Who cares? An ethnographic research on the workforce integration of first-generation immigrants in geriatric care in the Netherlands and Germany

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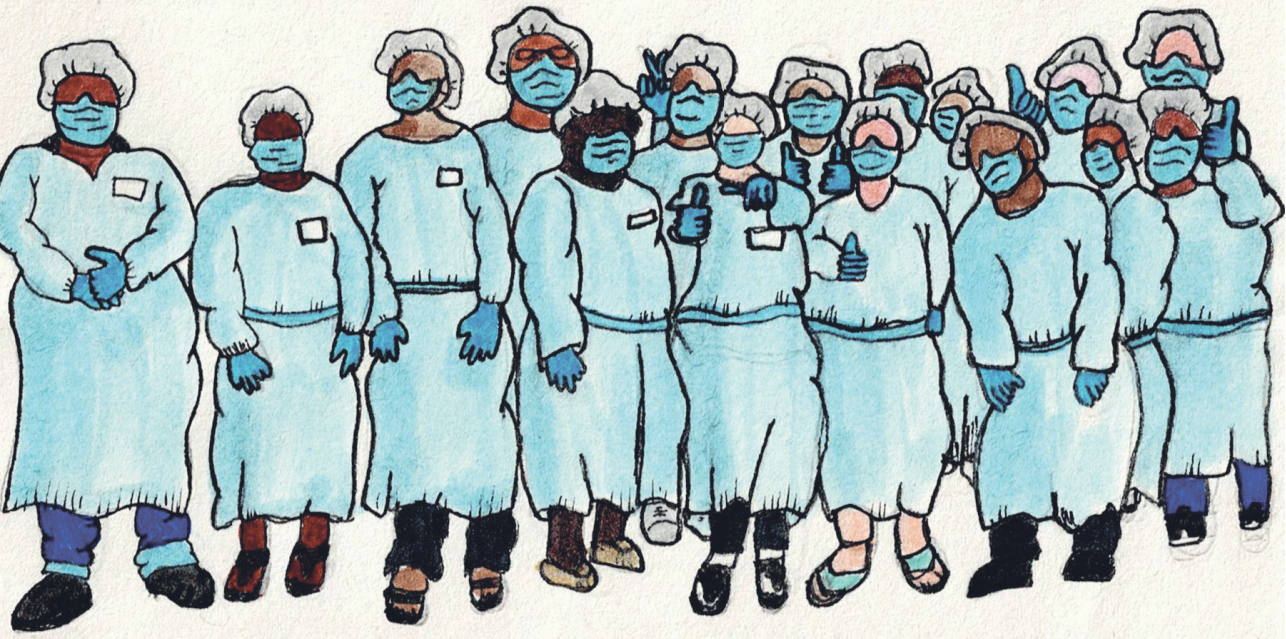

Chapter 3

TINKERING BETWEEN FIRST-GENERATION IMMIGRANT NURSES AND NATIVE NURSES

"She always refuses my care, I think she still needs time to accept me".

This chapter is single-authored. Published as: Ham, A. (2021). First generation immigrant and native nurses enacting good care in a nursing home. *Nursing ethics, 28(3), 402-413.*

Tinkering between first-generation immigrant nurses and native nurses to enact good care in a Dutch nursing home

ABSTRACT

Background: Several studies have investigated the experiences of first-generation immigrant nurses in new workplaces. Yet, little is known about how native nurses and newcomers collaborate in their care for ageing residents in European nursing homes. **Objective:** To gain a deeper understanding of interactions between first-generation immigrant nurses and native nurses in their care for ageing residents in a Dutch nursing home. **Methods:** Ethnography, including 105 hours of shadowing immigrant and native nurses, eight semi-structured interviews with four immigrant and four established nurses, and two focus group discussions with eight immigrant and six established nurses in a Dutch nursing home. Data were analyzed by a post-positivist grounded theory coding approach. **Ethical consideration:** The Medical Ethical Review Committee of the Leiden University Medical Center approved this study. **Results:** The interactions between established staff and newcomers were influenced by norms, rules and regulations, policies and protocols. In daily practice and institutional structure, we observed both opportunities and challenges. The strict time schedules and the requisite standards of care were opportunities related to nurses' expectations. Residents' needs were sometimes challenging and inhibited newcomers' active participation. However, sometimes new practices were developed where nurses created common ground, tinkered, and formed an inclusive playing field to enact good care. **Conclusion/ discussion:** This study shows that despite obstacles, there was room to make small changes in the rules of the game of nursing. These moments of tinkering may be sufficient to establish a stable, inclusive workforce for first-generation immigrants and give room to the evolvement of hybrid professional identities. **Implications:** The findings of this Dutch study are relevant for nursing ethics related to 'good care' and nurses in other cultural contexts on how the integration of immigrant nurses in European countries in general could be facilitated.

