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Internationally qualified nurses' perceptions of the competencies that pertain to patient safety

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ABSTRACT

Internationally qualified nurses represent 25% of the New Zealand nursing workforce, similar to Australia, Canada, the US and UK. The transition from vastly different health systems can have implications for patient safety. Through understanding the perspectives of internationally qualified nurses, educational and healthcare agencies may be better able to support this transition. This study investigated internationally qualified nurses' perceptions of the competencies that pertain to patient safety. These were analysed alongside the Nursing Council of New Zealand (NCNZ) competencies designed to define and measure competence for patient safety. Qualitative case studies of four internationally qualified nurses were discussed using Communities of Practice theory as the conceptual framework. The primary data sources were two semi-structured interviews with each of the internationally qualified nurses during a Competency Assessment Programme to obtain New Zealand nursing registration. Competency Assessment programme documents also provided data. Thematic analysis of the individual cases followed by cross-case analysis revealed that the social, cultural, and historical context of the health system and nursing role mediates how maintaining patient safety is perceived and enacted in practice. Recommendations from the findings of this study are important for ongoing internationally qualified nurses' transition support.

1. Introduction

Nurse migration is an international phenomenon driven by multiple and complex reasons. In New Zealand (NZ), Australia, Canada, United States, and the United Kingdom, expanding and aging populations, coupled with nursing shortages, have contributed to an increase in recruitment of internationally qualified nurses (Habermann and Stagge, 2010). For many nurses migrating to these countries, English is an additional language and the social, cultural, and historical context of the health system differs significantly from their country of origin. The challenges of transition for these internationally qualified nurses are highlighted in literature (Adeniran et al., 2009; Stankiewicz and O'Connor, 2014; Njie-Mokonya and Josephine, 2014) and, despite many of these nurses' extensive nursing experience (Peisachovich, 2015), there are implications for patient safety (Xu and He, 2012). Yet research in this field is limited (Lum et al., 2011; Woodbridge and Bland, 2010). This research explores internationally qualified nurses' perceptions of the competencies that pertain to this core nursing concept, using Communities of Practice theory as the conceptual framework.

2. Background

2.1. The NZ context

Internationally qualified nurses represent 25% of the NZ nursing workforce (NCNZ, 2017). Registration in NZ is regulated by the Nursing Council of New Zealand (NCNZ). If NCNZ requirements are met an internationally qualified nurse can apply to complete a Competency Assessment Programme in order to demonstrate their ability to meet competencies for registration in NZ. There are currently 20 NCNZ approved Competency Assessment Programmes in NZ (NCNZ, 2017). After successful completion of a Competency Assessment Programme, internationally qualified nurses are entered on the NZ register of nurses and work within the NZ health system. The internationally qualified nurse's transition begins with these initial stages and is an ongoing process that requires understanding and support from the educational and healthcare sectors.

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2.2. Internationally qualified nurses

Current research on internationally qualified nurses' transition focuses on ensuring that processes and programmes can provide adequate training and support to ensure patient safety (Peisachovich, 2015). Effective communication is a key factor in patient safety (Xu and He, 2012). Communication has been identified as one of the primary challenges facing internationally qualified nurses by employers, regulators, and the nurses themselves (Adeniran et al., 2009; Shen et al., 2012).

Communication is embedded in culture and context (Arasaratnam, 2012; Xu et al., 2010). An American study investigated the non-verbal communication behaviours of 52 internationally qualified nurses using videotaped scenarios with standardised patients. Findings indicated that patients' non-verbal and intuitive cues potentially conflicted with internationally qualified nurses' own cultural practices, with implications for patient safety (Xu et al., 2010).

Peisachovich (2015) also used videotaped simulated clinical activities in a study in Canada with a purposive sample of four internationally qualified nurses enrolled in a university bridging programme. The videos were followed by stimulated recall and focus groups. This study investigated the participants' understanding of clinical judgement to support applications in practice. During the course of this study, the nurses gained added insight into the way their culture influenced their perception and interpretation of information in the clinical setting, and realised how this could impact patient safety (Peisachovich, 2015). The findings supported the need for more research in the area of internationally qualified nurses' perceptions and understanding of the culture of nursing in different countries.

