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SCOPING REVIEW

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The reported experiences of internationally qualified nurses in aged care: A scoping review

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Abstract

Aim: To examine the experiences of internationally qualified nurses, including those from culturally and linguistically diverse backgrounds, transitioning to and working in the aged care sector of high-income countries.

Design: A scoping review.

Data Sources: CINAHL, MEDLINE and PSychINFO databases were searched to find eligible literature published from January 2010 onwards.

Review Methods: This scoping review was based on the framework by Arksey and O'Malley and the PRISMA-ScR guidelines. The literature search was conducted by the first author, and all three authors reviewed the retrieved studies for eligibility and inclusion.

Results: Fourteen articles were eligible. Data was categorized into three broad themes: stress of migration and transition; miscommunication, racism and discrimination; and aged care specific challenges which included two sub-themes 'shock of aged care' and 'bottom care'.

Conclusion: Internationally qualified nurses, particularly if they are culturally and linguistically diverse, face unique stresses and challenges in aged care and face barriers in the recognition of skills and qualifications. The under-utilization of skills is not only a loss in terms of patient care but is linked to fears of de-skilling, losing professional development and opportunities for career progression.

Impact: Internationally qualified nurses are positioned as a solution to aged care shortages in high-income countries; however, there is a scarcity of research exploring their experiences. In the context of the global aged care staffing crisis, an understanding of the stresses and challenges faced by internationally qualified nurses will further strengthen efforts to recruit, support and retain skilled nurses in aged care.

KEYWORDS
discrimination racial, health workforce, nurses international, racism, residential facilities

1 | INTRODUCTION

Nursing workforce shortages are a global concern, and high-income countries are increasingly reliant on internationally qualified nurses (IQN) from low- to middle-income countries to fill nursing vacancies (World Health Organization, 2016). Data indicates that IQN from culturally and linguistically diverse (CALD) backgrounds make up between 15 and 30% of the general nursing workforce in the United Kingdom (UK), United States (US), Canada, Australia and New Zealand (Canadian Institute for Health Information, 2020; OECD, 2017; US Department of Health Human Services, 2017), many of whom completed their nursing education in Asia or Africa (Thompson & Walton-Roberts, 2019). The aged care sector is particularly reliant on IQN from CALD backgrounds, with data indicating they constitute 35%–60% of the aged care workforce in high-income countries such as Australia (Department of Health, 2020). Research exploring transitional experiences of IQN in countries such as Australia, UK and the US suggests they face numerous challenges post migration, including shock, frustration, loneliness and sadness (Iheduru-Anderson & Wahi, 2018; O'Brien & Ackroyd, 2012; Stubbs, 2017). In addition, IQN of colour from CALD backgrounds experience discrimination and racism (Mapedzahama et al., 2012). However, little is known about the specific challenges that IQN face in aged care as the majority of studies are in the context of acute care services. This is a significant gap in our understanding, particularly given the reliance on IQN from CALD backgrounds in this sector.

This scoping review examines the available evidence to determine what is known about the experiences and needs of IQN, and IQN from CALD backgrounds in particular, working in aged care. CALD is a broad term reflecting a diverse group of people from a non-English speaking background, who were born overseas or have a parent who was born overseas (Pham et al., 2021). Despite having some utility in identifying marginalized migrant groups, this term has been criticized for positioning minorities as 'other' to people from English speaking backgrounds and for obscuring racial issues for migrant people of colour (Sawrikar & Katz, 2009). Acknowledging these critiques, in this paper we use the term CALD strategically to draw attention to the experiences of IQN from low- to middle-income countries.

2 | THE REVIEW

In high-income countries, ageing populations have led to an unprecedented demand for aged care services. Globally, there are an estimated 727 million people over the age of 65 years, and this number is predicted to double in the next 30 years (World Health Organization, 2020). In many high-income countries, long-term care facilities such as residential aged care are facing a staffing crisis as they struggle to meet the increasing demands for skilled aged care staff (Hodgkin et al., 2017). One of the most significant challenges to addressing staff shortages is the persistent negative image of aged care among nursing students and registered nurses (RNs), who perceive it as unskilled, low-paid and low-status work (Naughton et al., 2019). The devaluing of aged care may be in part due to historical feminization of the aged care workforce and associated low pay in the sector (Palmer & Eveline, 2012; Ravenswood & Harris, 2016). Women constitute close to 90% of aged care workers in many countries, including Australia, UK and US, and are usually paid significantly less than healthcare workers in other settings (Kumar et al., 2022).

Yet, the perception of aged care nursing as unskilled is far from the truth. RNs, including IQN, working in the sector often require an advanced level of nursing practice to manage care responsibilities (Cope et al., 2016). They require specialist clinical knowledge and problem-solving skills required to work with older adults with dementia and other complex health needs (Pennbrant et al., 2020). RNs are also expected to coordinate care and drive clinical governance while carrying the burden of supervising unskilled care workers (Dellefield et al., 2015). Indeed, an estimated 70% of the aged care workforce across OECD countries are made up of unskilled and unregulated care workers without specialist qualifications in nursing such as personal care workers or Assistants in Nursing (AIN) (Mavromaras et al., 2017; OECD, 2020). Aged care nurses also face stress related to constant time pressures, low staffing and inadequate resources (Davis et al., 2016; Hodgkin et al., 2017), and struggle with professional isolation due to being the sole RN in an aged care facility (Ritchie, 2013).

The combined burden of complex care, high-responsibility, low reward and professional isolation in aged care has been linked with reduced RN job satisfaction, absenteeism and high staff turnover (Costello et al., 2019). Unsurprisingly, RNs are increasingly rejecting careers in aged care, with the majority of undergraduate nurses listing aged care as their last employment preference (Hunt et al., 2020). Meanwhile, skilled RNs continue to leave the sector citing pay disparity, job dissatisfaction, unsupportive working environments, stress and burnout (Cameron & Brownie, 2010). This is a significant problem as inadequate staffing is associated with increased adverse events, reduced patient safety and increased mortality (Cho et al., 2020; Peters et al., 2021). The sector has, therefore, increasingly sought to recruit migrant workers including skilled IQN to meet workforce shortfalls (Howe, 2022).

