IS NURSING TRANSFERABLE AND PORTABLE:

THE EXPERIENCES OF TRAVEL NURSES

By

RAE RAMSDEN

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We accept this capstone project as conforming to the required standard

Dr. Sonya Grypma, PhD; Supervisor

_____

Dr. Lynn Van Hofwegen, PhD; Second Reader

_____

Dr. Barb Astle, PhD; External Examiner

_____

TRINITY WESTERN UNIVERSITY

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Executive Summary

Nursing is understood as a transferable and portable profession. This suggests that as professionals, registered nurses should be able to accumulate and share their knowledge from differing locations and cultural experiences, which in turn should connect and support nurses as a professional body rather than alienate them from professional status. This study was designed to help us better understand the question of portability and transferability by examining the experiences of six travel nurses. The travel nurses described ways in which they believed their skills and practice standards transferred between countries supporting portability and transferability of the profession. This study was conducted in the United States Southwest during the period between October 2013 and March 2014. The interviews were recorded with English-speaking travel nurses who had international work experience within the countries of Australia, Canada, England and the United States of America. The interviews were transcribed and analyzed following the interpretive descriptive qualitative design methodology by Thorne (2008). The findings revealed the following five themes: (1) ability to transfer skills; (2) navigating policy differences; (3) overcoming English language differences; (4) acculturation, transitioning into new locations; and, (5) becoming aware of healthcare costs.

Keywords: Registered Nurse, Agency Nursing, Agency Nurse, work experience, travel nursing, travel nurse.

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Chapter One: Introduction and Background

The professional designation “registered nurse” presumes transferability and portability of nursing knowledge and skills across national and cultural boundaries. This interpretive descriptive study explored the experiences of six English-speaking travel nurses with the negotiation of national and cultural differences during international placements in Australia, Canada, and the United States of America, while they maintained the standards of practice of both their originating and travel sites.

Distant nursing assignments require the travel nurse to temporarily relocate away from family and friends and may expose them to stark or subtle cultural differences presumed to not be present between predominantly English-speaking countries. The intentions of this study were to examine and explore the experiences of six travel nurses while investigating the transferability and portability of the profession.

Background

According to the Canadian Projection System, a nursing shortage is expected to persist until 2018 (Deschamps, 2013). In Canada these shortages are growing as the population ages. In 2008, the United States was confronted with a critical nursing shortage which was expected to worsen unless long term solutions were found. The hiring of foreign educated nurses (FENs) was identified in the literature as being a practical and realistic solution to the nursing shortage problem (Ea, 2008). This registered nursing shortage saw an increase in the migration or globalization of qualified registered nurses coming to practice in Canada and the United States. Application and integration is thought to be easier for nurses emigrating from countries with similar healthcare systems, identified as being the U.S., U.K., New Zealand and Australia (Deschamps, 2013). With the increase of FENs applying to work in Canada and the United

States, questions arose from the nursing professions whether or not; these foreign qualified nurses were prepared to practice meeting the requirements of a different work environment. In Canada transferring of nursing credentials varies between the ten provinces and three territorial nursing boards who examine number of hours worked, as well as all candidates having to pass the Canadian Registered Nursing Exams (CRNEs), except in Quebec where candidates are required to speak French (Deschamps, 2013). For example, in the province of British Columbia, College of Registered Nurses of British Columbia (CRNBC, 2014) requires FENs to verify hours worked, provide a list of all previous employment(s), provide notarized copies of all license(s), verification of education with a recognized nursing school, pass an English fluency test, as well as sit for Substantially Equivalent Competency (SEC) assessments followed by individualized bridging programs where needed. They recommend internationally trained registered nurses not secure any employment in the province until all these requirements have all been met, as there is a timely process where all applications are scrutinized individually. For FENs in countries such as Australia and the U.S., regulations are also in place that assesses the eligibility for nursing registration (Smith, Fisher, & Mercer, 2011).

According to a closer review of 76 articles published between 1992 and 2014, I examined the transitional experiences of FENs after they were considered competent for practice by the regulating bodies in Australia, Canada and the United States. These studies examined how FENs faced acculturation in their new homes and how new managers could best facilitate successful transitioning (Collins, 2004; Ea, 2008; Fuehn et al., 2005; Hall et al., 2009; Ronquillo, 2012; Walters, 2008; Wheeler et al., 2013).

In stark contrast, my study examined the experiences of English-speaking nurses in foreign English-speaking travel assignments. It could be said that English-speaking nurses

navigate similar experiences by encountering new work environments, new patients, new doctors and new colleagues. This could be overwhelming for travel nurses due to the many differences from that of their home countries, albeit English speaking. By investigating the experiences of English-speaking travel nurses working in English speaking placements, this qualitative study looked at barriers that may have existed in foreign placements by maintaining the transferability and portability of the profession, as well as upholding the standards of practice.

I am a travel nurse. That is, I am a Canadian trained registered nurse who has been employed under contract with a hospital in the Southwest United States. Being a travel nurse I understood that one has to be comfortable with skills and possess an ability to adapt quickly to changing situations. Perhaps the best advice I have ever received while travelling was to be open to change. Living abroad and being a travel nurse enabled me to bring forward the guiding questions to launch this study. I began to realize that English-speaking nurses had unique experiences to share with the profession and, as evidenced by the literature, they were also an understudied population. I lived in a temporary housing complex with other travel nurses from Canada, England, Australia and the United States and my demographic characteristics fit the inclusion criteria of the study informants.

According to Ericksen (2006):

> Travel as we know today started in 1978 when a contract nurse arrived at a New Orleans hospital during Mardi Gras, when the annual celebration increased hospital census, there was this necessity that this particular facility needed an extra pair of hands. (p. 19)

Travel nursing is based on supply and demand, and travel nursing has entered the healthcare landscape addressing global nursing shortages by being a mobile professional, prepared to supplement temporary staffing shortages. To Ericksen, “Travel staffing has become more widely

known as a cost-effective solution for hospitals across the country to manage their flexible staffing" (p. 20).

Oftentimes hospitals require extra clinicians when they anticipate spikes in patient census (Keller, 2009). This is true of the American Southwest, the location of my study. According to Ericksen, "the Sunbelt States still see seasonal population increases, mostly due to the influx of snowbirds. Because older people consume more healthcare resources, there is a greater need for providers in these regions" (p. 24). This location in the Southwest U.S. during the winter months is a prime destination for elderly snowbirds; also, being an agricultural area, the Southwest attracts thousands of migrant farm workers. Due to poverty these migrant workers and their families could be considered a high risk population requiring additional healthcare resources. Historically, the population for this particular region expands exponentially during the months of October through April which requires the temporary hiring of medical staff, including registered nurses to cover the increased healthcare needs of that community. This region is also predominantly populated by Hispanic and Latino Americans which also exposes travel nurses to regional cultural differences.

Definition of Terms

Travel nurse. The definition of travel nurse for the purpose of this study refers to nursing services provided by registered nurses travelling and working on a casual basis or temporary assignment by entering a contractual arrangement with a hospital. Travel nurses may be citizens of the host country, or of another country. For example, in the American Southwest, hospitals offer temporary employment to Canadian, Australian and other American nurses to assist with increased demands during seasons when there are additional tourists or snowbirds in the region. *Travel nurse* and *agency nurse* are used here interchangeably.

Agency nurse. The definition in this study identifies the nurses who have their work organized by a private contractor, known as an agency, to carry out work within any number of hospitals (Bates, 1998). *Travel nurse* and *agency nurse* are used here interchangeably.

Policy and protocol/policies and protocol. This refers to the guidelines in place which nurses are required to follow when performing clinical procedures. Policy and protocol for specific hospitals can be retrieved by using manuals or online websites, but ideally must be readily available for nurses to access. Registered nurses must perform procedures as outlined by these guidelines. In regard to nursing practice these manuals are also thought to be based on the standards of practice to provide safe competent care and, guided by the most current nursing research, also known as *evidenced based practice*.

Standards of practice. Practice standards, or standards of practice are defined here as the qualifications for the profession of registered nurses. They encompass ongoing skill acquisition, and critical application and evaluation of relevant knowledge and judgments. Nurses are accountable and responsible for their practice. Standards are set out to promote safe, competent and ethical nursing practice. Standards of practice are outlined and further defined by Boards or Colleges of Registered Nurses responsible for licensure at a particular location or jurisdiction. For example, in the province of British Columbia, standards of practice are outlined by the College of Registered Nurses of British Columbia (CRNBC, 2013) and are guided by these four practice standards: (1) Professional Responsibility and Accountability; (2) Knowledge Based Practice; (3) Client-Focused Provision of Service; and, (4) Ethical Practice.

Project Description

Project purpose and objectives. The purpose of this study was to explore the experiences of six travel nurses working in the Southwest United States. The focus was to

examine how travel nurses negotiated national and cultural differences while maintaining standards of practice while on assignment. Insights from this study may help potential employers and educators to better understand the assumption of transferability and portability of professional nursing skills between English-speaking countries. The study may also provide additional information to nurses who may entertain travel assignments at some point in their careers which might entail crossing borders to work between Australia, Canada, England, and the United States.

Project method. According to Leedy and Ormrod (2013) the research method is the general approach a researcher takes to carry out the research project; to some extent, this approach dictates the particular tools the researcher selects. Semi-structured interviews were planned guided by open-ended questions to capture story telling. The open-ended questions provided informants the opportunity to fully describe their experiences. Travel nurses with existing relationships with the researcher were first approached and asked to participate in this study. The purposive and convenience sampling was used to select individuals who could provide meaningful insights for the research question. Interviews were conducted asking the open-ended questions listed in Appendix A. In this qualitative study an *interpretive descriptive research design* (Thorne, 2008) was chosen for analysis. The interpretive descriptive design is a qualitative research approach that develops from two sources: (1) an actual practice goal; and, (2) an understanding of what we do and don't know on the basis of available evidence.

Inclusion criteria were that the travel nurse informants: (1) were able and willing to articulate their experiences in an interview with the researcher; (2) were able to communicate in English; and (3) worked as a travel nurse at least one other international setting that was geographically distant from their primary residence. Five travel nurses were Canadian and

American trained nurses and one travel nurse was trained in England. Their native home countries are: three from Canada; two from United States of America; and, one from England.

Relevance and Significance

According to Thorne (2008) there are countless ways in which qualitative research can meet the standards of disciplinary relevance including whether the knowledge generated is appropriate to the development of the disciplinary science. The reliability of the data collection and analysis is judged on the researcher's ability to tell the story of the participant adhering to truthfulness, attention to context and power (Streubert & Carpenter, 2011). Following the interpretive descriptive method a small sample size was selected. The significance of this study was to further build on existing knowledge of viewing nursing as a professional body in which registered nurses can participate in travel work, supporting transferability and portability of a professional status. Replicating this study with another group of English-speaking travel nurses, at an alternative location, may reveal different results. This study could be interpreted as being supportive to the nursing body of knowledge, as it brought forward findings which may require further inquiry in an understudied population.

The study focused on finding patterns and themes identified with individual human experience, which is challenging to quantify into objective data, and this brings into question the relevance and significance of the a study being scientifically contributory to a professional knowledge base. The counter viewpoint is that this study examined a subjective reality in constructing what was real for individuals, which was best collected and analyzed in an interpretive descriptive qualitative research design.

The findings can be utilized for potential nurse managers to be taken into consideration for transitioning travel nurses into their institutions. The findings may also provide information

to nurses who might want to engage in travel nursing. The pressure on healthcare institutions to stay within operating budgets while maintaining flexibility and patient safety may result in an increased presence of the travel nurse in Canada, as it is already widely used in United States. In Northern and remote communities in Canada we see nursing shortages being addressed with agency nurses (e.g. a nurse from this study working in Northern British Columbia on an agency assignment), thus this study has significance for those employers, agencies and nurses. This study could be used in developing further questions regarding future inquiry on travel nursing,

Presently, in both countries, Canada and the United States, registered nurses must pass national exams in order to apply for licensure -- the Canadian Registered Nursing Exams (CRNEs) in Canada; and, the National Council Licensure Examination for Registered Nurses (NCLEX) in the United States. The travelling Canadian registered nurse practicing in the U.S. supports the idea of transferability and portability of the profession between both countries; however, this nurse must still take the NCLEX exam; similarly, the U.S. registered nurse must take the CRNE exam in order to practice in Canada. With changes underway in Canada adopting the NCLEX model in 2015, there may be more opportunities for nurses to travel between both countries without re-examination. Therefore, this study is also a timely submission.