Research also highlights the perception of internationally qualified nurses' lack of preparedness for practice in their new countries (Allan, 2010; Stankiewicz and O'Connor, 2014; Woodbridge and Bland, 2010). In a qualitative study, internationally qualified nurse participants transitioning to practice in Canada believed the orientation and professional development opportunities offered to them were inadequate (Njie-mökonya and Josephine, 2014). The participants acknowledged that they needed a period of two to three years of transition to be working effectively in Canada. This perception of the orientation and transition process was supported by the data from Taiwanese internationally qualified nurses (Ho, 2015). Research with 31 Filipino internationally qualified nurses in America highlighted the need for orientation programmes designed specifically for internationally qualified nurses, emphasising the importance of seeking internationally qualified nurses' feedback on these orientations (Lin, 2014).

The need for specific preceptor training is vital to the success of the transition process (Allan, 2010). Allan investigated the preceptoring experiences of 93 internationally qualified nurses in the United Kingdom. Interviews revealed discrimination and bullying towards the participants and a lack of understanding of their learning needs. Similarly, Okougha and Tilki (2010) from their qualitative study of Filipino and Ghanaian internationally qualified nurses in Britain recommended that the emphasis placed on the internationally qualified nurses' understanding of their new culture in the transition process must be reciprocated by a workplace emphasis and understanding of internationally qualified nurses' culture to provide better support for the transition process. This implies that not only do transition programmes play a role in preparing internationally qualified nurses for practice but that the institutions that employ them have responsibilities to acknowledge the challenges of transition and work towards supporting it (Stankiewicz and O'Connor, 2014; Woodbridge and Bland, 2010).

Internationally qualified nurse transition was described as a process of reshaping and enlarging previous learning, that was more likely to occur within social practices that support transition (Van Kleef and Werquin, 2012). These researchers used Communities of Practice theory to investigate the Canadian internationally qualified nurses Prior Learning Assessment and Recognition (PLAR) process. The PLAR

process equates prior learning and credentials with the standards required in Canada for fitness to practice. The researchers concluded that nurses who were educated outside of Canada stood on the periphery of the nursing community without a voice despite being key stakeholders in the transition process. These findings suggest that the nursing community can support transition by hearing and understanding internationally qualified nurses to create processes more supportive of and conducive to internationally qualified nurse transition (Van Kleef and Werquin, 2012).

2.3. Communities of Practice theory

Communities of Practice (CoP) theory was introduced by Jean Lave and Etienne Wenger (1991). This section summarises the theory and justifies its use for this study. The theory recognises that learning is a social process, arising out of a cultural and historical context located in the dual relationship of a person and their social world (Farnsworth et al., 2016). A CoP is a group formally or informally convened for a common purpose, with the characteristics of mutual engagement, joint enterprise, and shared repertoire (Wenger, 1998). Mutual engagement reflects the relationships of the community that produce a sense of giving and receiving, and the building of trust. Joint enterprise refers to the process of working together to fulfil the objectives of a particular community. Shared repertoire incorporates the routines, tools, language and artefacts associated with this community. The combination of these three characteristics create an environment where learning occurs (Wenger, 2000). This is particularly relevant when considering situated learning within a profession.

According to CoP theory, individual CoPs define competence within their area of practice and boundaries that determine who may participate (Farnsworth et al., 2016). In this study, the participants were internationally qualified nurses seeking to enter the NZ workforce through a nursing regulatory body (who define competence for nursing in NZ) with the goal of acquiring NZ nursing registration.

CoP use in healthcare is relatively recent, emerging in the literature in the late 1990s-early 2000s (Woods et al., 2016) as a useful approach to develop and research optimal learning environments for healthcare students and newly qualified nurses (Li et al., 2009). Using CoP theory, studies have found that the relationships of students and novice practitioners with both staff (in particular, preceptors), their tutors and their peers in the clinical environment had an enhancing or inhibitory effect on learning (Arkan et al., 2018; Lee et al., 2018; Sayer, 2014).

The CoP situated learning perspective also considers active participation and reflective practice as vital ingredients for learning. These were evident in clinical placements for students where active participation in patient care was encouraged (Ailey et al., 2015; Berry, 2011; Grealish and Ranse, 2009) and when preceptors provided students with feedback (Davis, 2006; Portoghese et al., 2014; Ranse and Grealish, 2007).

Finally, using CoP as a model to support online professional learning environments has been investigated in healthcare literature (Woods et al., 2016). Findings included validation of practice and knowledge sharing as effective in an online CoP of health professionals in Singapore (Hara and Hew, 2007) and community nurses in Canada (Valaitis et al., 2011).

