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Overseas qualified nurses' communication with other nurses and health professionals: An Australian observational study

ABSTRACT

Aims and objectives: To understand the interprofessional and intraprofessional communication patterns of overseas qualified nurses as they coordinate care for patients in Australian hospitals.

Background:

Numerous studies have informed the transitioning experiences of overseas qualified nurses with non-English speaking backgrounds working in English speaking workplaces. Only a few observational studies have involved examining the intercultural communication experiences of overseas qualified nurses and none have considered their intra and interprofessional communication patterns.

Design: A qualitative design was adopted, using participant observation and discourse analysis.

Methods:

This study was from Jan 2017 to March 2017. Thirteen overseas qualified nurses working in acute, sub-acute and interventional cardiology settings in a Melbourne metropolitan hospital

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were shadowed over a period of 12 weeks in order to collect data that inform their communication patterns. The COREQ checklist was used.

Results:

This observational study informed by genre analysis revealed that intra and interprofessional communication occurred more commonly under the clinical communication goals of coordinating care and less commonly under facilitating interventions. Communication strategies ranged from structured interactions with use of communication tools to unstructured ad hoc interactions. Analysis of the discourse patterns demonstrated that effectiveness of interactions was affected by hesitancy, lack of assertion and few strategies to manage inadequate or aggressive communication by other team members. Poor clinical communication with peers was not always caused by the nurses from non English speaking backgrounds. Positive, interpersonal interactions with laughter, language-switching, and small talk were evident in interactions with nurses from similar cultural backgrounds but were rare with local colleagues.

Conclusion:

The linguistic evidence from this study shows variations in communication competency between participants, which emphasises the importance of not viewing Overseas Qualified Nurses' communication training needs as homogenous. With the growing multicultural nature of healthcare teams, this study underscores the need for intercultural communication training for team integration and patient safety.

Relevance to clinical practice:

Continuous professional development should incorporate intercultural communication training to ensure team effectiveness within nursing teams as well as interprofessional teams.

Key words: Intraprofessional communication, interprofessional communication, overseas qualified nurses, internationally educated nurses, team communication, intercultural communication, discourse analysis.

Introduction

Overseas qualified nurses (OQNs) also known as Internationally Qualified Nurses contribute considerably to addressing nursing workforce shortages in developed countries (Australian Bureau of Statistics, 2013; Buchan & Sochalski, 2004; Hawthorne, 2001). As OQNs' nursing practice, including clinical communication, can be influenced by their educational backgrounds as well as their language and cultural backgrounds, there are likely to be transition problems to a healthcare workplace in a new country (Chun, Birks, & Mills, 2018; Li, Nie, & Li, 2014). Considerable literature exists on clinical communication of OQNs from non-English speaking backgrounds (NESB), which mostly draws on interview data with OQNs and preceptors. However, there are few observational studies of OQNs (Crawford, Roger, & Candlin, 2017; Deegan & Simkin, 2010), and we know of no qualitative observational studies focusing on OQNs' communication with other nurses and with other health professionals, referred to hereafter as intra and interprofessional communication. To build on the existing literature, this observational study sought to investigate OQNs' clinical communication with the healthcare team involved in their patients' care.

Background

Effective communication between members of the healthcare team is pivotal for safe and high quality patient care (Garling, 2008; Iedema, Piper, & Manidis, 2015; Nagpal et al., 2012). Health professionals communicate critical information about patient care in written and spoken formats, synchronously and asynchronously, face-to-face, and using communication technologies (Coiera, Jayasuriya, Hardy, Bannan, & Thorpe, 2002). By its very nature, inter and intraprofessional communication is complex due to the myriad clinical settings across which health professionals communicate, as well as due to time pressures and interruptions. Such factors can compromise patient safety (Johnson et al., 2017; Manias, Gerdztz, Williams, McGuinness, & Dooley, 2016). For instance, studies have underscored that interruptions during clinical handover between healthcare team members can potentially contribute to near misses, disruptions in patient care, critical incidents and mortality (Eggins & Slade, 2013; Manias et al., 2016). There are several barriers to effective team

communication. These barriers can include professional hierarchies, differing levels of education and expertise within the team, unfamiliarity amongst team members, unfamiliarity with the language and jargon used in particular clinical settings, and ethnicity and cultural background differences (O'Daniel & Rosenstein, 2008). A further factor is language competence and fluency for team members whose native language is not the same as the language of the work setting, such as for OQNs in Australia whose first language is not English.

Intercultural communication challenges have been reported about OQNs who migrated from NESB into English speaking healthcare workplaces, including Australia (Newton, 2012; Xiao, Willis, & Jeffers, 2014). In this paper, we define intercultural communication as interactions between culturally and linguistically diverse individuals (Roberts, 2008). For OQNs who are from non-English speaking backgrounds, intercultural communication can require significant adjustments and affect effective workforce integration (Xiao et al., 2014). These OQNs' interactions with other team members may reflect a lack of awareness and understanding of the established team communication norms or patterns; they may also not be aware of the nuances in the meanings of words used in a specific cultural context (Ting-Toomey, 2007; Xu & Davidhizar, 2004). Additionally, lack of fluency and communicative competence in English can negatively impact on collaborative relationships with other nurses and general adaptation to the clinical and social settings (Lum, Bradley, Dowedoff, Kerekes, & Valeo, 2015; Magnusdottir, 2005; Xu & Davidhizar, 2004). For example, lack of fluency when reporting on patients or providing information, can cause tensions between colleagues and patients as well as misunderstandings (Jose, 2011; Ma, Quinn Griffin, Capitulo, & Fitzpatrick, 2010).

There can be negative consequences for OQN nurses, colleagues, and patients when intercultural communication is sub-optimal. In intercultural, interprofessional interactions, OQNs' emotional responses such as uncertainty, fear of making mistakes, as well as behaviours influenced by cultural and professional hierarchies can be interpreted as incompetence by their colleagues (Deegan & Simkin, 2010; Gerrish, 2004; Holmes & Major, 2003; Philip, Manias, & Woodward-Kron, 2015; Takeno, 2010). Nursing handovers between OQNs and local nurses have reportedly been compromised by barriers such as accented English, use of slang by the native speakers, and handover sheets with unfamiliar abbreviations (Deegan & Simkin, 2010). Insufficient vocabulary and conversational gambits

to suit the variety of clinical encounters in an unfamiliar language and cultural context, as well as a lack of confidence, can also hinder initiating and maintaining conversations (Lum et al., 2015; Philip et al., 2015). In addition, OQNs recount feeling challenged and vulnerable when required to exercise assertive communication, negotiation skills and the need to maintain egalitarian relationships during interprofessional and intraprofessional encounters in a fast paced clinical environment (Tregunno, Peters, Campbell, & Gordon, 2009). A heightened sense of self-consciousness in their day-to-day clinical interactions can result in maladaptive behaviours of ‘keeping a low profile,’ which can hinder these nurses’ capability to challenge, advocate or question any workplace concerns as required by the standards of professional practice in Australia (Holmes & Major, 2003; NMBA, 2016)

There have been numerous interview studies conducted on OQN from non-English speaking background (NESB) countries as well as nurse educators’ perspectives of clinical communication (Deegan & Simkin, 2010; Newton, 2012; Philip et al., 2015; Philip, Woodward-Kron, Manias, & Noronha, 2018); however, there appears to be no observational studies on OQN intra and interprofessional communication. Most studies on OQNs’ clinical communication have reported issues in a general way rather than examined them in depth or provided any supporting evidence from interactions. To the best of our knowledge, there is only one observational study exploring the intercultural aspects of OQNs’ communication (Crawford et al., 2017). In that Australian study, research was undertaken in a private hospital setting focusing exclusively on nurse-patient communication and was conducted with four nurses. In contrast, this study focuses on OQNs’ interprofessional and intraprofessional communication. Knowledge gained through observing and analysing the discourse patterns of OQNs will expand the evidence base on OQN intercultural clinical communication.

