-to-researcher). That is, I paired two IQNs from either the same ethnic background (e.g., Ricky and Lola as English-speaking European IQNs), healthcare setting (e.g., Lilly and Carmel in aged care), or nursing role (e.g., Jessie and Nightingale as nurse educators; Mons and Rose as nurse managers). I called this type of research conversation a ‘Zoom Pair Share’. In the first 20 minutes, IQN participants talked about their professional backgrounds and experiences. As our rapport grew as a ‘participant trio’ in the second ZPS, the beginning of the meeting was spent ‘catching up’ on IQNs’ previous stories. In the next 30 minutes, participants shared a challenging/positive workplace interaction and asked each other what advice they would give to another IQN and/or an IQN manager in a similar situation. I found that Zoom meetings were also easier to schedule with participants during the snap Delta COVID-19 lockdown in August 2021 and the subsequent pandemic restrictions. This gave me the ability to pivot throughout data collection, leading to my growing competence and confidence as a researcher.

I experienced several scheduling and technological difficulties with Zoom Pair Shares, but these were overcome by flexible, participant-centred responses. Examples of key challenges were when participants were at work during a scheduled Zoom meeting. Lilly was the only registered nurse on duty at her facility, so she was called away during the first Zoom Pair Share with Carmel. Moreover, participants (Carmel, Rose) were sometimes at home with a child requiring attention. This led to several distractions (audio, physical, visual), which required management during the call as well as during transcription, owing to noise in the room. Sometimes IQNs did

not save the Zoom link or were unfamiliar with logging into Zoom (Rose), which resulted in a delay in their logging on. I was mindful of my participants' time, so I had to monitor the conversation's timing to ensure we could finish within the hour.

In addition, for their second Zoom Pair Share, Nightingale forgot about the start time and Jessie had logged onto the Zoom late. Resolving to myself to "just make it work," I held a half-hour Zoom research conversation with Jessie and asked her to pose some questions for Nightingale to answer. Jessie would then see Nightingale's responses in the transcript, which made her happy. When I did manage to get Nightingale on a Zoom call later that day, she exclaimed, "I'm so disappointed at not being able to speak to Jessie. I was really looking forward to speaking with her, and I've messed up. I'm really, really sorry." This showed the rapport the IQN co-participants had and Nightingale's excitement to speak with a fellow nurse she had already spoken to several months prior.

There were several key strengths of Zoom Pair Shares, namely the opportunity for nurses to share their own—and provide constructive observations about others'—workplace interactions in healthcare settings. Nursing lecturer Kate (pseudonym, personal communication, July 6, 2020) advised that IQNs benefit both professionally and personally from peer support, so Zoom Pair Shares would allow IQNs to build a sense of community. The collegial and rapport-focused approach inherent to the Zoom Pair Share is, in my opinion, highly relevant to narrative inquiry, wherein participants are co-constructing knowledge and making sense of shared experiences (Haydon et al., 2018). Zoom Pair Shares also allowed for more open, honest, and collegial talk as participants were in their home environment, which Archibald et al. (2019) found as well.

IQN participants were happy to meet and talk with another IQN within their role and/or sector as they valued their peers' knowledge and experience. In addition, I found that participants were supportive, attentive, and friendly with their co-participants during the Zoom Pair Share. For instance, in their first Zoom Pair Share, Jessie and Nightingale were excited about talking together. Jessie told us, "I've been waiting for this day. I said, 'Who'll be my pair?' I've been anxious to see." IQNs shared stories in an engaging and authentic way, seeking their co-participants'

feedback and stories of their own experience of challenging workplace interactions with colleagues. They also gave helpful and relevant advice about workplace communication strategies and/or tools for their co-participants to try.

7.8.3.3 Flower Diagrams.

After participants told a story about challenging or positive workplace interaction with their colleagues, I invited them to colour in a petal and/or part of a petal on the respective Flower Diagram that represented their feelings about this interaction. I also encouraged participants to write meaningful words and/or draw pictures or symbols in the petal(s) to facilitate/encourage their thinking and articulation of workplace interactions in verbal or non-verbal ways. For example, during our first research conversation, Carmel drew a star in the ‘Triumph’ petal, telling me, “I am a star.” The colour was a catalyst for another retelling of the story, especially when participants explained what colour they chose and why. Participants told me more about what each conversation partner said, as well as what an observer (or ‘fly on the wall’) might have noticed about aspects of the interaction. The purpose of this activity was for participants to spend time reflecting on the interaction while they were colouring in. This often led to IQNs’ further reflection on their social interactions with colleagues, thereby providing opportunities for participants to make sense of their workplace interactions in line with Kupferberg (2010).

The relevance of Flower Diagram data was the rationale(s) that participants gave for selecting a petal and a colour in relation to their restorying of a challenging or a positive workplace interaction. After a participant coloured in a petal, I always asked, “Why did you choose the [name] petal?” and “What does [colour] mean to you?” This allowed the participant to share richer details of their emotional response to the interaction. The Flower Diagram was a vehicle for participants to begin to think about their emotions triggered through restorying the workplace interaction. Consistent with Nandagopal’s (2008) findings, IQNs’ expression of their emotions using the Flower Diagram may have helped them not only to resolve their feelings but also to develop self-knowledge of their own reactions to workplace interactions.

Carruthers et al.’s (2010) investigation into the connection between colour and emotion via an innovative Colour Wheel—a colour-based research instrument to

help detect mood disorders in patients—found that there are ‘positive’ colours and ‘negative’ colours that may indicate an affective or cognitive state. In this study, anxious individuals selected red to represent their feelings of anger and upset and avoided selecting yellow—a happy and positive colour. They were also more likely to choose dark shades rather than pale shades. Nevertheless, it was beyond the scope of this study to investigate possible links between specific colours and the emotional or cultural meanings that participants attributed to them. For example, in research conversations, participants chose red for the ‘Disaster’ petal because: (i) their face turned red in embarrassment (Lola); (ii) their colleague’s face turned red in anger or frustration (Lilly); or (iii) the colour red symbolised a stop sign or a warning/alert for a difficult conversation (Lilly).

The Flower Diagram was also a catalyst for IQN participants to retell their storied experience of a challenging or positive workplace interaction. As they remembered and relived their workplace interactions, they were invited to reflect upon their emotions and learnings involved in these storied experiences. Johnson (2004) found that the use of visual tools (e.g., a self-authored picture book) in narrative inquiry permits greater professional reflection and self-critique. Flower Diagrams certainly generated visual and textual narrative data that encompassed rich examples of participants’ self-reflection. This was seen in the colours and words that IQNs chose when storying and expressing their emotional experiences related to their workplace interactions. Indeed, Mons found that completing the Flower Diagram was “not just colouring in—it was therapeutic.” See Appendix L for Jessie’s detailed and colourful Flower Diagram, on which she had reflected upon the colours she had chosen to describe her feelings about a challenging workplace interaction.

7.8.3.4 Self-Reflective Journal (Optional Reflections).

According to nursing lecturer Kate (pseudonym, personal communication, July 6, 2020), IQNs are expected by their employers and by the New Zealand Nurses Organisation to reflect regularly upon their practice. In line with Kupferberg (2010), the purpose of the Self-Reflective Journal (later renamed Optional Reflections) was for participants to reflect upon their workplace interactions as an IQN, allowing for their “insights gained from the past [to] be applied” (p. 373) to their nursing practice.

I invited participants to use the prompts below to send me an email or voice message (via WhatsApp) about their reflections upon their challenging and/or positive workplace interactions with colleagues:

- i. What happened during the interaction? Where were you? What were you and your colleague doing?
- ii. What did your colleague say to you? What did you say to your colleague?
- iii. What would you say to a colleague who experienced this kind of workplace interaction?
- iv. Where to from here? Is there anything you want to do as a result of this interaction?

There are, though, operational tensions between IQNs' workloads and expectations for reflection as part of professional practice (Assoc Prof M. Brunton, personal communication, November 23, 2020).

IQN participants accepted my invitation to talk with me every three or four months about their challenging and positive workplace interactions. However, with their work and family commitments, they found it difficult to find time to write journal entries/reflections. My nursing consultants, Kate (pseudonym) and Assoc Prof Marg Brunton, observed that IQNs would be understandably resistant to writing or speaking about their workplace interactions in between research conversations. This was because Self-Reflective Journals would be perceived as overly burdensome for IQNs. According to Assoc Prof Brunton (personal communication, November 23, 2020), interviews and focus groups are the most effective data collection methods for IQN research participants. Therefore, her advice was for me to make journal entries an optional exercise—rather than a compulsory requirement—for participants. In my February 2021 researcher journal, I wrote:

I remember the look on Lilly's face when she found out the journal was optional because I think if I hadn't made it optional, she might have pulled out. Also, my nursing consultants told me earlier in the study, "You're asking a lot of your participants." I didn't really get it until I got it.

The first three participants I recruited (Lilly, Mons, and Carmel) were all engaged in recording their reflections upon challenging and positive workplace interactions. Carmel scheduled time to write her reflections in a notebook I had given her. She found writing down her reflections gave her insight into her emotions, especially negative emotions. For instance, in our second research conversation, Carmel shared the story of her discovery of ongoing medication errors in her facility. Carmel said she had advised the facility manager and her clinical nurse leader about the errors, but they were “not doing anything.” Reflecting upon her efforts to convey her concerns, Carmel wrote about asking her manager, “Why is this happening repeatedly, and how are we going to prevent this from happening again?” She had noted in her journal that one of her colleagues had told her that the manager had even removed the medication errors. This led Carmel to think that she was “just favouring the other RNs or just covering up the mistake. [...] It's about the medication and the safety of the residents, so I'm really concerned about it. So, that's a challenge.” The ‘Story of a Challenging Workplace Interaction’ Flower Diagram (see Figure 9) shows Carmel’s feeling of ‘Huh?’ (indicated by her selection of the ‘Misunderstanding’ petal), wondering why the manager was removing the medication error from clinical documentation.

Carmel’s reflections about a positive outcome of her insistence in notifying management about repeated medication administration errors, and their removal from official documentation, are indicated her journal:

I write it here: We had an RN meeting, and it’s one of our main discussion on our RN meeting. [...] And then the regional quality manager came here to discuss to us, “OK, you have increasing medication errors, and this is what I’m going to do...” She discussed the policy about medication errors and made sure that we understand it. So, I’m happy about that because I made an action. And I’m glad that there’s a positive outcome on that negative situation.

Carmel also wrote in her journal that trials in the nursing workplace were common, and it was important to understand other people’s perspectives. As she noted on her ‘Story of a Positive Workplace Interaction’ Flower Diagram (see Figure 10), her

advice to IQNs was to “continue doing what is right. Do your job well. Integrity [is] doing what is right, even when nobody is looking.” Her positive reflections in her notebook, and the colourful designs on her Flower Diagram, were indicative of Carmel’s feelings of happiness that a senior manager had followed up Carmel’s concerns and made them a professional learning opportunity for other nurses. The Self-Reflective Journal (Optional Reflections) was thus a channel for IQN participants to engage in professional reflection and feel motivated by their “notes to self” in their clinical practice.

