Where are we?
Workplace communication between RNs in culturally diverse healthcare organisations:
Analysis of a 2-phase, mixed-method study

Summary document

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Overview of the research project

The purpose of this study was to examine cultural influences on communication, perceptions and practices of registered nursing staff engaged in healthcare practice. The diversity aligned to the fast-changing cultural composition of the population is reflected in the health professionals who provide healthcare services. Cultural diversity now seems set to be a permanent and dynamic feature of the healthcare sector and it is vital to address accompanying complexities to ensure the work experience is beneficial to health professionals and those they care for. Therefore, it is important to attempt to understand what influence the associated changes are having on the dynamics of both communication and workplace practice in an important service of public value.

This is the first identified study of the cross-cultural communication interface between Registered Nurses from diverse ethnicities in the Aotearoa-New Zealand health sector. The use of the following 2-phase mixed-method study sought to obtain the advantages of combining both quantitative (online survey) and qualitative (interviews and critical incidents) methods of data collection and analysis to enhance the validity and reliability of the research project.

Phase 1

An extensive literature review revealed a paucity of national and international research focusing on the communication interface between internationally qualified nurses (IQNs) and those who first obtained registration in NZ (NZRNs). There were, however, numerous studies with a sole focus on the adaptation experiences of IQNs. Such studies are valuable, but they tend to provide insight from the perspective of particular groups. The voices of other groups that occupy and interact within the same workplace environment are largely absent. This is a significant limitation as communication is always a two-way process, and especially in a healthcare setting, competent communication underpins effective and safe teamwork and practice.

An extensive review of cross-cultural communication theory and research consistently identified factors that are influential in the experiences of respondents and this body of knowledge was used as a basis for informing the research. A structured questionnaire survey was devised with a focus on respondents' organisational experiences of communication interaction and work performance. However, apart from the demographics section, all questions were open-ended and participants were invited in both the print and verbal version to share their experience of the cultural interface beyond the stated 10 questions. Critical incidents were included to generate insight into both the type of events that occurred that were meaningful to respondents. Interviewees were asked whether there were memorable culture-based challenges they had experienced and if so, how they had responded to the situation (whether it was resolved or not did not matter). Subsequently, the survey questionnaire tool was piloted with six international academic staff who provided feedback on the clarity of the questions and made suggestions for minor alterations.

Procedure

Following the receipt of ethical approval to conduct Phase 1, an advertisement was placed in the *Kai Tiaki Nursing New Zealand* magazine with a short description of the aim of the research, asking for volunteers to participate in an interview to discuss various cultural perspectives relevant to the current workplace. As RNs responded to the request for participation either by phone or email, the study was discussed with them by the first author. They were asked if they would be willing to participate in a semi-structured interview, at a time and venue of their choice. Queries were addressed and an information sheet was provided by email or post. Respondents were provided with further contact details should they have additional questions. With one exception, all who enquired agreed to participate in the study.

It was initially envisaged that focus groups would be held in various locations. However, this was possible on only one occasion with three respondents (and two interviewers present), because of the nature of time commitments and shiftwork. Accordingly, volunteers were offered alternative means of responding to the questionnaire other than face-to-face, including

telephone interviews and completion of an online and hard copy versions of the tool. Informed consent was obtained from all respondents prior to data collection commencing. The first author conducted the in-person and telephone interviews at a time and place nominated by respondents and sent surveys to those who required online and hard copy versions. The time-frame between the first and final interview was 15 weeks. The face-to-face and telephone interviews varied between 50 and 65 minutes in length. All interviews were recorded with consent, and the interview tapes were transcribed under the auspices of a confidentiality agreement.

Participants

The data on which Phase 1 of the study is based resulted from face-to-face (32) and telephone (9) interviews, and completion of online (7) and hard copy questionnaire surveys (5) from a total of 53 participants. Respondents ages ranged from 25 to 60+ years and 46 were female, 7 were male. Years as an RN ranged from 1 to 30 years, as did years of practice in NZ. Participants worked in 7 of the 20 DHBs in Aotearoa-New Zealand.