Keywords: First-generation immigrant nurses, native nurses, tinkering, good care, nursing home residents, the Netherlands.

INTRODUCTION

Among the huge influx of immigrants to the Netherlands during the refugee crisis in 2015 were skilled professionals with nursing degrees (Kubal & Dekker, 2014). Immigrants were encouraged by the Dutch government to participate socially and economically in the Dutch workforce (Engbersen, et al., 2015; Entzinger & Scholten, 2015). Although nursing practices share similarities globally, nursing is socially, culturally and politically constructed. Variations in nursing practice pose a challenge for successful workforce integration (Moyce, et al., 2016) . Different scholars have studied workforce stagnation in the Netherlands in recent decades. Some have argued that even when first-generation immigrants have proper qualifications, they are often not seen as professionals who can contribute to labor organizations. Often, they are approached as less-educated people in need of help and re-training (Ponzoni & Ghorashi, 2017). Other scholars have related stagnation to discriminatory practices and racism, which causes feelings of exclusion, discomfort, and alienation (Moyce et al., 2016). First-generation immigrant nurses often feel disconnected and experience tensions via cultural clashes, communication problems, and interpersonal conflicts. Cultural and language differences were also identified as contributing to their sense of displacement and professional isolation Andriessen, et al., 2012; Essed, 2002; Wekker, 2016). Worse, first-generation immigrant nurses are expected to expend significant effort to adapt to their new health care institutions, whereas much less is demanded from established nurses (Muller, et al., 2017).

Two Australian studies reported that support programs in health care organizations by native nurses can minimize the impact of challenges faced by first-generation immigrant nurses in their transition into the new nursing workforce. For example, mentoring support appears to improve professional relationships between staff and patients (O'Callaghan et al., 2018; Ohr, et al., 2016).

Several studies have shown that successful workforce integration is a collaborative process, one of "ongoing learning." Such a process enhances team cohesion and addresses taken-for-granted organizational cultures (Ely & Thomas, 2001; Fuijmoto & Härtel, 2017). Numerous health care institutions in the Netherlands have taken important initiatives to improve the workforce integration of newcomers. Nursing homes, for example, offer opportunities, such as re-training in nursing and language skills, that help immigrants better integrate. However, critical diversity scholars have shown that even when such institutions intend to include

newcomers, challenges often remain, for both established and immigrant staff (Ghorashi & Rast, 2018; Ponzoni & Ghorashi, 2017).

Although nurses from different societies are trained differently, their shared aim is to contribute to the common good by caring for ageing citizens (Amalbert, et al., 2016; Kingma, 2018). According to Benner (2019) nurses in caring situations (re)act upon concrete situations and make small changes to improve their care. Such situational practices of "embodied caring" are aimed at both comforting and empowering vulnerable others. Nurses who share this interest often develop a professional manner of collaboration, one which positively affects their professional performance (Benner, 2019). According to nursing scholars, team collaboration and interaction between nurses play an important role in the quality of care (Eika, et al., 2015).

Professional performance and caring outcomes are connected to the socialization of nurses, i.e., to their professional education, previous experiences, and collaboration in the context of care (Allan, et al., 2015). For immigrant nurses, working in a new environment means learning to relate and adapt to another habitus. According to Bourdieu (1990), *habitus* is the system of ingrained habits, skills, and dispositions common to individuals located in close proximity to each other, experiencing similar conditions and thereby being more likely to share perceptions and temperaments that translate into similar practices and representations. Bourdieu claimed that by continual negotiation, individuals get a "feel for the game" (Bourdieu, 1990; pp. 66-67).