Therefore, the aim of this paper is to examine the interprofessional and intraprofessional communication patterns of OQNs as they coordinate care for patients in Australian hospitals.

The research questions were:

- i) What are the interprofessional and intraprofessional communication activities in which OQNs engage as part of their daily clinical work?
- ii) What are the discourse patterns of these intra and interprofessional communication activities, including the interpersonal dimension of these activities?

The first research question had a macro, descriptive focus seeking to identify how communication intersected with and enabled the conduct of the clinical work in which the OQNs were engaged. The second question provided a more micro, language focused account of how these communication activities were carried out .

Methods

Design

A qualitative design using participant observation and discourse analysis was adopted. Observational data of OQNs' communication with patients, patients' families, and with other health professionals involved in the care of patients were collected. In the initial phase of this qualitative study, the first author explored the 'communicative ecology' of the research setting (Roberts and Sarangi, 2005, p. 633) by immersing herself in the wards where OQNs were employed, and examining the nurses' perspectives on settings, barriers and enablers of communication. A key strategy in preparing for observations comprised researcher immersion in the research environment. This immersion involved the observer spending time conversing with possible participants in the clinical settings, in order to develop rapport and ensure familiarity. Researcher immersion was important because it encouraged participants to carry out the clinical activities without feeling wary of the observer's presence. Observations were audio recorded to capture the descriptive elements of nurses' clinical activities. Following observations, the observer wrote up field notes to document her thoughts, ideas, and perceptions about her interactions with participants and the clinical activities that took place.

Setting and sample

The study was conducted in a 400-bed multi specialty public teaching hospital in Melbourne, Australia, with observations conducted in acute, sub-acute, and interventional cardiology areas of the hospital. These areas were chosen as the presence of OQNs was relatively higher in these areas compared with other areas of the hospital. The healthcare workforce of this hospital was multi-ethnic with employees from Caucasian, Asian and African backgrounds.

The nurse participants recruited were working in the hospital. Inclusion criteria were nurses who gained their nursing qualification overseas and gained registration in Australia, whose

primary spoken language was not English, and who were OQNs currently working in the Australian healthcare system. This included OQNs who had some prior experience working in English speaking countries. We chose not to exclude these OQNs as many OQNs from NESBs working in Australia have had nursing experience in English speaking countries. Further, to the best of our knowledge, none of the literature on the clinical communication of OQNs from NESBs has distinguished different degrees of communicative competence between those with experience in other English speaking countries and those without. The exclusion criterion was OQNs working in Australia over 15 years.

Recruitment was instigated by the first named author by visiting different wards of the hospital with an associate researcher who was an employee of the hospital, and therefore, known to all the nurse managers in the hospital. With follow-up visits, the first named author recruited the OQN participants from NESB, with the assistance of the nurse managers, who helped identify nurses within their team with initial nursing qualifications from overseas. Nurses were first invited to participate in the interview component of the study (Author reference, 2018). At the conclusion of the interview, participants were invited to participate in the observational component which was conducted by the first named author, who was formerly an OQN before changing to an academic role. Participants were aware of the observer's background as an OQN which was helpful in the recruitment process. However, to ensure that her personal experiences does not impact or guide the data analysis process, the researcher engaged in reflective processes with the other members in the research team to safeguard study rigour. This engagement included regularly recounting and reflecting on observations in team meetings to check for bias and raise possible alternative interpretations. In the interview study, 21 OQNs agreed to participate in the interview while 8 OQNs declined to participate in the observations. Overall 13 OQNs participated in the observations and none of the consented participants withdrew from the study. The data collection period was from Feb 2016 to March 2017 with the observational component commencing in Jan 2017.

Data collection

Observations were conducted in 2.5 to 3-hour periods of the morning and afternoon shifts during weekdays and weekends, based on availability of the consented OQN participants. Each OQN was observed once for the 2.5 to 3-hour period. The first named researcher typically joined the OQN participant after the team meeting or nursing handover. OQN

participants were shadowed during their interactions with colleagues, patients, and patients' families. During observations, the researcher carried a digital audio recorder, and she offered participants the option of pausing the recording if they preferred for certain interactions not to be captured. None of the participants took up this option.

An important aspect in the conduct of observations is the positioning of the researcher (Schneider & Whitehead, 2016). To carry out their clinical duties, participants moved around swiftly to areas such as the patient's bedside, medication room, and nurses' station, which required the researcher to be constantly moving with the participant. The observer's conversations with participants were reserved to the 'down times' when participants were taking short breaks at the nurses' station. These opportunities were utilized if any clarifications were needed. The boundaries of observations comprised the clinical activities involving the shadowed nurses in their interactions with other health professionals, patients and their families. Observations were not captured if participants interacted only with inanimate objects, such as retrieving a linen skip or seeking out a blood pressure machine. Further, to minimize influencing the participant interactions, the shadowing was carried out in an unobtrusive manner. As noted above, the researcher did not speak to the participants during their clinical work, and stayed in the background.

Ethics

The research was approved by [name of hospital ethics review committee blinded for review]. The Participant Information and Consent Form was provided to all participating nurses and written consent was obtained prior to commencement. The observer also obtained verbal consent from the nurses' team members, other health professionals involved in the patients' care, and the assigned patients. During observations, shadowed nurses, other health professionals, patients or their families may have mentioned names or situations that would potentially identify individuals or the hospital. At the transcription stage, identifiable or potentially identifiable data were removed. All sound files and transcriptions were kept in a password protected computer, which were only accessible by the researchers.

The COREQ guidelines were followed in the conduct of this study. See Supplementary File 1.

Data analysis

Data analysis commenced by listening to the audio-recordings to transcribe the talk in which the OQNs were involved. Through repeated listening, the distinct features of the interactions were captured using transcription conventions (Table 1) adapted from (Eggins & Slade, 1997).

[insert Table 1 about here]

The observer's field notes assisted with transcription such as identification of multiple speakers, the different settings, and any communication tools used in the interactions. The analysis of communication activities and the discourse patterns was an interactive process with the first author undertaking the initial analysis, and the other authors checking the analysis independently until agreement was reached.