Rigor and Limitations

Because of my close relationship to the participants in this study, I incorporated reflective activities which included keeping a journal following each interview and during data analysis to capture and identify my reactions. I attempted to bracket my personal assumptions and experiences regarding travel nursing by identifying and acknowledging ways in which my own direct experience related to the phenomenon. My main focus was to gain a better understanding of the experiences of others, and results are representative of what something was like from an

insider's perspective. "Bracketing can be extremely difficult for a researcher who has personally experienced the phenomenon under investigation. Yet it is essential if the researcher is to gain an understanding of the typical experiences that people have had" (Leedy & Ormrod, 2013, p.146).

Limitations of this study are: (1) Despite my efforts to build a trusting relationship beforehand endeavouring to capture as rich and as candid data as possible, the informants might have chosen to disclose only what they perceived to be socially acceptable; (2) As only female informants participated in this study, one could state that results could be biased and that male informants might have had differing experiences to share; and, (3) The purposeful small sample size was manageable for the research model however, was deemed a limitation to the overall inquiry as it leans towards an incomplete picture by being more indicative of a fixed snapshot at one point in time with a small select group of individuals and if replicated the probable results may reveal different findings.

Outline of Paper

Chapter Two: Literature review. The results of the literature review are briefly overviewed and details of articles deemed more relevant to this study are summarized and discussed in this chapter.

Chapter Three: Research design, method and procedures. The research design methodology interpretive descriptive design as outlined in Thorne (2008) was utilized in the collection and analysis of interview data. This chapter explains in-depth how thematic analysis results were achieved following the interpretive descriptive model.

Chapter Four: Findings. The findings begin by briefly profiling each of the participants. The findings identified five prominent themes derived from the data: (1) Ability to transfer skills; (2) Navigating policy differences; (3) Overcoming English language differences;

(4) Acculturation, transitioning into new locations; and, (5) Becoming aware of healthcare costs.

Chapter Five: Discussion. The discussion evaluates and interprets the implications of the findings by identifying the sources of potential bias, limitations, and barriers to the study. The discussion covers the contribution through comparative analysis with the existing literature and justifies why readers inside or outside the specialty of nursing should attend to the findings.

Chapter Six: Summary and recommendations. The conclusions and recommendations summarize the findings and how they might contribute to the body of nursing knowledge and identifies where additional research might be undertaken.

Chapter Two: Literature Review

A literature review was conducted as part of my proposal which utilized the databases of CINAHL, EBSCO, Medline and Sage Publications. Appendix B is the original log outline of that search and the number of articles found; Appendix C represents a follow-up literature search performed post data analysis. As there was limited peer reviewed information on travel nursing research, decisions were made early to include: (1) Non-English speaking FENs because of their experience in foreign placements; and (2) information which was considered dated (by more than five years). Additional articles as discovered during the project were also added to my literature research list. Of the possible 535 articles, 76 articles were saved on RefWorks® to review. From this list of published articles, only 56 articles were identified as being more relevant than the others. There were 53 published in English (published in the United States, Canada, the U.K., Australia and New Zealand), and of these articles, only 31 were identified as being peer reviewed. The narrative articles were dated from 1992 to 2014 and research studies were dated from 1990 to 2014.

Most of the literature reviewed focused on the relationships between employers and the travel nurses on the job. There were also a number of experiential, first-person narratives written by travel nurses. The literature review was conducted to gain an understanding of existing knowledge of transferability and portability in travel and agency nursing. Upon completion of the data collection and during the analysis, a follow-up literature review was conducted to help make sense of the findings and further investigate how the data related to what was already known.

The research articles introduced here, review both English-speaking and non-English-speaking travel nurses. Like travel nurses, FENs with non-English speaking backgrounds, also

had to transition into new workplace environments. Some of these primary findings were deemed more relevant and represent the most current journal publications from 2003 to 2014. Because of the many journal articles of experiential personal narratives, I concluded with one of those journal articles as part of this summary of literature.

Literature Review

Hall et al. (2009) conducted a retrospective exploratory[1] research study on nurse migration from Canada to the United States of America (U.S.), focusing on what factors may have influenced the reasons why nurses choose to leave Canada. "The purpose of this study was to gain a more comprehensive understanding of the characteristics and behaviors of Canadian-educated and US-educated RNs from the NSSRN (National Sample Survey of Registered Nurses)" (p. 199). Demographic characteristics from the NSSRN data set identified a sample of 235 Canadian educated nurses in 1996; 222 in the year 2000; and, 249 in 2004; and demographic data from the Canadian Institute for Health Information set identifying the sample of 232,412 in the year 2000; and 246,575 in the year 2005. These sample criteria were considered sufficient to detect significance by the researchers. The NSSRN data set included 37 questions. Data analysis was descriptive statistics to describe education, employment status, work history and demographic characteristics of Canadian-educated RNs living in the U.S. They then compared to RNs in Canada by collecting data from the Canadian Institute for Health Information database on the basis of the similar survey questions from the NSSRN. The National Canadian Nursing Advisory Committee (2002) hypothesized that new Canadian nursing graduates were leaving the country in search of jobs, or leaving nursing altogether because of lack of full-time employment. From this study the researchers found that "full-time work opportunities and the potential for ongoing education were key factors that contributed to the migration of Canadian nurses to the

[1] Retrospective exploratory - A study that involves collecting data about past events.

U.S.A. In addition, Canada appeared to be losing baccalaureate-prepared nurses to the U.S.A." (p. 198). Overall the study could provide policy leaders with important information regarding employment options of interest for registered nurses, such as flexible working schedules, full time employment, higher wages and benefits, and the opportunity for advanced education. An unexpected finding from the data was that there were a higher proportion of male Canadian-educated RNs working in the U.S. than in Canada. Limitation to this study was that individual nurses were not followed; this was a quantitative study which secured survey data from the Canadian Institute for Health Information Registered Nurse Database (2001, 2005) and the NSSRN data base from selected years (1996, 2000, 2004) from identifiable descriptive demographic characteristics. The authors note that further work needs to be explored regarding the retention of Canadian nurses. This quantitative research study is included in the literature review as it addressed why nurses might choose foreign employment (Canada to U.S.).

A doctoral thesis by Collins (2004) addressed immigrant nurses working in Canada. In this qualitative study of career mobility among immigrant Caribbean registered nurses in Canada, the author described personal experiences in cultural differences, globalization of nursing and acculturation to host societies. The research question was: What factors create barriers or act as facilitators to career mobility among immigrant women of color who are RNs in Canada? Interview data was collected by a convenience sample of 14 women from the Caribbean who had migrated to Canada between 1960s and early 1990s. Like travel nurses, FENs are confronted with obtaining driver's licenses, social security cards, locating the nearest food stores, banks and places of worship when traveling to foreign placements. As well as the main focus of addressing the job of nursing, this study included non-work related issues, including unfamiliar lifestyle outside of work. This study on the experience of immigrant nurses

identified barriers related to systemic practices that influenced the regulation of nursing, as well as relationships in work environments. The study found that these nurses adapted by developing individual strategies of resistance and advanced in their careers in nursing. It recommended that the nursing profession implement antiracism policy to build equitable status and remuneration for immigrant and minority groups in nursing. This qualitative study was selected for the literature review as it pertained to FENs negotiating new work environments which could be considered similar to those encountered by traveling nurses and was therefore supportive of the research question regarding portability and transferability of the profession.

In the study conducted by Manias, Aiken, Peerson, Parker, and Wong (2003a) perceptions and experiences of agency nurses who worked on a casual basis in acute care settings were investigated. This qualitative research study used semi-structured interviews from ten agency nurses registered at one of three major nursing agencies in Melbourne, Australia. The nurses ranged from 25 to 46 years of age; four to 25 years in nursing experience; and, one to 14 years as agency nurses. Nurses were identified to participate from a mail-out to 100 active agency nurses who worked at least one agency shift in the previous three months. A stratified sampling [2] technique based on demographics was used to establish the final sample which included ten agency nurses. Data analysis followed five stages: familiarization, identification of thematic framework, indexing, charting and mapping and interpretation. To ensure rigor, two researchers independently conducted data analysis. Orientation was deemed to be an important consideration for agency nurses as well as how these orientations differed between hospitals. Negative experiences included working on an on-call basis with short notice, and short call cancellations. These were considerations that travel nurses talked about routinely, as well as being transferred

[2] Stratified sampling - is the process of dividing members of the population into homogeneous subgroups before sampling.

to units where they had little or no experience, such as intensive care (ICU) or emergency (ER). Aspects which travel nurses enjoyed the most were the flexibility in working hours they wanted to work, working for themselves and not having to deal with the politics of the units. Travel nurses spoke at times feeling disengaged from staff, as in “us and them type of thing” and the fact that the hospital had “gone agency” to back-fill as being a last resort to maintain safe nurse patient ratios. Regarding clinical skills, travel nurses felt that a wealth of experience was gained working in a variety of settings which allowed them to consolidate their skills and to provide a higher quality of patient care. Data from this particular article did not address the re-location experiences of nurses.

In a separate article, the viewpoint of nurse managers and agency employers were investigated. Here the same researchers Manias, Aiken, Peerson, Parker, and Wong (2003b) described perceptions of hospital nursing managers and agency nurse providers. The research question was: How do the views of hospital managers compare with those of agency nurse providers in relation to agency nursing work. The researchers conducted interviews with eight hospital nursing managers and three agency nurse providers. Researchers approached hospital administrators to identify nurse managers to participate in this study, as they recognized that these personnel had the responsibility of working with agency nurses. And, from three nursing agency providers, the researchers approached senior staff to participate in the study. Data analysis consisted of five steps: familiarization, identification of themes, indexing, charting and mapping and interpretation. Two investigators independently conducted a data analysis and then compared their findings. An exploratory semi-structured interviewing technique was deemed appropriate and found major themes of planning for ward allocation, communication and professionalism. The managers were concerned about adequate numbers of nursing staff, while

agency providers were concerned about the allocation of temporary staff. One interesting aspect that they found was managers focused on communication between agency nurses (travel nurse) and other permanent members of the health care team, while the agency providers were more concerned with the hospital as an organization and the agency nurse. Relevant finding were disconnect in communication between individual nurse managers and agency providers. Regarding professionalism, hospital managers were concerned about continuity of care, quality of care, and the morale and stress of permanent staff. Hospital managers felt that agency nurses were not able to fully adopt evidence based practice because they "did not hold responsible hospital posts in areas such as quality assurance and policy reviews" (p.463). However, agency providers recognized agency nursing as a good career choice for experienced nurses, as this exposed nurses to practice a diversity of skills in differing settings and there was an expectation that their practice was better than the normal ward staff. For example they noted that "nurse managers wanted travel nurses to be good people with good acute nursing skills, feeling they could just pick up the rest" (p. 402). This study recommended that further inquiry needed to be done to obtain the views of the travel nurse with the views of the permanent staff who work with travel nurses. Although this study was conducted in Australia, it brought forward general aspects such as nursing in unfamiliar environments, which seemed more relevant in the literature review pertaining to travel nursing.

Ea (2008) looked at U.S. hospitals to hiring FENs to address the critical nursing shortages. Building on the works of Alba and Nee (1997), Berry (1980), Schiller, Basch, and Blanc (1995), the purpose of this article was identifying strategies employers could implement to assist FENs to transition smoothly into the U.S. health care system and mainstream society. These strategies and recommendations were derived from the reported experiences and

challenges from FENs as they acculturated into host societies. The authors argued that there was a three phase process in which FENs acculturate: initial contact, conflict and adaptation. This article provided readers with strategies to help FENs acculturate by identifying areas of concerns such as difficulty in communication, change in professional roles and responsibilities, complicated work related routines, feelings of alienation, being devalued, and differences between personal and societal values. To aid employers in the U.S. to implement successful transitioning of FENs, this journal article provided possible strategies or theoretic tools which focused on addressing diverse cultures. The author recommended that further research in global migration and misdistribution of nursing personnel worldwide was needed.