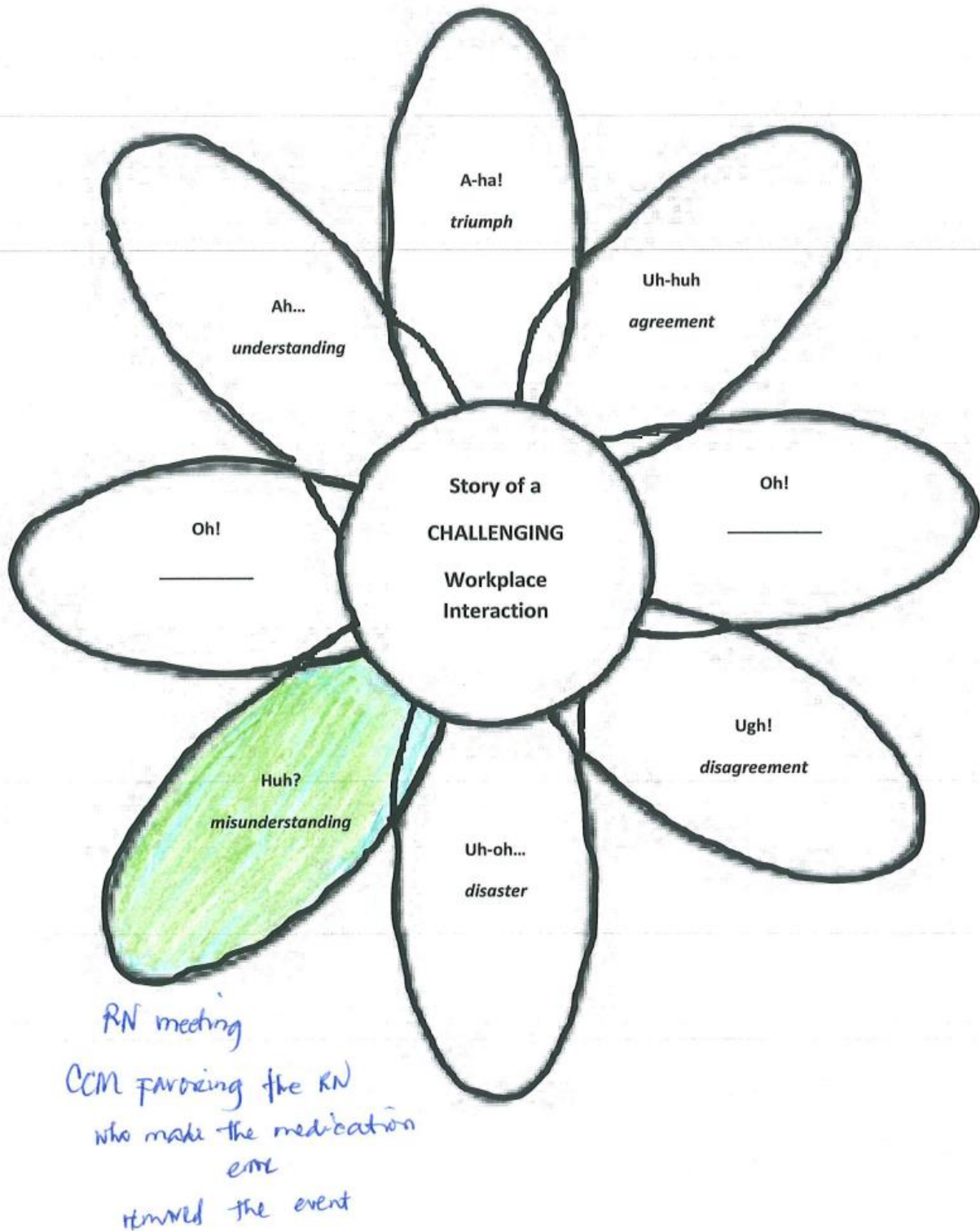


Figure 9. Carmel, 'Story of a Challenging Workplace Interaction' Flower Diagram, Self-Reflective Journal 1, December 2020

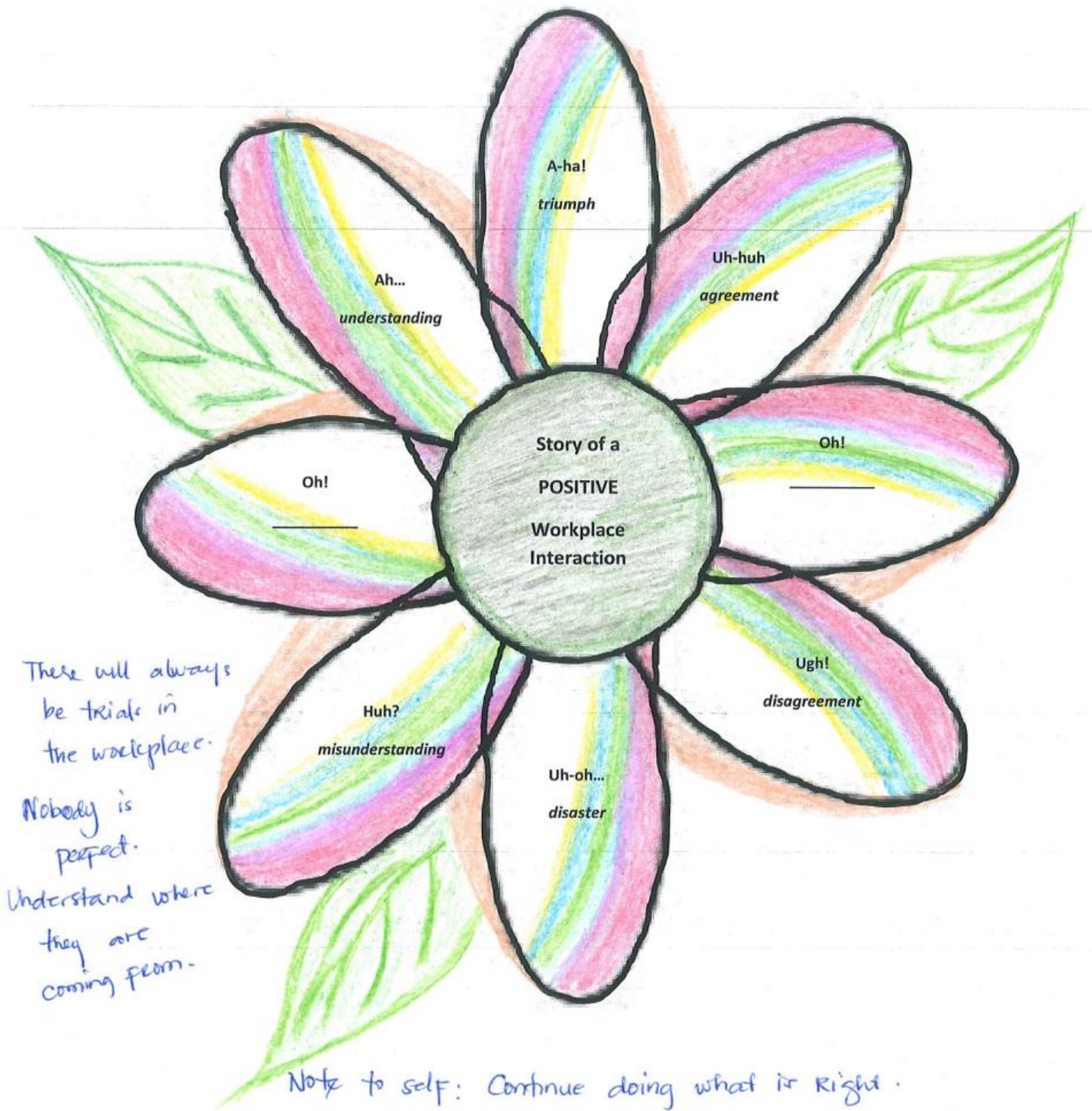


Figure 10. Carmel, 'Story of a Positive Workplace Interaction' Flower Diagram Self-Reflective Journal 1, December 2020

7.8.4 Evaluation of Data Analysis Procedures

My data analysis frameworks, tools, and procedures were inspired by my doctoral supervisor's comment when I was scoping my research topic that, with nurses, communication is life or death. Using thematic analysis and multimodal positioning analysis procedures helped me peel back the layers of IQN participants' workplace interactions. Following are the limitations and strengths of each analytical procedure in making sense of my narrative data and revealing aspects of IQN participants' sense of professional self.

7.8.4.1 Thematic Analysis.

In line with Braun and Clarke (2021), coding transcripts of research conversations with NVivo involved creating a code, or several codes, for a meaningful chunk of narrative data. In NVivo I set up a static set for what I conceptualised as being thematic areas, within which I created static sets for all the different subthemes. Then, I would save codes directly into the relevant subtheme. Coding my long transcripts—many of which were 8,000 to 10,000 words in length—was time-consuming as I used a grounded approach to labelling codes. At each level of abstraction, I would review the codes and look for patterns of meaning in order to group codes systematically into thematic areas. My coding process did not feel daunting to me, though, because I knew that carefully labelling meaningful chunks of narrative data would help me organise my data analysis and interpretation.

This data coding process was valuable, too, in helping me think more about how I was going to present my findings in due course. Based on my transcribing research conversations and discussing IQNs' workplace interactions with participants, I already knew there were key thematic areas that I felt most of those conversations linked with. Those were workplace culture, workplace communication, and workplace interactions. Another thematic area that was related to IQNs' concerns comprised the topics of racism, exploitation, and favouritism, as well as participants' advice to fellow IQNs, CAP course providers, nurse educators, and management. The fifth thematic area was IQNs' professional experience and how it was viewed by colleagues and managers. Finally, the sixth theme was related to IQNs' agency, wherein participants were reflecting on their experience and thinking, 'What could I

do differently next time? What have I learned from this?’ In line with Bamberg (2011), participants were engaging in self-reflection and, what I termed in my August 2022 researcher journal, “looking in the mirror to look outwards.”

7.8.4.2 Multimodal Positioning Analysis.

I elicited participants’ stories of their workplace interactions to co-construct meaning with participants. Multimodal positioning analysis (MPA) is my interpretation of what the storied representation of an IQN in their own local context fits within, and means for, the wider nursing community. The rationale for the use of the MPA model was based on my research being framed by the idea of positionality, which is an important aspect of identity construction. It took an extended period to conduct multimodal positioning analysis because of my top-down process of coding. The first level of analysis was a rewording or summary of the main idea of the sentence or meaning unit synthesised into a short description. I had set up static sets in NVivo for the three positioning levels and the four MPA criteria. This approach allowed me to consider participants’ language carefully, which I had already done when I was transcribing research conversations. As MPA findings would be written in narrative form, it was essential that I spent time writing a comprehensive summary of the chunk of text selected for coding and analysis.

Having the framework for the MPA model to respond to my three research questions helped me analyse diverse aspects of discursive positioning at levels 1, 2, and 3 within Bamberg’s (1997, 2003, 2020) positioning analysis framework. I also asked my supervisors to review my coding of Lilly’s first research conversation using my systematic MPA model. This was because I concurred with Green et al. (2020) that a peer-validation process for my MPA model ought to give it credence. Furthermore, I came to know my data very well through this intense MPA process of coding my participants’ stories of challenging and positive workplace interactions. In September 2022, I reflected in my researcher journal that I was “feeling my data” and gaining a sense of their inherent complexities: “This awareness and understanding of my narrative data will help me present and defend my research in future.”

7.9 Concluding Remarks

The global nursing shortage is a catalyst for the international migration of nurses, particularly from low-income to middle- and high-income countries. IQNs' experiences of having challenging and positive conversations with colleagues in the healthcare workplace may impact the likelihood of their staying in New Zealand to live and work. Consequently, my research aim was to investigate IQNs' professional identity positioning, as revealed through their storied experiences of workplace interactions with colleagues, to develop relevant and applied knowledge for the benefit of IQNs and the wider nursing community. This study sought to bring into focus the value of not only attaining and retaining nurses but sustaining IQNs here in New Zealand for their professional and personal wellbeing. Filling a gap in the literature was not the sole rationale for this project. The broader question and justification for this study was understanding how migrant nurses cannot just be retained but supported and valued as well. IQNs' social, emotional, and cultural integration, retention, and support are key consequences of this research.

The ways in which IQNs experience transitioning into their career in New Zealand may affect how they feel about staying long term (Brunton et al., 2020). It is not enough for the New Zealand healthcare sector to attain migrant nurses to fill skills shortages, nor should employers be satisfied with retaining IQNs in the medium- to long-term. Healthcare providers need to sustain IQNs in their career so that they choose to stay working in New Zealand, despite lower salaries than those offered in countries like Australia (McClure, 2023). Johnson et al. (2012) recommended studies into nurses' professional identity, particularly if there could be positive outcomes for nurses' career pathways and employers' operational processes and policies. This study therefore sought to generate understanding of IQNs' workplace interactions, identity positioning, and concerns for IQNs' wellbeing and agency. As a result, I have provided recommendations to develop relevant policies and practice, as well as future research projects, to support IQNs and wider healthcare communities in New Zealand.

On a personal note, I consider this research study to have been an invaluable learning experience for me as a researcher, a teacher, and—to my participants over the course

of the study—a friend. Despite the unforeseen challenges to participant recruitment and data collection brought about by COVID-19, I enjoyed every stage of my doctoral research project. I particularly valued the emotional rapport I developed with my participants as I co-experienced their feelings of angst and resilience during the 2020–2022 COVID-19 pandemic restrictions. I concur with the acting associate professional services manager for NZNO in 2020, Kate Weston, who considered that New Zealand “owes [healthcare] workers a vote of thanks for the work they did” (Manchester, 2020, p. 13). My sense of fellowship with my participants can be seen by my ‘coffee catch-up’ with Rose a full two-and-a-half years after our first research conversation. Rose (personal communication, August 18, 2023) expressed her feelings of happiness and satisfaction in having enhanced her self-knowledge, self-esteem, and self-reflection by engaging in research conversations with me and her co-participant, Mons. I responded in kind by telling Rose how grateful I felt at having the opportunity to build heartfelt and memorable connections with my IQN participants both during and after the study.