Mendoza, Kuntz, and Berger (2012) extended Bourdieu's concept of habitus to "professional habitus," i.e., the shared perspectives, norms, and practices that professionals develop as a result of socialization processes in education and employment. When immigrant and established nurses collaborate, their often divergent professional norms and practices might conflict. For the immigrant nurse, the new nursing field might, at first glance, seem like a similar "game." But when they eventually internalize the rules of the game of the host country, they may be challenged to reconcile these new rules with those familiar to them from their home country.

For established nurses, friction is caused by new workers' unfamiliarity with what is ordinarily take for granted. Consequently, both groups of professionals, must adjust and negotiate how to play the game. Thomas and Ely (2001) stated that this can be achieved through an integration-and-learning approach, i.e., by incorporating the new workers' perspectives and redefining what counts as daily "normal" practice. The current research sought to explore how first-generation immigrant nurses

and native nurses creatively coordinate their actions toward the enactment of good care for the elderly of a Dutch nursing home by closely observing the micro-dynamics of such practices in a particular context. Accordingly, we envisioned workplace integration as a reciprocal process whereby first-generation immigrant nurses and native nurses mutually adjust and adapt their professional practices, ideally resulting in ongoing changes for both groups that improve the enactment of good care (Ramji & Etowa, 2018).

SITUATIONAL ACTING: TINKERING IN NURSING CARE

Each caring situation involves specific norms, purposes, and values that are interconnected in different ways. Dealing with different "goods" in care practices, such as the health or wellbeing of patients, implies sensitivity to variations in what constitutes "good" between health care professionals and their patients (Allan, et al., 2015; Martin, et al., 2015; Mol et all, 2010). There are multiplicities of goods relevant to care practices. However, different goods can also cause friction in daily practices because of the conflicting norms they represent. For example, attending to patients' *hygiene* can be a good practice in the context of a nursing home. Attending to patients' *autonomy* can be considered a good practice as well. However, if a patient does not want to be washed, then attending to his/her hygiene will conflict with respecting his/her autonomy. In cases like this, the quality of care depends on the way in which compromises are made between different goods. Compromising to ensure "good care" is often not so much the outcome of a reflective *judgment* as it is *performed* in daily practice. According to Dutch philosopher Mol (2008; 2010), successful performances are often the outcome of a practice that she coined "tinkering." In situations in which different goods are juxtaposed, nurses will often "tinker" in order to enact good care, i.e., they continuously adapt, attune, and calibrate their work toward the good that matters most at that particular time and place. Mol stated that the quality of care depends on compromises between goods and the persistent willingness of caregivers to adapt and attune to the situation at hand.

In this study, the notion of *tinkering* was used to explore the way in which first-generation immigrant nurses and native nurses collaborate and creatively coordinate their actions for the enactment of good care. The aim of the study was to gain a deeper understanding of interactions between first-generation immigrant nurses and native nurses in their care for ageing residents in a Dutch nursing home. This aim prompted the following research question: How do newly

arrived, first-generation immigrant nurses and native nurses tinker to enact good care for ageing residents in a Dutch nursing home? This question could only be addressed by closely observing everyday care practices *in situ*.

METHOD

The research site was a Dutch healthcare institution, located in a rural village, that provides care for psychogeriatric, medical, and terminally ill residents. Due to a staff shortage, 10 first-generation immigrant health care professionals were recruited in 2015. Moreover, at that time, Dutch society was experiencing a large influx of refugees, and the institution was therefore hoping to contribute to the workforce integration of these newcomers. The immigrant nurses came from East African countries and had lived in the Netherlands for between six months to three years. There were five men and five women, aged 20 to 40 years. They all held either a bachelor's or nursing degree from their home countries. Their work experience (in their home countries) varied from one to five years. Since their foreign nursing diplomas were not recognized by Dutch authorities, the nursing home offered them a Dutch (re)vocational qualification re-training program, lasting 18 months. The 10 native nurses were all Dutch women between the age of 18 and 68. They worked in the wards at levels two or three as per the Dutch Qualifications Framework. Their career experience ranged from 6 to 15 years. The majority of the staff were born and raised in the village and were as such closely connected with the community by church membership and family ties.