In their qualitative study of overseas nurses working in Western Australia, Smith, Fisher, and Mercer (2011) looked at the lived experiences of a sample of non-English-speaking background nurses (FENs). Data was collected by interviews and included 13 nurses, their ages ranging from 25 and 55 years, from countries including China, South Africa, Japan, Taiwan, Zimbabwe, Hong Kong, Philippines, Sweden and Nepal. Data analysis was performed following Moustaka's method of analysis, which encompassed eight steps (Creswell, 2007; Moustaka, 1994, as cited in Smith et al., 2011):

1) Each transcription was read and every significant statement was listed and given equal value. This process is called "horizontalization".
2) In order to establish to invariant constituents, the recorded expressions were scrutinized for significant depth of the experience. A label then was applied, constituting a horizon of the experience.
3) Grouped together, the invariant constituents were flagged under a theme label.
4) Both the invariant constituents and the themes were checked against the complete record

of the participant's transcription.

5) Using the validated invariant constituents and themes, an individual textural description of each participant's story was written, including verbatim quotations.
6) Following this step, an individual structural description was constructed, where the imaginative variation was applied to the previous individual textural descriptions.
7) Then, a textural-structural description of the meanings and essences of the experience for each participant was written.
8) After completing the 13 textural-structural descriptions, a composite description of the meanings and essences of the experience was written.

The authors found that FENs described their new work environment as being overwhelmingly different to that of their home countries. An area of concern was informed consent, with Australian patients (like Canada and the U.S. patients) actively participating and making choices regarding their health care. Some FENs were unfamiliar with this practice, which would be quite problematic. With the FENs being more focused on patient care rather than on the documentation, the need to keep accurate records was also identified as a deficit. This article referred to the working relationship with doctors and made reference to "Ontario, Canada where the international nurses indicated that the local nurses were very assertive and quite involved in clinical decision making and therefore had a more egalitarian relationship with physicians" (Smith et al., 2011, p. 293). The study focused on preparedness to work, working with patients and working with doctors. The study affirmed nursing as being universal, but it also provided evidence that the practice of nursing as a profession is also socially shaped meaning the FENs had to adjust their practice to fit within roles of the new healthcare settings (Smith et al.).

In their qualitative research study of migrant health nurses employed in seasonal satellite

nurse-managed centers, Lausch, Heuer, Guasasco, and Bengiamin (2003) focused on the unique experiences of nurses employed in the upper U.S. Midwest who cared for the migrant farm workers. The migrant farm workers often lack health insurance and generally do not have the funds to pay for costly emergency medical services they might incur while in the U.S. In this particular study, the settings were small health centers equipped with no running water or electricity. The nurses themselves embraced the temporary assignments and participated in a brief overview of Hispanic culture in order to provide culturally sensitive care to the migrant workers. This study used a semi-structured interview guide with open-ended questions collecting data from ten nurses who were selected from six of the 11 satellite nurse-managed centers. Four themes identified were: seeking seasonal employment; establishment of nurse-managed centers; learning the Hispanic culture from migrant farm workers; and, referring Hispanic farm workers for medical care. The results of this study emphasized that the migrant health nurses' daily contact with their clients enabled them to establish a rapport which led to therapeutic trusting relationships and thus provided a culturally sensitive and lifestyle appropriate care to the migrant farm worker population.

Wheeler et al. (2013) conducted a qualitative study of the internationally educated nurses (IENs) in the Southeastern United States of America. This study was part of a larger study that utilized an explorative approach and structuration theory. Purposive sampling was used to recruit participants; after an IEN was recruited, the researchers sought to recruit a U.S. RN from the same unit and shift. Inclusion criteria for IENs were nurses, who were raised, received their initial nursing education (leading to licensure) and had at least one year of practice in their home countries. Participants in this study included IENs from Caribbean, European Union, Sub-Saharan Africa, Southwest Asia, East Asia, Pacific and Oceania, who had received their

Associate Degree, or Bachelor's degrees in the U.S. and other U.S.-trained RNs. The methodology included two rounds of semi-structured interviews with 42 IENs and 40 U.S. RNs from two urban hospitals located in the southeastern U.S. Methodology for data collection and analysis followed Creswell (2003, as cited in Wheeler, 2013) method of constant comparison. From the first round of interviews discrimination became evident, which prompted the researcher to ask specific questions in the second round when nurses were asked to describe discrimination at work. The analysis followed the structuration theory (Gibbens, 1984 as cited in Wheeler, 2013) and with the qualitative findings researchers built on interpretive explanation methodology (Sandelowski & Barroso, 2003, as cited in Wheeler, 2013). The study found that some problems IENs incurred were dealing with the attitudes of the U.S. patient, especially the lack of respect they received and how they negotiated discrimination in the workplace. This would be in line with nursing being socially shaped with culture. Nurses commented on difficulties transferring between different hospitals, and although they denied difficulty with the language, their co-workers and patients expressed difficulty understanding their accents. IENs felt that standards of care transferred regarding skill sets but also stated they experienced or witnessed discrimination which included derogatory comments, questioning the nurse's role, and refusing care by a patient's family and/or family members because of the nurse's skin color or accent. Regarding supervisory hospital personnel IENs report managerial favoritism, lack of advancement, discrimination by physicians and fellow nurses. The study revealed five ways in which IENs coped: ignore it, excuse the behavior, confront it, change units or shifts or leave position and/or work harder to prove themselves. From this study recommendations included: healthcare institutions implementing policy to address discrimination; healthcare personnel receiving training to work with different ethnicities; and, supervisors being trained to support nurses and

manage discriminatory interactions originating from patients and their families.

In concluding my literature review, a first person narrative was selected from Morrison (2012) who, as a Phoenix-based travel nurse, submitted editorials regularly to the *Healthcare Traveler* (a journal published for travel nurses). In Morrison's submission of July, 2012, regarding travel nursing, he addressed issues nurses should consider before entering the travelling arena such as needing to be independent (both professionally and personally), to be comfortable while hundreds of miles away from family and friends, and to be flexible. Morrison points out nurses considering entering travel assignments be proficient in skills such as IV starts, nasogastric tubes and Foley insertions, possess "good critical skills and the ability to put out fires before they are even started" (Morrison). This article was selected from 35 first person narratives reviewed as the intended audience was for the "first-time traveler," with the premise of transferability of skills.

Chapter Summary

My literature review on travel nursing found 76 pertinent articles, guided by the research question, is registered nursing as skilled profession is both portable and transferable between settings. This was done by defining searches to include foreign educated, immigrant and non-English speaking nurses who transitioned into the U.S., Canada and Australia. These articles were included because it was felt that barriers encountered by FENs, might also exist for English speaking travel nurses. The study by Manias et al. (2003a, 2003b) addressed the experiences of the travel nurse; however, this study did not include international placements. Although there were published articles on the utilization of travel nurses through local agencies, those tended to be through the lenses of the managers or employers rather than that of the agency nurses. Due to the popularity of travel nursing, there are many published personal narratives on this topic. In

summary the literature review of the experiences of travel nursing alone proved to be an understudied population; however, the decision to expand it to include the experiences of FENs in Canada, the U.S. and Australia provided additional information regarding the transferability and portability of the profession.

Chapter Three: Research Design

Research is defined as a systematic process of analyzing, and interpreting information – data - in order to expand our knowledge of a phenomenon which we are interested in (Leedy & Ormrod, 2013). We already know registered nurses travel between English-speaking countries such as Canada and the United States and that their education and training is presumed transferable and portable. The purpose of this study was to explore how these nurses adapted on temporary assignments; and, in their experiences, was nursing fully transferable and portable as is presumed. This qualitative study utilized the method called "interpretive descriptive" as developed by Thorne (2008). Data collection was primarily through individual semi-structured interviews with six travel nurses. In this chapter the design, sampling, procedures, analysis, ethics, limitations and scientific quality (validity and reliability) are discussed.

Design

According to Thorne (2008) interpretive description is a qualitative research approach that requires integrity of purpose derived from two sources: (1) an actual practice goal; and, (2) an understanding of what we do and don't know on the basis of the available evidence. The term description, in this study, is documenting what was perceived by examining a phenomenon. Interpretation is how the data was analyzed, or interpreted utilizing human social phenomena (Thorne). This study utilized an interpretive descriptive research design by conducting one-to-one interviews with six travel nurses, transcribing the data and illuminating themes from the analysis of the transcripts. Research Ethical Board (REB) approval was provided by the researcher's educational institution (Trinity Western University).

Sampling

Six nurses participated in the study. Purposive sampling was used. According to Leedy and Omrod (2013), "qualitative researchers are intentionally nonrandom in their selection of data sources. Instead, their sampling is purposeful: They select those individuals […] that will yield the most information about the topic under investigation" (p. 152). Purposeful sampling was used by identifying nurses who had international work experience from an available pool of travel nurses accessible to the researcher. Through my role as a travel nurse, I had access to the social community of travel nurses working in the Southwestern U.S. The potential participants were identified by me, the researcher and approached individually because of their first-hand international experience as travel nurses. Additional potential participants were sought by asking participants to identify nurses they thought might be interested in participating. One of the six participants worked with me in the same agency and specialty area; the others worked in other specialty areas in the vicinity.

For this study all six participants comparably have international experience working as registered nurses; further demographic details are shown in Appendix I. The nurses were all Caucasian and married with ages ranging from 39 to 59 years. Their length of nursing experience ranged from 8 to 30 years. Their practice experience locations were from Canada, England, the United States and Australia. At the time of the interviews, participants were on temporary travel assignments at the same location and at the same time in the Southwest United States.

Procedures

Interviews were conducted between October 2013 and March 2014. Participants were asked open-ended questions using an interview guide approved through the REB process (Appendix A). Interviews were recorded and then transcribed verbatim. Following the interpretive descriptive design as outlined by Thorne (2008), an in-depth analysis was conducted

by repeatedly going over the data until common concepts and themes began to emerge, a period commonly referred to as open coding or sorting (Thorne). Time spent immersed in the data was necessary to capture the uniqueness of each informant's lived experience. While following the interpretive descriptive design, similarities and differences emerged which allowed axial coding to create a matrix of headings and categorizations of the data (Appendix D). This data was then collapsed into major headings to capture the major themes of the interviews and allow a closer examination of the concepts and themes (Appendix E). By keeping the research questions in mind and reviewing the data a final code book was developed (Appendix F). Five common themes were identified:

1) Ability to transfer skills
2) Navigating policy differences
3) Overcoming English language differences
4) Acculturation, transitioning into new locations
5) Becoming aware of healthcare costs.

Ethics

A main ethical consideration was to secure informed consent from participants and to provide all with assurances of anonymity. Directed by the guidelines outlined by the REB through Trinity Western University, each participant was provided with a letter of information (Appendix G) regarding what the research study was about and why I was interested in interviewing them. Before any recordings took place, each participant signed the informed consent (Appendix H) and was given a copy for their personal record. Each participant was advised that they could withdraw from the study by referring to the contact information contained in their copy of the informed consent. All transcripts were coded by removing all

personal information, including identity; and, each informant was assigned a pseudonym name to further protect their personal identity which is only accessible by me (the researcher). Data collected was approved, kept confidential, password protected and in the custody of me (the researcher) in a locked file. Transcripts are to be shredded (and recordings erased) within two years of completing the thesis as stipulated in the Trinity Western University REB application, Section (E) Informed Consent Process, item (d).

An addendum was submitted to REB after data was collected to allow U.S.-trained registered nurses with international experience to participate in this study, as one nurse travelled to Australia and Canada, and one nurse travelled between Canada and the U.S.

The researcher being a Travel Nurse strengthened this study, as this placed me in a unique position to bring relevant questions to the participants and to critically analyze the data while bracketing my own assumptions in a reflexive log (to capture and identify researcher bias). Reflexivity was necessary to define my role as the researcher while being a member of the participating group under study; however, this also gave me a greater understanding of the participants, what they did and how they related with one another. Maintaining confidentiality meant that during the comparative data analysis, interview data was not shared between the participants.