IQN predominately include CALD women from low- to middle-income countries with India, the Philippines, Nigeria, Kenya and Zimbabwe being common countries of origin (Dywili et al., 2013; Osei et al., 2023). IQN are notably highly educated and skilled, with the majority holding bachelor degrees and post-graduate qualifications (OECD, 2016), with an average of 3–7 years' nursing experience prior to migration (Salami et al., 2018). The majority of IQN have worked in acute care settings, including in senior positions and specialized fields such as critical or intensive care, midwifery and neonatal care (Adhikari & Melia, 2015; Humphries et al., 2012). However, post migration, IQN often find that their expertise and advanced skills, experience and qualifications are not recognized (Cameron et al., 2019). As such, migrant workers, including skilled IQN, may have limited options and are more likely to take up positions in the least sought-after sectors of health, such as aged care (Olwig, 2018).

Despite the high number of IQN employed in aged care, research exploring IQN experiences has focused largely on those

employed in acute care settings (Alexis, 2013; Xiao et al., 2014). Research indicates that IQN in acute care settings struggle with stressors related to migration and adjustment to a new culture and workplace environment. Indeed, it has been argued that IQN from CALD backgrounds experience a 'cultural shock' (Zhou, 2014), which refers to the idea that stress, anxiety or discomfort felt by IQN migrants relates working and living in an unfamiliar cultural environment (Muecke et al., 2011). Fitzpatrick (2017), however, challenges the notion that 'culture' is the underlying factor in migrant stress, arguing that the term 'culture' should be removed from 'culture shock' as it perpetuates stereotypes about subjugated cultural groups by emphasizing cultural difference rather than highlighting contextual factors and conditions that negatively impact on CALD workers and cause a sense of shock. A few studies point to issues beyond 'culture shock', including reports of IQN from CALD backgrounds being treated differently or made to feel inferior to their colleagues (Ohr et al., 2016). However, there are a notable lack of studies exploring the experiences of IQN including those from CALD backgrounds in aged care. This represents an important gap in the literature given that firstly, low- to middle-income countries have a lower population of older people with comparatively fewer residential care settings (Dyer et al., 2019) and as such, aged care settings may be new or unfamiliar to some IQN. Secondly, the majority of IQN in aged care are women of colour from low- to middle-income countries, yet there is a tendency to overlook the experiences of these migrant nurses within the literature (Dywili et al., 2013; Mapedzahama et al., 2012).

3 | AIMS

This scoping review aims to address this gap in the literature by examining published literature that (i) describes the reported experiences of IQN transitioning to, and working in aged care settings; (ii) identifies reported experiences of IQN that are specific to CALD nurses, including intersectional experiences related to gender, race, language, culture, religion or social class.

The research questions guiding this scoping review were: (1) What is known in the existing literature about the experiences of IQN who are transitioning to, and working in the aged care sector of high-income countries? (2) Are any experiences specific to IQN from CALD backgrounds, including intersectional experiences related to gender, race, language, culture, religion or social class?

4 | METHODS/METHODOLOGY

4.1 | Design

A scoping review was undertaken using the framework proposed by Arksey and O'Malley (2005), and further developed by Levac et al. (2010). This method enables researchers to determine the breadth and depth of evidence in an area of study, and can provide a broader overview of research than other review methodologies (Pollock et al., 2021). Steps 1 to 5 of the Arksey and O'Malley (2005) framework were followed throughout this review including: (1) identifying the research question; (2) searching and identifying relevant studies; (3) study selection; (4) data extraction and collation; (5) summarizing and reporting the results. This review is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) Extension for Scoping reviews (Tricco et al., 2018).

A review protocol detailing questions, search terms and strategy, inclusion and exclusion criteria, objectives, data extraction and reporting processes was developed prior to undertaking the scoping review.

4.2 | Search methods

Medical Subject Headings (MeSH), specific subject headings and keywords were determined in collaboration with a research librarian and trialled using Boolean (AND/OR) methods. After an initial search across databases, the final search was undertaken in electronic databases that covered the majority of literature on nursing and aged care and included CINAHL, MEDLINE (Ovid), PSychINFO and Google Scholar. The initial search was conducted in July 2022, an alert was set up to notify of new or recent papers. Variations of search terms related to the two domains, IQN and aged care for example, 'internationally qualified nurse' OR 'internationally educated nurse' OR 'migrant nurse' AND 'aged care' OR 'residential care' OR 'gerontologic care' OR 'long-term care home'.

A grey literature search was also conducted. This initially included a comprehensive online search of the internet using key words and a search guide provided by a librarian, which was then extended to include a search of grey literature databases such as 'Grey Matters' and 'Open Grey'. Grey literature was defined as knoweldge and related artefacts and may include conference papers, editorials, government reports, newspaper or magazine articles and web pages (Adams et al., 2017). The search was further expanded through a hand search, which examined the reference lists of included papers for any additional articles that may have been missed in the database search.

4.3 | Search outcome

The retrieved articles were assessed against the inclusion criteria: peer-reviewed, full text articles, published in English, focused on IQN in residential or long-term aged care settings and conducted in high-income countries. IQN were defined as RNs who had completed their initial qualification leading to nursing registration in a country other than where they were currently employed; high-income countries were defined as countries with a gross national income per capita of US$12,695 or more (World Bank, 2020), and residential or long-term aged care settings were defined as facilities or organizations providing ongoing care to those over the age of 65. Articles that focused on

long-term care of elderly patients in community or home-care settings were also included in this review. Papers that included experiences of IQN working in the role of a care worker, AIN or nursing aide – and not in the role of RN – were included as this was deemed relevant to IQN work experiences in aged care post-migration, for example, lack of recognition of qualifications and skills. Original studies using qualitative and quantitative approaches were included in this review. None of the identified studies used a mixed-methods approach.