Ashley et al. (2018) found that nurses appreciate a supportive culture at work, especially when they feel they are building clinical skills and professional relationships, which may increase their job satisfaction and reduce attrition rates. Through their participation in this study, IQNs benefited from gaining greater understanding of their workplace interactions, clinical practice, and dynamic identity positioning within the nursing community. My IQN participants told me this research will have value because, as Jessie pointed out, IQNs’ voices are being heard. Furthermore, Lola confirmed that through this research IQNs will have a supporting document that may help improve the recruitment and registration process to retain and sustain IQNs in their New Zealand nursing career. Findings from this study may lead to greater understanding and support of IQNs as they build a successful long-term nursing career in New Zealand.

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Appendices

Appendix A

Confidentiality agreements



Exploring the professional identity and positioning of internationally qualified nurses as they participate in workplace interactions with colleagues in New Zealand healthcare settings

FOCUS GROUP CONFIDENTIALITY AGREEMENT

I (Full Name - printed) agree to keep confidential all information concerning the project:
.....(Title of Project).

I will not retain or copy any information involving the project.

Signature:

Date:

.....

Appendix B

Participant consent forms



Exploring the professional identity and positioning of internationally qualified nurses as they participate in workplace interactions with colleagues in New Zealand healthcare settings

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read and understood the Information Sheet attached as [an appendix]. I have had the details of the study explained to me; any questions I had have been answered to my satisfaction; and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study. I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I wish/do not wish to have my recordings returned to me.
3. I wish/do not wish to have data placed in an official archive.
4. I agree to participate in this study under the conditions set out in the Information Sheet.
5. I understand that the time limit for me to withdraw data will be one month after an interview.

Declaration by Participant:

I _____ [print full name] hereby consent to take part in this study.

Signature: _____ Date: _____



Exploring the professional identity and positioning of internationally qualified nurses as they participate in workplace interactions with colleagues in New Zealand healthcare settings

FOCUS GROUP PARTICIPANT CONSENT FORM

I have read and understood the Information Sheet attached as [an appendix]. I have had the details of the study explained to me; any questions I had have been answered to my satisfaction; and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study. I understand participation is voluntary and I may withdraw from the study at any time.

1. I understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.
2. I understand that all the information I provide will be kept confidential to the extent permitted by law, and the names of all people in the study will be kept confidential by the researcher.

Note: There are limits on confidentiality as there are no formal sanctions on other group participants from disclosing your involvement, identity or what you say to others in the focus group. In that regard, there are risks in taking part in focus group research, and taking part assumes that you are willing to assume those risks.

3. I agree to participate in the focus group under the conditions set out in the Information Sheet attached.

Declaration by Participant:

I _____ [print full name] hereby consent to take part in this study.

Signature: _____ Date: _____

Appendix C

Optional Reflections guide



OPTIONAL REFLECTIONS

(A) Your reflections as an IQN in a New Zealand healthcare setting

You may wish to write / speak about your reflections on workplace interactions with colleagues during this project. In your reflections on a challenging and/or positive workplace interaction, I invite you to reflect upon:

- What happened during the interaction? Where were you? What were you and your colleague doing?
 - your colleague said to you.
 - you said to your colleague.
- What would you say to a colleague who experienced this kind of workplace interaction?
- Where to from here? Is there anything you want to do as a result of this interaction?

Please feel free to share your reflections with me in the following ways:

EITHER

Write your notes / reflections in the notebook I give you and then return it to me at our next Story-Led Conversation.

OR

Email me at danataylorphdproject@gmail.com or text me at [REDACTED] your responses to the guiding questions above. (If you like, you're welcome to write your reflections in a Word Doc or Google Doc, which I can share with you for your convenience.)

OR

Voice record on your smartphone your responses to the guiding questions above and email / WhatsApp / (text) message your recording to me as an MP3 file.

(B) ‘Story of a Workplace Interaction’ Flower Diagram(s) for your reflections

Once you have written / spoken about a positive or challenging workplace interaction, please complete a Flower Diagram (see the next page).

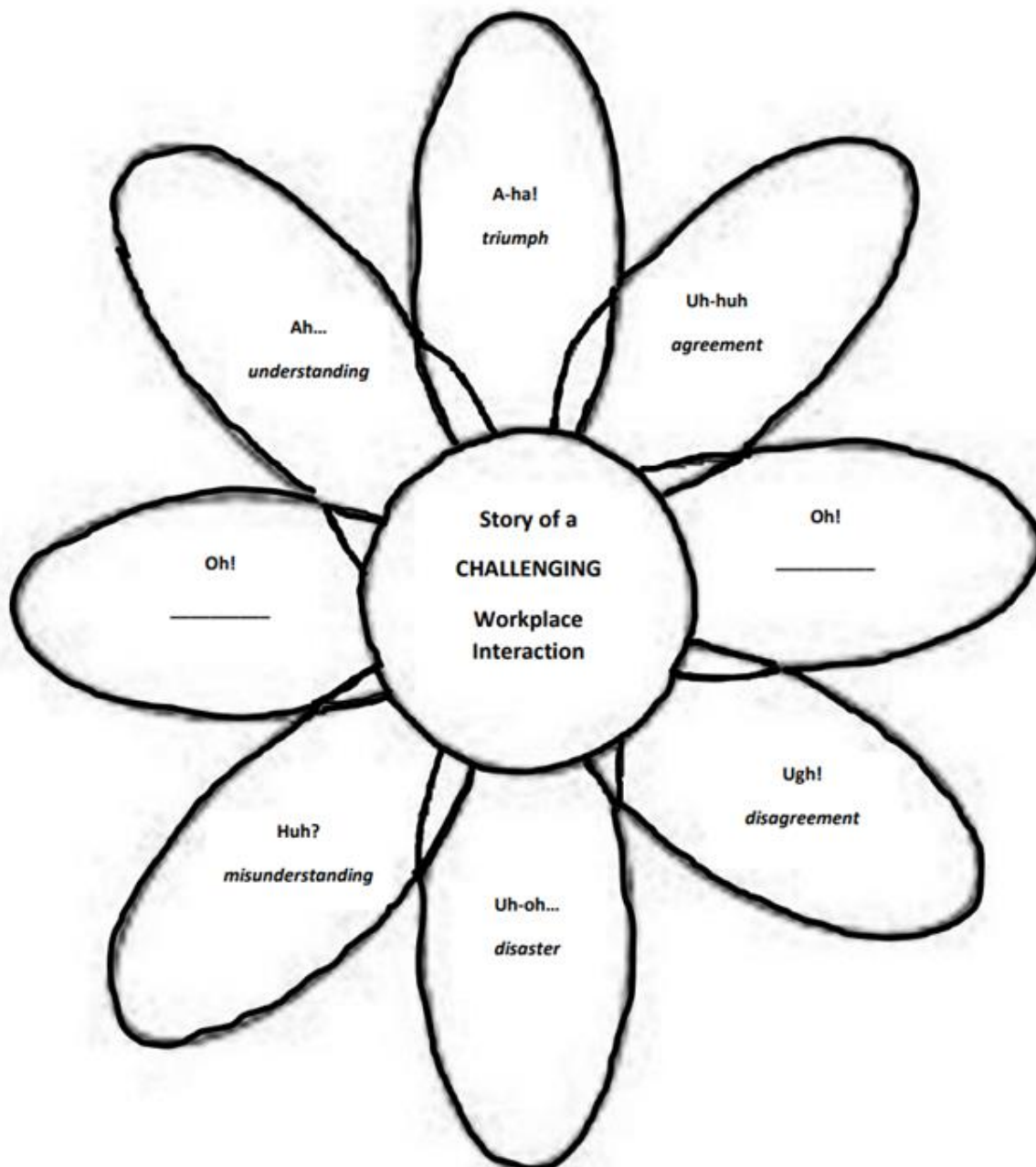
(A) 'Story of a Challenging Workplace Interaction' Flower Diagram

Complete your 'Story of a Challenging Workplace Interaction' Flower Diagram (see page 4) after you have written / spoken about your reflections about a challenging workplace interaction with colleagues.

1. Colour in a petal or petals to describe the challenging workplace interaction you wrote / spoke about in your reflections.

Optional:

2. Write any other words in the petal(s) to describe your feelings about this challenging interaction with a colleague or colleagues. Write or speak about your reasons for writing these words.
3. Draw any shapes or pictures in the petal(s) or in the flower to describe your feelings about this challenging interaction with a colleague or colleagues. Write or speak about your reasons for drawing these shapes or pictures.



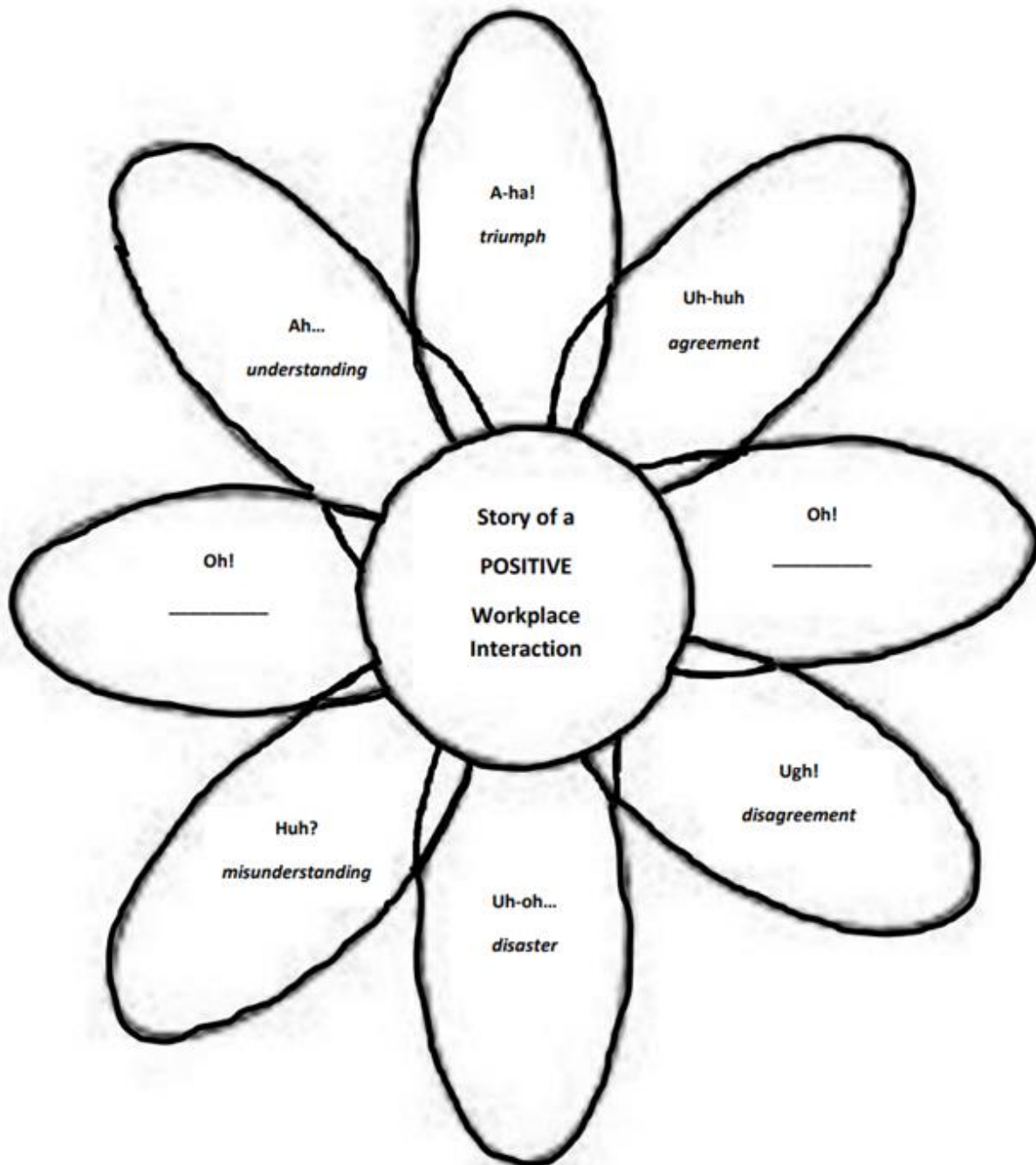
(B) 'Story of a Positive Workplace Interaction' Flower Diagram

Complete your 'Story of a Positive Workplace Interaction' Flower Diagram (see page 5) after you have written / spoken about your reflections about a challenging workplace interaction with colleagues.