Findings

A thematic analysis of the data provided insight into a number of paradoxes that are causing very real and tangible challenges for health professionals in today's workplace. These included; a polarised workplace (loss of a sense of community compared with learning from other cultures), ethnocentrism "othering" – (discord compared with empathy), value-based conflict – (compared with values are global), institutional distancing – (managerial directives versus distancing) and a lonely journey – (weathering change). A secondary focus group held by the first author with seven respondents affirmed the findings. An overview of the Phase 1 themes is below, including some of the sub-topics that were identified in the clusters which compromised the categories (themes):

Workplace paradoxes of:

Theme 1 - A polarised workplace (Loss of a sense of community cf learning from other cultures)

- Lost art of nursing R13N; R14N
- Black humour R13N; R27S
- Teams – authority/deference R11N; R14N
- Hierarchy - R13N; R17N
- Adaptation/strategies, R10F
- Need to learn about 'Kiwi' culture

Theme 2 - Value-based conflict – (cf. values are global)

- Moral emotions – 'silencing' and emotional labour
- Death and dying
- Dependence/independence dichotomy, R10F
- Lack of understanding
- Values/value – medal
- **Cf:** Values are global R10F; R21N; R22N; R32F; R45I; R39N

Theme 3 - Ethnocentrism "othering" – (discord cf. empathy)

- Deficit equates to difference
- Covert racism both ways 'simmering' R09A
- working for acceptance – google and memorise slang R10F
- mentoring/understanding R05C; R10F
- 'sense of shame R09A

- Losing face
- Discrimination R32F
- Adjustment phases (worse in beginning)
- Differences within culture, R05C - stereotyping
- Deconstructing 'common-sense' understanding - tick boxes vs 'common sense' and "data in head", R14N; R23M; R17N

Theme 4 - Institutional distancing -managerial directives vs distancing

- Bullying, R11N; R12F; R37F
- Feeling isolated, R11N
- Whitewash, R11N; R07N
- Lack of specific feedback on practice
- Organisational culture, R10N.
- Lack of trust in 'others', management, the system
- Trust and transparency

Theme 5 - A lonely journey - weathering change

- Finding a voice – speaking up vs. remaining silent
- Finding 'my own way'
- Language
- Pragmatics – context, accents, idioms, slang
- Sense of 'talking about them' in another language
- Have to work harder for acceptance, R31F; R09A; R10F; R19U; R20S

Phase 2

Phase 2 of the research project involved using the Phase 1 data to inform the development of an online questionnaire survey tool to provide insight into whether these findings were applicable to the wider population of nurses.

Procedure

The final questionnaire survey tool had five sections. In the first section respondents were asked to rate the importance of statements (identified from Phase 1 interviews) to their own practice. Respondents were asked to indicate how strongly they agreed or disagreed about the importance of each statement in their work as an RN. The Likert type 5-scale measure ranged from 'strongly agree' to 'strongly disagree'. In section two, participants were asked to describe a critical incident related to the cultural interface in the workplace. Whether it was resolved or not was not important, rather the priorities and responses were of interest. In the third section respondents were asked about what resources they would find useful in helping them to practice in a culturally diverse workplace, and in the following section 4, about which cultures they would like more information. In the final section, respondents were asked to complete a number of demographic questions.

The first cluster in section one of the questionnaire comprised items related to *developing a sense of community*. Quotes from RNs were extracted from the Phase 1 theme of "a polarised workplace" which contrasted the perceived loss of a sense of community, compared with the value of learning from other cultures about healthcare practice. There was direct reference to developing work relationships and communication with colleagues from diverse cultures. Language, slang and jargon were also included as well as the RN's response to NZ as a bicultural country.

The second cluster was named *developing insight into cultural values different from my own*. Quotes extracted from the Phase 1 theme, "value-based conflict" compared to perceptions of global values were used to explore the ways in which RNs sought feedback and developed their

own cultural competency in establishing mutual understanding and potential conflict and discomfort that may arise when dealing with cultural difference.

The third cluster of *developing practice through learning from colleagues with cultures different from my own* was extracted from the Phase 1 theme relevant to "ethnocentrism or 'othering' – discord compared with empathy". The combination of the activity of mentoring and developing mutual understanding asked respondents what initiatives they have undertaken to enhance their awareness of the ways in which their own cultural beliefs influence their practice. Also, respondents were asked about their own adaptation to incorporate 'other' perspectives in their practice.

The fourth cluster of *advocacy* was developed from respondents' quotes related to the role of managers in facilitating the communication interface in a culturally-diverse work setting. These quotes were encompassed in the Phase 1 theme of "institutional distancing – managerial directives vs. distancing". The recognised importance of the managerial role in fostering cultural understanding and also addressing any evidence of racism or discrimination identified in any organisational setting also informed this cluster.

The final cluster of *a supportive organisational culture* was informed by the final Phase 1 theme of "a lonely journey". This theme included the difficulty that IQNs experienced in finding their 'own way' in a foreign context. However, the same experience was also reported by some NZ RNs. The relevant quotes related to how proactive respondents considered their healthcare organisation was in supporting their education about cultural understanding. Also, the perceived fairness in a diverse workplace alongside the priority given to safe practice was central to this cluster.