3. The study

3.1. Aim

The purpose of this study was to investigate internationally qualified nurses' perceptions of the competencies that pertain to patient safety. This investigation happened at two points during a Competency assessment programme: Prior to exposure to the NCNZ competencies in the theoretical and clinical component of a Competency Assessment Programme and after completion. By taking these two data points, it

was possible to see evolving perceptions of safety. Exploring these perceptions helps inform educational and healthcare sector support for internationally qualified nurses undergoing the transition process.

3.2. Primary research question

How do internationally qualified nurses report their perceptions of nursing competencies that relate to patient safety?

Sub questions.

- How do internationally qualified nurses report perceptions of competencies that pertain to patient safety at the beginning of a Competency Assessment Programme?
- How do internationally qualified nurses report perceptions that pertain to patient safety at the end of a Competency Assessment Programme?
- How are these competencies articulated in documents relating to the Competency Assessment Programme?

3.3. Design

This research used a qualitative multiple case study design (Merriam, 2009; Yin, 2014), with four internationally qualified nurses, each as a case. The study took place within the defined context (Creswell et al., 2007) of a Competency Assessment Programme in New Zealand. Wenger (1998) CoP theory was chosen as the theoretical framework as CoP is a social learning theory that locates the experience of learning between an individual and their social world (Farnsworth et al., 2016). Thus, it provided a stance for this study (Merriam, 2009) that was investigating aspects of the challenges of new learning and transition for internationally qualified nurses in the New Zealand nursing context.

3.4. Participants

Participants were selected using purposive sampling. The inclusion criteria were: English as an additional language, living in NZ five years or less and enrolled as a student in the Competency Assessment Programme used for this study. This course comprised a two-week theoretical component followed by a five week clinical placement. There were 18 enrolled students who were emailed with an outline of the proposed study one week before they commenced. An outline of the study was also presented in class on the first day. Further written information and consent forms were left with the students along with contact details for the researcher.

Thirteen members of this class met the recruitment criteria and, of this group, four volunteered as participants for this study. The participants were all from the Philippines, two male and two female, aged from 26 to 39 years. Their nursing experience prior to coming to New Zealand ranged from two to fourteen years, in areas such as acute care, operating theatres, critical care, and intensive care units.

3.5. Data collection

Data sources were two semi-structured interviews with each participant, participant email reflections, and Competency Assessment Programme documents. Interviews were audio recorded and transcribed. The email reflection from the participants at the end of their first and last week of clinical placement briefly outlined the challenges and successes during this period. The Competency Assessment Programme documents were examined to gain insight into how the competencies pertaining to patient safety were evident in course documentation.

3.6. Ethical considerations

Ethical practice in research guided by policies, guidelines, and codes

relies heavily on the individual researcher's own ethical values (Merriam, 2009). As a nursing educator The NCNZ code of conduct and ethical behaviour (www.nursingcouncil.org.nz/nurses/Code-of-Conduct) were applied to this research. Ethical approval was gained from the university overseeing this research and the Ethics and Research Committee at the educational institution where the internationally qualified nurses were enrolled in the Competency Assessment Programme. Participants gave written informed consent. All information was kept confidential.

3.7. Analysis

Inductive analysis was used. The data were coded from each of the four cases using NVivo 11 and then organised into themes in an iterative process. The themes were analysed across the cases in order to aggregate and compare the findings (Yin, 2014), looking for competencies and descriptions pertaining to patient safety, and links to NCNZ requirements.

3.8. Rigour

Trustworthiness in research results is particularly important in applied professions such as nursing because of the close involvement in people's lives. It demands a rigorous process (Merriam, 2009). The researcher's nursing experience as a nurse educator in the institution where the Competency Assessment Programme was offered, although useful for understanding context, was also a potential cause of bias. To mitigate this, a reflexive research journal was kept, acting also as an audit trail, containing thought processes and the research process itself (Yin, 2014). In addition, data analysis and interpretation of findings were regularly checked with the researcher's supervisor (not a nurse), and with a nursing advisor for this research project. As a form of member checking, the transcripts and emerging findings were shared with the participants for verification of accuracy on two occasions after the data collection.

4. Findings

The findings present, firstly, a brief summary of the themes that emerged from participants' interviews and email reflections, giving the context of the participants' backgrounds and experiences during the Competency Assessment Programme. This is followed by a summary of the participants' perceptions of the competencies pertaining to patient safety at the beginning and end of the course, specifically addressing the research question and, finally, an analysis of the Competency Assessment Programme documents.