1. Colour in a petal or petals to describe the positive workplace interaction you wrote / spoke about in your reflections.

Optional:

2. Write any other words in the petal(s) to describe your feelings about this positive interaction with a colleague or colleagues. Write or speak about your reasons for writing these words.
3. Draw any shapes or pictures in the petal(s) or in the flower to describe your feelings about this challenging interaction with a colleague or colleagues. Write or speak about your reasons for drawing these shapes or pictures.



Appendix D

Participant information sheets



PARTICIPANT INFORMATION SHEET

[Approved 2019]

About me



Hi, I'm Dana Taylor. I'm an English language teacher and vocational educator at IPU New Zealand in Palmerston North. In my former role as a life and disability insurance underwriter, I developed an understanding of medical concepts and terminology that is helping me tutor migrant nurses as they prepare for the Occupational English Test. Having graduated with a Master of Teaching English to Speakers of Other Languages (TESOL) Leadership in 2016, I'm now studying towards a PhD in Humanities (Applied Linguistics).

About this project

I'm interested in exploring the professional identity of internationally qualified nurses (IQNs) who have been working in New Zealand healthcare settings for three to five years. Participants will reflect on both positive and challenging interactions with colleagues (e.g., nurses, doctors, and administrators). The overall aim of this project is for participants to retell stories of interactions that have impacted on their feelings of being a professional nurse. We will subsequently create shared understandings of how professional identity may be shaped by reflecting upon workplace interactions.

Study phase (2020-2021)

I will be recruiting eight IQN participants for the 14-month study phase. There will be two focus groups (at the middle and the end of the study), in which participants will be encouraged to tell focused stories about workplace interactions with colleagues within healthcare settings. Participants will keep a monthly self-reflective journal and attend three interviews with me, either in person or via Skype/Zoom.

Following are some questions you might have about this study:

How much time will I need to commit to this study?

In the study phase (2020-2021), participants will give fourteen hours to the project, comprising:

1. a two-hour focus group at the middle and the end of the study respectively (four hours)
2. a one-hour interview at the beginning, middle, and end of the study respectively (three hours)
3. two self-reflective journals (six hours) (Journal A: six entries = three hours; Journal B: six entries = three hours)
4. reviewing and commenting on transcripts and researcher notes (one hour)

Our meeting times and locations will be scheduled at your convenience and will be audiotaped. Information shared with me and other participants in focus groups may be used as part of this research. Please note that participants' responses are private and confidential. In no case will any information you give me about your own experiences and/or your workplace interactions be released or communicated to your employer and/or a government agency.

What happens with the information you collect from me?

I will protect the privacy and anonymity of all participants before, during, and after this study. Your participation in, and contribution to, this study will remain confidential to me, my supervisors, and others within the focus group.

I will remove all identifying information from interview and focus group transcripts and self-reflective journal entries. The data and consent forms I collect from all participants will be kept in secure storage at the Massey University campus in Palmerston North, and all data will be kept in a different locked filing cabinet. My supervisor and I will destroy all data after a set storage period of five years.

Participants and I will be working together to share understanding of emerging themes in the data. Consequently, I will ask you to review your transcript, confirm information to be included, and provide further feedback on my interpretations of your comments. At the end of the study, I will give you a summary of my findings.

What are my rights as a participant?

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

1. Withdraw at any time before and during the study.
2. Ask any questions about the study, as well as your role as participant, at any time before, during, and after your participation.
3. Decline to answer any question or share a story with me and/or other participants during interviews, focus groups, and self-reflective journals.
4. Provide personal and professional information on the understanding that identifying details about you and your employer will not be published.
5. Be given a transcript of each interview and focus group within one week following the meeting for your approval, comments, and feedback.
6. Be given a summary of findings and implications identified by the study for your comments and feedback prior to submission of my thesis.
7. Ask me to turn off the recorder at any time during the interview.

What if I become upset during an interview or focus group?

Following are free call support services (see www.whitecross.co.nz) you could contact if you were to suffer any discomfort or distress during or after participating in an interview or focus group:

- Call or text 1737 any time to talk with a trained counsellor.
- Lifeline: 0800 543 354 or text HELP to 4357.
- Depression Helpline: 0800 111 757 (24/7) or text 4202.
- The Samaritans: 0800 726 666 (24/7).
- Youthline: 0800 376 633 (24/7) or free text 234 (8am to midnight), or email talk@youthline.co.nz.

What will I be provided with to participate in this study?

I appreciate your time and effort in attending interviews and focus group meetings. I want you to feel comfortable speaking with me and fellow participants. I will provide participants with the following:

- refreshments for focus group meetings;
- petrol voucher(s) for participants who live outside Palmerston North to attend interviews and/or focus group meetings; and
- stationery for participants' self-reflective journals and for any notes they wish to make during interviews and/or focus group meetings.

How can I become involved?

If you would like to be considered for this research project, please note that you:

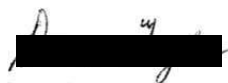
- must have received your professional nursing training overseas and gained your New Zealand nursing registration;
- must have been working full- or part-time for a public or private healthcare provider for between three and five years;
- will have English as your first or additional language; and
- will need to be available to participate in a 14-month study.

Please contact me on ph. [REDACTED] or dtaylor@ipu.ac.nz to find out more about participating in this research study. I look forward to hearing from you if my study sounds interesting to you and fits in with your personal and professional commitments.

Project contacts

My supervisors are Ute Walker, PhD (U.Walker@massey.ac.nz), Franco Vaccarino, PhD (F.A.Vaccarino@massey.ac.nz), and Wendy Holley-Boen, PhD (W.Holley-Boen@massey.ac.nz). Please feel free to contact me or either of my supervisors if you have any questions about the project.

Thank you for your time.



Dana Taylor

Ethics approval statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 19/29. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz.



PARTICIPANT INFORMATION SHEET

[Approved 2020]

About me



Hi, I'm Dana Taylor. I'm a communications lecturer at a New Zealand tertiary institute. In my former role as a life and disability insurance underwriter, I developed an understanding of medical concepts and terminology that is helping me tutor migrant nurses as they prepare for the Occupational English Test. Having graduated with a Master of Teaching English to Speakers of Other Languages (TESOL) Leadership in 2016, I'm now studying towards a PhD in Humanities (Applied Linguistics).

About this project

I'm interested in exploring the professional identity of internationally qualified nurses (IQNs) who have been working in New Zealand healthcare settings for at least three years. Participants will be invited to reflect on both positive and challenging interactions with colleagues (e.g., nurses, doctors, and administrators). The overall aim of this project is for participants to (re)tell stories of interactions that have impacted on their feelings of being a professional nurse. This will help create shared understandings of how professional identity may be shaped by reflecting upon workplace interactions. Such stories will be sourced from 'story-led conversations' held in a one-to-one setting as well as focus groups held with other participants.

Study phase (2020-2021)

I will be recruiting eight IQN participants for the year-long study phase to participate either in person or via videoconferencing (e.g., Zoom).

What will I do, and how much time will I need to commit to this study?

Over a period of 12 months (2020-2021), participants will be invited to contribute up to nine hours to the project, comprising:

- a focus group at the middle and the end of the study respectively (2 x up to two hours)
- a story-led conversation (up to 50 minutes) every three months (4 x 50 minutes)
- reviewing and commenting on transcripts and researcher notes (one hour)
- [OPTIONAL] a monthly reflection (around 30 minutes per month)

Our meeting times and locations will be scheduled at your convenience and will be audio-recorded.

What happens with the information you collect from me?

I will protect the privacy and anonymity of all participants before, during, and after this study. Your participation in, and contribution to, this study will remain confidential to me, my supervisors, and others within the focus group.

In no case will any information you give me about your own experiences and/or your workplace interactions be released or communicated to your employer and/or a government agency. Information shared with me and other participants in focus groups may be used as part of this research.

I will remove all identifying information from Story-Led Conversations and focus group meetings' transcripts and participants' Optional Reflections. The data and consent forms I collect from all participants will be kept in secure storage at the Massey University campus in Palmerston North, and all data will be kept in a different locked filing cabinet. My supervisor and I will destroy all data after a set storage period of five years.

Participants and I will be working together to share understanding of emerging themes in the data. Consequently, I will ask you to review your transcript, confirm information to be included, and provide further feedback on my interpretations of your comments. At the end of the study, I will give you a summary of my findings.

What are my rights as a participant?

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

1. Withdraw up to a month after being interviewed or recorded in the focus group.
2. Ask any questions about the study, as well as your role as participant, at any time before, during, and after your participation.
3. Decline to answer any question or share a story with me and/or other participants during story-led conversations and focus groups or when completing Optional Reflections.
4. Provide personal and professional information on the understanding that identifying details about you and your employer will not be published.
5. Be given a transcript of each story-led conversation and focus group within one week following the meeting for your approval, comments, and feedback.
6. Be given a summary of findings and implications identified by the study for your comments and feedback prior to submission of my thesis.
7. Ask me to turn off the recorder at any time during a story-led conversation.

What if I become uncomfortable or upset during a conversation or focus group?

During the story-led conversation or focus group, you may ask to pause or stop (in line with the rights above). Following are free call support services (see www.whitecross.co.nz) you could contact if you were to suffer any discomfort or distress during or after participating in a story-led conversation or focus group:

- Call or text [1737](tel:1737) any time to talk with a trained counsellor.
- *Lifeline*: 0800 543 354 or text HELP to 4357.
- *Depression Helpline*: 0800 111 757 (24/7) or text 4202.
- *The Samaritans*: 0800 726 666 (24/7).
- *Youthline*: 0800 376 633 (24/7) or free text 234 (8am to midnight), or email talk@youthline.co.nz.
- *EAP Services Ltd*: 0800 327 669 (EAP Services Ltd is a professional consultation service that partners with nursing and healthcare professionals, particularly concerning traumatic experiences.)

What will I be provided with to participate in this study?

I will provide participants with the following:

- refreshments for in-person conversations and focus group meetings;
- petrol voucher(s) or similar for participants to attend story-led conversations and/or focus group meetings; and
- stationery for participants' Optional Reflections and for any notes they wish to make during conversations and/or focus group meetings.

How can I become involved?

I appreciate your time and effort in participating in this study and want you to feel comfortable speaking with me and fellow participants. If you would like to be considered for this research project, please note that you will:

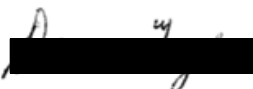
- have received your professional nursing training overseas and gained your New Zealand nursing registration;
- have been working full- or part-time for a public or private healthcare provider for at least three years;
- have English as your first or additional language; and
- need to be available to participate in a 12-month study.

Please contact me on ph. [REDACTED] or danataylorphdproject@gmail.com to find out more about participating in this research study. I look forward to hearing from you if my study sounds interesting to you and fits in with your personal and professional commitments.

Project contacts

My supervisors are Dr Ute Walker (U.Walker@massey.ac.nz), Dr Franco Vaccarino (F.A.Vaccarino@massey.ac.nz), and Dr Wendy Holley-Boen (W.Holley-Boen@massey.ac.nz). Please feel free to contact me or any of my supervisors if you have questions about the project.

Thank you for your time.



Dana Taylor

Ethics approval statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 19/29. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz .

Appendix E

Letter of request to enter institution

[Address redacted]

[Today's date]

[Name of manager]

[Job title]

[Healthcare facility name]

[Healthcare facility address]

Dear Dr [Surname],

REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH NURSES

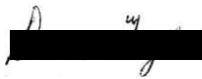
My name is Dana Taylor, and I am a PhD student at Massey University in Palmerston North. The research I wish to conduct for my doctoral thesis involves exploring the professional identity of internationally qualified nurses (IQNs) who have been working in New Zealand healthcare settings for between three and five years. Participants will reflect on both positive and challenging interactions with colleagues (i.e., doctors, fellow nurses, and administrators). The overall aim of this project is for participants to retell stories of workplace interactions that have impacted on their feelings of being a professional nurse.