A regression analysis for each of the questionnaire survey clusters indicates that nurses registered within the NZ healthcare sector believe more strongly about the importance of developing a sense of community in their work, developing cultural insight and learning from their colleagues than IQNs. However, although these are statistically significant findings ($p=0.000$), the differences are small. The findings are outlined below.

Participants

Following receipt of ethical approval for Phase 2 of the study, the online survey tool was loaded onto Qualtrics, piloted, minor amendments made and an invitation to participate with a link was sent to 2,400 RNs on the NZNO database. The survey was launched on 4 February 2016 and remained open until 7 December 2016. Two reminders were sent during this period. Some 10%, or 259 respondents completed the online survey. The ethnicity of respondents was typical of the diverse national population.

Analysis

Quantitative analysis

A principal components analysis of the resulting data was used as an appropriate method of identifying underlying latent constructs, reducing these to a more parsimonious representation of the relationships being measured in the 29 survey items. A factor is a latent variable that will express itself through its relationship with other measured variables. For example, when trying to capture the complexity of communication within teams, leaders and organisational settings, it would be impossible to measure the composite influences within such abstract and multifaceted concepts meaningfully. The research approach allows a single variable to provide a measure of the factor, rather than a set of items. These factors maximise the amount of variance explained in the data to produce the percentage of common variance as a goodness of fit index to correctly assess the most suitable factor model for the data.

Qualitative thematic analysis

The qualitative analysis of the data was similar to Phase 1, to identify and analyse the patterns of recurring themes in the data. The critical incidents were coded by identifying recurring regularities initially using NVivo™11 to sort and categorise the data. Headings were developed based on the coded information and incidents were sorted, first into categories using line-by-line coding to help organise the body of data. The data were subsequently analysed and headings established as most representative of the clusters, which were then grouped together into larger themes by the first two authors based on recurring regularities. The questionnaire

also included a section asking respondents to describe a critical incident (as in Phase 1). Again, this was included to verify whether the identified issues were reflected in actual events and workplace practice. In contrast to Phase 1, the data were then explored to identify relevance to the quantitative findings which resulted from the PCA to provide insight into the practice events and responses of RNs. The quantitative and qualitative data were combined to provide both statistical trends and validation from the qualitative data provided by respondents as outlined below.

Findings

In this research, the principal components analysis demonstrated there were three areas that accounted for 57.23% of variance in the sample:

Factor 1: My practice: Investing in teamwork (40.2%);

Factor 1 accounted for 40.2% of variance. The dominance of teamwork and personal responsibility threaded throughout. This factor derived from items across the first 3 sections of the Phase 1 survey of *sense of community, insight into cultural values and learning from colleagues from diverse cultures.*

Although just over half of respondents agreed their nursing was enhanced through working in diverse teams (58%), less than 50% reported having access to information about cultural styles to help their understanding of these processes. Of the sample, 60% agreed that problems with language, including the use of jargon or slang (40%) presented a barrier to communication between cultures. A very high number (93%) reported seeking feedback from culturally diverse colleagues to enhance mutual understanding, although only 40% have used mentoring initiatives in this respect. Some 83% of respondents believed that nurses hold universal values across cultures. Nonetheless, 49% reported that they perceived cultural differences may be stronger than those universal values.

Nurses appreciated the bicultural insight they received from cultural safety guidelines; however, both NZ RNs and IQNs all wanted training and resources that would inform them about the diverse population and 'Kiwi' culture they inhabit. Some events attested that when

culturally-diverse teams are experiencing miscommunication during their work practice, patient safety is compromised.

Factor 2: My work environment: Influence of management (12.2%);

Factor 2, which accounted for 12.2% of variance spoke to the *influence of management* in helping manage the cultural interface (incorporating questionnaire items primarily from *advocacy* (Phase one).

Although 52% believed their manager facilitated shared ownership of teamwork and practice with diverse colleagues, less than half (47%) report that their manager helps to foster cultural understanding within their work teams. Managers were perceived to use fair and open communication across cultures by 62% of respondents; however, only 41% agreed that their manager encourages them to learn about cultural diversity. Managers are perceived to address evidence of discrimination and racism in the workplace by only 46% of respondents. It is essential that proactive strategies are implemented to ensure that effective and culturally safe policies are in place.

There was a consistent perception of IQNs that they had to work harder for acceptance. The need to convince others of their professional competence resulted in IQNs expressing tension about dealing with the strangeness of a new culture, and at times, unfamiliar ways of doing things. However, RNs across both groups expressed their disappointment with their managers' sustained focus on efficiency. An environment that provides the time and space to learn and develop reflective practice is integral to supporting cultural understanding and team dynamics. In turn, this alternative is more desirable than the counter-productivity that is inevitable when staff feel they have no choice but to disengage.