Scientific Quality: Validity and Reliability

According to Steubert and Carpenter (2001) validity could be understood as how convinced is the researcher that what the informants have shared is valid information. This process of determining validity began with open-ended questions during individual interviews which were audio recorded and then transcribed verbatim. This increased the accuracy of the data collected because this was the closest “true” voice from the informants (Streubert &

Carpenter). Validity was captured by creating a unique code book developed from the data collected (Appendix F). External validity would focus on the descriptive and interpretive nature of this study with findings being representative of the voice of the informants. The same open-ended questions were asked to each informant. Being the only researcher, I conducted all the interviews and data analysis. Findings of interest were clarified individually in collegial discussions post interviews and during transcription to validate the representative voice of each of the informants.

Limitations

The informants were asked to participate and because of the voluntary nature of their participation, there is always a possibility that this group will present one particular perspective on travel nursing, that is, they are not representative of all travel nurses as a whole. The findings depict six Caucasian nurses whose homes represented various geographical locations and national or cultural identities, but who were employed in one particular location (the U.S. Southwest) and at one point in time (between October 2013 and March 2014); therefore, the findings of this study cannot be generalized for all travel nurse experiences, as the intent of the study was to gain a deeper understanding of each individual informant's first hand experiences. As only female nurses were interviewed, the experiences shared may be biased pertaining to sex. The sample size is considered small and is not without subjective components and that another group of individuals interviewed at another point in time, may generate different data. And lastly the researcher's personal participation as a travel nurse cannot be completely removed when working through the data analysis. I did have personal interest or conflict bias regarding the travel nurse experience. Arguably, an insider's perspective placed me in a position to be more relational in analyzing the data collected. This was managed by keeping a reflective journal

during data collection and analysis.

Chapter Summary

The chapter covers the research design methodology implemented to collect and analyze the data and examines the scientific rigor, ethics and limitations. The interpretative descriptive design (Thorne, 2008) was selected for the flexibility it provided in working with a small sample size. Open-ended questions were used in semi-structured interviews to capture individual experiences. Ethical considerations are in place to protect the identity of the selected participants. Limitations to the study are identified and acknowledged by the researcher which include a small sample size of participants, only females were interviewed, and the researcher's own personal interest in concurrently participating as a travel nurse.

Chapter Four: Findings

The findings presented here include a brief profile of each participant utilizing a pseudonym for identification, so that the reader can deeply relate to the informants. The five themes derived from the interviews were; *Ability to transfer skills*; *Navigating policy differences; Overcoming English language differences; Acculturation, transitioning into new locations;* and, *Becoming aware of healthcare costs*.The study focused on six registered nurses with international working experiences. International experience is defined here as crossing borders to work between two or more of the English-speaking countries (Canada, the United States, Australia and England). In this study these nurses were employed at one location (Southwestern U.S.) and at one point in time.

Profiles

Brenda graduated in Canada with a Baccalaureate of Science in Nursing; she then specialized in oncology before beginning her travel career. Brenda is presently working in Canada and the United States on independent and agency work assignments. At the time the interviews were conducted Brenda was working on a contract for five months on an oncology unit. The summer (2014) Brenda continued working on contract in Canada.

Mary graduated from a School of Nursing in Canada and is a diploma prepared registered nurse who, before beginning her travel, worked in a small hospital which provided community emergency and urgent care services. Mary has travel assignments in Canada and the United States. At the time interviews were conducted, Mary worked on a medical telemetry unit in a 13-week contract, after which she returned to Canada to work in a community hospital near her home.

Mona graduated in Canada with a Baccalaureate of Science in Nursing, and trained as an

operating room nurse before taking on travel assignments in the United States. Mona maintains a Canadian license and citizenship; however, she works predominantly in the United States on assignment. With Mona's nursing background, her job assignment was working in information technology; this contract position entailed Mona reviewing and making recommendations for electronic charting from a nursing perspective.

Pearl received her Baccalaureate of Science in Nursing in the United States, traveled to Australia where she studied for her Family Practice Nurse Practitioner, then returned to the United States where she secured her Masters in Nursing Education. Pearl has worked long contract assignments in Australia before returning to work in Canada and the United States. At the time of interviews, Pearl was working on a cardiac/stroke unit in the Southwestern U.S. Pearl now works in both the United States and Canada.

Sally is an American diploma prepared nurse who trained in intensive care (ICU); she is presently working as a travel nurse in both the United States and Canada. When interviews were conducted she worked in adult ICU and backfilled in gastroenterology (GI) and emergency (ER). She returned to work in Canada on contract in a skilled nursing facility focusing on geriatrics in Saskatchewan.

Eleanor graduated from a School of Nursing Program in England for the *State Registered Nurse*, she then went on to train and work there as a midwife before immigrating to the United States where she initially worked as a travel nurse. She was approached to participate in this study because of her past travel nursing experiences between England and the U.S. Eleanor was working as a temporary Nurse Manager overseeing a medical telemetry unit which accommodated the increase in census; this particular unit operated between the months of November (2013) and April (2014). Eleanor continued her employment with the same employer.

For this study five of the participants comparably have international experience working as registered nurses between Canada and/or Australia to the United States; and, one nurse who had international experience working in England to the United States. Demographic details are summarized for the six nurses who participated in Appendix I. Major themes derived from the interviews were: (1) Ability to transfer skills; (2) Navigating policy differences; (3) Overcoming English language differences; (4) Acculturation, adapting into new locations; and, (5) Becoming aware of healthcare costs. These themes are further summarized in Appendix F.

Findings

Ability to transfer skills. The six nurses interviewed agreed that their skills were transferable between hospitals and countries. Skills included clinical procedures as well as the critical application and evaluation of relevant knowledge and judgments. The Canadian trained nurses who transferred to the U.S. to work commented that their practice had not changed and the skills they learned and practiced in Canada transferred to the United States. Ultimately each nurse was guided by practice standards from their originating place of licensure, the basis being to provide safe competent care:

> The difference between Canadian and American nursing, just in general is, I think Canadians look more at it more holistic and I think American is more task oriented type of nursing. Canadian emergency, there we're still doing our task but, you know, were looking at more the people and their family and calling in and it's a little bit more focused on the psycho-social aspect of nursing and here it's like, let's treat the patient and be done with it and move on. Those are the two things that I've noticed in general. Skill wise they're about the same. (Brenda)

> Like me being a travel nurse, I mean that's the first thing is how do people want things done because nursing is nursing and I think that's just trans-cultural. Like I mean, if I'm going to insert an NG tube (nasogastric tube) in Canada and in the U.S., it's going to be the same, you know like *Perry & Potter* or whatever book they're using, pretty much generally it's going to be the same. But maybe it's the way they do it, and the documentation and the people here are all going to be different. (Brenda)

Pearl, an American trained nurse was required to preceptor for six months in an Australian hospital before being granted full licensure to work there even though she felt her skills transferred as an American baccalaureate prepared nurse. She found it upsetting as she presumed that her clinical skills would transfer to Australia from the United States. At that time, the majority of nurses practicing in Australia were diploma prepared, so being a baccalaureate she felt she was more than qualified, therefore facing discrimination by being devalued:

> They thought that I needed to be pre-ceptored, so for six months I was pre-ceptored in a hospital, this was in Australia. And it really upset me that I had to be pre-ceptored. (Pearl)

Sally, an American ICU trained nurse transferring to work in Canada was required to work through learning modules and be "signed off" on clinical procedures, such as inserting Foley catheters and starting intravenous catheters (IVs). This registered nurse felt Canada did not recognize the transfer of skills with advanced clinical assessments; implementation of critical judgement and evaluation. She commented her skills as a registered nurse transferred; however, she also had to be tested in clinical procedures in order to practice independently. These were thought to be bridging programs established by the provincial board of nursing in order to evaluate and license foreign educated nurses:

> I had all these books that I had to go through and I had to prove that I knew how to give shots and prove that I knew how to start IVs and Foleys and there was a lot of testing that you had to do, like there were modules that I had to go through. I think the skill factor is the same (between the U.S. and Canada). IV pumps are exactly the same, like the IV pumps I used in Canada are exactly the same as the ones I use in Missouri. (Sally)

A comment surfaced between the Canadian and American nurses regarding the dispensing of IV medications; that, there were many drugs that are pushed directly into an IV in the U.S. and that these same medications are routinely diluted in mini bags in Canada. This is called 'piggy-backing' and the diluted medications are dispensed at a much slower rate. Canadian nurses were very uneasy with the practice of pushing these IV medications when practicing in the U.S.:

> Here all the meds, like Solumedrol, policies are always in bags and to be run over a half an hour, now I'm pushing these meds and I was feeling uncomfortable with that, it seems that there's no adverse effects to it so, it's just another thing to get used to. (Mary)

When asked one of the American nurses who practiced in Canada commented on not being accustomed to not being allowed to push these medications as it was against the hospital's policy:

> Yes I had to learn that too, that was a big difference, I pushed one time and I wasn't supposed to, a high dose non-steroidal anti-inflammatory, Toradol, yes […] so those are big differences. (Sally)

American nurses commented on the use of stock medications in Canada, mentioning it concerned them that any medications that are 'used regularly' were stocked on floor units for nurses to dispense. As well as over-the-counter medications, popular prescription medications were also readily available. The main concern expressed by the American nurse was the loose-control of

these medications on the floor and the increased the possibility of infection by cross contamination. By loose-control, she meant the medications are readily available for immediate dispensing without being processed by a pharmacist. Stock medications are refilled to the unit, there is usually no control other than the medication administration record (MAR):

> Well just even for over-the-counter medications there is a big difference, if you went and gave somebody a Tylenol, it has to be dispensed by pharmacy (in US), and it has to be sent up, and there has to be charges, to where I know in Canada, all your over-the-counters, your *Tylenols*, your *ibuprofens* and your *Coumadin*'s, anything that was common and standard, not even *Coumadin* being over-the-counter, but something that you dispensed quite readily, say like everybody got a *Protonix* every day, a pill, it always amazed me, like I said, like it would be in a bin, like let's say you had a bottle of 100 of them, and if that person gets it, you get it, you're getting it out of the bottle which you give it to them, which always grossed me out, because you got how many different fingers in the bottle. (Sally)

In summary the registered nurses interviewed felt that their skills, that being advanced clinical assessments and implementation of critical judgement and evaluations transferred between setting and countries of Canada and the U.S. Their nursing was guided by standards of practice which supports the notion of transferability and portability of the profession. Manual skills, such as the described clinical procedures, also transferred; however, American nurses spoke of having to be tested and re-evaluated in Australia and Canada. When nurses were asked to perform differently (example pushing IV medications), they were uncomfortable; however, these same nurses adapted when they found no clinical evidence to support otherwise. This acknowledges the paradigm "different ways of doing," being supportive of therapeutic outcomes in nursing.