The approach to data analysis was primarily inductive using an analytical framework developed from within the data. The framework assisted with identifying the clinical communication events in which the OQNs engaged during their clinical work. The Analytical Framework of Observed OQNs Clinical Communication (Table 2) was developed to describe from a macro perspective the main OQN inter and intraprofessional communication activities. The development of the framework was informed by genre analysis (Eggins & Slade, 1997; Martin & Rose, 2003), a form of discourse analysis. A genre is described as a staged, goal-oriented social process (Martin and Rose, 2003). Genres can be written or spoken texts whose stages and purpose are familiar to the texts' participants and users. An example of a spoken genre in the hospital setting is a nurse handover; an example of written genre is a referral letter. Genre analysis is sensitive to the context in which the genre plays out. It and takes into account how participants, their relations with each other, and the topics of the text are construed through language to achieve the text's purpose or social goal. Informed by genre analysis principles (Eggins and Slade, 1997), this study sought to identify macro clinical communication activities that had distinct healthcare and communication goals and were constituted by predictable clinical tasks, including communication tasks. While genre analysis normally provides a linguistic description of the contextual variables such as participant role relations, our analysis first sought to provide an overview of the communication goals and activities in which the nurses engaged; therefore, our description of the contextual variables provides only the most salient elements: that is, participants (e.g. nurse-doctor), communication modalities (e.g. phone), communication tools (refers to clinical forms as well as communication protocols e.g. pre-procedure checklist), and settings (e.g.

nurses' station). These aspects are identified in the framework for each communication activity.

[insert Table 2 about here]

Through an iterative process revisiting the data, the three researchers refined the framework. This framework was then applied to the transcribed data to identify frequency, and types of communication goals, activity and tasks within the data.

Description of the analytical framework

The three main communication goals or activities as identified in the framework are referred to as the following:

1. Assessing patient: This clinical communication goal is achieved through the utilisation of several key related communication tasks such as to a) ask the patient's permission, b) inform the patient of the outcome of the assessment, c) elicit information and response to treatment from the patient and, d) facilitate communication to identify stressors while carrying out patient assessment.

2. Coordinating care: The various communication tasks that make up this communication goal are to a) seek information from the clinical team b) negotiate assistance from clinical team members with patient care and, c) provide or receive patient information from team members. These communication tasks occur, for example, when assigning a task to another nursing colleague, or organising a patient transfer from another ward or discharge home.

3. Facilitating intervention: In order to facilitate interventions for the patients under their care, various related communication tasks are necessary. These include a) ask the patient's permission, b) listen to the patient's fears and concerns, c) clarify information or misunderstanding with the patient d) discuss therapeutic effects and side effects of medications with the patient and, e) provide explanation to the patient of the procedure. These communication tasks are utilised when undertaking related clinical tasks of provision of interventions, for example administering medication, meeting hygienic needs, and so on.

The labelling and identifying of the clinical communication goals or activities, and tasks, and of the contextual variables was informed by the healthcare communication literature: for example, handover (Eggs & Slade, 2013; Levett-Jones et al., 2010; Marshall & Finlayson,

2018), coordinating care (Stein-Parbury, 2014).

The second phase of analysis sought to identify discourse patterns of the OQNs' intra and interprofessional communication activities. For each of the communication tasks identified in the framework, the analysis reviewed:

- i) the main speech functions of the OQNs [i.e. statement; question, command or offer] to achieve the task;
- ii) salient language choices to represent the focus of the interaction for example medications, medical terminology including procedures;
- iii) interpersonal aspects, including formality/informality, small talk and humour.

The focus on speech functions was to gain insights into how the OQNs elicited and received information as well as sought or offered assistance, and so on. The focus on what was talked about in the interaction was to provide insights into the range of vocabulary choices and to what extent these reflected shared knowledge between the OQN and the clinicians in the local setting. The focus on the interpersonal dimension was to identify how this aspect was managed between colleagues while engaging in their clinical work.

Results

Thirteen nurses from India (n=6), Philippines (n=6) and Nigeria (n=1) participated. These OQN participants ranged from 24 to 47 years of age with a mean age of 35.5 years. The participants were observed in the clinical settings of acute care (n= 9), sub-acute care (n= 2) and interventional cardiology (n = 2). The demographic details of participants are provided in Table 3. A total of 36 hours of audio data were recorded with the participant OQNs on thirteen different shifts. The participants are referred to by numbers in Table 3 (e.g., P1), but by pseudonyms in the data excerpts to protect the privacy and confidentiality of participants, since the number of participants is small (n=13).

[insert Table 3 about here]

Overview of OQN interprofessional and intraprofessional communication activities

The intra and interprofessional communication activities in which participants engaged as part of their daily work were multifaceted, and were in clinical settings where teamwork was required with other nurses, doctors, allied health staff, nursing students and non-medical

staff. The nature of the job required them to be on a communication ‘fast track’, constantly engaging in multiple communication and clinical tasks to achieve the communication goals. Table 4 provides an overview of the main observed communication goals/activities and associated communication tasks in which the OQNs were engaged. The number of observed communication activities is also provided.

[insert Table 4 about here]

For the communication goal of Assessing the patient, no intra or inter communication activities were observed as the participant nurses worked individually during this activity. The intra and interprofessional interactions occurred predominantly while Coordinating care and a few during Facilitating interventions. The majority of the OQN interactions in these latter communication activities occurred with the other nurses more so than with patients. The most frequent interprofessional interactions were with doctors, followed by allied health professionals. There were constant interactions with the non-medical staff, for example with receptionists and patient service assistants (PSA); however, these interactions tended not to be directly linked to patient care. The majority of inter/intraprofessional interactions occurred in shared spaces such as the nurses station, treatment room, medication room and in corridors. These interactions had to do with seeking information relating to patient care, negotiating assistance with patient care, providing and receiving nursing handovers, and reporting deteriorating patients to a doctor. Intraprofessional communication in the presence of the patient occurred when discussing therapeutic effects and side effects of medications when administering medications that required a ‘two RN check’ prior to its administration. The interprofessional interactions at the bedside occurred incidentally when doctors or allied health professionals came to the bedside with their individualized clinical goal whilst the participant nurse was present.

Communication modalities and tools

The findings for the communication modalities (e.g. telephone) and tools (e.g. progress record) are provided in Table 5. It was observed that the communication modalities and tools influenced the way that the OQN talk was structured with the clinical team. For example, talk that took place face to face tended to have less structure compared to a telephone interaction. Telephone calls tended to have a formal greeting and concluding statement. OQNs who held an ‘in-charge’ role (eg. P10 and P13) during the observations not surprisingly engaged in more intra and interprofessional interactions by telephone than face to face interactions.

Similarly, communication tasks for a patient transfer from another ward were more inclined to follow a structure based on the 'transfer checklist' that is used in the hospital. Certain communication tools were specific to certain settings: for example, a pre-procedure checklist was used only by P5 and P12 in an interventional cardiology setting, but very rarely used in a sub-acute setting. Participant nurses engaged in hands-on patient care (e.g. attending to patient hygiene needs) were less constrained by use of communication tools (e.g. P8 and P9) compared to times of the day when medication rounds were carried out, an activity heavily reliant on the relevant communication tools (e.g. medication chart and Dangerous Drug (DD) register use by P2, P3, P6, P7 and P11). Use of a timeplan was explicit when sharing the patient load with another nursing colleague; the timeplan was used as a checklist to tick off the completed clinical activities (e.g. P1, P2, P4, P6, P7, P8). The handover sheet was commonly used to retrieve specific clinical information except in the specialist units, where a patient information board was used as a point of reference (e.g. P5 and P12).