4.1. Participant data summary

4.1.1. Participant demographics and professional background

The four participants were all from the Philippines but there was diversity of age, gender, lifestyle and professional experience. Participant 1 was 39, female and had 12 years nursing experience in critical care and intensive care. Participant 2 was 26, male and had two years working in operating theatres. Participant 3 was 32, female with nearly three years nursing experience in operating theatres and briefly in a surgical ward. Participant 4 was 30, male and had four years working in paediatrics and adult ward settings. Participant 1, 3 and 4 had all worked in New Zealand in aged care as health care assistants and had lived in NZ ranging from two to four years. Participant 2 had been in NZ one month prior to the Competency Assessment Programme. Their perceptions of nursing in the Philippines highlighted limited financial resources in the healthcare sector and a hierarchical structure where power relationships were evident. They felt nursing was seen near the bottom of the hierarchy:

“I’m just like a plankton compared to a doctor.” (Participant 2)

“If you don’t have any other choices, you can be a nurse yeah because even the financial reward of it is almost the lowest.” (Participant 1)

A perception of fear and blame in their previous nursing roles was prominent in the data:

“I’m afraid of being told off.” (Participant 3)

“If there’s something wrong they’re going to suspend you.” (Participant 4)

“Even the patient won’t complain.” (Participant 4)

4.1.2. Participants perspectives concerning their clinical placement in the CAP course

The participants highlighted a feeling of welcome and acceptance in the clinical environment as well as a teamwork approach to patient centred care:

“It was a blast ... you’re part of the team it’s all about the patient.” (Participant 2)

“I love how they work as a team.” (Participant 3)

The complexity of the role of the nurse in New Zealand was evident to them after clinical placements and, although they relished enjoying the experience and learning a great deal, they also realised that moving forward there was a lot for them to learn:

“It’s hard because the multitasking that the nurses are doing here, it’s overwhelming, you find that it’s too stressful.” (Participant 1)

“I have very big changes to do.” (Participant 3)

4.2. Internationally qualified nurses’ perceptions of patient safety

To answer the primary research question, the participants were asked to reflect on their perceptions of competencies pertaining to patient safety in their countries of origin, and their expectations of these in New Zealand. In appreciation that the concept of ‘competencies’ used in the regulation language of nursing practice in NZ may differ from that in the participants’ country of origin, they were asked to describe what sort of values, attributes and skills they attributed to safe nursing practice. They were also asked to recall specific situations where they had to intervene to ensure patient safety.

4.2.1. Perceptions of the competencies that pertain to safety at the beginning of the competency assessment programme

The participants all reported that patient safety was the first priority and focus for them when caring for patients:

“Safety is number one priority. At the moment the client or patient comes to your care you always look out for safety first ... so before you, when you try to meet the patient in the room you try to make sure the environment is safe.” (Participant 1)

“The number one thing is that no matter what you do you always have to think about the patient safety because we come to nursing to save lives, not to make more harm everything you do you already have a rationale for that action.” (Participant 2)

“The environment, you just have to check the environment for the patient safety, just assess the patient, what he needs.” (Participant 3)

“Patient safety would be our focus, always on our patient, like for example someone who has some stroke or dementia, maybe when you see them when they’re walking sometimes they walk with the table so it’s really unsafe for them so I always prioritise the patient instead of waiting for them to fall to stop what they’re doing. I always focus on my patient and also giving them health teaching that will prevent them from further,

maybe they could catch some disease in the future” (Participant 4)

Regarding the competencies that are required to maintain patient safety, three out of four participants’ responses focused mainly on creating and maintaining a safe environment for patients. However, in the participants’ descriptions of situations where they had to act to ensure patient safety, a measure of critical thinking and problem solving was evident.