At the time of the research, the nursing home had no prior experience with diversity management, i.e., the practice of addressing and supporting diverse professionals within the nursing team. Thus, working with new colleagues from different ethnic, linguistic, and professional backgrounds was new for all those involved.

Ethical consideration

The executive board and managers of the wards were asked if their project could be monitored with this research. After informed consent, selection was done by a purposive sample of nurses in the nursing home: the new immigrant nurses and established nurses (with whom they worked with). Oral and written information was given by the researcher to the immigrants during class in the English and Dutch language and to the native nurses by email and orally to the residents. Letters with

information about the aim of the research, guarantee of anonymity and the freedom to withdraw at any time were distributed. The research was conducted with the involvement and approval of all participants in the nursing home by informed consent. All names in this article are pseudonyms. The Medical Ethical Review Committee of the Leiden University Medical Center approved this study (code P 16.087).

The study used a qualitative, ethnographic approach with a focus on the method of *shadowing* (McDonald & Simpson, 2014). When shadowing, the researcher closely follows individuals over an extended period of time. This method was chosen to enable the researcher to fully grasp interactions between nurses as well as how these interactions were embedded in the context of the institution (Hammersley, 2018). Observations were documented in detailed field notes in order to yield *thick descriptions* (Silverman, 2013). The aim of the ethnographic method is to elicit an *emic* perspective (the perspective of "insiders") and meaningfully link this perspective with an *etic* viewpoint (the perspective of the "outsider," such as the researcher) in order to assess how people (in this case, nurses) interpret and act upon situations (Hammersley and Atkinson, 2019).

Data collection

Ten first-generation immigrant nurses from East African countries and 10 native Dutch nurses participated in this study. The new nurses had temporary resident permits (for five years). The health care institution provided them with Dutch vocational qualifications through re-training as well as positions in the medical wards of the nursing home at nursing student level three (HCP level 3), of the six-level classification of the Dutch Qualifications Framework (see table 1).

Table 1: Nursing Care staff in the Netherlands

English title	Dutch title	Dutch qualification level*	Training length (in years)
Baccalaureate-educated registered nurse	HBO-verpleegkundige	6	4
Vocationally-trained registered nurse	MBO-verpleegkundige	4	4
Certified nurse assistant	Verzorgende	3	2-3
Nurse assistant	Helpende	2	2
Nurse aide	Zorghulp	1	0.1 -1

*According to the Dutch Qualifications Framework (NLQF)

Three professional pairings (three newly arrived nurses collaborating with three native nurses) were shadowed more intensively, e.g., by participant observations, for two days a week over a four-month period, for a total of 105 hours. These three professional pairing couples were chosen to shadow, because the three different couples were working in different teams in different wards. This enabled us to craft thick descriptions of the collaboration, the interactions and informal conversations between the two groups of professionals in three different teams.

Eight in-depth interviews were conducted, four with immigrant nurses and four with established nurses. Selection of the eight persons interviewed was done based on their collaboration and teamwork in the medical wards (working in the same ward, but in different teams). There were also nursing teams, especially those working with dementia residents, who did not work with the newcomers. On the basis of our observations, three topics were discussed: mutual learning, collaboration, and the enactment of good care. The interviews occurred in the nursing home and lasted between 45 and 75 minutes. They were audio-recorded and transcribed verbatim in the original languages (Dutch or English) (Green & Thorogood, 2018).

Two focus group discussions also took place, each lasting between 60 and 120 minutes: one with eight first-generation immigrant nurses (two immigrants were not able to participate because of other commitments), and another with six of the eight native nurses who worked with the newcomers, the other two nurses had to remain on the ward). On the basis of observations and interview outcomes, four topics during the focus groups were discussed: opportunities and challenges in caring practices, and similarities and differences between established and immigrant nurses.

Data analysis

Inspired by a post-positivist grounded theory coding approach (Charmaz & Belgrave, 2018; Denzin, 2019), the ethnographic fieldnotes and transcripts were read several times in order to develop familiarity with the data (Evans, et al., 2016). Following this approach, we first *open coded* the data, attaching a label to each part (Charmaz & Belgrave, 2018; Denzin, 2019*)*. Then, the data were *axial coded*; these codes were compared with the earlier open codes. The codes were then merged, grouped, and labeled. Next, to generate more abstract core concepts, *selective coding* was used (Charmaz & Belgrave, 2018; McCann & Polacsek, 2019).