[insert Table 5 about here]

OQNs intra and interprofessional communication goals and tasks

Coordinating care: The communication goal of coordinating care incorporated the clinical tasks of assigning tasks (nurse to nurse), coordinating the care team, nursing handovers, interprofessional reporting of patient's deteriorating condition, and organising patient transfers and discharges. The three main related communication tasks comprise a) seeking information or advice b) negotiating assistance for patient care, and c) providing or receiving a report on the patient.

- **Seeking information or advice**

Seeking information was a common intraprofessional communication task. To achieve the clinical communication goal of coordinating care, patient information was sought from nursing team members, for example, to update patient progress and care requirements. This task was observed to be mostly carried out by OQNs in a team leadership position such as by the Associate Nurse Unit Manager (ANUMs).

A telephone conversation (excerpt in Table 6) was in relation to seeking the patient's medical history prior to receiving the patient from another ward. The telephone interaction entailed

seeking of patient information by the participant OQN, Victor, based on the transfer checklist used in his clinical area. The closed ended questions, as in turns 3, 5 and 7 were based on the outline of the checklist that was used by the OQN in this interaction. Once the required information was received, Victor showed immediate readiness (turn 9) to receive the patient to their area.

[insert Table 6 about here]

- **Negotiating assistance for patient care**

Negotiating assistance for patient care was another communication task that commonly occurred between OQNs and their clinical team. In contrast to a more structured interaction utilised when seeking information, the interactions in negotiating assistance were observed to be more ad hoc and unstructured. This occurred in instances when the required intervention was beyond the OQN's workload capacity, or when assistance was required from a team member to safely carry out an intervention.

The excerpt in Table 7 is an example of interprofessional negotiation where OQN Faye had made a few attempts to insert a cannula (intravenous access) into her new patient who was admitted to undergo a day procedure. As she was unsuccessful, the doctor on duty was paged to take over the procedure. Whilst the doctor was performing the procedure, there was negotiation between the nurse and the doctor (turns 9 -12) to provide support to the doctor with the procedure. The OQN expresses her capacity to take over ('I can' in turn 9) and confidently confirms the offer ('sure!' in turn 11).

[insert Table 7]

More frequently, the OQNs negotiated with their nursing colleagues to gain assistance with patient care, for example as shown in Table 8. Here, OQN Dolly needed assistance in providing pressure area care for her patient. Her request is politely (would you mind) and colloquially expressed (giving me a hand). While Dolly's first use of the colloquial expression 'to give someone a hand' is non-native speaker like (line 1), it does not impede communication.

[insert Table 8 about here]

- **Presenting/receiving report on the patient**

There were many intraprofessional exchanges in which the nurses engaged in giving and receiving patient information. These exchanges took place between nurses within a clinical unit, and sometimes with nurses in other clinical areas within the hospital. The participants during this communication task utilised communication tools such as the handover sheet, or patient's medical record to draw on information relating to their patient. In the excerpt in Table 9, OQN Dolly had gone to the Day Procedure Unit (DPU) to receive a new patient to their ward. The interaction is between Dolly and the DPU nurse (N2), who was providing handover on her patient. Unlike in the previous excerpt, Dolly's communication was less successful: her manner of receiving information was not authoritative nor confident, evident in her soft voice (turn 7), her mitigated way of expressing a request for a handover "I think" and the modalised "should be" and "may" (line 9), as well as the hesitant request for a clarification (turn 13), a request that goes unanswered. There was no evidence in this interaction of Dolly's assertion in order to receive the key information that she required from N2 (turns 13-15), who seemed to be in a hurry to get the patient transferred.

[Insert Table 9]

In contrast to the above example of less assertive communication with a nurse, the following example shows a nurse maintaining communication despite a challenging interaction with a doctor. In the participating hospital, the communication protocol of Introduction, Situation, Background, Assessment and Recommendation (ISBAR), a mnemonic that is created to improve safety when exchanging critical information, was expected to be used by staff members. In the excerpt in Table 10, OQN Anita walked over to a junior doctor with her patient's chart open in her hand and began the conversation relating to her patient's condition. Without any introduction of the patient, Anita reports her concerns about her patient's progress (turn 1). Initially, the doctor sounds unclear of what Anita was referring to (turn 2), however, he catches on by scanning through the chart (turns 4 and 6). As soon as the Situation and the Background of the patient was understood, the doctor starts writing his recommendation (turn 10). The clinical reasoning behind his action was not made clear, neither was it questioned by the nurse. The doctor's approach appeared patronising, evident in his tone of voice and comment (turn 20) and hierarchical in his abrupt questioning of Anita (turns 14, 16, 18 and 20). Despite this, Anita maintains composed communication throughout the interaction. Although there was the requirement for Anita to follow the ISBAR protocol, it was only superficially utilized, resulting in the doctor needing to ask numerous questions to obtain patient information; thus excerpt 10 can be characterised as an inefficient interaction.

[Insert Table 10]

Facilitating interventions: Facilitating interventions was another communication activity in which intra and interprofessional communication took place. One clinical task contributing to this communication activity was administering medications, in which the related communication task was discussing the therapeutic effects and side effects of medications with patients in the presence of another nurse.

- **Discussing therapeutic effects and side effects of medications with patient**

OQNs also needed assistance from other nurses when facilitating interventions like checking and administering medications. In the extract provided in Table 11, OQN Jemima is at the bedside of a patient receiving an Iron infusion. The purpose of the interaction at the bedside was to fulfill the legal requirement to confirm that the ‘right medication’ was administered to the ‘right patient’. A nursing student who was preceptored by the OQN was also present during this interaction. The involvement of the nursing colleague is minimal (turns 2, 4 and 6) which highlights the accountability of the primary RN, in this case the OQN, in these sorts of interactions. Here, it was observed that Jemima, who is meant to educate the patient on the therapeutic effects and the side effects of the medication, was carrying out this activity in a superficial manner (turn 7) with little information provided. The student nurse, who was with Jemima, identifies this gap and take on the patient education role (turns 15 and 17). Although it was required for the OQN to stay at the patient bedside for at least 15-20 minutes after the commencement of the iron infusion, there was no initiation by the OQN to educate the patient. The omission may be due to an expectation that the student nurse needed to take on this role of educating the patient, or because the OQN did not want to overwhelm the patient with details of the side effects, or other factors.

[insert Table 11]

Unlike the above interaction, the OQN in the next interaction in Table 12 was conducting a medication round with another nurse and had a very brief time during which he had to check the patient and also provide the patient with information about the medication. However, due to the colleague’s impatience evidenced in turn 2, the repeated “sign *here*”, Jeff hurried the process and moved on to administer medication to his next patient where similar assistance was required from his colleague. It was also noted that several shortcuts were taken in the checking process resulting in a very brief encounter with the patient.

[insert Table 12]

Discourse patterns and features of the OQNs inter and intraprofessional communication

Speech functions: The dominant speech functions in the inter and intraprofessional talk were transactional pairs for exchanging patient information: question-response, including clarifications. One common discourse feature was the brevity of the OQN responses in the question-answer exchange pairs with little elaboration or explanation. While the brevity of response could be interpreted as motivated by a desire for succinctness, sometimes, the lack of elaboration required further probing by the other interlocuter (e.g. nurse or doctor). For example, Anita (excerpt Table 10) did not explain to the doctor why the patient did not have a cannula, with the result that the doctor had to ask further questions. In contexts where the OQNs received patient information from other nurses, there were instances in which it was evident that some OQN participants did not have the language resources or perhaps confidence to ask further questions or clarify when patient information was lacking. For example in excerpt 9, Dolly receives a patient but only confirmed that she did not have a handover when asked by the other nurse. Dolly's request for a handover was tentative: I think there should some handover, ...*maybe* (line 7). OQN intraprofessional communication appeared to be more efficient when facilitated by communication tools such as a checklist, in which simple questions were used to guide the information seeking.