This project will be conducted under the supervision of Ute Walker, PhD (U.Walker@massey.ac.nz), Franco Vaccarino, PhD (F.A.Vaccarino@massey.ac.nz), and Wendy Holley-Boen, PhD (W.Holley-Boen@massey.ac.nz). I am hereby seeking your consent to advertise for potential IQN participants via notices in the staff room and on public notice boards within your healthcare facility.

I have attached a condensed version of my project proposal, which includes copies of the participant information sheet and consent forms to be used in the research process. I have also included a copy of the approval letter which I received from Massey University's Human Ethics Committee.

If you require any further information, please do not hesitate to contact me on phone [REDACTED] or e-mail danataylorphdstudent@gmail.com. Thank you for your time and consideration.

Yours sincerely,



Dana Taylor

Appendix F

Letter of approval from Human Ethics NOR 19-29



Date: 05 September 2019

Dear Dana Taylor

Re: Ethics Notification - NOR 19/29 - **Exploring the professional identity and positioning of internationally qualified nurses as they participate in workplace interactions with colleagues in New Zealand healthcare settings**

Thank you for the above application that was considered by the Massey University Human Ethics

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely



Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Appendix G

MDHB locality approval and recruitment flyer



Doc. Code:

Policy for Health Research

MDHB APPROVAL FORM FOR Advertising of Research

Use this form if your application is for;
<ul style="list-style-type: none"> A cost-neutral study (no budget required at MDHB) AND or wish to advertise your project on the Midcentral DHB premises Volunteers to participate

Research ID (Research Officer to complete)

2020.09.001

Section 1: General			
Full Project Title	Exploring the professional identity and positioning of internationally qualified nurses as they participate in workplace interactions with colleagues in New Zealand healthcare settings		
Principle Investigator	Dana Taylor		
MDHB Service Area	If relevant	Designation	If relevant
Address	[REDACTED]		
Phone	[REDACTED]		
Email	dtaylor@ipu.ac.nz		

For student projects (e.g. summer, masters and doctoral), please provide name of MDHB clinical supervisor, if different to the contact person (above).	
Supervisor Name	Signature
Job Title	Phone No.
Service	Email
Other Contact Name	Phone No.
	Email
Student Led?	Yes/No

Section 2: Proposal
<p>Indicate the study type: e.g. Outcome analysis, Registry, Low risk interventional study <i>For definitions, please refer to: Standard Operating Procedures for Health and Disability Ethics Committees, version 1.0 2012 http://ethics.health.govt.nz/operating-procedures</i> <i>type or paste text here</i></p>
<p>Student-led research: Minimal-risk narrative inquiry Briefly, what is the principal study question (hypothesis) that your study will examine? Internationally qualified nurses (IQNs) are valued in New Zealand as capable and competent participants in the New Zealand nursing labour market. IQNs come to New Zealand with nursing experience in their home countries, but their pre-existing professional identity can be impacted in the first five years of their New Zealand career. Narratives are a way to access nurses' conceptualisations of their lived experience and the identity constructions available to them. Through telling and retelling stories about their own and others' actions and utterances within workplace contexts, IQNs generate meaning from positive and challenging interactions with their colleagues. To what extent, then, do IQNs use discursive positioning to express aspects of their professional identity when reflecting upon their interactions with colleagues in New Zealand healthcare workplaces?</p>
<p>To investigate this research problem, I have devised the following three research questions: Research Question 1 How do IQNs position themselves and others as they tell and retell stories of participating in workplace interactions with colleagues in New Zealand healthcare settings?</p>



Research Question 2

How does IQNs' use of discursive positioning jointly construct aspects of their professional identity?

Research Question 3

What are the implications of understanding, and responding to, participants' stories for the IQNs themselves and the wider nursing community?

Describe what taking part in the study will involve for participants.

Eight IQNs who have been working in New Zealand for between three and five years will be randomly selected for this 14-month study from those who respond to recruitment posters and word-of-mouth advertising. Data from IQN participants, for whom English will be either their first or additional language, will be collected via semi-structured interviews ('Story-Led Conversations'), Self-Reflective Journals, and focus group meetings.

For the study phase (2020-2021), participation is envisaged to comprise 14 hours in total. Participants will be invited to contribute the following amounts of time during data collection:

- a Story-Led Conversation (one hour) at the beginning, middle, and end of the study respectively (= three hours);
- a focus group (two hours) at the middle and the end of the study respectively (= four hours);
- a Self-Reflective Journal (= six hours), comprising Journal A and Journal B (three hours respectively); and
- reviewing and commenting on transcripts and researcher notes (= one hour).

Participants may potentially benefit from the narrative inquiry processes of reflective storytelling. Through sharing their storied experiences of workplace interactions with colleagues, participants' professional realities will be explored and co-constructed. This should help IQN participants not only make sense of positive and challenging workplace interactions, but also allow for their voices to be heard, thereby leading to greater understanding of IQNs' lived experiences in New Zealand healthcare settings.

Brief description of study methods

In this narrative inquiry, I will use interviews, focus groups, and participant journals to explore the research problem and identify aspects of IQNs' positive and challenging workplace interactions with colleagues that may impact working environments and nurse retention. I will implement semi-structured questioning techniques to access qualitative data during interviews and focus group meetings held in a private meeting room within a public space at mutually convenient times and days. (Videoconferencing via Zoom or Google Hangouts Meet might be used if necessary.) Participants will also complete a Self-Reflective Journal entry every three to four weeks when they experience a positive and a challenging workplace interaction with colleagues that they want to reflect upon.

Final Reporting Mechanism

Participants in interviews and focus groups will be involved in generating co-constructed knowledge. Consequently, information collected from these sources will be sent to participants for their confirmation and further discussion. All participants will receive a summary of findings at the conclusion of the project.

My research project will be presented as a descriptive and holistic case narrative thesis that will be accessible to IQNs in New Zealand, employers, registered nurses, and nursing students alike in the following formats:

- I will present my findings to Māori community groups, the Multicultural Centre in Palmerston North, and the New Zealand Nurses Organisation (NZNO) via community workshops and symposium presentations.
- I will send an electronic copy of my thesis to the NZNO for online dissemination and upload my thesis to my doctoral research website: www.tinyurl.com/danataylorphdproject.
- I will submit an abstract to the New Zealand journal *Nursing Praxis* (as recommended by one of my confirmation event panellists) for publication.



Doc. Code:

Policy for Health Research

My research aim is to enact new knowledge in real, relevant, and applied ways for the benefit of IQNs and their colleagues within primary, hospital, and aged care settings. Another research output is thus a set of guidelines for managers of New Zealand healthcare facilities to help IQNs further develop their professional communication skills.

Section 4 Administration and Declarations	
Required for all applicants	
Project expiry date (Date advertisement will be removed)	01/09/2022
I will inform MDHB Research Support Officer when study is complete	YES/NO [Redacted]
SUPPORTING DOCUMENTS CHECKLIST – remember to submit the following with this application form if relevant	
<input checked="" type="checkbox"/> Evidence of Ethics approval <input checked="" type="checkbox"/> Evidence of cultural consultation <input checked="" type="checkbox"/> Proposed Advertisement	
See the supporting documents attached with my project abstract.	
Nb. If approved all advertising material will need to have the following disclaimer attached: <i>Midcentral District Health Board has reviewed this study and it has met our study criteria, however this is not a Midcentral District Health Board affiliated project and Midcentral District Health MDHB specifically DISCLAIMS LIABILITY FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES and assumes no responsibility or liability for any loss or damage suffered by any person as a result of the participation in the research and or information provided by the participant to the researcher.</i>	
IMPORTANT – submit supporting documents and application form in electronic version by email to the Research Office email address (research@midcentraldhb.govt.nz)	

Section 5 MDHB Professional Approval			
Clinical Director / Service Manager / Leader / Medical Director / Nursing Leader			
Name	C. EVES		
Service	Nursing and Midwifery		
Department			
Job Title	EDNM		
Signature	[Redacted]	Date	9/9/2020
Comments:			
Section 7 Clinical Board Acknowledgment of Registration			
Name	Kelvin B. Lingshewal		
Job Title	Chief Medical Officer		
Signature	[Redacted]	Date	9/9/2020
Comments:			



Section 8 Office use only		
	Date	Comment
Date Received		
Date Acknowledged		
Application sent for Approval		
Final Endorsement		
MDHB Registration Number		
HDEC Reference Number		



Research participants wanted

Are you—or is someone you know—
an internationally qualified
nurse (IQN) who has been working in
New Zealand healthcare settings for
three to five years?

I will be exploring the professional
identity of IQNs as they reflect on their
interactions with colleagues within New
Zealand healthcare settings.

Midcentral District Health Board has reviewed this study and it has met our study criteria, however this is not a Midcentral District Health Board affiliated project and Midcentral District Health MDHB specifically DISCLAIMS LIABILITY FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES and assumes no responsibility or liability for any loss or damage suffered by any person as a result of the participation in the research and or information provided by the participant to the researcher.

**Project approved by the Massey University Human
Ethics Committee: Northern, Application NOR 19/29.**

Please contact me to find out
more or register your interest:

www.tinyurl.com/DanaTaylorPhDProject

Ph. [REDACTED]

Project supervised by Ute Walker, PhD (u.walker@massey.ac.nz), F. Vaccarino, PhD (F.A.Vaccarino@massey.ac.nz), and W. Holley-Boen, PhD (w.holley-boen@massey.ac.nz).

Appendix H

Conversation outline



CONVERSATION OUTLINE

Following is the conversation outline for our four Story-Led Conversations (SLC), which will be up to 50 minutes per conversation (or equivalent).

(A) Welcome to the Story-Led Conversation

Welcome to the first conversation

1. I will introduce myself and my professional background, along with my interest in this research topic and the migrant nursing sector.
2. I will explain the study per the Participant Information Sheet (see attached) and answer any questions you might have.
3. I will first explain the Story-Led Conversation, Optional Reflections (see [appendix]), and ‘Story of a Workplace Interaction’ Flower Diagrams (see [appendix]).
4. I will ask you to read and sign the consent forms (see attached).
5. I will then invite you to tell me about yourself as an internationally qualified nurse: your training, career, professional development, and nursing experience in New Zealand.

Welcome to the second, third, and fourth conversation

1. I will ask you how work has been since we last met and how things have been going with your work colleagues.
2. I may ask you follow-up questions about our previous Story-Led Conversation; for example, “You mentioned in our last conversation [specific

challenging and/or successful aspect(s) of workplace interaction / professional identity]. Tell me more about this.”

3. I may ask for further clarification about any aspect(s) of interest from the transcript and/or the notes I took of our Story-Led Conversation and/or your Optional Reflections.
4. I may ask for further clarification of any non-literal language you may have used during our Story-Led Conversation (taken from the transcript).

(B) The format of our Story-Led Conversation

1. I will ask you to tell me about one challenging and one positive workplace interaction with a colleague.
2. Following your story about this challenging and positive workplace interaction, I will invite you to:
 1. Look at the respective Flower Diagram (see [appendix]). Choose a petal and/or part of a petal, as well as a coloured pencil from the set I give you, that represent your feelings about this interaction.
 2. Colour in and/or modify this petal with text or illustrations.
 3. Respond to the following reflection prompts:
 1. Tell me more about when your colleague said [X] to you.
 2. Tell me more about when you said [X] to your colleague.
 3. What might a fly on the wall have noticed about [aspect(s) of the interaction]?
 4. Reflect upon my question, “So, where to from here?” This question aims to elicit a possible learning opportunity, follow-up interaction, further self-reflection...
3. I will ask you if there is there anything else that you would like to say about these stories you have told me.
4. We will have time to ask and answer any follow-up question(s) about the Story-Led Conversation, Optional Reflections, and ‘Story of a Workplace Interaction’ Flower Diagram.
5. Before we end the conversation, we will confirm the date and time of our next meeting either in person or online (e.g., via Zoom).

Appendix I

Zoom Pair Share



ZOOM PAIR SHARE CONVERSATION OUTLINE

Following is the conversation outline for our two Zoom Pair Share (ZPS), which will be 60 minutes per Zoom call.

(A) Welcome to the Zoom Pair Share

Welcome to the first ZPS:

1. I will welcome you and your co-participant, who is currently an internationally qualified nurse (IQN) in a New Zealand healthcare workplace.
2. I will remind you of the focus group confidentiality and consent forms you signed at the start of my doctoral project. I will ask you each to confirm your acceptance verbally.
3. I will then invite you to briefly tell each other about yourselves as IQNs, particularly your nursing training, work experience, and professional development in New Zealand.