4.2.2. Perceptions of the competencies that patient to safety at the end of the competency assessment programme

After exposure to the NCNZ competencies through the course, participants reported that overall their perceptions concerning the competencies required for patient safety were the same:

“Patient safety, somehow it’s still the same.” (Participant 1)

“It will always be the priority.” (Participant 2)

Significantly more insight was gained concerning these perceptions when asking the internationally qualified nurses to describe nursing practice experiences in the NZ setting:

“NZ nurses ... they’re using critical thinking ... they don’t just work following tasks On the registered nurse level, you can see the leadership on that, they are the ones taking charge so it’s good to see they’re the ones handling all the management issues ... they are very proactive and the scope is really very wide” (Participant 1)

“So the difference there is when I came there, Oh ok you’re part of the team and they are very welcoming You will be able to discuss the cases for the day so that’s very comforting It’s really cool here in NZ because in the Philippines it’s like the patient and you here it’s like a cobweb and the patient must connect together, it’s all going to the middle to the patient.” (Participant 2)

The NCNZ competencies for nurses comprise of four domains of practice with sub-sets of competencies that as a whole represent competence and therefore safe nursing practice (NCNZ, 2016). Attributes such as teamwork, interprofessional communication and collaboration, a partnership relationship with patients, assertiveness, patient advocacy, leadership, accountability and reflection are represented in the NZ nursing competencies (NCNZ, 2016).

As evident in the data, the participants reported observing some of these attributes in action while on clinical placement. However, when the participants were asked in the second interview if their perceptions of the competencies required for patient safety had changed after their exposure to NZ nursing practice, overall they had not. This suggested that although the participants did notice these attributes as part of the nursing role in NZ, they did not appear to view these competencies as relating to, or linked to, patient safety.

4.3. Competency assessment programme documents

Analysis of three Competency assessment programme documents contributed data: the course timetable outlining content covered in the two theory-based weeks, the Course Outline, and a lesson plan for one day back on campus, half-way through the five-week clinical placement. The programme documents all specifically linked every session to NCNZ competencies, making it explicit for students how programme content informed clinical practice. Combined, the course documents covered all relevant competencies required by the NCNZ to demonstrate safe nursing practice.

5. Discussion

Using CoP theory provides a useful framework to synthesise, summarise and discuss the main themes that emerged across the four cases and Competency Assessment Programme document analysis as

participants' transition was embedded in a socio-professional experience.

5.1. Participant context

The participants described a hierarchical healthcare system in the Philippines with explicit power relationships among staff members. Descriptions of encounters with doctors, senior nurses and managers reflected these power relationships which negatively impacted on the nurses as a consequence. The first and perhaps the most prominent was a culture of fear of disagreeing with authority figures, similar to that of the Filipino nurses in Lin (2014).

This hierarchical structure also limited the opportunities for internationally qualified nurses to develop critical thinking or problem-solving skills, with nursing training focused on learning tasks and nursing roles that have limited scope for autonomous practice. Filipino and Chinese internationally qualified nurses in Lin (2014) and Van Kleef and Werquin (2012) reported that independent decision making was not considered part of the nursing role by these participants in their respective countries. Despite these perceptions, this study's participants' narratives concerning their own patient care experiences in the Philippines did reflect levels of critical thinking and problem solving.

In addition, the findings indicated that the hierarchical structure limited patients' power in their country of origin. This also aligned with Lin (2014) who recounted that Filipino nurses were not being taught or encouraged to consider or advocate for patients' rights and found it difficult to adjust as an internationally qualified nurse in a system where patients had the right to make choices concerning their treatment options.

5.2. Internationally qualified nurses' exposure to the NCNZ competencies

During the five-week clinical placement, the Competency Assessment Programme focused on the nurses understanding, applying and meeting the requirements of the NCNZ competencies. The participants' narratives reflected this and are discussed below using the CoP concepts of mutual engagement, joint enterprise and shared repertoire.

5.2.1. Mutual engagement

The two participants who undertook their clinical placement in operating theatres saw clear differences in the nurse's role and responsibilities from their previous nursing experiences. Both participants reported they appreciated an environment where the multidisciplinary team worked together for the benefit of the patient. The participants felt accepted and had a voice that was encouraged to be expressed and respected. One participant expressed a sense of belonging and inclusiveness that encouraged learning and adaptation to the new environment. Literature on interaction in a CoP highlights acceptance, respect, and participation of the learner in practice as conducive to and enhancing learning (Lee et al., 2018; Hägg-Martinell et al., 2015; Thrysoe et al., 2012). However, participants from the aged care setting did not clearly reflect experiences in relation to mutual engagement.

5.2.2. Joint enterprise

The two participants in theatre relayed how they noticed nurses in New Zealand were focused on the patient and catering to their needs in a holistic fashion. They recognised the value of consistent communication with patients. This was consistent with the findings from Peisachovich (2015) Canadian study where internationally qualified nurses in Canada saw a different approach to patient care through a process of interaction and discussion with staff and patients in the clinical environment. One more experienced participant in this New Zealand study (in aged care), identified that leadership was expected from nurses at all levels in NZ practice. She saw how the role of the nurse in NZ was autonomous and multifaceted, a similar view to the internationally qualified nurses in Lin (2014).