Navigating policy differences. Regarding policy and protocol, two nurses agreed that they differed between hospitals, and not between countries and one nurse stated that the standards of practice were very different between England and the United States. One Canadian nurse who worked at more than one location in the United States found that some hospital procedures were based on policy and protocol, and other hospitals based their procedures on the latest research, also known as evidence based practice. Her experience was that policy and protocol differed between hospitals but not between the two countries. This nurse commented:

> They (Children's, US hospital) were always on top of the latest research and they worked hard to make sure they practiced well and took really good care of their patients. So, it was, it seemed like it was a hospital wide issue. (Mona)
>
> I was trained to do everything be the book, you know and to really understand what you were doing and why you were doing it and to always be doing everything the best you can possibly do it, you know. And if you felt you couldn't do it under the circumstances, you speak up […] as far as my own personal practice, nothing changed. (Mona)

The nurse from England felt the American policy and protocol to be somewhat behind what she was used to. Coming from England, she felt a loss of autonomy from supporting her practice based on the latest research, to then being guided by a hospital's policy and protocol manual, as she found she was required to do in the U.S.:

> I mean I've been a nurse for 30 years, a lot of it was you need to read the research, you need to understand the research and use that to base your standards of practice on, so it was early Evidence Based Practice which I didn't have here when I first came. (Eleanor)
>
> I had a vision of America being so much more advanced and I was actually surprised at how behind England it was, and in those days I would say it was about 10 years behind,

> and I got that experience from coming over as a midwife. In England we had LDRP concept (labour & delivery, recover & postpartum) we delivered, we delivered in the same place, we didn't get people to complete, take them to an OR, put them up in stirrups and bright lights and you know the doctor didn't have to deliver, we did what the patient wanted, it was very patient centered. (Eleanor)

Similarly to Eleanor, before taking an assignment in the U.S., Mary a Canadian nurse envisioned practice in the U.S. to be the same as it was in Canada. She similarly found a constraint related to policy and procedure expectations: routine procedures were to be performed as outlined in that hospital's policy and protocol manual, which requires nurses to read over before performing routine procedures:

> I felt I could step right in there were a few changes in policies, for instance I'll give the PICC (peripheral Inserted central line) removal, as an example; both the patient and the nurse wearing a mask to remove a PICC, that is not one of our policies in, and I'm just using that as an example, yes it's not one of our policies in Manitoba to do that. In [Manitoba] a PICC line just comes out. (Mary)

The American nurses commented on the importance being familiar of the policy and protocol in individual hospitals in clinical practice:

> Well this hospital was just a residency program [for physician training], just for first and second years [students and] then they moved onto another place. I had a patient that was going to be discharged and they had a central line and we've always pulled out central lines, so you know doing all the discharge, I pull out the central line and the patient is sitting there, the next thing I know I have a resident at the door "where's their central line?" "Well I took it out." "Well you guys aren't supposed to take out central lines!"

> Well that was bizarre. So you have to, like, a lot of times figure out even in different settings what your role is as a nurse, what you can and can't do, when you're working teaching hospitals, sometimes it doesn't carry over. (Sally)

In summary, American and Canadian hospitals have policy and protocol guidelines in place for registered nurses to follow. According to our nurses interviewed these guidelines differed between hospitals rather than between countries. Some hospitals were more up-to-date on the latest research, whereas others were not. Nurses who were trained in early 'evidence based practice' described a loss of autonomy by having to be guided by hospital policy and protocol. As intermittent travel nurses, these nurses did not openly challenge hospital policy, but rather adapted their practice to conform to hospital guidelines.

Overcoming English language differences. Travelling between English speaking countries (England and the United States), a nurse may not envision encountering difficulties with the English language; however, as the following section shows, some of the participants did:

> I was very shocked, it was a big cultural shock for me, the difference, I spoke a different language basically, our tones are different, we use different names for drugs, and everything was very different, more different than I expected. (Eleanor)
>
> Culture, very different language, very different, everybody thought I was Australian which was very bizarre to me. (Eleanor, from England)

Other English-speaking nurses had similarly surprising difficulties with English. Pearl, who immigrated to Australia with her baccalaureate of nursing degree, was required to undergo an interview before being allowed to work in the Northern Territories. During the interview conducted by the Australian Board of Nursing, she had difficulty understanding what was being

asked due to the unfamiliar accents. Possibly because of her difficulty understanding, decisions were that she had to be mentored for an additional six months in an Australian hospital before being allowed to practice independently in the Northern Territories:

> I went to the Northern Territory and I had to be interviewed by the Board of Nursing (pause) interviewed! Okay and I was going through learning all their accents and the whole thing, and I remember them asking all these different questions, because they were trying to decide [whether to hire me]. (Pearl)

The Canadian nurses also experienced subtle language differences in practice, which could be attributed to geography rather than country. In the following example, subtle differences between words (such as dinner meaning an evening meal in one setting and mid-day meal in another) can negatively influence patient care:

> The other day I was asked if the patient was NPO (nothing to eat or drink), “he’s just had his dinner that’s all,” and the person on the other line was not very happy with me and I said “I’m sorry I didn’t know he was NPO until after dinner,” and they said “he’s already eaten his dinner!” and I said “yes,” “but he’s supposed to be NPO after lunch,” and I went okay that’s right you have your breakfast, lunch and dinner, we have breakfast, dinner, supper and so that was a real, I was just , it was terrible. (Mary)

Between Canada and the United States, language can also present challenges, even between these two predominantly English speaking countries. While English is thought to be standard across both Countries (Canada & the U.S.) there are several recognizable variations in pronunciation, or accents attributed to regional dialects. With the globalization of healthcare workers, accents continue to be contributory to problems in communication. In this predominantly Hispanic area, nurses encountered English as a second language by some local

co-workers and patients and they expressed difficulty in understanding the local accents. For example, Mary, a Canadian who works in the U.S. noted the variety of accents to get used to in the U.S. setting:

> A language barrier and I've also noticed regarding languages, that I'm having a difficult time, I don't know maybe I'm getting hard of hearing, but I'm having a very difficult time understanding the doctors and I'm having a very difficult time understanding the Mexican nurses or the healthcare aids, I don't know if it's, if I'm just not understanding them because I can't hear them clearly or if it's their accent. I'm really noticing American accents and I haven't really been, I mean it's never occurred to me before that somebody would have had an accent but I really noticed a lot of them here now. (Mary)

In summary, the six nurses had to overcome barriers related to communication in English. They reported subtle differences that could affect patient outcomes in regard to word definitions. They reported difficulties understanding local accents. They had to go through a period of "getting used to" the local accents and this was something that they did not anticipate when deciding to travel to another English speaking country.

Acculturation, transitioning to the locations. Through the experience of leaving their homes and working on foreign assignments, travelling nurses recognize the diversity of culture. In their temporary places of work, they live and practice going into the unknown. The nurses spoke of becoming increasingly sensitive to cultural diversity which would have entailed encountering different patients and ethnic diversity. Previous studies on the profession of nursing support it being socially shaped with area culture (Smith et al., 2011). In these comments nurses spoke about encountering new environments:

> When I was working in Wyoming (laughs) it wasn't unusual to come home and find cows in the middle of the road and that was strange for me because I didn't grow up on a farm, I grew up in a city (laughs). Actually another funny thing that happened in Canada was a moose trying to get into our emergency department. (Mona)
>
> That [cultural diversity] I do love about travel nursing, because if you go on vacation someplace your there for a week and you're hitting the highlights and when you actually go and your there for 13 weeks or longer, you meet the people, you get involved with the people, you get to know the culture, the different foods, you find out there's a whole different world, even within the United States and in Canada. (Sally)
>
> Asked about cultural diversity, (pause) I mean it's great having cultures in there, it just adds a little spice to nursing in general, and I'm all for it, I've travelled all over so I just love people and other cultures and learning their cultures (pause) I don't know, that's what makes nursing interesting. (Brenda)

From the perspective of participants, a culture shock was not expected between the two countries Canada and the United States. However, Mary, this nurse from Manitoba (who had been working on assignment for just two weeks when she was interviewed) commented:

> There's so much cultural diversity here, regarding even people just the way they live, (pause) it's so different I realize, that to sum it all up, I realize how, (pause) closed up I am in a box when I'm at home and I like being in that little safe environment, but I still think that crawling out of that safe environment is what you have to do, like I say every time I've taken on an assignment, I'm humbled by it and I truly mean that because, I get working in a place for so long and you think that you know it all until you go someplace else and then you think "gee" I don't even know half of it. (Mary)

Eleanor, the nurse coming from England commented on what she perceived as the lack of professionalism demonstrated by lack of attention to dress codes and grooming. In her experience, attire is an “England Standard of Expectation.” This experience was not consistent however. For example, this hospital was currently adapting a mandatory uniform dress code (i.e. all navy blue for RNs) to be implemented by January, 2015. Still, working at this location, Eleanor found that the nurses just wore whatever they wanted to interviews for jobs which shocked her:

> I’d dress in business clothes and everybody else would be in jeans and T-shirts, to me that was (pause), that was what I would have to wear, people would come in, like a few weeks ago I’d be like interviewing them and people would come in with whatever they wanted to wear, it doesn’t bother me, I mean I’m not really that stuffy, but I was appalled as that was such a standard in England. (Eleanor)
>
> The professionalism, we were very much more [concerned with attire], I was shocked to see nurses with fingernail polish and long nails, I was an L & D (labour and delivery) nurse, and you do vag (vaginal) exams. (Eleanor)

An interesting point made, was that we know cultural differences can exist between countries, but the participants were surprised by cultural and language differences between the English-speaking nations (Australia, Canada, the U.S. and England). They were further surprised by cultural and language differences within a country. When asked about negotiating cultural differences and shocks in the United States, Mona, the nurse from Montreal described culture shock she experienced going from Montreal to Toronto:

> I’ve even had cultural shock in Canada itself. When I moved from Montreal to Toronto I experienced cultural shock. Montreal is a very multi-cultural and very European and

> friendly, kind of more attitudes. And so that's what I grew up with. And when I moved to Toronto, I found all the different cultures very segregated and not very friendly to each other. (Mona)

In view of enduring the hardship of relocation and acculturation, the question arose; why would some nurses choose foreign travel assignment over the security staying in their home countries. Mona, a Canadian nurse, expressed remorse as to not being given the opportunity for advancement in Canadian hospitals in a field she was trained for:

> I never worked in an operating room in Canada, I could never get in. There's something that I found different between here and there, because of the unions it's so difficult to get a job in Canada, I mean there is so much job sharing there and, good luck trying to get into an area you actually want because they don't consider who is going to be the best in the area, it's just who's next on the list [i.e. in terms of seniority]. (Mona)

Although Mona was negative about unions, Pearl, an American nurse, might have benefited from union affiliation. From these comments, unions may have intervened in an abusive situation, as Pearl described here:

> I was working for an agency which paid me terrible and provided me with housing 40 minutes away and I had to pay a toll bridge to go to work all the time. And when I got sick, no body helped me; in fact they were getting ready to fire me because I was sick. So I asked for an exit interview and told them shame on you for the way you treat your travellers [i.e. travel nurses]. (Pearl)

In conversation with the other two Canadian nurses, the topic of unions was never brought forward; it was only Mona who expressed disappointment in lack of advancement in Canada because of unions enforcing seniority. Some of the participants made note of practice which is

done routinely for nurses and other employees in hospitals in the U.S. but not in Canada – that is, that they are all required to pass a drug screen test. This is conducted before employment begins. Within 30 days from a start date a nurse will provide a urine drug screen and mandatory annual diagnostic test for tuberculosis and immunizations. This is usually not a mandatory practice in Canada, as pointed out by Sally, an American nurse who worked in Canada:

> One thing that I always get and I don't know if you guys have to do this? Anytime I start a travel job here [U.S.], or do anything to have a job, I have to do a drug test (urine) and I've never had to do a drug screen in Canada for a job...so I don't know if that's just... [Pauses, remembers that Canadians might have to take] TB test, that's an annual thing you have to have here every year, in Canada you don't have to do that. (Sally)

Regarding transitioning into different work environments, Brenda, a nurse from Canada, spoke to the differences in shift schedules between Canada and United States, with the absence of an 8-hour shift choice at this location; all shifts were 12-hours. Brenda also commented that there was loss of team nursing as staff worked either all nights or all days; consequently a loss of team nursing can set in with an "us versus them mentality" due to the segregating of employees into nightshift workers and dayshift workers. Generally the staff did not mix schedules at this location. Although nurses identified this difference in shift culture as being between countries, it did vary between hospitals, so may be best seen as a hospital policy rather than a country policy. The participants noted that by taking travel assignments, they don't have to engage in politics. Similarly, if they find themselves in hostile environments they know that the assignment will eventually end and they can move on. This was seen as an advantage to travel nursing:

> Did that [assignment] for another 9 months and that become very political, things with the chief [Indian Band, Canada] and them [the Band] telling me what patients I should

> see and not see in home care, you know, in home care it got very political, I tackled that, then left. (Brenda)
>
> I think one thing that is interesting about travelling is you learn how to pick your battles and you don't have to get involved with the politics. That was always the number one reason for me always travel nursing […] For me travel nursing works well because I don't get involved with the politics and the gossip, the stuff that makes nursing bad […] I'm going to do my job, I get along with everybody and I can walk out the door, so I mean for me that's great, not having to get involved in the politics. (Brenda)

According to the participants, being the travel nurse means, they are sometimes seen as the outsider in the culture of a unit. As such, they self-monitored their position in the practice. They wanted to fit in with the healthcare team. However, they sometimes found themselves bending their own morals in order to blend in, and this could be problematic, as expressed by Pearl working in Australia:

> Everybody else, a lot of them were like nasty and that was another thing that was hard for me because um I could see myself sometimes trying to blend in, you sometimes start bending your own morals, yes, your own way of thinking, even though you would think to yourself "I'm kind to everybody," but yet you have to blend in with people that were saying bad things. And you'd either have to keep your mouth shut because you didn't want to get harassed yourself and just do the right thing, and that's usually what I did. Just because of, you know peer pressure. (Pearl)

In summary, transitioning included being confronted by different cultures, not only between countries, but within countries at different regional locations acknowledging the cultural diversity. Supporting how nursing is socially shaped, professionalism in work attire was also

commented on. Working with union membership in Canada protects registered nurses; however, these same unions can prevent new graduates from advancement due to lack of seniority. In order to be prepared for employment, nurses in the U.S. are required to pass drug screens; this was not something that was routinely practiced in Canada. Nurses spoke about hostile environments, politics of a unit and being the outsider; however, travel nurses saw a light at the end of the tunnel with the end of the contract. Unfavourable politics encountered included gossip, and "everything that's bad about nursing" was seen as temporary annoyances.