Welcome to the second ZPS:

1. I will ask you both how work has been since we last met and how things have been going with your work colleagues.
2. I may ask you follow-up questions about our previous ZPS; for example, “You mentioned in our last conversation [specific challenging and/or successful aspect(s) of workplace interaction / professional identity]. Tell me more about this.”
3. I may ask for further clarification about any aspect(s) of interest from the transcript and/or the notes I took of our Story-Led Conversation and/or your Flower Diagram.
4. Your co-participant may also have some questions and/or insights to discuss with you.

(B) Discussing emerging themes about workplace communication

1. I will present some of the emerging themes from my research related to IQNs’ challenging / positive workplace communication experiences in New Zealand.
2. You will be invited to share your ideas about some of these themes as they relate to your own challenging / positive experiences of workplace communication.

(C) Participating in Story-Led Conversations

1. You will have the opportunity to take turns telling a story of a challenging or positive workplace interaction with a colleague. This story could be new or one shared with me
2. Following your story about a challenging or positive workplace interaction, we will ask you to complete a Flower Diagram to represent your emotions of the story:
 - a) Look at the respective Flower Diagram (see Appendix, pp. 4 - 5). Choose a petal and/or part of a petal, as well as a coloured pencil from the set I gave you, that represent your feelings about this interaction.
 - b) Colour in and/or modify this petal with text or illustrations.
 - c) Respond to the following reflection prompts from Dana and/or your co-participant:
 - i) Tell us more about when your colleague said [X] to you.
 - ii) Tell us more about when you said [X] to your colleague.
 - iii) What might a fly on the wall have noticed about [aspect(s) of the interaction]?
 - d) Reflect upon our question, “So, where to from here?” This question aims to elicit a possible learning opportunity, follow-up interaction, further self-reflection...
3. Before we end the conversation, we will summarise some of the key learnings / conversation topics during the Zoom Pair Share. We will also confirm the potential date and time of our next ZPS meeting together.

APPENDIX

'STORY OF A WORKPLACE INTERACTION' FLOWER DIAGRAMS

(A) 'Story of a Challenging Workplace Interaction' Flower Diagram

Complete your 'Story of a Challenging Workplace Interaction' Flower Diagram (see page 4) after you have written / spoken about your reflections about a challenging workplace interaction with colleagues.

1. Colour in a petal or petals to describe the challenging workplace interaction you wrote / spoke about in your reflections.

Optional:

2. Write any other words in the petal(s) to describe your feelings about this challenging interaction with a colleague or colleagues. Write or speak about your reasons for writing these words.
3. Draw any shapes or pictures in the petal(s) or in the flower to describe your feelings about this challenging interaction with a colleague or colleagues. Write or speak about your reasons for drawing these shapes or pictures.

(B) 'Story of a Positive Workplace Interaction' Flower Diagram

Complete your 'Story of a Positive Workplace Interaction' Flower Diagram (see page 5) after you have written / spoken about your reflections about a challenging workplace interaction with colleagues.

1. Colour in a petal or petals to describe the positive workplace interaction you wrote / spoke about in your reflections.

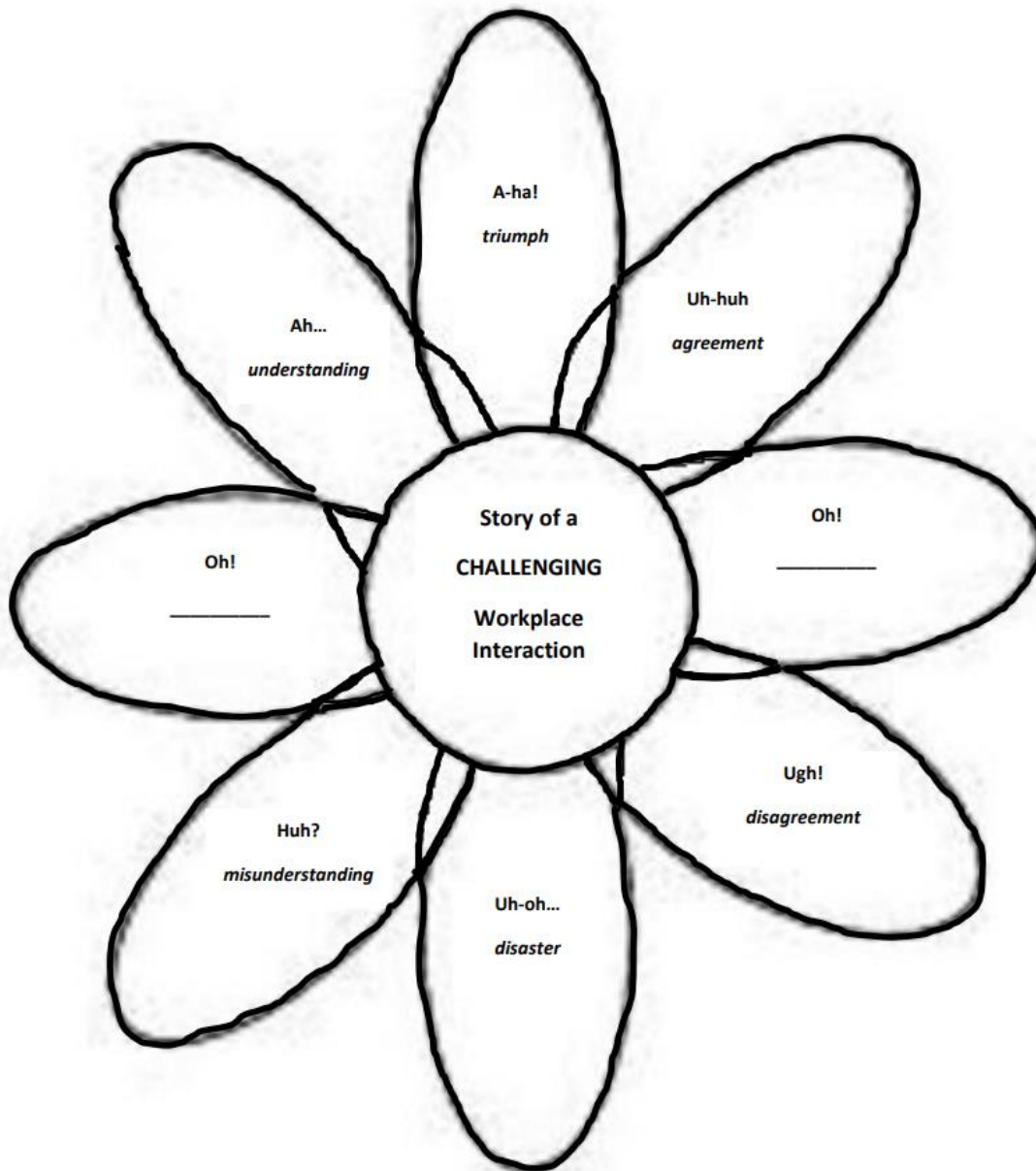
Optional:

2. Write any other words in the petal(s) to describe your feelings about this positive interaction with a colleague or colleagues. Write or speak about your reasons for writing these words.
3. Draw any shapes or pictures in the petal(s) or in the flower to describe your feelings about this challenging interaction with a colleague or colleagues. Write or speak about your reasons for drawing these shapes or pictures.

PARTICIPANT NAME [pseudonym]: _____

DATE OF ZOOM PAIR SHARE (ZPS): _____

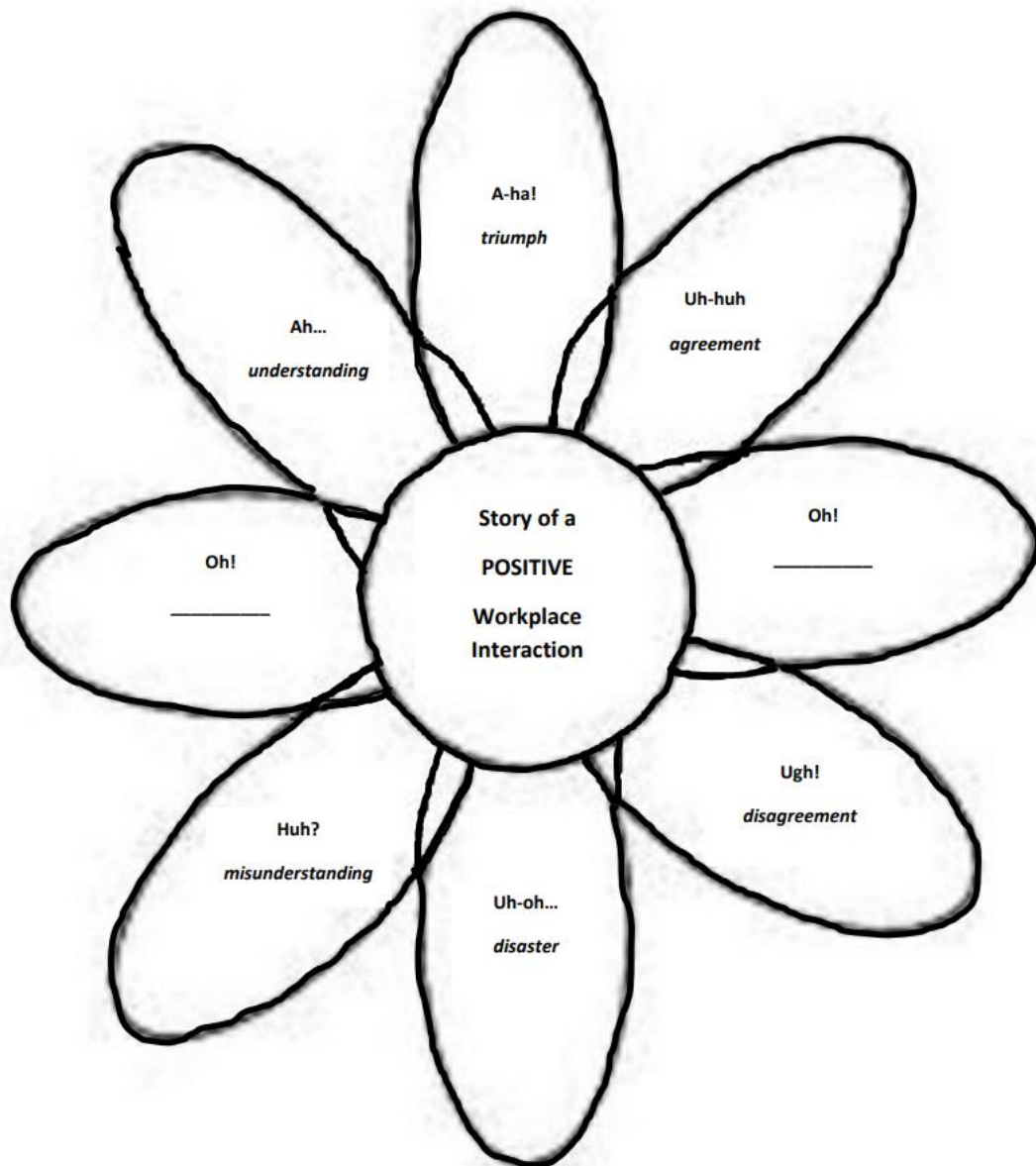
ZPS CO-PARTICIPANT NAME [pseudonym]: _____