5.2.3. Shared repertoire

The findings from the document analysis provide evidence of the shared repertoire of nursing in NZ. The Competency Assessment Programme information documents clearly and repeatedly directed the students to the tools that define nursing competence in NZ. Despite this, it was only when these were explained and modelled in the clinical environment that one participant reported starting to make the links to nursing practice. Internationally qualified nurses in Peisachovich (2015) likewise reported they did not transfer the information taught in the classroom until they saw it in practice.

The findings from one participant reflected the effect of the three characteristics of a CoP, mutual engagement, joint enterprise and shared repertoire, combining to enhance learning and transition. The participant's relationship with their preceptor was significant and was described as making the internationally qualified nurse feel accepted, valued and respected. Furthermore, this preceptor was able to discuss and role model the NCNZ competencies as enacted in practice, crucial for safe nursing practice in the NZ context. This highlights the importance and effectiveness of preceptors articulating and emulating practice as it is expected in a CoP (Allan, 2010; Sayer, 2014; Thrysoe et al., 2012). The need for well trained and supported preceptors is recognised in other studies (Allan, 2010; Njie-Mokonya and Josephine, 2014; Riden et al., 2014).

5.3. The challenge of transition

The four participants expressed the challenge of transition after their clinical placements. Other studies (Ho, 2015; Lin, 2014; Njie-Mokonya and Josephine, 2014) suggest that internationally qualified nurses believed they needed a period of one to three years for transition, with understanding and support during the process (Okougha and Tilki, 2010).

Van Kleef and Werquin (2012) combined CoP with Beach (2003) consequential transition theory as an additional way to gain insight into the challenges of the transition process. This situated perspective posits that learning occurs and is consequential when the learner is engaged in the process and consciously reflects upon the situation. This results in changes in the learners' perspectives of themselves and their social positioning (Beach, 2003). The value of reflection is clearly articulated in the NCNZ competencies (NCNZ, 2016), and a vital part of Tanner's (2006) clinical judgement model for nurses. The model is based on the premise that a nurses' sociocultural context influences their process of clinical judgement and that a constant reflective process is a vital component for developing clinical judgement and safe nursing practice (Nielsen et al., 2007). Literature on the enhancement of student learning in the clinical environment also highlighted the value of reflection (Davis, 2006; Ransie and Grealish, 2007; Hägg-Martinell et al., 2015; Portoghesi et al., 2014).

6. Limitations

Although this was a small study of four internationally qualified nurses of the same nationality, over a period of seven weeks, this snapshot of practice and perceptions was enriched by document analysis and the use of CoP.

7. Conclusion

Previous studies have explored some challenges involved with internationally qualified nurse transition and the implications for patient safety. Exploring internationally qualified nurses' perceptions concerning patient safety in the New Zealand context provides a unique perspective when considered alongside a Competency Assessment Programme.

The most significant finding of this study was that the social, cultural, and historical context of the health system and nursing role (that

is, the competencies required for safe nursing practice) mediates how maintaining patient safety will be perceived and enacted in practice. These findings suggest that given that internationally qualified nurses are transitioning from roles in a very different context, making sense of and applying the competencies that relate to patient safety in New Zealand is a challenging task and can therefore have implications for patient safety. This also highlights the importance of engaging with participant perspectives in order to identify specific areas required for learning.

8. Recommendations

Findings suggest that the link between the four domains of practice as a whole outlined in NCNZ competencies and their relationship to patient safety could be made more explicit, for internationally qualified nurses undergoing a formal transition process, particularly in the clinical setting. There are also implications for supported ongoing professional development by healthcare agencies for internationally qualified nurses after completing a Competency Assessment Programme, including targeted education and support for preceptors. Facilitated online forums, using reflective frameworks for a determined period of time after a Competency Assessment Programme, are also recommended to continue to induct the nurses into an ongoing professional community of practice. This may work well as an academic-clinical collaboration to further support internationally qualified nurses' transitions.

Further research into the impact of changing roles and power relationships during internationally qualified nurses' transitions could produce understanding and applications for Competency Assessment Programmes. Research on preceptor training may enhance the effectiveness in supporting the transitions, both in initial stages and for ongoing professional development once employed as a New Zealand registered nurse.

Conflicts of interest

None.

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