Atlas-ti 10 was used to generate *emic* and *etic* coding (Bergman & Lindgren, 2018; Hammersley & Atkinson, 2019). The *emic* codes consisted of images and ideas used by the nurses, such as, "*I am crazy about news.*" The *etic* codes comprised theoretical concepts, like 'resistance' and 'tinkering' and were used as *sensitizing concepts* to get a general sense of reference and guidance (Hammersley & Atkinson, 2019) . With this combination of inductive and deductive analysis, we gained a deeper understanding of interactions between the nurses. Finally, participants were involved by *member checking* for *respondent validation* (Brear, 2018). The main theoretical findings were presented to the participants to check validity. The reactions of the participants indicated that our findings were consistent with their experiences and perspectives.

RESULTS

Three themes emerged from the data and will be presented here. 1). Opportunities for situational acting 2). Organizational constraints and challenges for situational acting 3). Similarities and differences in care practices.

Opportunities for situational acting

Immigrant nurses experienced difficulties understanding the unfamiliar language patterns, accents, and pronunciations used in the Dutch nursing home, which consequently hindered comprehension in interactions. The immigrant nurses reported being self-conscious about and sensitive to their use of the new language and how it would be perceived by both residents and colleagues. Some did not dare to speak, while others sought to adopt colloquial Dutch expressions, such as local slang, in order to connect to residents, which would ostensibly reduce tension in communication.

Since established nurses were primarily responsible for the nursing coordination, organizational care, and/or managerial duties, they also had a more dominant position in the nursing home. However, when immigrant nurses began collaborating in the daily care of residents—for example, washing residents together with established nurses—normalizing practices and power positions appeared to be superseded by new practices. Although their limited exposure to the new cultural context and informal language use sometimes made it challenging for immigrant nurses to engage in casual conversations with residents, power positions were occasionally altered:

Today I shadow Binyam and Irma. "I'm crazy about news," Irma says, "and those residents, they know everything, so I often ask them if they have any news." She laughs: "And then you hear a lot of what is going on in the village!" We meet Mr. Albers, an 86-year-old man, sitting near the table, a cigarette between his fingers. "Hi," Irma says when she sees Mr. Albers, "I'll open a window!" and then she walks straight ahead to do so. Binyam walks toward Mr. Albers and shakes his hand. "Good morning, Mr. Albers," Binyam says, taking a seat next to him. "And," Binyam asks, looking at Mr. Albers, "any news?" "Any news?" Mr. Albers repeats. He looks at Binyam, furrows his eyebrows, and asks: "What kind of news do you want?" then starts coughing. Binyam takes the newspaper, which is on the table in front of Mr. Albers, and reads a front page article aloud, which is about a Dutch football game. Now they talk about football, football games, and their victories. Irma looks at Binyam and Mr. Albers and says to the researcher: "Ah, yes, these two, they like talking about football together." Irma does not interrupt the conversation. After being quiet for a while, she asks Binyam: "Maybe you can guide Mr. Albers to the bathroom?" Binyam looks at Mr. Albers, who nods, and so he takes his arm, supporting him to the bathroom for the morning care routine, all the while continuing to chat about football.

When Irma mentioned the news, she had been referring to the latest gossip. Binyam tried to do so as well, but he had not been understood. So instead, he switched to talking about football news in the newspaper. This created not only a bond between Binyam and Mr. Albers, but also a shift in power relations, as they were now men who both liked talking about football. Likewise, there were more minor events were established positions of power were temporarily changed. In situations in which professionals enact care for residents, established roles may be more easily bypassed. Our data show that when nurses were providing care together—for example, washing—the care was never questioned: they simply cared on equal terms. Together, they laughed, cared, and created a joyful and safe atmosphere, one in which they attuned to, learned about, and mixed each other's caring styles.