Becoming aware of healthcare costs. One interesting finding reported by the Canadian nurses was how working in the U.S. heightened their sensitivity to (and in some cases their realization of) the costs of healthcare. The Canadian nurses reported in Canada they were acculturated to focus on the patient's needs and not on counting the cost or the billing for healthcare. It was when they travelled to the U.S. where they became aware of actual end-user costs of healthcare:

> I don't like this one in the U.S. compared to my Canadian [experience], because never have I had to look at billing before. (Brenda)
>
> Big disconnect between the people who are were using that stuff [i.e. medical supplies, equipment and pharmaceuticals] and the people who were paying for it, or planning it or whatever. So I really found nurses were, are much more involved in the general operation of the hospital in the U.S. than in Canada – in Canada you just go in you're a nurse and that's it. (Mona)
>
> I was suddenly realizing wow, like how much we waste in Canada, because you never, ever think about it at all. You know that even the smallest things like a cotton swab, how much money that costs, you know you drop it on the floor and go "oh now it's dirty" and

> you throw it away or whatever [without considering the cost]. (Mona)
>
> The only different thing which was not related to standards of practice that was weird for me was having to keep track of charges. So that was an eye opening thing. I was amazed to find out how much things cost. I can't say that it was a bad thing; it was really weird at first that it was kind of an extra thing I had to do in my job. I was like, "oh my gosh," I'm not only responsible for documenting and taking care of the patient, but I have to, I'm really responsible for documenting correct charges and it's like I can get into trouble if I don't do it right, you know. It was really eye opening. (Mona)

The American nurse Sally, who travelled to work in Canada, also commented on not having to be accountable for the billing:

> First time I ever discharged somebody from the acute care hospital, I sent them home with everything, everything that was in their room, I sent home, like if there was extra [supplies]. And then I got told that if extra wound care stuff [was left] I count not send it home with the patient. Because to me, I am always constantly looking for where do you charge this, where's the sticker, how do you charge for this. And that always blows my mind the difference [between Canadian and American hospitals is that in Canada] nothing is charged for. So there again I don't think there's an accountability [in Canada]. (Sally)

Although the cost of healthcare was never an intended theme to be included, this was brought up by all Canadian and American nurses during interviews. The Canadian nurses strongly felt that becoming aware of costs had influenced their practice, meaning it was something that they think about when providing care by minimizing waste.

Chapter Summary

The findings from this study can be differentiated into five themes: (1) Ability to transfer

skills; (2) Navigating policy differences; (3) Overcoming English language differences; (4) Acculturation, transitioning into new locations; and, (5) Becoming aware of healthcare costs. Each participant expressed a belief that their nursing skills and practice standards were transferrable between countries. However, they also found that clinical practice was ultimately guided by the policy and protocol set out by the institutions where they were employed. Although these specific hospital policy and protocols may have been different, each of the travel nurses interviewed adhered to these while on assignment. Participants also spoke to negotiating difficulties with language. Each nurse's native tongue was English; they did not envision this as being as problematic as it was. In terms of transitioning, participants spoke to their experience of culture differences in acclimatizing to new areas; meeting new people; exploring new areas; and, experiences in learning different "ways of doing." One notable experience was that hospitals perform mandatory drug screens in the US, whereas this is not a requirement in Canada. Canadian nurses spoke to the realization of the actual cost of healthcare, as billing the patient was never an expectation in Canada and while on assignment in the U.S. they became cognizant of costs while providing care to patients. American nurses were concerned at the lack of accountability or responsibility in managing the costs while in Canada practicing.

With regard to transferability and portability of the profession, clinical skills transferred, but most importantly skill acquisition, and critical application and evaluation of relevant knowledge and judgment also transferred. Unexpected findings were English-speaking nurses encountering problems with communication between Canada and the U.S., as well as within the countries. Although nurses negotiated between a nationalized healthcare model in Canada and a privatized model in the U.S., American and Canadian participants had concerns over waste in Canada which was also an unexpected finding.

Chapter Five: Discussion

This study supports the transferability and portability of the registered nurse primarily between Canada and the United States, that is, the participants fully expected and found that the nursing skills and professional standards were relevant to their work as travel nurses. However, the findings of this study reveal that the transition between nursing cultures was not always smooth or as seamless as they had originally expected. This study used English-speaking informant nurses who could be described as having firm roots in Western culture and medicine having been trained in the U.S. or in Canada. This demographic made my comparative analysis between the published research literature somewhat problematic, as the published literature focused primarily on FENs or IENs (non-U.S. or non-Canadian trained). Therefore, the following analysis presents a unique viewpoint from an understudied population. Despite this difference in demographics, the participants in my study encountered many similar experiences to those in the previous research studies.

In the study by Smith et al. (2011), FENs needed to adjust their practice to conform to new work environments. Examples were having lower patient loads, conforming to patient centered models of care supporting informed consent and the need for accurate documentation. This was supportive of nursing being a socially shaped profession; meaning that some FENs who traveled from foreign placements encountered different role definitions in the workplace. Unlike the FENs from that study, our six English-speaking nurses who worked between Canada and the U.S. were accustomed to similar healthcare delivery models.

Regarding the transfer of skills, the six nurses expressed that their skills transferred and that they did not incur practice problems between Australia, Canada and the U.S. However, they did note that hospital’s policy and protocol had to be followed. The nurses were ultimately

guided by practice standards which transferred to new places of employment. Nurses travelling to new placements needed to review the policy and protocol in every clinical assignment as differences did exist. This finding was deemed important because of the more recent trend towards the implementation of research-based or evidence-based practice, indicates some hospitals are adapting to the latest research guidelines, whereas others may be lagging behind.

Policy and protocol (per: Mona when working at Children's Hospital in the U.S.) was based on the latest research, or what the latest research says was best practice, hence research based practice or evidence based practice [EBP]. It would seem that nurses reported that policy and protocol varied between hospitals rather than it being a "country thing." Having policy and protocol in place enabled the American nurses to transition into Canadian hospitals, as they were accustomed to reviewing them before performing clinical skills. Although certain nursing skills are within the scope of practice of a registered nurse who has been trained to perform that skill in one region or country, a specific hospital's policy and protocol may prevent this same nurse performing this procedure, as it may not be allowed according to their current policy. I would conclude that travelling nurses could be used as instruments of change and perhaps benefit the profession in keeping up-to-date with evidence based practice. However; travelling nurses abide by the hospital policy and protocol, which varies between hospitals and a nurse must be cognizant of this while on assignment. This is an important finding because there is an emphasis that hospital administrators or employers should regularly review and keep policy and protocol up-to-date. Interesting for further study, would be how traveler nurses could be change agents while appropriately following hospital policy and protocol.

I surmise from the experiences from the nurse from England that our practice guidelines are behind. The nurse from England stated that her practice was based on the latest research and

what she was expected to do in the U.S. was out of date; this was what she was taught almost 30 years ago. She referred to what she did in England as being the early evidence based practice and that the United States was behind England in this regard. She provided a few examples of practice procedures she observed in the U.S. such as '*episiotomies*[3]'. To this nurse, this practice procedure she observed was outdated and she was "horrified" that they were still in usage. However, although she presumed that these outdated procedures were part of the U.S. practice standards, in speaking with other nurses, she found out that these differences were between hospitals rather than countries. In her English training over 30-years ago, she was taught that clinical practice was guided by the latest research and nursing was a patient centered model. The questions that arise concerning these differences are, is this more discipline specific with midwifery in the U.K. being more progressive in child birth approaches, and are differences evident in other areas, such as Medical Surgical. This is another interesting query which could require further investigation, as it concerns how evidence based practice is practiced.

The nurses encountered difficulties with language, specifically in understanding different accents and similar words used but with different meanings. During orientation, nurses were asked to avoid slang phrases and speak in standardized English; however, difficulties still surfaced negotiating accents and tones and comprehension. This was not envisioned as being problematic when taking on travel assignments in English-speaking countries and the nurses admitted to being surprised that it was, as it was not what they had expected. According to Ea (2008), communicating was identified in this study as being one of the major challenges that FENs face after immigration. The report of six English- speaking nurses being intimidated by accents, use of idioms, and speed of speech of the native speakers, was an unexpected finding.

[3] Episiotomies: also known as perineotomy, is a planned, surgical incision on the perineum and the posterior vaginal wall during second stage of labor.

This raises the possibility that English-speaking, as well as non-English speaking travel nurses encounter the same problems with verbal communication.

With the advent of internet communication, all nurses interviewed kept in close contact with family and friends from back home. Thus, they found that the transition of being away from home was not too traumatic. The nurses spoke about discovering a world outside of their own and appreciated the diversity of meeting new people, trying new foods and exploring different landscapes. These are the main factors that are thought to enrich travel work in general (Morrison, 2012).

Transitioning in practice meant encountering different “ways of doing” things and nurses did report stark differences which at times made them feel uncomfortable. However, the nurses quickly adapted to these changes. Having to submit to urine drug screens, TB-tests or mandatory immunizations were not thought to be barriers in practice. According to Berg et al. (2012) prevalence of healthcare worker drug abuse problems could be reduced by implementing mandatory drug screens. Any employer in the U.S. is permitted to enforce mandatory drug screens, whereas in Canada this is not a prevalent practice. According to British Columbia Nurses Union (BCNU), an employer must have ‘good reason’ to urine drug screen an employee; the employer must first approach the union representative presenting a case; the employee must be given up to 72-hours’ notice; and, the union representative must be present during collection. The Union acts to protect employees who might have drug addictions by advocating for their treatment and rehabilitation.

Moving between countries meant applications for licensure, visa screens, credential verifications and re-writing nursing exams in the U.S. Since 2008, the U.S. has implemented a mandatory health credentialing verification visa screen. The traveling nurse from another country

(including Canada) intending to work in U.S. as a registered nurse must have her education credentials and all previous licenses verified by a separate agency (such as the non-profit Commission on Graduates of Foreign Nursing Schools, CGFNS, who is supported by the American Nurses Association and the National League for Nursing). This process can take three to six months. If the nurse is an American citizen trained in Canada, this is not a requirement, however she must still pass the NCLEX exams. Canadian nurses did not need to enroll in bridging programs however were required to pass the NCLEX exams and have their credentials verified by a credentialing agency before licensure in the US. Regarding travelling from the U.S. to work in Canada, only one diploma prepared American nurse was required to enroll in a bridging program to qualify for provincial licensure and challenge the CRNEs. The other master's prepared American nurse had been licensed to practice in Australia and her credentials were accepted in Canada. This supports verification of foreign credentialing as being individualized applications. One American nurse was not required re-examination to be licensed and work in Ontario; however, she was required to be pre-ceptored for six months in Australia. I questioned the nurse (who has dual citizenship with Canada and the U.S.) why she chose to attain her nursing education in Canada? She replied the Canadian license and education opened doors to the Commonwealth countries and provided greater opportunity for travel; whereas, the U.S. License alone did not. According to CGFNS, the state nursing boards in the U.S. recognize nurses educated in Canadian Schools of Registered Nursing as fulfilling the requirement for the U.S. credentialing (CGFNS). The nurse from England, Eleanor, encountered many problems in the U.S. having her British education recognized as fulfilling entry prerequisites for the U.S. university BSN programs. She passed the NCLEX exam initially and was permitted to practice as an RN; however, when she wanted to upgrade and apply for her BSN, her previous education

was not recognized, nor did the England courses transfer over from her school of nursing. This required her to re-take some Associate Diploma courses (i.e. History of Nursing) in fulfillment and retake all degree courses – most of which Eleanor felt were repeated (i.e. Mother and Child). The Associate's Diploma (ADN) is a two year program which is the minimum requirement for a registered nurse to practice in the U.S., unlike Canada's BSN requirement. An addendum was submitted and approved to include U.S.-trained nurses; however, only after I had returned to Canada.