Retrieved articles were also assessed against exclusion criteria. Publication dates were restricted to 1 January 2010 until 30 April 2023 to assess the experiences of IQN migrating in the context of contemporary migration processes and global aged care settings. This time period was also selected as it corresponds with the time since commencement of the National Registration and Accreditation Scheme for Nurses in 2010, which bought registration of nurses under a national Nursing and Midwifery Board of Australia regulatory body, as established by the Australian Health Practitioner Regulation Agency (AHPRA, 2015). Studies that focused on the role of IQN in hospital settings or contained participants working across mixed settings (i.e., both hospitals and aged care settings) were excluded as it was unclear which context findings were related to. Similarly, studies that did not explore IQN experiences of aged care, or only provided an aged care managerial perspective and did not overlap the domain of IQN experiences, were excluded. Articles were also excluded if it was unclear whether participants completed their initial nursing qualification overseas. Finally, letters to the editor, editorials and commentaries, and those not electronically available were also excluded.

A grey literature search retrieved several newspaper articles pertaining broadly to aged care, and one article exploring experiences of racism of migrant workers in the Australian Aged Care setting. These articles, however, did not met the inclusion criteria as it was unclear if workers were indeed IQN or had obtained an initial nursing qualification overseas. Subsequently, no grey literature was included in this scoping review. Refer to Figure 1, PRISMA flow diagram (Tricco et al., 2018).

4.4 | Data extraction

Thirty-four articles were retrieved via databases, and 13 additional studies were identified through other sources such as Google Scholar and manual searches, with a total of 47 articles found. After 9 duplicates were removed, 38 articles were screened. The first author reviewed all title and abstracts, and full texts were reviewed by all authors. A title review removed eight articles that were not aged care specific ($n=5$), and not nursing specific ($n=3$). An abstract review removed 5 articles that did not explore transition and work experience ($n=4$) and did not include IQN ($n=1$), leaving 25 articles for full-text screening. The full text review excluded 11 articles that did not explore contextual factors of aged care ($n=5$); it was unclear whether RNs obtained initial qualification overseas ($n=5$) and were focused on recruitment only ($n=1$), leaving 14 articles relevant to this scoping review.

4.5 | Quality appraisal

A quality appraisal was undertaken as recommended by Levac et al. (2010) but is not reported here as this is not required for a scoping review (Arksey & O'Malley, 2005).

4.6 | Synthesis

Data was extracted, charted and collated using data extraction tables (Arksey & O'Malley, 2005). This involved extracting, organizing and summarizing descriptive data, research design, study population characteristics and findings on the experiences of IQN and IQN from CALD backgrounds. The data was analysed thematically through an iterative and inductive process that involved comparing and synthesizing collated findings. All authors met at regular intervals throughout the review process and discussed any challenges or uncertainties around data extraction and synthesis (Levac et al., 2010). Rigour was maintained through multiple readings of the articles and discrepancies were reviewed and discussed (Pollock et al., 2021). This process resulted in three key themes and two sub-themes as outlined below.

5 | RESULTS

Of the 14 papers that met the inclusion criteria (Table 1), most used a qualitative design ($n=12$, 86%), and two studies used a quantitative design ($n=2$, 14%). The studies were conducted in UK and Ireland ($n=3$), Australia ($n=3$), New Zealand ($n=2$) Norway ($n=2$), Germany ($n=1$), The Netherlands ($n=-1$), Singapore ($n=1$) and Taiwan ($n=-1$). The majority of studies were undertaken in residential aged care facilities ($n=13$) with one in a community setting providing care for elderly patients.

All papers included IQN participants that met the review criteria. Only four studies explored experiences of IQN working exclusively in RN roles (Angus et al., 2021; Baluyot, 2019; Ham, 2021; Jenkins & Huntington, 2016). The remaining papers included IQN in a variety of roles including two papers of IQN working as an RN, Enrolled Nurse (EN), AIN or care worker (Adhikari & Melia, 2015; Pung et al., 2017); three papers of IQN working as AIN or care workers as a result of qualifications or skills not being recognized by the host country (Nursalam et al., 2020; Stuart, 2012; Yong & Manthorpe, 2016); and five papers of IQN working as RN, AIN or care workers, who were part of a broader participant group referred to a 'migrant workers' (Adebayo et al., 2021, 2023; Munkejord & Tingvold, 2019; Nichols et al., 2015; Schilgen et al., 2019).

While all 14 papers included IQN participants from CALD backgrounds, only 4 papers focused exclusively on IQN from a specific country or region: East African countries, India, Indonesia and Nepal (Adhikari & Melia, 2015; Ham, 2021; Nursalam et al., 2020; Yong & Manthorpe, 2016) with 5 papers including a mix of CALD participants from diverse backgrounds, for example, Africa, Asia (Adebayo et al., 2021, 2023; Angus et al., 2021; Jenkins & Huntington, 2016;