PARTICIPANT NAME [pseudonym]: _____

DATE OF ZOOM PAIR SHARE (ZPS): _____

ZPS CO-PARTICIPANT [pseudonym]: _____



Appendix J

Multimodal Positioning Analysis coding

290.	So, recently, one of the residents rang her bell.	<p>Commented [1]: Level 1 Positionality = Agency and control (Line 311 - 312): Having the authority to give instructions to a caregiver and expecting acknowledgement</p> <p>Commented [2]: Temporal dimension</p>	
291.	She wants to go to toilet.		
292.	So, when I looking for care staff,		
293.	I have seen the senior care staff—		
294.	she was sitting somewhere		
295.	and talking to the phone.		
296.	So, I told her...		
297.	She was talking to someone,		
298.	and that's fine.		
299.	She was talking.		
300.	And after that, [I asked her to]		
301.	please take care of that particular resident.		<p>Commented [3]: Level 1 Positionality = Agency and control (Lines 313 - 315): Lack of control because the caregiver did not follow instructions to complete an urgent task</p> <p>Commented [4]: Temporal dimension</p> <p>Commented [5]: Level 3 Positionality = Agency and control (Lines 304 - 320): As a Clinical Lead, Lilly knows she has the authority to ask a senior care staff member to complete a job-related task (toilet a resident). She is therefore justified in being "not happy" when her instructions are not followed. Lilly considered this a challenging conversation because the caregiver angrily challenged Lilly's authority, resulting in disagreement and misunderstanding.</p>
302.	And I went [back] after half an hour,		
303.	and she's still talking to the phone.		
304.	I was not happy with that.		
305.	When the conversation had already finished,		
306.	I asked her, "Why you are not toileting that resident?"		
307.	She got very angry.		
308.	She said, "I know what to do.		
309.	You don't need to tell what to do."		
310.	Then she went away.		
311.	That was one of the challenging conversation		
312.	I had with one of the care staff	<p>Commented [6]: (1) Level 1 Positionality = Sameness and difference (Line 317): We are the same (we are professional healthcare workers), but we are different (You don't understand the urgency. You're too busy with a non-urgent phone call.) (2) Level 1 Relationality = Other-positioning (Lines 319 - 320): An experienced caregiver who knows her job (3) Level 1 Relationality = Interactive positioning (Lines 319 - 320): The caregiver is positioning Lilly as demanding and unreasonable in not recognising her knowledge and experience. Note that Lilly rejects this positioning because the crux of her story is the caregiver apologising to Lilly (lines 328 - 329), which Lilly repeats in line 333.</p>	
313.	over the past week.		
314.	Yeah.		
315.	She toileted her,		
316.	and she came back to me.		
317.	And she said sorry		
318.	because she was not in a good mood.		
319.	Yeah.		
320.	And she done everything,		
321.	and after she came in		
322.	and told sorry to me.		<p>Commented [7]: (1) Level 1 Relationality = Other-positioning (Lines 326 - 329): Positioning caregiver as professional (following instructions from an RN manager) and reflexive (apologising with a reason) (2) Level 1 Consequentiality = Moral implications (Lines 328 - 329): Saying sorry for ill temper ("not in a good mood")</p>
323.	Yeah, and so had she managed to		
324.	take care of the resident		
325.	in an appropriate way		
326.	that you were satisfied with?		
327.	Like, the results...?		
328.	It took a long time.		
329.	It took nearly half an hour		
330.	to toilet the resident,		
331.	and it should have taken ten minutes.		
332.	So, I was not happy	<p>Commented [8]: (1) Level 1 Relationality = Other-positioning (Line 331): The caregiver is positioned as a thorough worker ("she done everything"), although we later find out that the task was not completed in a timely manner (see Lines 339 - 342). (2) Level 3 Consequentiality = Professional reflexivity (Lines 348 - 349): Lilly's reflection acknowledges the value in taking time to reflect ("later she realised") and apologising to a co-worker to maintain a professional relationship.</p>	
333.	because she was late.		
334.	She was on the phone.		
335.	So, she was angry.		
336.	That's not the way.		
337.	But later she realised		
338.	and she apologised.		
339.	Yeah, yeah.		
340.	And how did you feel when she apologised?		
341.	What were you...?		
342.	What were your reactions to that?		<p>Commented [9]: Level 2 co-construction of meaning between researcher and participant</p> <p>Commented [10]: (1) Level 2 Relationality = Other-positioning (Lines 340 - 342): Lilly is positioning the caregiver as careless and unprofessional in taking too much time in completing a short task.</p> <p>Commented [11]: Level 3 Relationality = Interactive positioning (Lines 343 - 349): In the healthcare context, RNs in management roles, like Lilly, are positioned as having the right to ensure care staff tasks are completed in a timely, ...</p> <p>Commented [12]: Level 2 elicitation and co-construction of meaning between researcher and participant</p>
343.	I feel...Initially I feel happy.		
344.	She was very angry.		

345. *but then I feel very happy*
 346. *because she came to me.*
 347. *She said sorry,*
 348. *so I feel very happy.*
 349. Yeah, yeah.
 350. So have you had any interactions
 351. with this caregiver since then?
 352. Yes, yes.
 353. *The same day, the caregiver came*
 354. *and she said sorry,*
 355. *and after we had some discussions.*
 356. *There was something she did right.*
 357. *She has a good attitude.*
 358. *Nothing more.*
 359. Nothing more
 360. Yeah, yeah.
 361. *It's just that moment.*
 362. Just that moment.
 363. And maybe she wasn't thinking.
 364. She was caught up with her phone call
 365. and just hadn't quite realised
 366. maybe the importance
 367. of what you were asking her to do.
 368. Yeah.

Commented [13]: Level 2 Positionality = Temporal constancy and change (Lines 339 - 359): Lilly positions herself as having an applied knowledge of caregiving tasks, explaining to Dana the usual timing for the task ("ten minutes") Lilly is at first "not happy" with the caregiver's tardiness. However, in the end, she positions herself as a gracious recipient of the caregiver's apology, which came after her toileting the resident and having time to reflect ("It took nearly half an hour to toilet the resident...But later she realised and she apologised.")

Commented [14]: (1) Level 2 Emotionality = Literal language (Lines 355 - 356, 359) : "She was very happy, but then I feel very happy" Note the emphasising adverb 'very' and the repetition of "I feel happy", indicating her satisfaction with the caregiver's (moral) in-person apology. (2) Level 2 Consequentiality = Moral implications (Lines 358 - 359): Lilly is showing that she appreciates a sincere, personable apology if someone is at fault. (3) Level 2 Consequentiality = Social-cognitive implication (Lines 357 - 359): Lilly is showing her expectation that a person will "come to her" to say sorry if they have made a mistake.

Commented [15]: (1) Level 1 Relationality = Other-positioning (Lines 366 - 368): The caregiver is positioned as being open to correction and having "a good attitude", so she is a professional. (2) Level 1 Relationality = Self-positioning (Line 369 + 372): Lilly indicates that she did not have any further discussion with the caregiver, and the correction was made "just that moment". Lilly is positioning herself to be an RN manager (Clinical Lead) who deals with a challenging situation when it happens so that errors are corrected and negative emotions are dealt with.

Commented [16]: Level 2 co-construction of meaning between researcher and participant

Appendix K

IQNs' advice for nursing managers and educators

1. Offering advice to management

- 1.1. Refrain from asking IQNs to do tasks that are outside their skill set. This puts them in an awkward, awful situation of not wanting to refuse as they may feel their work visa is on the line.
- 1.2. After giving correction to staff, adopt a team approach and observe staff performing the task so they take care and cooperate with management directives.
- 1.3. Ask RNs and healthcare staff for suggestions on quality improvement as they have valuable patient-focused ideas.
- 1.4. Ask senior RN colleagues for input in policy-making.
- 1.5. Avoid hiring managers who just want to work and not connect with or understand staff.
- 1.6. Be a supportive, people-focused manager. Your team will want to do well for you and achieve their KPIs, without compromising the site or colleagues.
- 1.7. Be available for communicating and working with staff on the floor.
- 1.8. Be available to support colleagues on the floor.
- 1.9. Be balanced in communication with staff—not too friendly, not too rough.
- 1.10. Be more supportive to IQNs. Remain open to IQNs' different ways of communicating and practising.
- 1.11. Be open to staff feedback and ideas for workplace collegiality and functionality, leading to improvement.
- 1.12. Be yourself—not a distant, high-above manager—and show you are proud to be part of the team with staff.
- 1.13. Bring in Māori protocols of sharing sessions in mental health contexts across DHBs to support patient and staff emotional wellbeing.
- 1.14. Understand that communication with team members is the centre of maintaining staff relationships.

- 1.15. Conduct fair interviews with all nursing staff and students—males or females, Kiwis or IQNs.
- 1.16. Consider having a monthly staff fun event to boost staff morale and reduce stress to prevent burnout.
- 1.17. Consider putting up motivational quotes on notice boards for staff to gain inspiration for work and personal life.
- 1.18. Create boundaries and rules for patients and family members when communicating with staff.
- 1.19. Develop two-way communication with staff for everyone's benefit, by understanding, making contact, and talking with staff.
- 1.20. Do not say anything during a staff resignation or performance management meeting as staff will either justify or correct your perception.
- 1.21. Employ managers and clinical leads with a range of leadership styles and attributes.
- 1.22. Encourage IQNs to be vocal of their feelings and know they will be helped and not condemned.
- 1.23. Encourage IQNs to change their mindset that it is disrespectful to question and challenge managers in a constructive way.
- 1.24. Encourage IQNs to use a time and work management software application (like Cortana) to book focus time for learning and rest breaks to prevent staff burnout.
- 1.25. Encourage teamwork and a team attitude to achieve success and manage crises and problems before they occur.
- 1.26. Ensure IQNs in a new management role have the opportunity for leadership mentoring and experiential learning from an experienced and supportive senior colleague.
- 1.27. Ensure RNs understand their responsibility to patient safety and not being slack in completing documentation to avoid surprises during auditing or family inquiry.
- 1.28. Explain the importance of sharing the workload to keep every team member safe and well.
- 1.29. Explain to staff that health and safety is to keep the team safe.

- 1.30. Express to RNs that registration is bound by legislation. Offer professional development to RNs who are putting self and patients at risk.
- 1.31. Follow up professionally and caringly with a colleague who responded negatively to being given a job.
- 1.32. Get out of the ivory tower and onto the coalface to find out what RNs do, and deal with, in their jobs.
- 1.33. Go out to the coalface and listen to what RNs have to say about their various roles so you can help them support patients and colleagues better.
- 1.34. Give IQNs written feedback so they have time to translate and process messages before responding to feedback.
- 1.35. Guide your team and be an example for them.
- 1.36. Have a colleague take notes at a staff performance management or resignation meeting to discuss the evidence and give the decision time it deserves as it is someone's livelihood.
- 1.37. Have an open-door policy and be supportive of staff.
- 1.38. Have staff use calendars to schedule work tasks.
- 1.39. Have two managers present—one talking, one taking notes—at staff performance management meetings so fewer hurtful words are said, resulting in less bullying, criticism, and mutual blame.
- 1.40. Help IQNs set professional goals.
- 1.41. Hire a team lead who is compassionate and empathetic.
- 1.42. Hire a team lead who understands and supports staff to perform well.
- 1.43. If a staff member confesses to having a bad day and treating a resident or patient badly, send them for counselling and give them time off work.
- 1.44. If training staff, employ a remote educator to train staff in person or make the most of training resources available.
- 1.45. If you are short staffed, call your own staff first as you know their abilities and the residents will be happier.
- 1.46. Invite IQN recruitment agencies and overseas-trained healthcare workers to liaise with DHBs and help upskill IQNs.

- 1.47. Recognise that IQNs can feel shy when their pronunciation is misunderstood. They may avoid speaking or saying some words that may not be understood.
- 1.48. Keep your team happy, and support team members rather than focusing solely on KPIs.
- 1.49. Know that many people have misconceptions about IQNs' intelligence and abilities because of language and cultural differences.
- 1.50. Know that some IQNs may be strong, autonomous practitioners who will give advice to doctors. However, other IQNs will find it difficult to question doctors' decisions if something is wrong.
- 1.51. Know that some people treat IQNs badly and think that IQNs who are developing their English skills are stupid, although many are highly educated.
- 1.52. Know your team and how to communicate with them in a multicultural environment.
- 1.53. Liaise with IQN recruitment agencies which understand IQNs' training and background.
- 1.54. Liaise with WorkSafe after an assault on a nurse. Provide support to show nurses they are valued.
- 1.55. Listen to IQNs' needs and views.
- 1.56. Listen to nurses and nurse educators, and allow their input about organisational changes so they can feel valued.
- 1.57. Listen to your staff, and be extra supportive as they work hard.
- 1.58. Maintain privacy, calmness, and comfort for staff members if providing counsel.
- 1.59. Make IQNs or international nursing students comfortable. Give them the opportunity to open up, by not restricting, disrespecting, or scaring them. This will help migrants to flourish in the country they choose to live in.
- 1.60. Make sure a colleague is supported in performing a task again after having received counsel to give them confidence.
- 1.61. Prepare New Zealand healthcare staff for the arrival of IQNs from different countries.