Canadian nurses who came to work in the U.S. spoke of being quite shocked when discovering the cost of health care to the end user. After working in an environment where supplies are tabulated and charged to the patient, the Canadian nurses reflected on how much is wasted in Canada. The American nurses, according to each of the participants (Sally and Pearl), were taught accountability, which entailed being responsible for accurate billing to individuals, as well as how items are charged out, or managed. Regardless of privatized or not-for-profit medical models, there is a fiscal obligation to be solvent. For example, continuously giving away supplies at discharge increases the costs of care to the healthcare consumer:

> We also must communicate to patients, nurses and physicians that hospitals can no longer afford to give things away. Someone always ends up paying. Nurses are trained to help people, to be generous and giving for example a nurse may give a patient a bunch of sterile pads rather than instructing him to go to his local pharmacy. Even those who mean well can put hospitals out of business. (Lefever, 1999)

This is something that is not taught in Canadian nursing schools in quite the same depth as it was re-enforced in the U.S.

In one particular interview, a Canadian nurse spoke to how fragile the health care system

is in Canada. She thought that it would be a shame if our nationalized health care model transitioned to the privatized payer system. Making Canadian nurses aware of costs perhaps is one way to improve management of resources, thus salvaging a service to all Canadians.

In comparing these findings to the literature review this study supported the experiences of culture shock as related to relocation and difficulty with the English language. In the literature review it was noted that graduate nurses often leave Canada because of lack of opportunity in advancement (Hall et al., 2009). One of the Canadian nurses interviewed did indeed leave Canada because she was unable to secure work in a specialty she was trained for as a new graduate. Her main barrier was lack of job seniority rather than lack of skill set.

Chapter Summary

In summary, the nurses confirmed that their skills transferred between settings confirming the transferability and portability of the profession. Regarding clinical practice, nurses were guided by the standards of practice and following an institutions policy and protocol. The nurses confirmed similar barriers encountered by FENs in previous studies in regard to working in foreign environments; however, one unexpected barrier was with the English language. This was not an expected finding, as these were all English-speaking nurses working in predominantly English-speaking countries (Canada, Australia, the U.S. and England). Although cost of healthcare was not solicited, all nurses spoke to this topic, so their viewpoints have been included in this study as an unexpected finding.

Chapter Six: Recommendations and Conclusions

One of the overall themes from this study is that English-speaking nurses encounter some of the same barriers that non-English speaking nurses encounter in new job placements with "language" and transitioning into new work environments. This study highlighted the essence of travel nursing supporting globalization through transferability and portability of the profession. A better understanding in the diversity of nursing internationally may pave the way for a smoother transition as nursing is a social construct (Smith et al., 2011). It would seem, that traveling between countries, nurses as professionals will encounter different social identity constructs.

This study found that, for the participants, skills transferred between countries and nurses were guided by their learned standards of practice, their main foci to provide safe, competent, ethical and accountable care to the public whom they serve. Clinical skills were guided by policy and protocol established by each individual institution. Being a travel nurse means "`having to be flexible in one`s practice as no two hospitals are going to be the same and the expectation is to fit in with how that particular hospital provider operates" (Morrison, 2012, p. 18).This is a significant finding since, emphasizing the importance for all nurses to be familiar with a hospital's policy and protocol, whether or not these are based on the best evidence for practice. It is possible that travel nurses could be vectors of change by sharing any new information as they encounter these differences. Perhaps employer nurse managers when engaging the exit interviews may also canvass agency or travel nurses for relevant changes in clinical practice they may have experienced at their sites. Travel nurses can further consolidate and enrich their practice by working at multiple job sites. The travel nurse has to be open to change, flexible and a quick learner – these are traits that are thought to promote growth. Like one Canadian nurse quoted so nicely:

> I'm humbled by it and I truly mean that because, I get working in a place for so long and you think that you know it all until you go someplace else and then you think 'gee' I don't even know half of it. (Mary)

One of the most interesting and unexpected findings in this study was that English-speaking nurses, encountered similar problems as FENs with language related to accents and changing word definitions when they moved across work settings. Although hospital units in this study recognized linguistic differences and provided orientation to instruct nurses to use "standardized English" and to avoid slang terminology, problems were still encountered understanding patients and doctors. For example, in regards to differing word definitions, the term *dinner* may refer to lunch in the Prairies but it could also mean supper on the West Coast. As was seen, this simple difference could have negative implications for the patient. Interestingly, although some names for drugs are different between both countries, the nurses did not encounter any problems with this considering that part of the seven rights of medication dispensing is to "know" the drug you are giving and this would entail looking up the drug monograms. This seems to be an important finding affirming the value of the seven rights protocol taught in nursing programs (CRNBC).

Travel nurses transitioning into new work environments included language barriers similar to those experienced by migrant foreign-educated nurses from non-English speaking countries. Regarding language barriers noted in Ea (2008), were FENs needed to navigate the complexities in communication, struggling to understand idioms, jargon, and accents of native speakers and understand the culture and the values of the people who speak the language. Travel nurses were intimidated by differing accents, the use of idioms and the speed of speech spoken by native speakers. Perhaps during orientation hospitals could gather and present common

idiomatic expressions or colloquial terms for new nurses to review.

The Western style of nursing practice encourages assertiveness, equality, advocacy and fairness (Ea, 2008, p. 10). Even though travel nurses possess these attributes, at times they remain silent for fear of upsetting harmony on the unit, choosing “not to become involved in the politics and everything that is bad about nursing.” Although the small pool of nurses interviewed cannot be representative of the entire population this may be a helpful finding in that it confirms negative politics exist. Toxic work environments might also include discrimination, harassment, gossip or being devalued; nursing as a profession as with any other employer needs to be on top of this.

From the six interviewed nurses the following conclusions were derived from this study:

1. Skills transferred between the countries of Australia, Canada, England and the United States, with clinical practice being guided by practice standards of the originating home country.
2. Policy and Protocols differed between hospitals rather than countries and nurses need to familiarize themselves with these manuals during new placements, as institutions differ from one another.
3. Nurses who travel may incur problems understanding the English language due to dialects, accents, use of idioms or speed of speech and could greatly benefit from a course in communication offered as an integral part of orientation.
4. Cultural orientation into new work environments should also address information about the community. A brief history of the area identifying the local patient populations’ cultures would benefit travelers.
5. In Canada regarding the fiscal responsibility of healthcare, nurses need to be made aware

of end-user cost and how nurses, themselves, can contribute in their practice by being more proactive in minimizing waste.

Recommendations

The guiding research question of this study was: Is nursing transferable and portable? I examined the lived experiences of travel nurses, at one location and at one point in time. The interviewed nurses had international experience working in Australia, Canada, England and the United States. This in itself- that is, the fact that such a thing as travel nursing exists supports the notion of transferability and portability of the profession. Clinical skills transferred however are guided by an institution`s policy and protocol. Upon hiring a travel nurse, managers need to provide ready access to these manuals on and off site in order for nurses to prepare for practice. Policy and protocol guidelines need to be updated routinely in order to be supportive of the latest research and to be a catalyst for evidence based practice. Nurses support the spirit of inquiry and welcome evidence base practice; however, constraints commonly voiced are lack of time to investigate and difficulty in interpretation of studies. According to the study participants, evidence based practice is not globally practiced between settings. A hospital in a snowbird community in Arizona or California is going to be quite different from an urban hospital in the Pacific Northwest or in a rural hospital in Saskatchewan.

Regarding language, employers need to be made aware of the differences that exist in the English language, even though the traveler may be English-speaking. Again, reinforcing communication in “standardized English,” and avoiding the use of slang terminology would help; however, nurses did report that accents were difficult to overcome at times. Being self-conscious may certainly silence a traveler when communicating in groups. Providing nurses with written orientation material as well as verbal presentations may indeed be warranted here.

Conclusion

In conclusion the findings were that the six nurses encountered no problems transferring their skills between settings and that their practice was guided by practice standards which were deemed similarly defined between countries. The nurses adjusted their clinical practice to follow policy and protocol as outlined by the employers. Some nurses were trained in evidence based practice and encountered problems in loss of autonomy, to being now guided by policy and protocol. Nurses confirmed that the English language is spoken differently between geographical locations and that they went through a period of getting used to dialects and accents. The participants adjusted to different ways of doing things, experienced cultural shocks, however recognized diversity between countries, as well as within countries. Becoming aware of healthcare costs was not solicited from the participants; however, Canadian nurses all spoke to discovering how much it costs. Whereas, the American nurses spoke to the lack of accountability in not charging out costs. This was included as an area of interest; and, was not supported with a literature review on that topic.

In comparing the literature review, nurses from this study may have chosen travel for the flexibility it provided and opportunity for advancement in specialized fields as outlined by Hall, (2009). Our nurses did not report anti-racism as FENs reported in Collins (2004) and Wheeler et al. (2013); however, our nurses were not visible minorities and were from English-speaking backgrounds. We could surmise from both of these studies that discrimination in the workplace still exists; however our nurses did not report feelings of alienation as temporary staff members. In Manias et al. (2003), the in-depth studies on travel nursing conducted in Melbourne, Australia did report similar findings with my study, such as flexibility in working hours they wanted to work, working for themselves and not having to deal with the politics of the units. Ea (2008),

stated communication was of importance to FENs and our study further confirmed these findings with our English speaking nurses encountering differences. In Smith et al. (2011) the study affirmed nursing as being universal, but it also provided evidence that the practice of nursing as a profession is also socially shaped meaning the FENs had to adjust their practice to fit within roles of the new healthcare settings. In our study, the nurses may have not encountered barriers in these social constructs as nursing as a profession was deemed similar between the English speaking countries involved.

Results from this study are what I had expected being a travel nurse. I expected the cultural shocks, exploring diversity, meeting new people and visiting new places. In regard to work place environments, I expected that skills transferred and that indeed, the profession is both portable and transferrable between two settings (Canada and the U.S.). What I did not expect was the findings revealing the difficulty with the English language for English-speaking nurses. However, upon reflection, I can also confirm that, I too, needed time to “get used to” the local jargon. The nurse practices in collaboration with others and not in isolation; therefore communication is an integral part of the practice. In the globalization of healthcare workers which includes the hiring of foreign trained technicians, doctors and nurses, as well as the patients themselves, an emphasis on understanding conversational English is crucial in providing safe competent care. It is not unfathomable to see texting being introduced in communications between healthcare workers. The six participants were aware of this and although others outside the profession may have viewed their experiences as “not significantly different” from any other occupation, communication was deemed essential to the nursing practice.

The nurses interviewed experienced the transition from nationalized healthcare to privatized healthcare systems. Further research may be valuable in studying travel nursing in

Canada particularly focusing on how employers might utilize agency nursing services, or looking deeper into the transitioning between a private versus national healthcare systems. Overall, the nurses felt that the Canadian, English and Australian national systems of healthcare to be far superior in delivery of services to everyone regardless of socioeconomic position in comparison to the American system where they were employed. Although this study did not intend to examine the costs of healthcare, this was brought up by informants on more than one occasion, therefore included was an unexpected result in this study.

Future research on this particular population of travel nurses needs to examine the experiences of nurses working in acute care settings in Canada while on travel. This research could identify the barriers that need to be overcome and how employers might facilitate successful transitions knowing what these barriers are. Regarding education, the continuation and support of courses in nursing as a global entity further supports transferability and portability of the profession. It is hoped that the results of this study can be added to the existing literature on travel nursing.