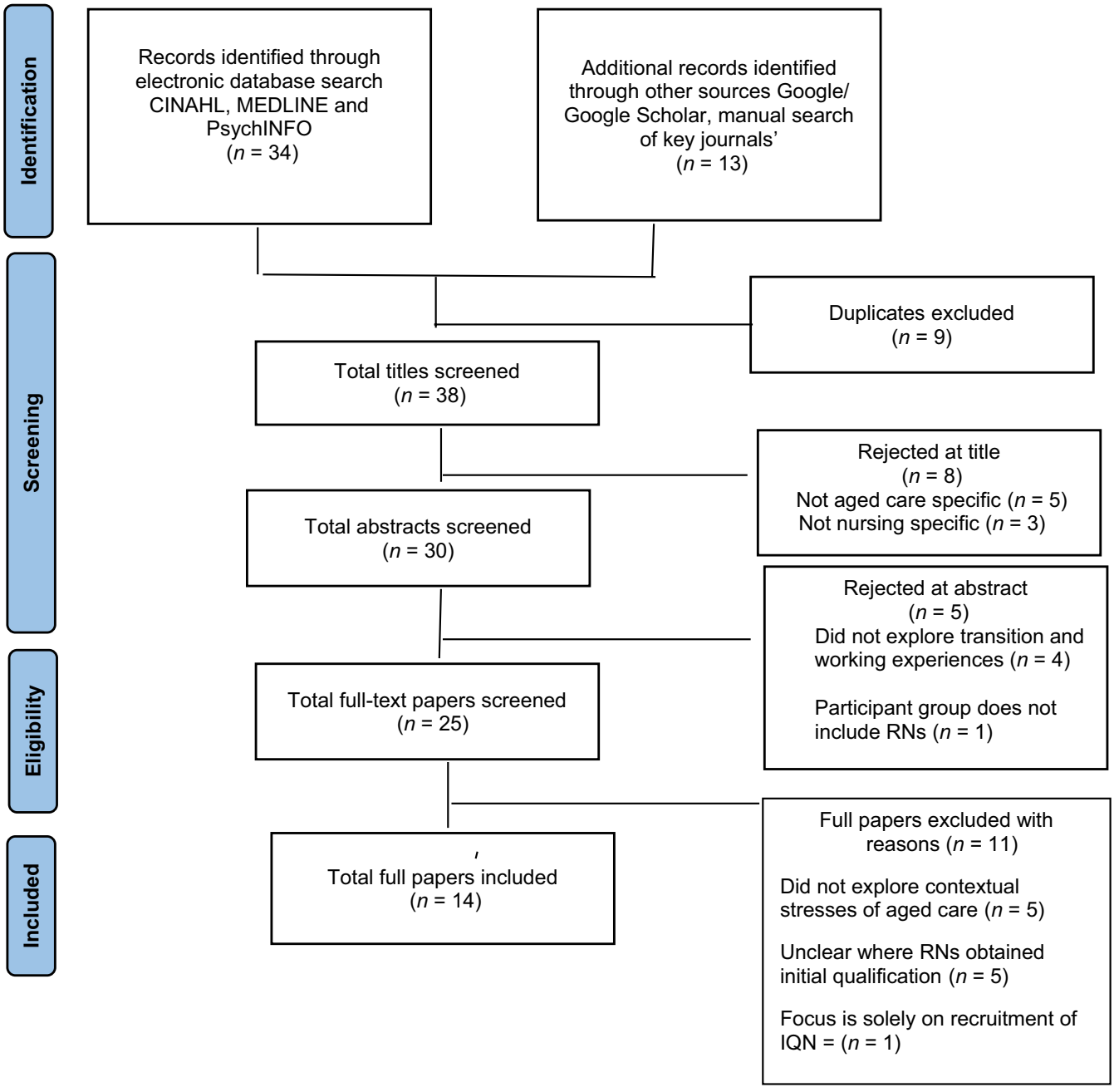

FIGURE 1 PRISMA flow diagram of paper selection.

Pung et al., 2017). Three papers included a mix of IQN with CALD backgrounds and IQN with European backgrounds as a part of a broad cultural mix (Baluyot, 2019; Munkejord & Tingvold, 2019; Nichols et al., 2015). Two papers included IQN from CALD backgrounds that did not state country of origin (Schligen et al., 2019; Stuart 2012). Given the diversity of cultural backgrounds and roles held by IQN, in the description of themes below, we will refer to participants generally as 'IQN', which includes those from a CALD background working in a variety of roles (e.g., RN, EN, AIN or care worker). We also use the term 'IQN from CALD backgrounds' to emphasize the specific experiences of this group and refer to specific cultural backgrounds and roles when this was clear in the literature.

Three broad themes were identified in the analysis of data relevant to IQN working in a variety of roles (e.g., RN, EN, AIN and care worker) in aged care, including struggles with 'stress of migration and transition', 'communication, racism and discrimination' and 'aged care specific challenges'. While the first two themes, 'stress of migration and transition' and 'communication, racism and discrimination', examine factors that are not unique to aged care, the character of these experiences in an aged care context are highlighted. In the third theme, 'aged care specific challenges' are reported. These expereincs of IQN appear to be unique to the aged care context and are examined within the two sub-categories, 'shock or aged care' and 'bottom care'.

TABLE 1 Data extraction table.

Authors/year	Country	Methods	Participants	Findings
Adebayo et al. (2021)	Australia	Quantitative	272 participants incl. IQN – exact breakdown unclear. Working as RN (16), EN (16) care worker (198) and other (26). Participants from 46 nationalities incl. CALD background – African (141), South Asian (50), Southeast Asian (38), Northeast Asian (18) Other (25).	Ethnicity and self-reported English language/communication difficultly negatively impacts job-related stress (ethnicity, $p < .001$; English proficiency, $p = .04$). Stress has a negative impact on job satisfaction. 58% of participants have Bachelor or higher-level qualifications and are working below their qualification level. RNs and ENs had the highest acculturation stress. Addressing acculturation stress may improve job satisfaction and retention among IQN and aged care workers.
Adebayo et al. (2023)	Australia	Qualitative	20 'migrant worker' participants from CALD background (Nigeria – 9 India – 6 and Philippines – 5) working in RN (4) EN (1) and care worker (15) roles	Participants experienced stress with adjusting to new workplace and faced communication challenges, racial discrimination, stress in caring for patients with dementia – described as confronting and disturbing. Challenges with limited support network related to visa status. Poor staffing in aged care linked with intentions to leave the sector.
Adhikari and Melia (2015)	UK/Ireland	Qualitative	21 IQN from CALD background (Nepal) working in RN (14) and care worker (7) roles.	Nepali nurses are highly qualified and experienced in specialized areas, however work in aged care. IQN from CALD backgrounds experience stress, discomfort and shock in seeing elderly people in residential care and face additional stress adapting to care worker role. Aged care described as bottom care – lacking career choices and professional development opportunities, leading to frustration, low job satisfaction and fears of de-skilling, few opportunities for career progression.
Angus et al. (2021)	New Zealand	Qualitative	24 IQN from CALD background (India, Philippines and Zimbabwe) working in RN roles.	Most participants previously worked in acute settings – unfamiliar with aged care. Communication as a challenge – accents, colloquialisms along with cultural differences in communicating, e.g., politeness, respectfulness and adherence to workplace hierarchy. Those with accents different to their colleagues faced greater challenges – frequently misunderstood and not getting all necessary information from colleagues. Palliative care confronting – lack of prior palliative care training, cultural differences with death and dying.
Baluyot (2019)	Norway	Qualitative	16 participants incl.8 local and 8 IQN from CALD and European background (Asian, African and Central Europe) working in RN roles.	Communication challenges – verbal and nonverbal communication. IQN faced initial resistance from local staff along with racism, social avoidance or rejection from local workers.
Ham (2021)	Netherlands	Qualitative	20 IQN from CALD (East African) background working in RN roles.	Communication challenges incl. unfamiliar language patterns, accents and pronunciation. Transitioning to a new country and role required nurses to re-set and change their habitus to fit in to perception of 'normal'. Racism and refusal of care from elderly patients. Aged care physically and psychologically challenging. Poor staffing levels and lack of career progression linked with intention to leave.
Jenkins and Huntington (2016)	New Zealand	Qualitative	6 IQN from CALD background (India – 1 and Philippines – 5) working in RN role.	Aged care is socially and culturally unfamiliar – shock in seeing residential care settings. IQN from CALD backgrounds experience physical, social and professional transitions simultaneously. Physical – stress with arrival in new country and workplace, feeling isolated. Social – adapting to culture and developing local connections. Professional – adapting to aged care setting. Frustrations with nursing board with lengthy or inconsistent processes.