- 1.62. Provide a three-month orientation time, support, resources, and educational resources for IQNs.
- 1.63. Refrain from asking IQNs to do tasks that are outside their skill set. This is because IQNs may be put in an awkward position of not wanting to refuse as they may feel their work visa is on the line.
- 1.64. Seek, and respond constructively and positively to, staff feedback.
- 1.65. Show appreciation to staff for their feedback and suggestions for improvements to workplace communications that help staff understand their job better.
- 1.66. Show gratitude to staff if they help the team beyond expectations.
- 1.67. Show support to IQNs when they make a mistake to encourage them to take ownership of mistakes and learn from them.
- 1.68. Support IQNs' professional development.
- 1.69. Take health and safety issues seriously when assigning workload to nurses. IQNs may not have time to take rest, meal, or toilet breaks, which negatively impacts nurses' health and wellbeing.
- 1.70. Understand that IQNs may be sensitive and shy to speak out and be heard.
- 1.71. When assigning caseloads, look down on the situation objectively and see that if a nurse is overly laden with work, it is unsafe for patients and staff.
- 1.72. When providing correction, support colleagues to maintain confidence in doing the task.
- 1.73. When training staff, if there is a behavioural issue, give the RN space and come back to the training later.
- 1.74. Write clear, concise instructions in plain English.
- 1.75. You have to juggle personal opinion, evidence, and empathy in managing and responding to staff issues.
- 1.76. Your staff need to know you are human too and not sitting up on top of a high rock, barking down at staff.

2. Offering advice to nursing educators and CAP providers

- 2.1. Advise IQNs on the nursing responsibilities, open communication, and teamwork required in the placement.

- 2.2. Advise IQNs that their preceptor nurse on placement is there to support and guide them. They should feel confident to ask questions and say no if not feeling comfortable in a nursing situation.
- 2.3. Be encouraging, positive, and patient when giving feedback to trainees.
- 2.4. Encourage IQNs to treat people how they would want to be treated.
- 2.5. Give CAP participants the opportunity to spend time and have induction with a healthcare manager who is also an IQN.
- 2.6. Help IQNs see the value in respecting *tangata whenua* (Māori people) and following Treaty principles.
- 2.7. Provide a glossary of Kiwi idioms, slang words, and colloquialisms.
- 2.8. Provide more time for IQNs to have mentoring and training before they start work.
- 2.9. Remind IQNs of the importance of treating everybody the same and not discriminating between ethnicities or cultural backgrounds.
- 2.10. Teach IQNs about the importance of *karakia* and making connections with others to bridge cultural gaps.
- 2.11. Tell trainees the truth directly but without offending them.
- 2.12. You cannot control the reactions of nurse trainees. Even if you are frustrated or angry, step back and show patience and understanding to all trainees.
- 2.13. Trust the Nursing Council's support of IQNs' credentials as they [the Council] have examined IQNs' qualifications from home country.
- 2.14. Identify the learning needs of trainees. Ask them the nature and length of verbal or written feedback they best learn from.
- 2.15. Use questioning techniques to check IQNs' learning and understanding and stimulate critical thinking.
- 2.16. Speak slowly and enunciate words because accents can be hard for IQNs to pick up.
- 2.17. Tailor written feedback to IQNs' need for lengthy advice with examples as a learning opportunity.
- 2.18. Use plain English, and avoid using idioms and colloquialisms that IQNs may not understand.

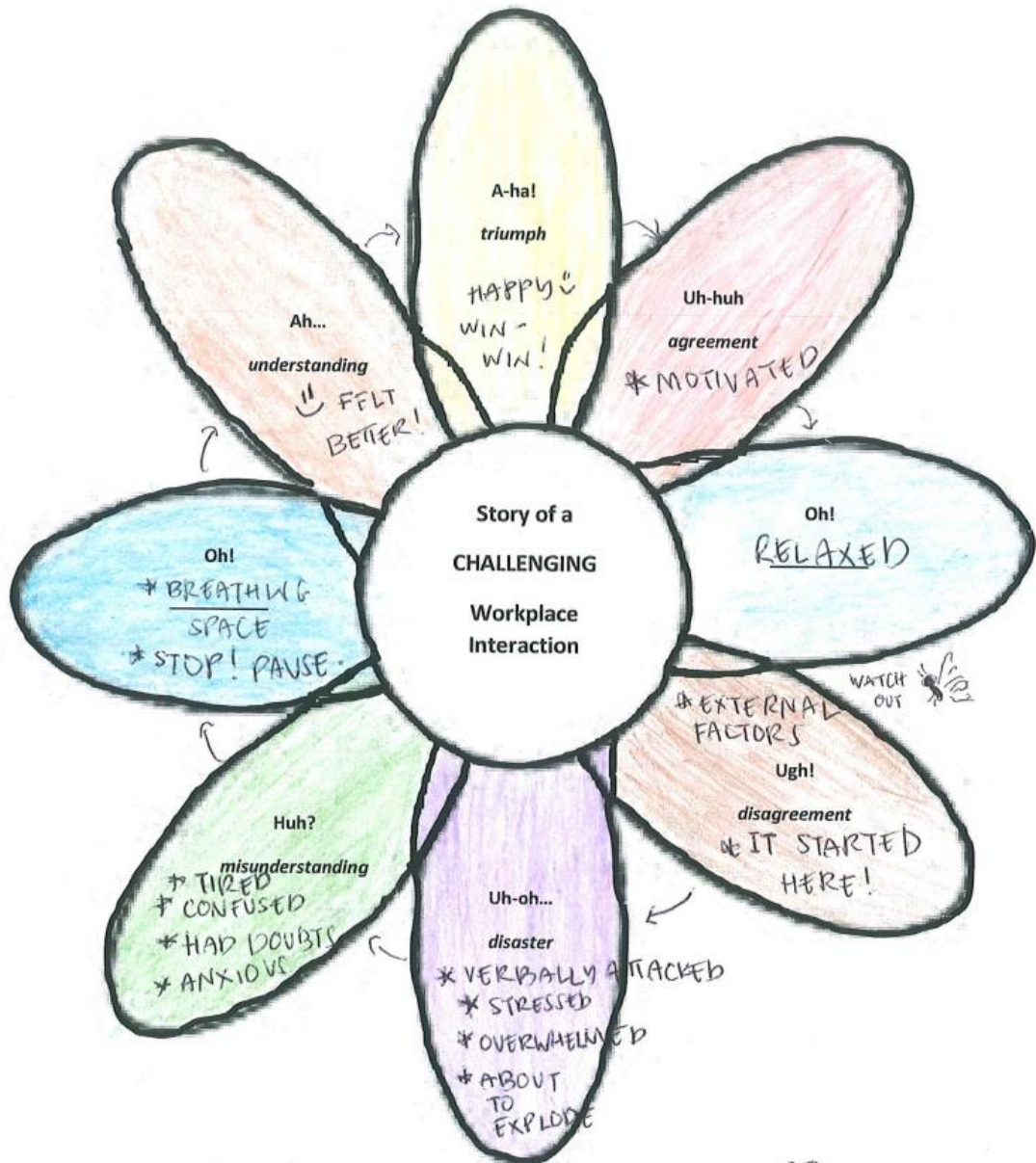
3. Reflecting upon health and safety issues in New Zealand workplaces

- 3.1. It is a health and safety risk in in-patient contexts for nurses to miss their breaks or not drink or eat enough all shift. Ensure rest and meal breaks are scheduled and taken by IQNs to uphold their physical and mental wellbeing.
- 3.2. Recognise the importance of keeping team members safe and sharing teamwork to manage staffing issues. This is to provide support to workers and uphold health and safety.
- 3.3. Uphold the continuing professional learning of nursing skills and healthcare workplace regulations, like the Health and Safety in the Workplace Act 2015 and the Privacy Act 2020.
- 3.4. Support IQNs in escalating concerns about medication administration errors to management as a professional learning opportunity for all team members.
- 3.5. Give correction to a staff member who has made a medication error because it is a significant patient risk if the wrong medicine, or too much medication, is given.
- 3.6. Being expected as nurses to work with people who may not want to have a COVID-19 vaccination, or who may have been infected with COVID-19 and do not want to be tested, is a health and safety issue.
- 3.7. IQNs should not feel pressured to complete a task if it might compromise patient care. Preventing patient harm or medication administration errors is crucial in healthcare settings.
- 3.8. Encourage IQNs to ‘stand up for themselves’ if they do not possess the skills and expertise to complete a task. If a nurse does something wrong, they risk patient safety. They could also lose their nursing registration and professional reputation.
- 3.9. IQN managers need to maintain a balance between being friendly and serious to ensure staff follow instructions to uphold health and safety.
- 3.10. IQNs’ induction should comprise sufficient training and orientation to help IQNs understand clinical and cultural practices in New Zealand.
- 3.11. IQNs should take a self-directed approach to their professional development. This can be through observing, practising, assisting, and learning their own and others’ clinical practice.

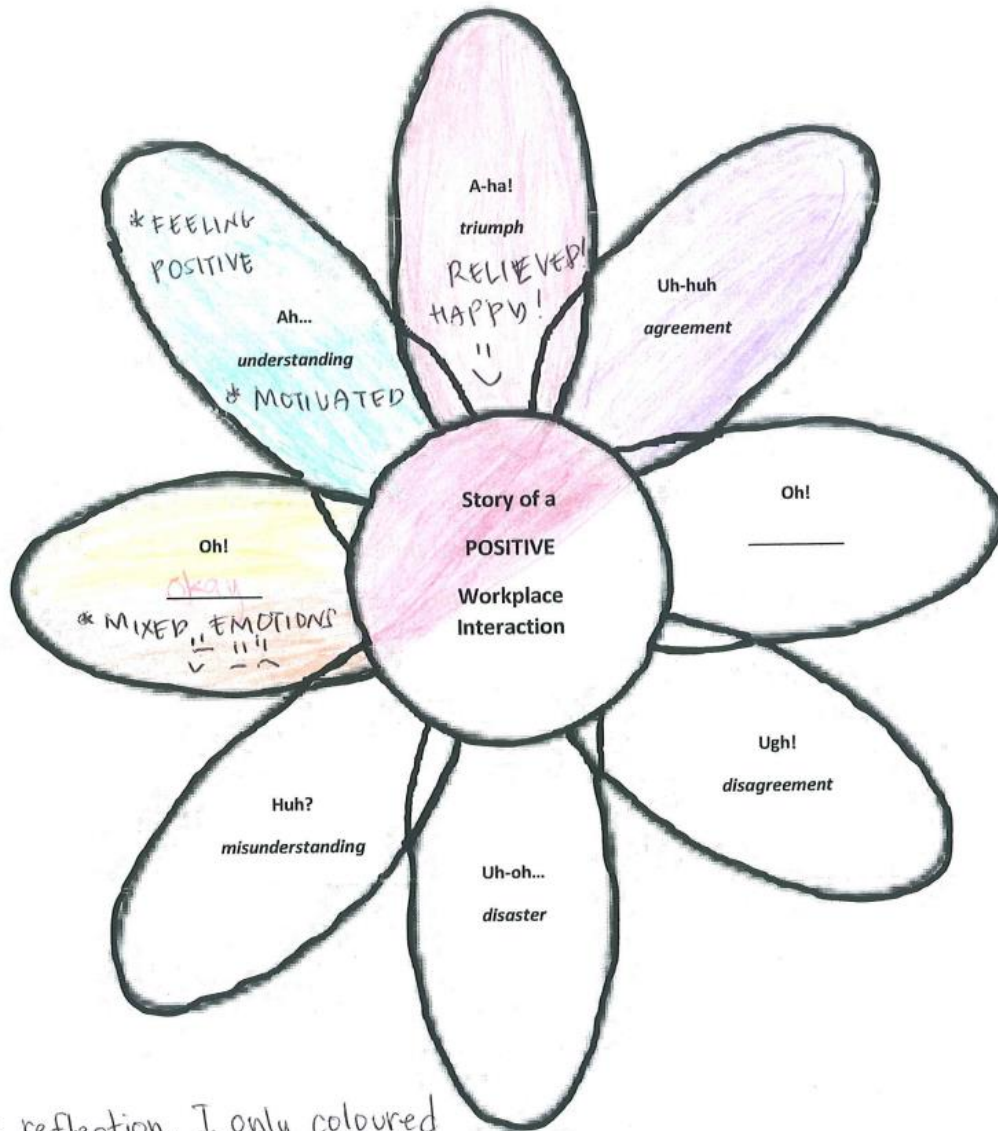
Appendix L

Jessie's Flower Diagram

Story-Led Conversation 1, 10 February 2021



Upon reflection, I realised that my story is like a flower. The petals (my feelings, thoughts, and behaviour) are interconnected. They make up the core of my challenging workplace story. 😊



In this reflection, I only coloured 4 petals as listening to and understanding the other person, ~~and~~ then coming up with a plan/agreement on how to address difficulties (can) lead to success! ☺ yehey!