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Appendix A: Interview Questions

Interview Questions

1. Can you comment on your nursing practice here and your nursing practice at home?
2. Can you comment on the standards of practice in nursing addressing the portability and transferability of the profession?
3. Can you think of extraordinary experiences while travel nursing?
4. What has been the strangest thing that has ever happened to you while travel nursing?
5. Can you comment on any cultural diversity or differences between here and your home?

Appendix B: First Literature Search

Results First Literature Review:
LOG – LITERATURE SEARCH
December 19, 2012
Question: To examine the transition experiences of travel nurses' who work temporary job sites in USA & Canada?
Population:
This literature review will focus on Registered Nurses, who are travelers (working away from home, in another country, another State other than their home State); Female & Male; working in variety of specialty areas in hospital settings (ER, ICU, LDR, Pediatrics, Med-Surgical, PAR, etc.)
Controlled Vocabulary Key Words:
- Travel Nurse
- Travel Nursing
- Agency Nursing
- Migrant Nursing

Inclusion Criteria:
- Working in another State, or Country (away from their Home)
- Registered Nurses (ADA, BSN, MSN)
- English Articles
- Published in the last 5 years

CINAHL:
Travel Nursing Results (S1) – – New Search Registered Nurses -26,575 results (S1); Added Travel Nursing with Bolean AND 105 results (S2); added experience 20 results (S3) – Transferred to RefWorks 14 articles to read.
Registered Nurses – 26,575 (S1); added Agency Nursing 363 results (S2); added experiences 90 (S3) – Transferred to RefWorks 18
Medline:
Registered Nurses 7,881 results (S1) – Added Travel Nursing 3 results (S2) – none relevant - Changed Travel Nursing to Agency Nursing 171 results (S2) and added Experiences for 40 results (S3) – Transferred to RefWorks 4 articles
Go Back to CINAHL and redefine search from (S2) Travel Nurse Change to Agency Nurse. Have 31 Articles to READ Through!

February 13, 2013
JSTOR
Search Term: “Agency Nurse Experience” 13,801 hits
Sort by “Newest to Oldest” Switch to Journals 13,793
Added term “Qualitative” 1,668 hits added “travelling” 125 hits – 3 possible keepers
Found one Article that really addressed topic – so started checking that article’s references: “Agency-nursing work: perceptions and experiences of agency nurses” Manias, Elizabeth et. Al. (2003).
Sage Search
Nursing – Travelling – Experience – 688 hits
Migration – registered nurses – experience 149 hits (no keepers)

EBSCO
Registered Nurses – Migration – Experience 8 hits (no keepers)
CINAHL
Nursing – Migration – experience 30 hits full text – (1 keeper)
Nursing – experience – travelling – 6 results
Medline
Nursing – experience – travelling – 16 results – (no keepers)
February 27th – I have started my proposal and realize I need some information about the history of the travel nurse, or agency nurse –
CINAHL
Registered Nurses – 26,935 add history – 529 – Travel – 8 – got one keeper
Searching data bases also randomly “travel Nurse” with Sage publications – where I went through over 200 articles

Appendix C: Post Literature Search

Results Post Literature Review:
LOG – LITERATURE SEARCH
May 18, 2014
Question: To examine the transition experiences of travel nurses' who work temporary job sites in USA & Canada?
Population:
This literature review will focus on Registered Nurses, who are travelers (working away from home, in another country, another State other than their home State); Female & Male; working in variety of specialty areas in hospital settings (ER, ICU, LDR, Pediatrics, Med-Surgical, PAR, etc.)
Controlled Vocabulary Key Words:

- Travel Nurse
- Travel Nursing
- Agency Nursing
- Migrant Nursing

Inclusion Criteria:

- Working in another State, or Country (away from their Home)
- Registered Nurses (ADA, BSN, MSN)
- English Articles
- Published in the last 5 years

CINAHL: Relevant to Nursing
Travel Nursing Results (S1) – – (Inserted date **2013/2014** articles) New Search Registered Nurses – 130 results (S1); Added Travel Nursing with Bolean AND results (S2); added experience 20 results (S3) – Transferred to RefWorks 1 article to read.
Registered Nurses – 2,254 (S1); added Agency Nursing 3 results (S2); added experiences 0 results (S3) – Transferred no new articles RefWorks
Medline (2013/2014):
Registered Nurses 1,134 results (S1) – Added Travel Nursing 1 results (S2) – 1 article transferred to RefWorks - Changed Travel Nursing to Agency Nursing 366 results (S2) and added Experiences for 52 results (S3) No new articles transferred to RefWorks.
JSTOR
Search Term: “Agency Nurse Experience” 13,608 hits (newest to oldest)
Added term “Qualitative” 42,984 hits added “travelling” 4,257 hits – Scrolled through publications dated 2013 to 2014 – of which no new articles were found relevant
Sage
Nursing – Travelling – Experience – 2 articles – not relevant
Migration – registered nurses – no new results found
EBSCO (premier)
Registered Nurses – Migration – Experience 5 hits – 1 article very similar to my study

Appendix D: First Code Book

FIRST CODE BOOK

The experience of cultures:

a) Culture Shocks
b) Missing Own Culture
c) Accents, Language - Misunderstandings
d) adapting practice to harmonize with culture
e) Making sense of it
f) respecting other cultures, discovering other cultures

Nursing is Global / Transferability

a) Skills are transferable
b) Human condition in illness, same everywhere
c) Universal Recognition - portability
e) Frustration with getting licenses / Different Boards
f) Foreign education not recognized by Universities
g) maintaining licensure
g) Skills, Standards behind

Comparing Canada & U.S.A.

a) Wasted resources in Canada
b) Cost of Healthcare, eye opener
c) Insurance
d) Social Versus Private
e) Wages
f) Lack of opportunity in Canada, lack of respect ,not being valued
g) change of nursing role professional vs employee
h) which is better

The experience of the Travel Nurse

a) Climate differences
b) Different environments / use of computer
c) Respect, Trust
d) Survival
e) Risk Taking
f) To blend in, to get along
g) politics at work / peer pressure
h) transitioning
i) lack of job security
j) doing what you want to do

	k) Influence l) seeing the world, discovering travel m) not liking on-call n) being needed o) Task focused / Work Horse p) influencing career choices q) Support / Scheduling / working with others r) Stress s) Strength, pride t) independence u) Wages v) Challenges w) Bullying x) unknowing y) working with doctors z) meeting people
Nursing Education	
	a) Education b) Frustration with recognition c) Unequal credentialing
Healthcare Standards	
	a) Protocols standards of practice b) Evidence based Practice c) Standards differing within countries/boards

Appendix E: Second Code Book

The experience of cultures:
- a) Culture Shocks
- b) Missing Own Culture
- c) Accents, Language - Misunderstandings
- d) being open to change

Nursing is Global / Transferability
- a) Skills are transferable
- b) Human condition in illness, same everywhere
- c) Canadian Universal Recognition - portability
- d) Benefits of international licenses
- e) Frustration with getting licenses / Different Boards
- f) Foreign education not recognized by Universities

Comparing Canada & U.S.A.
- a) Wasted resources in Canada
- b) Cost of Healthcare, eye opener
- c) Insurance
- d) Social Versus Private
- e) Wages
- f) Lack of opportunity in Canada
- g) Cost discrepancies between countries
- h) which is better

The experience of the Travel Nurse
- a) Climate differences
- b) Different environments
- c) Respect, Trust
- d) Survival
- e) Risk Taking
- f) To blend in, to get along
- g) politics at work
- h) transitioning
- i) lack of job security
- j) doing what you want to do
- K) To change style of practice, or not change (speak up)
- l) seeing the world, discovering travel
- m) not liking on-call
- n) being needed
- o) New learning

Healthcare Standards
- a) Protocols standards a hospital thing not a country thing
- b) Evidence based Practice

Appendix F: Final Code Book

Themes from interviews with travel nurses

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(1) Ability to transfer skills:
- Skills transferred between countries
- Clinical practice guided by practice standards

(2) Navigating policy differences:
- Differed between hospitals but not between countries
- Loss of Autonomy – from knowledge base practice to being guided by Manuals

(3) Overcoming English language differences:
- Troubles understanding accents differing word definitions, names of drugs

(4) Acculturation, transitioning into new locations:
- Different ways of doing
- Experiencing Culture shocks
- Recognizing diversity

(5) Becoming aware of healthcare costs:
- Eye opener – how much it costs, realization of end user costs (Canadian Nurses)
- Lack of accountability in charging out costs (American Nurses)

Appendix G: Letter of Information

Study: What can a Travel Nurses description of transitional and other related experiences tell us about the phenomenon of Travel Nursing?

I am a student in the Master of Nursing Program at Trinity Western University, and this study will complete my degree requirement.

The purpose of this study is to explore and understand real life experiences through the lens of the Travel Nurse. Data will be collected by documenting interviews with an audio recorder. I have attached the interview questions that I will be asking for you to contemplate. The interview should be no longer than 30 minutes.

If you have agreed to participate in this study and the following meeting has been mutually arranged on

_____ (insert date) at _____(insert time)_____

_____(insert location)

If you are unable to attend, or if you wish to withdraw, please don't hesitate in calling Rae Ramsden

Appendix H: Informed Consent

Informed Consent Letter

Project Title: *Is nursing transferable and portable: The experiences of travel nurses.*

Researcher: Rae Ellen Ramsden

Advisor: Sonya Grypma, PhD, (604)888-7511 (office)
School of Nursing, Trinity Western University, 7600 Glover Road, Langley, B.C. Canada, V2Y 1Y1

Purpose: The researcher will elicit nurses' perspectives about the experience of travel nursing. You are being asked to participate because of your experience as a travel nurse.

Procedures: If you agree to participate, you will be interviewed for 30 minutes about your perspectives on travel nursing experience. The interview will be conducted by Rae Ramsden, MSN(c) researcher and will be audio-recorded. You may ask to turn off the recording at any time. The interview will be held at a time and place convenient to you. The findings of the project are related directly to the compilation of a final Thesis. You may ask for a copy of the transcript of your interview.

Potential Risks and Discomforts: No risks or discomforts are anticipated.
There is no remuneration offered to participate in this study, participants are volunteers.

Potential Benefits to Participants and/or to Society: Nurses often benefit from talking with other nurses about their nursing experiences. In addition, your participation will contribute to increasing knowledge based on travel nursing.

Confidentiality: Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. All documents will be identified only by pseudonym and kept in a password protected online accessible only to the researcher and the researcher's advisor. Data will be collected anonymously and actual names will not be linked with any information. Data will be stored anonymously by the researcher (on her password protected computer) for potential future use -your responses will be put in anonymous form and kept for further use after the completion of the study.

You may refuse to participate or withdraw at any time without jeopardy until December 2013. Participants who withdraw, recordings and transcriptions will be destroyed immediately. In this study all other recordings will be destroyed when the study is completed – this is anticipated to be in one year's time.

Contact for information about the study: If you have any questions or desire further information with respect to this study, you may contact the researcher, Rae Ramsden

Contact for concerns about the rights of research subjects: If you have any concerns about your treatment or rights as a research subject, you may contact Ms. Sue Funk in the Office of Research, Trinity Western University at 604-513-2142 or sue.funk@twu.ca.

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that your responses may be put in anonymous form and kept for further use after the completion of this study.

Date of Signature:…….

_____

Participant Signature Date

_____

Printed Participant Name

_____

Researcher – Rae Ramsden

Appendix I: Demographic Profile

Demographic profile of travel nurses (n=6)

Participate Name/Age Countries Practiced	Primary Specialty	Years Nursing Experience	Years Travel Nursing
Brenda, 39 Canada/United States/ Australia/New Zealand	Oncology	8	6
Eleanor, 43 England/United States	Labor & Delivery	30	19
Mary, 55 Canada/United States	Medical Surgical	25	4
Mona, 42 Canada/United States	Operating Room Nurse	20	6
Pearl, 59 United States/Australia/ Canada	Medical Surgical	30	10
Sally, 47 United States/Canada	Intensive Care	25	9

Home Country underscored