TABLE 1 (Continued)

Authors/year	Country	Methods	Participants	Findings
Munkejord and Tingvold (2019)	Norway	Qualitative	22 participants incl. local workers (11) 'migrant workers' (9) and IQN (2). IQN participants from CALD background. Remaining participants from CALD and European backgrounds (Asia, Africa, Russia, and Europe). IQN both working as Auxiliary Nurse (EN equivalent). Remaining participants working in RN (2), Aux Nurse (7), Nursing Assistant (9), head nurse (1) and apprentice (1).	CALD staff may feel less valued and respected in aged care. IQN face difficulty in having education/qualifications recognized, colleagues making assumptions they held minimal or lower qualifications. Staff members' perceptions of competence interrelated with language. Feelings of not being trusted by patient relatives. CALD staff who 'look or speak differently', e.g., accent, tend to be placed on the bottom of the hierarchy despite qualifications. Racism from elderly patients or relatives, especially faced by those with darker skin. Racism explained as 'not common' and mostly only perpetrated by those with dementia.
Nichols et al. (2015)	Australia	Qualitative	58 participants incl. local workers (23) and 'migrant workers' (35) from CALD (33) and European (2) backgrounds. CALD backgrounds include African and Southeast Asian countries, Western Pacific – mainly Philippines. 23 of the 35 migrant workers had a degree or diploma in country of birth – 13 of which were health related. 5 completed bridging program prior to recognition of qualification. 35 CALD staff working in mixed roles incl. RN, care workers and allied health – exact breakdown unclear.	CALD participants cite lack of knowledge or experience with aged and dementia care. Stress in adapting to new role and expectations. Workplace culture and practices may be 'new and bewildering'. Aged care provides ease of access or entry point for health. Communication an over-arching theme. CALD staff experience prejudice, discrimination and stereotyping from patients, based on cultural differences. Prejudicial treatment from local staff – prejudgement about workplace skills, assumptions about the universality of workplace norms and a reticence to tolerate diversity in language and cultural practices. Discrimination and intolerance from elderly patients especially those with dementia sometimes perceived as 'understandable'.
Nursalam et al. (2020)	Taiwan	Qualitative	16 IQN from CALD background (Indonesia) working as care workers.	All participants worked as RN in home country however 100% working as care worker in host country. Stress in adapting to new roles. Communication – a significant barrier. Feelings of being trapped due to not having nursing qualifications recognized. IQN from CALD backgrounds feel victimized by fraud, working in positions typically held by those with lower qualifications, feelings of losing professional identity (linked with dirty work), 'feeling trapped in aged care' and having a limited career pathway.
Pung et al. (2017)	Singapore	Quantitative	97 IQN from CALD background (Philippines or Malaysian) working as RN (34), EN (23) care worker (40)	All participants worked as RN previously however only 24% of participants working as RN in host country. 32% expressed intentions to leave their job in aged care. Negative correlation between job satisfaction and demands of immigration ($p < .01$) suggesting that higher job satisfaction levels were associated with lower demands of immigration. Feelings of exclusion from host country.
Schligen et al. (2019)	Germany	Qualitative	48 participants incl. local (24) and 'migrant workers' (24) incl. IQN (referred to as those with a foreign certificate) breakdown of IQN participants not stated. Migrant workers from 16 different countries incl. CALD backgrounds. International participants working as RN (4) Geriatric Nurse- RN specialist (8) and Geriatric Nurse Auxiliary/EN (9) and care worker (3).	Aged care described as physically and psychologically stressful. IQN participants reported unequal treatment, e.g., poor rostering and experience 'heavier' working conditions compared to local nurses. Differences in language a main stressor and impedes team collaboration and nurse-client relationships. Racism, discrimination and refusal of care from elderly patients. Religious discrimination.

(Continues)

TABLE 1 (Continued)

Authors/year	Country	Methods	Participants	Findings
Stuart (2012)	UK	Qualitative	52 IQN from CALD (not specified) backgrounds working as care workers.	All participant RNs in home country – 100% working as care workers, Communication stress – trying to understand and interpret needs of elderly patients, shouted or laughed at by patients or colleagues for not understanding. Stress in adapting to new role and dementia care. A feeling of 'not being trusted' or valued by colleagues.
Yong and Manthorpe (2016)	UK	Qualitative	12 participants incl.11 IQN. From CALD (India) background working as care workers.	11 of 12 participants were qualified RNs in India prior to migrating. Communication/Language concerns – speed and accents of speech. Stress in adapting to new role. First 6 months a 'steep learning curve'. Participants experienced a sense of 'identity evaluation' – some feeling perturbed about new role as care workers. A lack of prior knowledge and experience with dementia care. Low pay in aged care.

Abbreviations: CALD, culturally and linguistically diverse; EN, enrolled nurse; IQN, internationally qualified nurses; RN, registered nurse.

5.1 | Stress of migration and transition

High stress levels associated with migration and workplace transition was a key theme evident in the data across eight studies (Adebayo et al., 2021; Adhikari & Melia, 2015; Jenkins & Huntington, 2016; Nichols et al., 2015; Nursalam et al., 2020; Pung et al., 2017; Stuart, 2012; Yong & Manthorpe, 2016). This was reported for all IQN, irrespective of the role that they were working in; RN, EN, AIN or care worker. Stress described by all IQN related to complex migration procedures and frustration with local nursing board registration processes, for example, lengthy time for processing of registration and perceived barriers to recognition of qualifications (Adebayo et al., 2021; Jenkins & Huntington, 2016; Pung et al., 2017). On entering the workforce, IQN experienced high levels of stress in undergoing simultaneous physical, social and professional transitions (Jenkins & Huntington, 2016). This stress was frequently linked with adjusting to new roles and expectations in the workplace with Nichols et al. (2015) noting that workplace culture and practices may be 'new and bewildering' (p. 29). However, Stuart (2012) highlights that IQN in aged care faced particular difficulties understanding and interpreting the needs of elderly patients.