Organizational constraints and challenges for situational acting

At the time of this research, the nursing home for the elderly had a shortage of staff. All managers were convinced that more staff was needed and that by employing immigrants they would be able to improve the care for the residents. Before the

immigrants arrived, the nursing staff received oral and written information from management about the arrival of the new employees. Additionally, management set up a voluntary buddy system, in order for each newcomer to be coached by a native nurse. Some of the native nurses wanted to give room to newcomers and enable them to work in their own familiar way. They really functioned as their mentor and even asked questions about how nursing was done in their country of origin. One of them for instance said that when one of the residents was suffering from an epistaxis, she had learned from her new colleague an effective treatment that she did not know. However, many of the established staff felt that due to organizational constraints such as hectic time schedules, they lacked the time and energy to give sufficient support to the new workers. Moreover, they were critical of the requirement to keep a meticulous record of how much minutes each task took them, and the pressure they felt to live up to certain standards of care.

The newcomers, on the other hand, experienced these very same time schedules as very helpful. As there was no (English) written job description document for the health care profession in the institution, it helped them to better understand exactly what was expected of them and to act accordingly.

The majority of residents were satisfied with the care they received from the new nurses. Some residents, however, refused their care. One of the immigrant nurses recounted to the researcher how a resident had once told him to leave and "go back where he came from." This resident later told a local staff member that he did not want to receive care from an "alien" or a "foreigner." The management of the organization was aware that not all residents accepted the new staff. However, because of their lack of experience with the integration process of immigrant nurses, they did not know how to respond to the discriminatory remarks and prejudiced behavior of these residents. How did established nurses deal with such resistance? Sometimes, they applied a very pragmatic solution:

> *Teklit and I enter the small nursing stationary where five native nurses are seated. They hand over the washing list to each health professional. On the list is written exactly what needs to be done in the time scheduled for each task. For instance, in precisely 10 minutes, they need to assist Mrs. Dikkens with a bed bath; they then have six minutes for changing clothes and two minutes to assist with medication before they can serve breakfast. "We both need to care for six residents," Mirjam says to Teklit. She looks at Teklit's washing*

> *list, and she says: "Oh, Mrs. Dikkens is on your list." "Yes," Teklit responds "she always refuses my care, I think she still needs time to accept me." Mirjam nods [like she agrees], looks at her list, then suggests: "When you start with Mr. Jansen [who is on her list], I will attend to Mrs. Dikkens [on Teklit's list] and I will help you when I finish, alright?" Teklit agrees and off they go.*

In general, the established staff and the newcomers agreed that they had to provide good care, which meant respecting residents' needs and striving to meet their expectations. In the above situation, two nurses were tasked with caring for six residents within a certain timeframe, and so they opted for a *practical* solution to accomplish their tasks: simply swapping the residents on their list. For them, this was an efficient way to deal with resistance from some residents. Nonetheless, the refusal of care by such residents affected the normalized daily routines for providing good care, compelling nurses to make changes in response. Stylistic differences in these responses presented challenges and affected the dynamics and interactions between nurses. Some local nurses started a dialogue with those residents who refused care from the new nurses, while others just ignored the predicament and continued with their job. Some nurses reported the problem to management, which did not know how to handle it, as no guidelines on how to respond had been provided. Some nurses thought that resistant residents simply needed more time to become accustomed to receiving care from black men. Other nurses were more judgmental, attributing resistance purely to racism. One nurse claimed that the behavior of native nurses is integral to determining how residents will respond to new staff. Should local nurses behave in a non-inclusive manner, the development of professional relationships between residents and new staff will be impeded. All the immigrant nurses believed that if the local nurses accepted them as professionals, the residents would as well.

Similarities and differences in care practices

The interactions between established staff and newcomers were influenced by formal standards of care, i.e., norms, rules and regulations, and policies and protocols. All immigrant nurses agreed that these formal standards were well organized. They recognized similarities between Dutch care protocols and those applied in the healthcare systems in their home countries. On the one hand, the immigrant nurses attributed various benefits to these formal standards of care and considered them to be admirable hallmarks of the Dutch care system. On the other hand, they felt that being so well organized had unintended side effects:

> *Here everything is standardized and assigned to the responsible person: they do what they have to do…like, it is my responsibility to do this, so I do not have to take extra steps or to go to another…In our country, everything has to be set together in the department by teamwork, so you automatically make extra efforts for the patients.*

The immigrants realized that the context of work in the Netherlands differed from that experienced in their home countries, where working in a healthcare institution was inherently team-centered and not as concerned with precise scheduling and individualized tasks.