Factor 3: My institutional environment: Organisational culture (4%)

Factor 3 accounted for 4% of the variance, and the focus was on both recognition of the importance of staff and also a patient focus on safe practice, derived from items comprising *the institutional environment - organisational culture* comprising data from (*institutional distancing* – Phase 1).

Just 39% of respondents agree that their organisation provides mentoring for colleagues from diverse cultures, although 54% of respondents stated that the organisation is proactive in supporting their own education about cultural understanding. However, healthcare organisations are overall seen to ensure fair treatment across cultures (67%), with 71% of respondents reporting that their organisation ensures that safe practice is a priority within a culturally-diverse environment.

Although NZ nurses valued the opportunity to learn about other cultures they also were experiencing a sense of confusion and loss of a sense of community as they struggled with heavy workloads and the concurrent need to help others adapt to their familiar workplace, and new ways of doing (and thinking about) daily practice. On the other hand, and perhaps most significantly, the data illustrate that with small changes managers can benefit from the willingness of many RNs to engage with change and participate in initiatives to help foster collaborative working relationships across cultures. The search for information and understanding illustrates the clear desire for both NZRNs and IQNs to obtain support to enable them to foster good working relationships and in turn create a more enjoyable and productive working environment in an increasingly diverse workplace where multiculturalism is the consistent norm. However, the focus on efficiency was very costly in this context.

Recommendations were offered to help with achieving successful outcomes that will be used to improve the workplace experience of RNs in every way possible. An overview follows.

Implications and recommendations for the future

The recommendations focused on the need for a supportive environment, for managers to find a way of relating to their staff more effectively and time to facilitate learning and hence develop understanding between diverse cultures. Although healthcare organisations are reliant on highly functioning teamwork for the delivery of safe patient care, there appears to be limited investment in ensuring culturally competent inter-professional relationships. It would be valuable for IQNs to be initially orientated into the integral role of healthcare teams in NZ

(issues around hierarchy are especially important). Another means of establishing a positive working environment is to provide staff with helpful educational resources to nurture teamwork through increasing understanding of cultural difference in developing work relationships.

Language plays a central role in interaction between colleagues, professions and patients. Some early education for nurses founded on the challenges of negotiation and clarification to foster good working relationships would help address key issues and barriers. IQNs have signaled a need pastoral care and mentoring as they feel their difference equals a deficit in their professional practice. The perceived need to convince others of their professional competence resulted in compounding tension when dealing with the strangeness of a new culture and unfamiliar practice. On the other hand, NZRNs were also struggling with the added complexity of an increasingly diverse workplace.

The establishment of trust requires understandable and transparent management to influence the performance, interaction and behaviour of staff to create a sense of belonging to the organisation. A managerial commitment to understanding the significant influence of cultural values would provide insight into possible reluctance of nurses to integrate into the healthcare system. Professional perceptions of what is valued and acceptable in the structural procedures and process of the organisation will influence commitment to the organisation. This requires organisations to develop proactive policy and practice to promote culturally-aware management sensitive to intercultural complexity. In a broader context, the findings suggest that it may be useful for NZNO and the Nursing Council of NZ to consider updating cultural safety guidelines with a view to the role of diversity in communication with both colleagues and patients.

The perception that most managers failed to address evidence of discrimination and racism in the workplace indicates urgency for proactive strategies to ensure that effective and culturally safe policies are in place. Managerial work includes the need to both navigate and negotiate situations of conflict and ambiguity among their staff. Some level of support and training for managers would assist as there was evidence they struggled to manage issues centred on

diverse cultural values and styles of communication. Perhaps most significantly, the data illustrate that with small changes managers can benefit from the willingness of many RNs to engage with change and participate in initiatives to help foster collaborative working relationships across cultures. If managers are willing to take a risk and acknowledge their dilemmas, genuine interaction with staff to seek their input may engender a number of potential solutions.

A time and resource constrained environment compounded difficulties with communication and practice in diverse teams. The lack of mentoring initiatives is one significant outcome of a time-constrained environment. NZ nurses report struggling with heavy workloads and the concurrent need to help others adapt to their familiar workplace is in some cases, the final straw. Disengagement is too high a cost to risk. When culturally-diverse teams are having ongoing difficulties working together, patient safety is compromised.

Conclusion

The authors would like to express their sincere appreciation to both the Nursing Education and Research Foundation for making available the funding for this research and to the RNs who willingly gave their time and provided valuable insights to support the research with richness and depth of data. It is our genuine hope that findings can and will be used to improve the workplace experience of RNs in every way possible. Our society owes RNs a duty of care in the same manner that they take care of and advocate for us – usually, when we are at our most vulnerable.