IQN, irrespective of the role in which they were employed, reported that migration and transition stress negatively impacted job satisfaction (Adebayo et al., 2021; Pung et al., 2017). However, the specific roles they held were also implicated in higher stress levels. For example, Adebayo et al. (2021) indicated that those working in RN or EN roles had higher stress levels than those working in aged care worker roles ($p = .03$). However, four studies indicated that high levels of stress were specifically reported by IQN who had to adjust to a care worker role due to their nursing qualifications and skills not being recognized (Adhikari & Melia, 2015; Nursalam et al., 2020; Stuart, 2012; Yong & Manthorpe, 2016). Those working in care worker roles reported stress and frustration associated with loss of professional identity or feeling trapped in a different nursing qualification system (Nursalam et al., 2020; Young & Manthorpe, 2016).

5.2 | Communication, racism and discrimination

Communication challenges, racism and discrimination from colleagues and patients were reported by IQN. Ten of the 14 papers made specific mention of communication and language challenges that exacerbated workplace and transition stress (Adebayo et al., 2021, 2023; Angus et al., 2021; Baluyot, 2019; Ham, 2021; Nichols et al., 2015; Nursalam et al., 2020; Schilgen et al., 2019; Stuart, 2012; Yong & Manthorpe, 2016). For IQN from CALD backgrounds, communication and language challenges related to English language proficiency, navigating unfamiliar language patterns, feeling self-conscious when communicating and difficulty understanding accents (Adebayo et al., 2021, 2023; Angus et al., 2021; Baluyot, 2019; Nichols et al., 2015; Pung et al., 2017; Stuart, 2012). Adebayo et al. (2021) further demonstrated that self-reported

English language proficiency correlated with job-related stress (English proficiency, $p = .04$). Of the four studies that focused specifically on IQN working in an RN role, two reported that communication challenges could initially lead to IQN being rejected by work colleagues (Angus et al., 2021; Ham, 2021).

The use of colloquialisms, idioms and slang by colleagues and patients added another layer of complexity to communication, even if IQN from CALD backgrounds were instructed in English in education systems in their home country (Adebayo et al., 2021; Baluyot, 2019; Ham, 2021; Nichols et al., 2015; Schilgen et al., 2019). IQN from CALD backgrounds also found that a lack of understanding of colloquialisms could lead to experiences of exclusion and discrimination from work colleagues, who might laugh or abuse them for not understanding requests by peers or patients (Stuart, 2012). Stuart (2012) highlights that IQN from CALD backgrounds who were working in aged care settings faced particular difficulties in understanding and interpreting the needs of elderly patients, and Nichols et al. (2015) noted that the increasingly multicultural nature of the aged care workforce adds to communication related challenges.

In six studies, IQN of colour reported experiences of overt racism in aged care from elderly patients (Adebayo et al., 2023; Ham, 2021; Munkejord & Tingvold, 2019; Nichols et al., 2015; Schilgen et al., 2019; Stuart, 2012). These papers cite examples of participants' reporting racist remarks from elderly patients: 'Some of them will tell you to go back home, or you black this – you black that' (Nichols et al. 2015, p. 26); and being called 'nigger' and told to 'get out of here' (Munkejord & Tingvold, 2019, p. 233). IQN of colour also experienced refusal of care from elderly patients, 'because you are black' (Schilgen et al., 2019, p. 63), or being called an 'alien' or a 'foreigner' (Ham, 2021, p. 40). One study also indicated that some IQN from CALD backgrounds experienced religious discrimination from patients, with one participant stating that they were not allowed to enter a patient's room while wearing the hijab (Schilgen et al., 2019, p. 63).

Some studies reported that IQN of colour rationalized racism and discrimination from elderly patients as 'understandable' due to advanced age, especially by those with dementia (Munkejord & Tingvold, 2019; Nichols et al., 2015). Workplace discrimination directed at IQN from CALD backgrounds also included less favourable working conditions (e.g., poor timing of shifts), fewer opportunities for career progression than local colleagues, social isolation and not feeling trusted by peers (Adhikari & Melia, 2015; Baluyot, 2019; Nichols et al., 2015; Nursalam et al., 2020; Pung et al., 2017; Stuart, 2012). IQN from CALD backgrounds also reported feeling that their capabilities were not recognized, with colleagues making assumptions that they held minimal or no qualifications (Munkejord & Tingvold, 2019).

5.3 | Aged care-specific challenges

Aged care was described in the literature as physically and psychologically demanding (Schilgen et al., 2019) and monotonous (Adhikari & Melia, 2015). Staff shortages and organizational constraints added to the difficulty of IQN adjusting to the sector (Munkejord & Tingvold, 2019; Schilgen et al., 2019). A further two themes emerged that were specific to aged care including: the 'shock of aged care' and 'bottom care'.

5.3.1 | Shock of aged care

Four studies reported that IQN participants lacked prior knowledge or experience of residential aged care, describing the sector as socially and/or culturally unfamiliar (Adhikari & Melia, 2015; Angus et al., 2021; Jenkins & Huntington, 2016; Nichols et al., 2015). Studies also described the initial discomfort participants felt in seeing elderly people cared for in a residential care setting (Adhikari & Melia, 2015; Jenkins & Huntington, 2016). For example, a Nepalese IQN participant employed as a care worker in the UK described a sense of shock at first encountering elderly people in a care facility, 'When I first went to my very first nursing-home, I was totally shocked' (Adhikari & Melia, 2015, p. 364). Meanwhile, an IQN participant from a CALD background working in New Zealand stated, 'I was amazed at how it works here- because in our country the family takes care of the elderly, so it was a bit of a shock' (Jenkins & Huntington, 2016, p. 16).