Some of the established staff assumed that adjusting was the sole responsibility of the immigrant nurses rather than a responsibility shared by them all. Consequently, they considered their own way of working to be the standard. Others realized that they needed to facilitate learning among the newcomers. Accordingly, they gave the new nurses room to demonstrate their clinical skills and to actively engage in the caring practice. One nurse believed that the established staff should invest more in the new workers so that they could adjust more quickly to the unfamiliar health care context. Some local staff found it difficult to delegate tasks and responsibilities to the new workers. They considered themselves to be in charge of the wards and were occasionally frustrated when things were done differently than what they were accustomed to. As one nurse said:

> *We once noticed that we hadn't found a wet washcloth and used towel in Mrs. Westendorps' bathroom, after we had given Sheeba the task to give her a bed bath, so we doubted whether she had done this. How can we trust and assign responsibilities if we cannot be sure that they follow up on orders?*

However, the institutional structure, i.e., strict time schedules, the residents' needs, and the requisite standards of care, made it challenging to give newcomers the room to integrate their own way of working.

DISCUSSION

This study examined how newly arrived, first-generation immigrant nurses and established nurses collaborate and creatively coordinate their actions toward the enactment of good care for the elderly of a Dutch nursing home.

Mol's (2010) concept of *tinkering* provided a useful lens to understand such fruitful interactions between immigrant and native nurses. According to Mol, the quality of care depends on the extent to which professionals are able to compromise between different "goods," i.e., on their persistent willingness to tinker. However, she also admitted that "in practice, stories about trying to tinker towards good care do not necessarily have happy endings". In the last case [of Teklit and Mirjam] discussed in this paper, due to the relationship between collaboration of immigrant and native nurses on the one hand and their tinkering by searching for a practical solution on the other hand, they were able to enact good care. However, the question remains: In the attempt to tinker for the good care of residents, are (new) colleagues withheld much-needed support? Although the nurses in this study practically tinkered to enact good care for their residents, their efforts did not constitute to the aim of good mentoring/ good integration of the new worker. Since the refusal of care by some residents, which affected immigrant nurses' ability to participate as professional nurses, was not adequately addressed. A recent report on the workforce integration of first-generation immigrants in the Netherlands also stressed the importance of mentoring and including newcomers as professionals (Ghorashi & Rast, 2018).

Evidence from previous research suggests that not only do good mentoring relationships between first-generation immigrant nurses and native nurses stimulate mutual learning processes, they benefit patients as well (Philip, et al., 2019). Moreover, mentoring relationships help to prevent negative experiences for newcomers while also helping native nurses to become more aware of their own habits and routines. In the nursing home discussed here, some local nurses wanted to make room for newcomers to work in their own familiar ways. They thus took newcomers on board as part of the nursing team and facilitated their learning process. As a result, they created common ground as well as possibilities for situational acting, for tinkering, in order to enact good care for the residents in the nursing home. This is in line with findings from other studies (Mitchell, et al., 2017; Snoeren, et al., 2016) that have shown that when local nurses support new nurses, the transition process for the latter is accomplished more smoothly. And when new nurses are open to such support from local nurses, they can together create new ways of caring.

However, challenges are also involved. First, there are organizational constraints, like staff shortages, lack of time and energy, hectic time schedules, and pressure from

quality controllers to meet certain standards of care, which often constitute "cultural cloning" (Essed, 2002). This means that local nurses often prefer for newcomers to simply adapt to the established way of working and formal standards of care.

Second, it proved difficult to protect newcomers from discrimination by some colleagues and residents. Xenophobia and racism exist in Dutch society, and hence they also pervade our health care institutions (Blanchet, et al., 2018; Essed, 1991). Previous research has shown how the workforce integration of first-generation immigrants is affected by the imposition one's own standards, by gossip, and by (mutual) suspicions of indifference (Ham, 2019).