Requests for assistance (rather than patient information) were often both modulated to indicate politeness (Would you mind...) and colloquial (...giving me a hand) (excerpt 8, Dolly). While several interlocutors with the OQNs used imperative forms to request an action (*Let's go*, or *Sign here!* excerpt 12), there were no instances in our data of the OQNs using this direct form for a request.

Throughout the observational data, there was no obvious miscommunication or breakdown in communication between the OQNs and other nurses or health professionals due to OQN language choices to refer to any patient information or medications. As noted in the researcher field notes, in terms of language features such as lexical (vocabulary) choices, syntactic (sentence structure), pronunciation elements (accent, intonation, modulation), there was considerable variation amongst the thirteen participants. For example, , with some OQNs exhibited greater fluency, more extensive vocabulary, and their pronunciation that had

less transfer from their first language into English than other OQNs. Deficits in vocabulary were noted to be compensated by use of visual cues, hesitancy, and use of non-specific words and expressions. For example, the speech of a female OQN, of Philippine background, when giving discharge instruction to a patient in the presence of another nurse, had numerous pauses, and references to visual cues: “*next week to confirm the booking...ahhh...ahhhh...you will receive...ahh... letter...to let you know ...and the number over here...ahhh...I..wrote it on this one (pointing to the discharge instructions sheet)*”. Furthermore, there were also OQNs with fluency of expression and a sufficient vocabulary, yet who had a marked accent.

Developing and maintaining interpersonal relations

There were informal, conversational elements in the data that enabled development and maintenance of positive interpersonal relationships between OQNs and their colleagues during their clinical interactions. These featured informal greetings including use of nicknames and terms of endearment, humour including laughter, and small talk. For example, in the following excerpt (Table 13), there was joking, laughter, and a term of endearment. OQNs tended to have more engaging interactions when there was a friendly, informal greeting.

[insert Table 13]

These informal elements, however, only sparingly occurred when OQNs conversed with their English speaking background colleagues. There was also an absence of interpersonal elements in some interactions. In contrast, the researcher field notes document several lively exchanges with laughter between OQNs speaking the same first language, for example, Tagalog by the Filipino nurses or Malayalam, one of the Indian languages by some Indian nurses. These exchanges only occurred away from the patient’s bedside or when nurses from other backgrounds were not present. Some of the common themes of the non-English language exchanges, as observed by the researcher when participants spoke in a language that the researcher understood was ‘social talk’: for example, what they are doing on their day off or sometimes it was venting about the busyness of the shift. Use of humor by the participant OQNs was also noted when speaking with other OQNs, for example, a male OQN from the Philippines to a female OQN from India “*ayah, so busy...next time I win tatts lotto, the next day I will resign*”. These types of casual exchanges were observed to be more spontaneously occurring when present with their ‘own kind’ rather than with the English speaking background nurses. Expressions such as exclamations from the OQNs’ first language were embedded in some of the English exchanges, for examples “*ayahh, it is so busy*” (where the

underlined expression denotes exasperation in some of the Asian languages). In addition, it was noted that the interactions appeared to be more informal and friendly (for example, excerpt in Table 14) where both nurses, who shared the same first language other than English, switched into a different style of speaking in English, with transfer of intonation patterns and expressions from their shared first language into English. These exchanges were characterised by a fluency and spontaneity that appeared to be easily understood by both OQNs from the same country; however, these patterns of speech may not be easily understood by other English speaking colleagues.

[insert table 14 about here]

These interactions contrast with exchanges that occurred with English speaking colleagues which tended to be short, purposive, and mostly lacking in reciprocated informal, interpersonal elements.

More informal, interpersonal nurse-doctor interactions were strongly linked to the OQNs' approach to the interaction. The use of a casual greeting, and assertiveness in the tone of voice tended to receive a better response. For example, a male OQN from India who approached a doctor with a "Hey doc! You have a minute?" received the response "Hey sure, what is it?". This in contrast to the case of Anita, an OQN female from India (Table 10), whose failure to make the initial connection through a casual greeting, may have contributed to the following unpleasant interaction with frustration on the part of the doctor.

Additionally, the researcher's field notes discern that there was a difference in the OQNs' relationship with the team in acute and sub-acute settings as opposed to a specialist unit such as the cardiac catheterisation lab. OQNs were noted to be engaged in more casual interactions, with humour and laughter with the team members (nurses and doctors) in a specialist setting compared to other acute and subacute areas. This difference may be due to the fact that the OQNs in specialist areas were part of more integrated teams and who had more frequent encounters with their English speaking colleagues in comparison to the OQNs in the ward areas.

Discussion

The findings of this observational study provide new knowledge into intra and interprofessional communication patterns of OQNs working in Australian health care. This is

one of the very few observational studies, and the only one of which we are aware, focusing on intra and interprofessional intercultural communication.

The daily work of the OQNs, as a member of the clinical team, was multifaceted, with constant interactions required with nurses, doctors, allied health staff, nursing students and non-medical staff. The findings revealed that the majority of intra and interprofessional communication occurred under the clinical communication goals of Coordinating care and Facilitating interventions. When working towards these goals, the key related communication activities in which the nurses engaged with the clinical team were seeking patient information, negotiating assistance for patient care, providing and receiving nursing handovers, and reporting patient deterioration to a doctor. One of the most common intraprofessional communication activities occurred when discussing therapeutic effects and side effects of medications in administering medications that required a 'two RN check' prior to administration. The communication strategies they adopted to achieve their goals were utilising closed ended questions based on communication tools such as transfer checklists to guide interaction, communication mnemonics such as ISBAR when exchanging critical patient information and ad hoc unstructured interactions for negotiating assistance for patient care.

On examining the discourse patterns, an important finding was the considerable variation in communicative competence amongst the 13 participants, with some OQNs exhibiting greater English language skills and language resources, including assertive communication than other OQNs. This may have been due to the prior experience of some OQNs in other English speaking countries. This is similar to the findings by Harris (2009, p. 302), in her ethnographic doctoral study with overseas qualified doctors working in an Australian hospital. Harris also points out that as a consequence of this variation, the doctors had different training needs as they developed their 'communicative registers' (p. 302) in the hospital. This implication is echoed in nursing studies of OQNs, in which the linguistic and cultural adjustment and adaptation needs of OQNs differ and are influenced by their varied educational, and cultural and language backgrounds (Chun et al., 2018; Kingma, 2008). Our study provides linguistic evidence of this variation, and underscores the need of not considering OQNs' training needs as homogenous.