Dementia care was identified as particularly unfamiliar terrain for IQN (Adebayo et al., 2023; Angus et al., 2021; Nichols et al., 2015; Stuart, 2012; Yong & Manthorpe, 2016). For example, Nichols et al. (2015) report that an IQN participant from a CALD background indicated that they had no prior knowledge or experience of dementia. As one participant described, 'back home, this dementia and care of elderly is all taken care of by the family' (Nichols et al., 2015, p. 26). In addition to being unfamiliar, dementia care was also described as stressful to participants across five studies (Adebayo et al., 2023; Munkejord & Tingvold, 2019; Nichols et al., 2015; Stuart, 2012; Yong & Manthorpe, 2016). Participants in Adebayo et al. (2023) describe initial experiences in caring for patients with dementia as 'confronting and disturbing' (p. 233). Meanwhile participants across other studies describe feeling stressed or anxious in dealing with behavioural symptoms of dementia, and difficulties understanding and interpreting patient needs (Adebayo et al., 2023; Stuart, 2012; Yong & Manthorpe, 2016). The unfamiliarity of dementia, along with the additional challenges faced with dementia care, arguably adds to the initial stress experienced by IQN working in aged care.

Palliative care was also noted to be a challenging component for IQN (Angus et al., 2021; Jenkins & Huntington, 2016; Yong & Manthorpe, 2016). Specific stressors included end-of-life care, lack of familiarity with local palliative care models and cultural differences in caring for the dying (Angus et al., 2021; Yong & Manthorpe, 2016). One participant noted that, 'In the Philippines we do everything just to make people live, but here, they are like "Okay, let's just leave her in peace, let's make her comfortable"' (Jenkins & Huntington, 2016, p. 16). Palliative care can also be confronting for

IQN due to inherently different cultural practices including death being a 'taboo' topic in their country of origin, or caring for the dying at home (Angus et al., 2021).

5.3.2 | 'Bottom care'

Aged care was poorly perceived by IQN working in RN, EN, AIN and care worker roles (see Table 1 for details of participants' roles and country of origin), with participants across four studies describing it as low-status work that was undervalued in comparison to acute care nursing (Adebayo et al., 2021; Adhikari & Melia, 2015; Nursalam et al., 2020; Yong & Manthorpe, 2016). In a further two studies, IQN referred to aspects of aged care as 'dirty work' (Adhikari & Melia, 2015; Nursalam et al., 2020). Whilst definitions of this term varied, 'dirty work' was usually associated with personal care tasks such as showering, toileting and contact with bodily fluids and odours (Adhikari & Melia, 2015; Nursalam et al., 2020). One UK study, examining experiences of skilled IQN working as care workers, referred to aged care as 'British bottom care' (Adhikari & Melia, 2015, p. 365). This extends the concept of 'dirty work' to include work considered to be low-status, monotonous, menial, unstimulating and not in keeping with professional qualifications; in other words, it is dirty, unskilled work that positions workers at the 'bottom' of occupational hierarchies (Adhikari & Melia, 2015, p. 365). IQN working in care worker roles also noted that the low status of aged care work was reflected in lower-than-expected pay rates (Yong & Manthorpe, 2016).

IQN across four qualitative studies described a link between 'dirty work' and the loss of professional skills and identity (Adhikari & Melia, 2015; Munkejord & Tingvold, 2019; Nursalam et al., 2020; Yong & Manthorpe, 2016). Fears of de-skilling were also expressed by IQN participants across a further five studies (Adhikari & Melia, 2015; Jenkins & Huntington, 2016; Nursalam et al., 2020; Pung et al., 2017; Stuart, 2012). For some, this was linked to professional qualifications and experience not being recognized, particularly where IQN were working as care workers in aged care. For example, IQN participants in Nursalam et al. (2020), who were employed as care workers, reportedly expressed frustration at not being able to perform skills that they had been trained to do as professional nurses such as airway suction or giving injections. However, fear of de-skilling was also expressed by IQN working in RN roles who stated that aged care work afforded them little opportunity to use their full array of skills: 'Sometimes we do not really able (sic) to do much nursing tasks… We are not really getting chance to do any IV injections. Sometimes we feel we are losing our skills' (Jenkins & Huntington, 2016, p. 6). Similarly, an IQN participant in Adhikari and Melia (2015) study expressed frustration at not being able to practice or learn new advanced skills, stating that, 'When I arrived here, it was all about only pad changes, basic wash, feeding people and putting them in bed' (p. 361). De-skilling was also linked with decreased job satisfaction and lower self-esteem, and for IQN it could leave them questioning their future career paths (Adhikari & Melia, 2015; Nursalam et al., 2020; Pung et al., 2017) or intention to leave the sector all together (Ham, 2021).

6 | DISCUSSION

This scoping review examined international literature on the experiences of IQN, including those from CALD backgrounds, transitioning to and working in the aged care sector of high-income countries. Findings from this review reflect reported experiences of IQN post migration and subsequently employed in a variety of roles including RN, EN, AIN or care workers. Irrespective of the role they were employed in, all IQN reported transition stress with migration, lengthy registration processes and adjustment to new cultures and workplaces with associated feelings of shock, bewilderment and doubt, reflecting previous research (Tie et al., 2019; Xiao et al., 2014). For IQN in aged care, however, additional stressors were noted including difficulty in gaining employment as RNs in their area of expertise. Of the 14 studies that met the criteria, only 4 focused on the experiences of IQN who were able to gain employment as RNs (Angus et al., 2021; Baluyot, 2019; Ham, 2021; Jenkins & Huntington, 2016). Many IQN from CALD backgrounds were employed in positions below their qualification level, for example, as EN, AIN or care workers, with prior experience, skills or qualifications not recognized (Adhikari & Melia, 2015; Angus et al., 2021; Nichols et al., 2015; Nursalam et al., 2020; Schilgen et al., 2019; Yong & Manthorpe, 2016). In some studies, the experience of IQN were explored as a part of a larger group under the umbrella term of 'migrant workers' (Adebayo et al., 2021, 2023; Munkejord & Tingvold, 2019; Nichols et al., 2015; Schilgen et al., 2019). Viewing migrant workers as one homogenous group made it difficult to fully ascertain the complexities for IQN, including those from CALD backgrounds, working in aged care. Nonetheless, the review findings provide some insight into their experiences.