Third, a lack of experience in diversity management is another obstacle to facilitating the participation and inclusion of newcomers. Power differences always play a role. When health care institutions recruit first-generation immigrant nurses, the space for reflexivity for all those involved, i.e., for the established staff to reflect on their own assumptions and expectations, as well as on taken-for-granted practices, must be created.

Limitations and strengths

The limitation of this study was its focus on the micro-level of personal interactions. Additional research is needed to further investigate the social processes and power dynamics taking place at the meso-level of groups and institutions, i.e. studies of the differences between what groups of established and immigrant nurses take for granted in the daily practice because of their different conceptions of professional care, as well as the way in which these group differences are perceived and managed on the level of the institution.

This study has several strengths. First, it sheds light on the challenges related to the workforce integration of immigrant nurses, especially the possibility of prejudice on both sides, the differences in professional nursing cultures and differences in conceptions of 'good care', which all can lead to mistrust and misunderstandings. Second, it increases our understanding of the opportunities for collaboration, situational acting and flexibility that are needed when preparing both established and immigrant nurses for working together in daily practice. In other words, it shows how in such a situation new, hybrid professional identities can evolve.

CONCLUSION

The aim of this study was to gain a deeper understanding of interactions between first-generation immigrant nurses and native nurses in their care for ageing residents in a Dutch nursing home. Good care does not always depend on compromises between goods. Nurses' actions are embedded in professional discourses related to their socialization, i.e., their professional education and their (previous) work in health care organizations. In this study, we have explored how immigrant and local nurses are sometimes able to tinker to enact good care for their patients.

Our data have shown that although the immigrant nurses had prior work experience in their countries of origin, working in a Dutch nursing home required them to reset and change their habitus. When newcomers want to be part of the new work environment, they will seek to adapt their way of working to what the established staff consider to be normal. Some established nurses tinkered, adjusting their own way of working in a way which created room for newcomers to actively participate in the caring practice. Indeed, there were situations where taken-for-granted practices were temporarily suspended, where both new and established nurses were connected and creatively coordinate their actions toward the enactment of good care for residents.

However, there were also obstacles that prevented newcomers from full participation in care situations. Due to organizational constraints, like staff shortages, strict timeframes, and the imposition of local standards, there was little space or time to face these challenges. The refusal of care by some residents was also an obstacle, one which affected both the established nurses' normalized daily routines and the newcomers' ability to participate in care practices.

By shedding light on the micro-dynamics that occurred between established and recently arrived, first-generation nurses, on the ways in which they sometimes were able to tinker, we have shown that small, mutual adjustments changed some of the rules of the game. This in turn allowed the expression of professionally hybrid identities, whereby both established and new nurses learned to navigate between, and mix elements from, two work cultures. Such moments of tinkering are ultimately sufficient. However, to establish a stable, inclusive workforce for newcomers, one also needs to create space for both established and immigrant nurses to reflect on how more significant mutual adjustments can be made.

Implications for practice

The findings of this study are relevant for nursing ethics related to "good care" and nurses in other cultural contexts. Based on this study's results it can be concluded that a levelled playing field for first-generation immigrant health care professionals and native nurses is needed to foster mutual workforce integration. Besides, adequate mentoring support is also important, as well as management awareness about the likelihood of and correct approach to prejudices and discrimination among both established staff and residents. When do nurses enact 'good care'? As our data show, when local nurses and new nurses are caring for their residents together, and are open to the input of others, they together provide 'good care'. This was not so much due to cognitive processes, but compassion, emotions and playfulness in safe spaces created interconnections between them. Thus, by carefully attending to the daily-taken-for granted care practice of nurses working together, we seek to contribute to the mutual workforce integration of immigrant and established nurses.

Our data show that individual prejudice was often related to negative conceptions of otherness, as in premises of exclusion and discrimination. Thus, when (inter) national health care institutions open up nursing programs for newcomers, the existence negative stereotypes and discrimination among some of the established staff and residents cannot be ignored, as xenophobia exist in European institutions (Blanchet, et al., 2018; Essed, 1991). We also suggest to organize positive intergroup meetings as well as reflective spaces, as they are significant factors in stimulating a supportive and inclusive workplace.

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