Several factors interfered with the effectiveness of communication. In situations that required the OQNs to pursue more information or when conveying critical information to team

members, factors impeding communication included lack of assertion, hesitancy and inadequate strategies to challenge poor communication of other health professionals. On the one hand, this finding underscores the need to view inter and intraprofessional communication as a collaborative undertaking, in which the OQN participants may have had inadequate conversational gambits and communicative competence in English to challenge poor communication; these communicative barriers may also be the result of perceived professional hierarchies between members in the healthcare team, and a lack of understanding of team communication norms and practices (Lum et al., 2015; Philip et al., 2015; Ting-Toomey, 2007). On the other hand, this finding provides evidence that poor clinical communication with peers is not always caused by the non-native speaking health professional.

Brevity of information provision, and lack of elaboration of important patient information to colleagues was another characteristic pattern of communication. This pattern contributed to less effective communication as it required further prompting and probing by the interlocutor to gather the required details. Communication tools such as ISBAR tended to be underutilized. Levett-Jones et al.(2010) argue that use of mnemonics such as ISBAR provides a standard communication framework, facilitating communication occurring in a consistent manner, which is especially useful for nurses who are new in an environment. Some OQNs in this study would benefit from further training in use of communication protocols. Time pressures exerted by colleagues resulted in shortcuts in communication activities where a communication protocol was required to ensure patient safety. Numerous studies have demonstrated that such time pressures can curtail crucial clinical communication processes and be detrimental to patient safety (Eggins & Slade, 2013; Johnson et al., 2017; Manias et al., 2016). The implications for intra and interprofessional communication is that safe and effective communication is the joint responsibility of all interactants.

Interpersonal discourse patterns between OQNs and their colleagues showed various degrees of engagement with colleagues and differing degrees of reciprocity of more informal communication. While some OQNs engaged in humorous, friendly talk as part of their inter and intraprofessional communication, there was a distinct lack of smalltalk with team members of an English speaking background. Workplace observational studies in healthcare have highlighted that sharing of anecdotes and smalltalk between colleagues on neutral topics of general interest that is skillfully balanced alongside the medical talk is noted to foster a

healthy interpersonal relationship between colleagues (Holmes & Major, 2003; Holmes & Stubbe, 2014). OQNs not partaking in such workplace cultural norms of smalltalk with colleagues of an English speaking background can create barriers to integration and effective communication. Lack of development of a good interpersonal relations within team members has the danger of local colleagues, with or without their knowledge, exhibiting non-inclusive behaviours towards their OQN colleagues. As Kingma (2008) highlights, non-inclusive behaviours towards OQN team members from NESB countries can have negative psychological impact that threaten patient safety, as well as disrupt cohesion within healthcare teams. OQNs, as newcomers into the Australian culture and workforce, need opportunities to engage in meaningful interactions with more established members of the community of practice in order to transform into active, contributing members of the professional community (Author reference, 2018). The findings from this study, however, have shown that the majority of the OQN intra and interprofessional interactions were short and purposive, with very minimal social talk with their English speaking colleagues. This was in stark contrast to the ease and comfort noted with OQNs whilst interacting with team members from their own cultural and language background. A similar pattern was also noted in Harris' study of overseas qualified doctors where the participants described their conversation as 'very fast' and 'very different' when interacting with their own group of people; whereas, they were 'slow' and 'didn't catch up and feel ... an idiot' when interacting with their English speaking counterparts (Harris, 2009, p. 299).

The study has several limitations. The study was conducted in one metropolitan public hospital in Melbourne, Australia. The study setting had a relatively high number of OQNs in its workforce; therefore, the team dynamics and the communication practices of the participants of this study may be different to other hospital with predominantly English speaking team members. In addition, this study was a naturalistic, observational study. It was therefore beyond the scope of this study to investigate the causes of the observed communicative behaviours of the OQNs, such as the influence of their personalities, education, or cultural factors. Further, participant behaviour may have been influenced by the presence of the researcher; however, the researcher minimized this impact by observing discretely and not interacting with the nurse during clinical work. Although most participants were from South East Asia, caution should be exercised in referring to the described patterns as homogenous for this group as each region has a different education model and English language; therefore, not all OQNs from South East Asia will demonstrate the inter and

intraprofessional communication reported in this study. It should also be noted that almost half of our participants had some prior nursing experience in English speaking countries. While we did not notice any distinct differences in the communicative competence of the OQNs with more experience in English speaking settings than others, future studies with a larger cohort of participants could investigate the impact of these experiences on the trajectory of integration and clinical communication. In addition, a recent integrative review has identified communication difficulties relating to jargon use, and has emphasized the influence of organisational 'nursing' culture in host countries impacting communication (Montayre, Montayre, & Holroyd, 2018).

Conclusion

Most OQN intra and interprofessional communication occurred under the clinical communication goals of Coordinating care and Facilitating interventions. Considerable variation in communicative competence was demonstrated with some OQNs exhibiting greater English language skills and linguistic evidence of this variation, therefore underscoring the need not to view OQNs' training needs as homogenous. Although inadequate conversational gambits and communicative competence in English interfered the quality of OQN communication, poor clinical communication were not always caused by the non-native speaking health professional. Future research should focus on OQN-patient communication to provide a more complete picture of OQN intercultural clinical communication patterns in Australian health care.

Relevance to clinical practice

This study provides discerning information for curriculum developers and clinical educators to understand the existing communication patterns of OQNS and enable the gaps to be addressed through structured training to improve clinical intercultural communication. There is the need to address intercultural clinical communication training of international nurses as well as nursing students. The study provides ready-to-use excerpts as 'teaching triggers' of crucial areas such as assertive skills, handling of poor communication of others and the importance of instigating social talk alongside professional talk with colleagues. In addition, it provides insight to OQNs of their existing communication patterns. Moreover, at an organizational level, this study contributes to human resource development by providing

understandings about the importance of team communication training for all employees to ensure workforce integration and better patient outcomes.

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Conflict of Interest statement

There is no conflict of interest to report

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What does this paper contribute to the wider global clinical community?

- Provides evidence to education providers and policy makers of the home countries and the host countries of the intercultural communication challenges experienced by overseas qualified nurses
- Evidence of OQNs' communicative competence, as well as highlighting the need for more interpersonal team communication skills.

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Table 1 Transcription conventions

Turn numbers	Speaker turns are numbered for ease of reference
<i>Italic script</i>	Italic script is used for speech
(laughter)	Paralinguistic features such as laughter are indicated in parentheses. Also prosody features such as tone of voice e.g. irritated, or volume of speech.
[inaudible]	Un-transcribable talk is indicated in square brackets
[patient?]	A guess of unclear speech is indicated by square brackets and a question mark
bold script	Emphasized words are indicated in bold script
==	Overlapping speech
...	Pauses are indicated by three dots

Table 2 Analytical Framework of Observed OQNs Clinical Communication

Clinical communication goal or activity	Related clinical tasks	Key related communication tasks
<p>1. Assessing patient</p> <p><i>CONTEXTUAL VARIABLES</i></p> <p><i>Participants:</i> nurse-nurse, nurse-other clinicians, nurse-patient, nurse-family</p> <p><i>Communication mode:</i> spoken face-to-face, written</p> <p><i>Communication tools:</i> Admission checklist</p> <p><i>Setting:</i> bedside</p>	<ul style="list-style-type: none"> • Conduct clinical assessment, including checking vital signs, pain, blood sugar level (BSL) • Assess pain • Conduct psychosocial assessment • Determine patient emotional state • Review admission checklist • Determine care needs • Monitor any adverse reactions during interventions 	<ol style="list-style-type: none"> a) Ask patient permission b) Inform patient the outcome of the assessment c) Elicit/Clarify patient information and response to treatment d) Facilitate communication to identify stressors