Communication and language were identified as key challenges for IQN from CALD backgrounds, exacerbating general transitional stress (Ham, 2021; Nichols et al., 2015). This finding reflects previous literature demonstrating communication as a key stressor for CALD nurses (Crawford et al., 2017). This review also highlights that communication difficulties were frequently associated with experiences of discrimination and racism, with IQN from CALD backgrounds reporting experiences of being mocked or abused due to not understanding local accents or colloquialisms.

IQN of colour from CALD backgrounds also reported examples of overt racism and rejection of care by patients, along with more covert and subtle forms of racism such as discriminatory treatment and devaluing of skills (Munkejord & Tingvold, 2019; Nichols et al., 2015). Less overt, brief and commonplace verbal communications that indicate disrespect, erasure or hostility towards a person based on race are noted as 'microaggressions' which has cumulative negative consequences for health and well-being of people of colour (Sue et al., 2007, p. 271). Studies also

reported that IQN of colour rationalized experiences of racism from elderly patients as a by-product of advanced age or dementia (Munkejord & Tingvold, 2019; Nichols et al., 2015). A recent article in the Australian media highlights racism as a widespread issue in the Australian aged care sector, noting that experiences may be overlooked because it is seen as 'part of the job' (Brook, 2023). Furthermore, Olasunkanmi-Alimi et al. (2021) note that migrant workers might not speak up about these issues for fear of losing their visa or job. The minimizing of incidents of racism has been noted previously (Deitch et al., 2003), and represents what Sue et al. (2007) have described as a 'microinvalidation', where the reality of racial oppression is denied (p. 274). For IQN of colour from CALD backgrounds, rationalizing these experiences represented a strategy for coping with racism, and arguably for maintaining employment (Nichols et al., 2015). It may also be the case that overt racism and micro-aggressions have become normalized for IQN from CALD backgrounds working in aged care in high-income countries.

The perception among IQN of aged care being 'dirty work' or 'bottom care' is also of note. The notion of aged care nursing as 'dirty work' has been discussed previously (Ostaszkiewicz et al., 2016); however, an extension to this concept was identified, with 'bottom work' not only referring to hygiene and personal care in aged care nursing, but also to low-status, monotonous, menial and unstimulating work that is considered to de-skill IQN (Adhikari & Melia, 2015). Previous studies outline a long history of high-income countries recruiting migrants from low-income countries for difficult-to-recruit care work (King-Dejardin, 2019). We argue that as IQN from CALD backgrounds are often over-qualified for care work roles they are employed in (Nursalam et al., 2020; Yong & Manthorpe, 2016), IQN likely maintain 'bottom care' due to discrimination, including barriers to the recognition of skills and qualifications, and difficulties in finding perceived higher status (acute care) work. This reflects literature relating to 'brain waste' or the under-recognition of skills, often resulting in skilled migrants taking up jobs for which they are over-qualified (Elo et al., 2020), notably more common in the health care sector than other settings (OECD, 2016). This phenomenon is highly evident in the experiences of women of colour as a result of gendered and racialized policies and practices that ultimately result in downward professional mobility of skilled female migrants (Elo et al., 2020).

This review highlights experiences of racism and discrimination as widespread for IQN from CALD backgrounds in aged care. However, in the Australian context, there were only three studies (Adebayo et al., 2021, 2023; Nichols et al., 2015) that explored IQN experiences in aged care; surprising given the reliance on this workforce. The lack of attention to this group of workers perhaps reflects a broader trend to overlook the experiences of migrants, who are frequently over-represented in jobs that are considered 'low status', poorly paid or characterized by hard or unpleasant working conditions (Anderson, 2010). Migrant women of colour represent the backbone of the aged care sector in high-income countries, and further understanding of their experiences will inform employers on how to best meet their needs and inform retention strategies within the sector.

6.1 | Limitations

The review included articles published 1 January 2010 until 30 April 2023. Although a rigorous process was undertaken to perform a thorough search, it is possible that some research may have been missed. A clear limitation relates to the variety of roles that IQN were working in within the aged care sector, with some employed as RN and some as AIN or care workers. This made it difficult to fully ascertain the circumstances and experiences of IQN in RN roles in some studies. Despite this, sufficient evidence was found to shed light on the experiences of IQN in aged care, and the particular difficulties for IQN from CALD backgrounds.

7 | CONCLUSION

IQN, particularly those from CALD backgrounds, are frequently positioned as a solution to the aged care staffing crisis across high-income countries; however, there is limited literature exploring their experiences. Similar to studies from acute care settings, this review demonstrates that IQN face high levels of stress associated with migration, transition and communication-related challenges. However, this scoping review is the first synthesis of available literature exploring the unique stresses and challenges in an aged care context, and findings demonstrate that IQN from CALD backgrounds frequently face additional barriers to recognition of skills and qualifications with many employed as aged care workers and not RNs in an area outside of their expertise; experiencing shock and unfamiliarity when employed in the sector. They are also subjected to racism and discrimination which can negatively impact mental health and wellbeing, and result in high staff turnover, compromise patient safety and increase financial costs to employers and the sector as a whole. In addition, the perception of aged care as 'low status' or 'bottom care', irrespective of the roles IQN were employed in, is a concern due to an under-utilization of skills, brain waste and the need for RNs to provide quality care in aged care settings is not met. Future research into the experiences of IQN employed in aged care settings is urgently needed, particularly given study findings related to experiences of racism, and discrimination for IQN from CALD backgrounds. Additionally, given the mix of roles of IQN across the 14 studies included in this study, further research is required to understand the specific experiences of IQN employed in RN roles in aged care. This is vital to ensure that aged care employers do not inadvertently cash in on discrimination, and instead attract, recognize, professionally develop and retain IQN in potentially fulfilling careers whilst addressing the workforce shortage.

AUTHOR CONTRIBUTIONS

Louise Sheehy made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. *Louise Sheehy*, *Tonia Crawford* and *Jo River*, involved in drafting the manuscript or revising it critically for important intellectual content. *Louise Sheehy*, *Tonia Crawford* and *Jo River* given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. *Louise Sheehy*, *Tonia Crawford* and *Jo River* agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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The authors have no conflicts of interest to declare. All co-authors have seen and agree with the contents of the manuscript.

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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