<p>2. Coordinating care</p> <p><i>CONTEXTUAL VARIABLES</i></p> <p><i>Participants:</i> nurse-nurse, nurse-patient, nurse-doctor, nurse-family, nurse-social worker/dietician/physio, nurse manager</p> <p><i>Communication mode:</i> spoken face-to-face, spoken - telephone, written</p> <p><i>Communication documents and tools:</i> Time plan, Care plan, Handover sheet, Patient label</p> <p><i>Setting:</i> nurses station, drug room, bedside, outside patient room, corridor</p>	<ul style="list-style-type: none"> • Assign task (nurse-nurse) • Coordinate the care team • Nursing handover • Report patient's deteriorating condition • Organise patient transfer/discharge • Manage patient referral • Check process of care provision (unfamiliar care context) 	<p>a) Seek information or advice</p> <p>b) Negotiate assistance for patient care</p> <p>c) Present/receive report on the patient</p>
<p>3. Facilitating intervention</p> <p><i>CONTEXTUAL VARIABLES</i></p> <p><i>Participants:</i> nurse-nurse, nurse-patient, nurse- family</p> <p><i>Communication mode:</i> spoken face-to-face, spoken-telephone, written</p> <p><i>Communication documents and tools:</i> Pre-op checklist</p> <p><i>Setting:</i> bedside</p>	<ul style="list-style-type: none"> • Administer medications (oral, parenteral, transdermal) • Prepare skin • Demonstrate procedure • Facilitate ambulation • Position dependant patient • Meet hygienic needs (mouth care, bed bath etc..) • Provide oxygen therapy • Provide intravenous therapy • Provide pre and post cardiac catheterisation care 	<p>a) Ask patient permission/consent/preferences</p> <p>b) Listen to patient fears and concerns</p> <p>c) Clarify misunderstandings</p> <p>d) Discuss therapeutic effects and side effects of medications with patient</p> <p>e) Provide explanation to patient of procedure (whether responsive or not)</p>

Table 3
Characteristics of OQN participants

Participant (P)	Gender	Age	Country of origin	Years of employment in Australia	Current area of work	Prior overseas experience
P1	F	25	India	3	Neurological/ Stroke	Dubai
P2	F	47	Philippines	12	Neurological/ Stroke	Ireland
P3	F	32	Philippines	5	Palliative Care	England
P4	F	30	India	7	Neurological/ Stroke	-
P5	F	44	Philippines	4	Cardiac Catheter laboratory	New Zealand
P6	F	36	India	6	Medical/ Respiratory	Ireland
P7	M	24	Philippines	2	Medical/ Respiratory	-

P8	F	32	India	4	Medical/ Respiratory	Ireland
P9	F	40	Nigeria	10	Medical/Oncology	-
P10	F	44	India	9	Neurological/ Stroke	-
P11	M	24	Philippines	2	Medical/ Respiratory	-
P12	F	45	Philippines	14	Cardiac Catheter laboratory	Ireland
P13	M	38	India	8	Rehabilitation	-

Table 4 Overview of observed OQN intra and interprofessional communication

Communication goals and tasks	Nurse-Patient	Nurse - Family	Nurse – Patient - Family	Nurse-Nurse	Nurse- Doctor	Nurse – Allied health	Nurse – Patient- Nurse	Nurse- Patient- Doctor	Nurse –Patient – Allied health	Nurse –patient - non medical
<i>1. Assessing patient</i>										
a) Ask patient permission	6*									
b) Inform patient of assessment outcome			2							
c) Elicit/clarify patient information and response to treatment	4		3							
d) Facilitate communication to identify patient stressors	1	1								
<i>2. Coordinating care</i>										
a) Seek review/information/advice	2			7		2			1	
b) Negotiate assistance for patient care				7	1		1	2		2
c) Present/receive report on the patient (inter and intraprofessional handovers)				2	2		1	1		
<i>3. Facilitating intervention</i>										
a) Ask patient permission/consent/preferences	7		2							

b) Listen to patient fears and concerns	7		2										
c) Clarify any misunderstandings	5	1	3										
d) Discuss therapeutic effects and side effects of medications with patient	6								5				
e) Provide explanation to patient of procedure (whether responsive or not)	12		2										

* refers to the number of different participants observed completing the task.

Table 5: Communication modalities and tools used by the OQNs

Participants	P1 Acute	P2 Acute	P3 Sub- Acute	P4 Acute	P5 Cath lab	P6 Acute	P7 Acute	P8 Acute	P9 Acute	P10 Acute	P11 Acute	P12 Cath lab	P13 Sub- Acute
Spoken face to face	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Spoken telephone			✓		✓					✓	✓		✓
Written										✓			✓
Time plan	✓	✓		✓		✓	✓	✓					
Information board					✓							✓	
Transfer checklist													✓
Medication chart	✓	✓	✓	✓		✓	✓				✓		
Handover sheet	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓
Dangerous Drugs register		✓	✓			✓	✓				✓		
Procedure checklist					✓							✓	

Progress record	✓				✓									
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Table 6 Excerpt from associate nurse unit manager (ANUM) (Victor) receiving handover of a patient by telephone

Turn	Speaker	Excerpt from transcript P13
1.	Victor	<i>Victor speaking...sure this time, yeah, no problem go ahead.</i>
2.	Nurse 2	[inaudible]
3.	Victor	<i>Is she allergic to anything? Does she need any single room? Any contact precaution?</i>

4.	N2	[inaudible]
5.	Victor	<i>Does she have any issues with her cognition or communication? Or any behavioural concerns?</i>
6.	N2	[inaudible]
7.	Victor	<i>No...yeah. Not physically, verbally aggressive?</i>
8.	N2	[inaudible]
9.	Victor	<i>Ok ok...we will be ready in ten minutes. Thanks, bye.</i>

Table 7 OQN Faye interaction with a doctor to gain assistance with a clinical procedure

Turn	Speaker	Excerpt from transcript P5
1.	Faye	<i>She is in bed 2. The ultrasound is at the bedside ==</i>
2.	Doctor	<i>==Oh ok...hello! (to the patient)</i>
3.	Patient	<i>Hello!</i>
4.	Doctor	<i>(sits down next to the patient and starts to scan the arm for veins) very good arteries but the veins are a bit tricky to find.</i>
5.	Faye	<i>hahaha..I know that's why we didn't want to try any more</i>
6.	Doctor	<i>I'll just have a look first...mmm...ok..the other one was bleeding at all, was it? ==</i>
7.	Faye	<i>==No..we thought we hit the vein, tried to aspirate but didn't get any blood back</i>
8.	Doctor (to the Patient)	<i>Can see your veins there..whereas the arteries we can't squash because it is a harder vessel..hahaha (proceeds to insert the cannula which was laid out by Faye)</i>

9.	Faye (to Doctor)	<i>My dear I can take over (reference to securing the cannula)</i>
10.	Doctor	<i>Ok, you can?</i>
11.	Faye	<i>Sure! (takes over to finish off the procedure)</i>
12.	Doctor	<i>Alright then, I'll leave you to it.</i>

Table 8 OQN Dolly, negotiating with a nursing colleague to assist with patient care

Turn	Speaker	Excerpt from transcript P1
1.	Dolly	<i>I need someone's hand to check his (patient's) skin. Amy (N2), are you free?</i>
2.	Nurse 2	<i>yeah, do you need me?</i>
3.	Dolly:	<i>yeah, I need to check his skin. Because they said he has couple of dressings I want to know what it is. Would you mind giving me a hand?</i>
4.	N2	<i>let's go</i>

Table 9 OQN Dolly receiving handover – interdepartmental

Turn	Speaker	Excerpt from transcript P1
1.	Dolly	<i>Hi my name is Dolly.</i>
2.	N2	<i>Hi my name is Lydia...he is from 2EW..so he is supposed to have scopy with us but not fit for that ...I don't know if they rescheduled but I'll confirm with the incharge. Mr Neil...Neil...hello...</i>
3.	Dolly	<i>(to the patient) Hello...my name is Dolly .</i>
4.	N2	<i>Yeah...she is going to take you back to the ward...ok..We're going to check your name band and make sure you are the correct patient she is taking ==</i>
5.	Dolly	<i>==1403826...Allan xxxx</i>
6.	N2	<i>Yeah...date of birth...yeah that is fine...So actually he had...mm..</i>
7.	Dolly	<i>(soft voice) He has a CVC?</i>
8.	N2:	<i>No...I don't think he has a CVC. So you had a full handover?</i>
9.	Dolly	<i>I think there should be some...may be==</i>
10.	N2	<i>==ok..he presented to ED with a decreased conscious state. ..on CT it is a relapse thing..so he had a decreased conscious state..I don't know how many days he stayed in the ICU but yeah..he was then transferred to 3EW. That is all from the wards that is the summary. Patient has past history type 2 diabetes. He has</i>

		<i>got a blister..I didn't see because there is a dressing on.</i>
11.	Dolly	<i>ok no problem. He is from 2EW yeah</i>
12.	N2	<i>yeah...he is from 2EW..he was only here for a procedure, so if there is anything you want to know more..just ask them...yeah..he has been good..and..(scanning through the chart)</i>
13.	Dolly	<i>(soft voice) so I need to start an IV?</i>
14.	PSA	<i>Hello==</i>
15.	N2	<i>==oh that is very quick. He has to go to 2EW</i>
16.	Dolly	<i>yeah next door.</i>

Table 10 OQN Anita, reporting on a patient condition to a doctor

Turn	Speaker	Excerpt from transcript P4
1.	Anita	<i>her urine output is borderline..so I can't give any..(speaking in a muffled tone).</i>
2.	Doctor	<i>urine...what..sorry?</i>
3.	Anita	<i>Her urine output was 155mls for last four hours==</i>
4.	Doctor	<i>==uuh..sorry (scans through the patient's chart)</i>
5.	Anita	<i>her urine output==</i>
6.	Doctor	<i>==so baseline...baseline..what is it?</i>
7.	Anita	<i>mm..25mls per hour..urine output==</i>
8.	Doctor	<i>==mm..yeah..give her some fluids...is she drinking much?</i>

9.	Anita	<i>no..she is a bit drowsy today..and she is refusing to eat and drink and she is coughing on thin fluids..that is why the speech is reviewing her now.</i>
10.	Doctor	<i>Yeah (writing up IV fluids)</i>
11.	Anita	<i>there is no cannula==</i>
12.	Doctor	<i>==she doesn't have a cannula?</i>
13.	Anita	<i>No she doesn't have a cannula</i>
14.	Doctor	<i>why not? (irritated tone)</i>
15.	Anita	<i>She is difficult to cannulate..I will try once==</i>
16.	Doctor	<i>==She had one the other day though? (frustrated tone)</i>
17.	Anita	<i>mmm</i>
18.	Doctor	<i>Was it taken out? (irritated tone)</i>
19.	Anita	<i>May be 3 days old</i>
20.	Doctor	<i>That is not a hard and fast rule..that is a guideline (irritated tone)</i>
21.	Anita	<i>We can't keep it if IV therapy not running</i>
22.	Doctor	<i>You got to keep it going...right? (irritated tone)</i>
23.	Anita	<i>I will try once and see how I will go</i>
24.	Doctor	<i>Thanks (completes the fluid order and gives the chart to N1)</i>
25.	Anita	<i>yeah, ok.</i>

Table 11 OQN Jemima commencing treatment on a patient

Turn	Speaker	Excerpt from transcript P6
1.	Jemima	<i>So Thomas Morgan..URxxxxxx..</i>
2.	N2	<i>Yeah.. date of birth..xx-xx-xx</i>

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3. Jemima *Yeah*
4. N2 *No allergies==*
5. Jemima *==Allergy... I don't know where..yeah...no allergies (pointing to the chart)*
6. N2 *mm...ok*
7. Jemima *Ok we are starting your infusion...if you feeling uncomfortable ...aahh..feeling..unwell...we are here anyway..ahh==*
8. Student *==Are we starting now?*
9. Jemima *Yeah..we are just starting..after another 10 minutes you can do one set of obs*
10. Student *ok...Thomas, how you are feeling?*
11. Patient *Fine*
12. Student *Alright..good.*
13. Jemima *You are ok?*
14. Patient *Yeah.*
15. Student *(reading through the instruction in the iron infusion emergency box)
Are you aware John with iron...did you have iron infusion before?*
16. Patient *Yeah*
17. Student *So you know like if you have chest pain, you feel dizzy or fainting...let us know*
18. Patient *(yawns)... How long does this go for?*
19. Jemima *It is for one hour...and we just giving the small dose first and if there is no reaction we will continue and give you the rest of them quickly.*
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Table 12 OQN Jeff administering medication to a patient

Turn	Speaker	Excerpt from transcript P11
1.	Jeff	<i>So this is Austin..UR xxxxx..allergic to xxxxxxxx...and then I will just wait for the other medication..after I fill out==</i>
2.	Nurse 2	<i>==sign!...sign here! (trying to rush the process)..I have to go now I am busy (in a loud frustrated tone)...arghh...so busy</i>
3.	Jeff	<i>Haha ok...ok now to 17 (both N1 and N2 walking towards the next patient)</i>
4.	N2	<i>let's go!</i>

Table 13 Telephone conversation of OQN Victor with a nursing colleague

Turn	Speaker	Excerpt from transcript P13
1.	Victor	<i>Hello Snap!</i>
2.	Nurse 2	<i>xxxxx</i>
3.	Victor	HeyI said hello Snap...and you said hey...hahaha ...alright...mmm..tell me!
4.	Nurse2	<i>xxxxx</i>
5.	Victor	mm...I guess 3E..what is the diagnosis honey ?
6.	Nurse2	<i>xxxxx</i>

Table 14 Medication checking by OQN Jeff with an OQN from the Philippines

Turn	Speaker	Excerpt from transcript P11
1.	Jeff	<i>Lou (N2)...do you mind checking this with me?</i>
2.	N2	<i>Ah forgot...that is why... I came ...then was like what am I supposed to do here?... I was looking for you...aaayah..</i>
3.	Jeff	<i>haha..yeah..after this one... I will help you...okay..ah</i>
4.		
