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The experience of internationally qualified nurses working in operating theatres in New Zealand: A qualitative pilot study

Abstract

Background: The global nursing shortage has led many developed countries, including New Zealand, to recruit internationally qualified nurses (IQNs) to meet workforce demands. Despite their critical role, many face challenges in adapting to new professional and social environments. Supporting their integration is vital for retention and optimal workforce utilisation.

Aim: To explore the work experiences of IQNs in New Zealand operating theatres (OTs) and identify how healthcare leaders can support their integration and retention.

Methods: A descriptive qualitative design was employed. Individual interviews were conducted with six IQNs working in OTs across New Zealand using face-to-face and video conferencing methods. The data were analysed thematically.

Results: Four key themes emerged: *adjustment and adaptation, working conditions, interpersonal relations, and leadership.* Key findings included challenges for IQNs in cultural adaptation, orientation, communication, and team dynamics. Conversely, participants also reported benefits such as improved work–life balance and greater professional autonomy.

Conclusion: The findings of this study point to the urgent need for structured, culturally responsive orientation and support initiatives to improve the experiences of IQNs in the perioperative setting.

Keywords: internationally qualified nurses (IQNs), operating theatres, working experiences, working conditions, adjustment and adaptation, workplace discrimination and bullying, management

Introduction

Nursing shortages are a longstanding global issue.[1-4] The international recruitment of nurses has become a key strategy to mitigate this issue in many countries worldwide.[5, 6] New Zealand has relied on internationally qualified nurses (IQNs) for more than two decades.[5, 7] These are nurses registered overseas who meet the Nursing Council of New Zealand (NCNZ) requirements for local registration.[8] To register in New Zealand, IQNs must pass an English proficiency test and meet educational and clinical practice criteria.[9] As of March 2023, IQNs make up 36 per cent of the nursing workforce [(10)], reflecting a growing dependence on this workforce to meet health system needs and support an increasingly diverse population.[11-13]

Perioperative theatres represent a distinct clinical environment within healthcare, defined by their high-stakes, fast-paced, and technologically intensive nature.[14, 15] Surgical procedures demand precise coordination among multidisciplinary teams, where effective communication and specialised technical skills are essential to patient safety and surgical outcomes.[16] The operating theatre's strict sterile protocols and physical isolation from other hospital departments contribute to a closed and high-pressure setting.[17, 18] In this environment,

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entrenched hierarchical structures and power differentials are often reinforced, shaping the interpersonal dynamics and workplace culture that are unique to perioperative practice.[19-21]

More specifically, perioperative services have been significantly impacted by severe shortages of experienced operating theatre (OT) nurses. This specialty demands extended training, often a full year beyond basic registration, and substantial investment, with estimated costs of US$65 000–75 000 per nurse. [20, 21]

Previously marked by low turnover, perioperative nursing now faces rising attrition due to an ageing workforce, post-pandemic surgical backlogs, staff burnout, and negative workplace cultures. [22, 23] Furthermore, toxic behaviours and bullying have been normalised in some OT environments, making retention more difficult[24, 25].

IQNs have therefore become essential in addressing this gap[26].In June 2025, IQNs represented 46.1 per cent of the perioperative workforce in New Zealand[27].

Current international literature highlights that IQNs face challenges such as limited orientation [28-30], language barriers[31-33], cultural differences[34-36], and discrimination[37-39], all of which affect their integration and retention in healthcare settings. While these issues are recognised in general hospital contexts worldwide, little is known about IQNs working in New Zealand's OTs. Despite their significant contribution to this high-demand environment, no research has explored their specific experiences in New Zealand. This pilot study aims to investigate the professional experiences of IQNs working in New Zealand OTs and provide foundational data for further research to enhance the integration and retention of IQNs within the operating theatre workforce.

Methods

Study design

A descriptive qualitative research design was utilised to investigate the work experiences of IQNs in the operating theatre in New Zealand. Descriptive qualitative research was well suited for this study, as it allowed a nuanced understanding of participants' experiences and interpretations of their roles within the broader social and professional context of migration and nursing practice in New Zealand [40, 41]. Data were collected using individual semi-structured interviews conducted face-to-face or via video conference (Zoom).

Sample

The study sample consisted of six IQNs employed in OTs across New Zealand. Eligibility criteria required participants to be IQNs with current or previous work experience in New Zealand operating theatre settings. Nurses were excluded if they were born in New Zealand, had completed their registered nurse education or were IQNs without operating theatre experience in New Zealand.

The IQNs were recruited through nationwide advertising. Recruitment and interviewing continued until data saturation was reached, no new information emerged in the final interview.[42] Given that Asian IQNs constitute 66.3 per cent of the IQN workforce in New Zealand[43], it was not unexpected that in this pilot study, all six participants were from Asian countries.

Data collection and setting

Five participants opted for Zoom, and one participant chose a face-to-face interview, which was conducted between 21 September and 30 November 2022. The interview location was chosen by the participants, enabling them to feel comfortable, relaxed and secure. The face-to-face interviews were conducted in a meeting room at the participants' workplace. Each interview lasted between sixty and ninety minutes.

The semi-structured interview protocol guided the interviews (see Appendix A), utilising open-ended questions to encourage participants to discuss their experiences freely [42]. With the participants' permission, the interviews were audiotaped and transcribed by the researcher.

Data analysis

Thematic analysis was utilised for this study. It is widely recognised for its flexibility and adaptability to various qualitative research questions [44], providing rich and detailed information while balancing data summarisation with in-depth analysis[45]. The research team included an IQN working in the operating theatre whose professional background and lived experience provided an informed insider perspective. This positionality enabled empathetic engagement with participants and a nuanced interpretation of their experiences in New Zealand's perioperative settings.

Participant recruitment and interviews continued until data saturation was achieved, meaning that no new information emerged [42, 46]. This aligns with the concept of 'information power,' where a smaller sample is adequate when the data are rich, focused, and closely aligned with the study's objectives[48]. Saturation was reached after six interviews, where subsequent data replicated previously identified insights [47].

All the interviews were transcribed, verified for accuracy, and analysed using NVivo software. The lead researcher immersed herself in the data through repeated reading and listening to the recordings to ensure deep familiarity[45, 49]. Initial codes were inductively generated and systematically applied across the dataset to capture patterns of meaning and unexpected insights [50].

Codes were refined, merged, and re-categorised through iterative review to establish coherence and conceptual relationships[47]. The evolving codes and emerging themes were discussed with the research team to enhance analytical rigour and interpretive validity. The final themes were defined, named, and supported with illustrative quotes[51, 52].

Validation

A pilot (test interview was conducted with an IQN operating theatre nurse who met the study criteria prior to data collection. Feedback from the participants and research team were used to refine wording, ordering, and probes in the semi-structured interview guide and to confirm interview logistics (e.g., mode, timing, privacy). Pilot data were used solely to improve the instrument and were not included in the final analysis.

A pilot interview was conducted and reported to optimise the guide and ensure procedures align with the Standards for Reporting Qualitative Research (SRQR)

Table 1: Participant demographics (N=6)

Participant Demographic Characteristics	n
Total number of participants	6
Job roles	
OT RN	1
OT RN (Senior)	2
OT Management Role	3
Gender	
Female	5
Male	1
Ethnicity	
North asian	4
Southeast asian	2
Nursing experience gained overseas	
1–5 years	2
5–10 years	2
10+ years	2
Nursing experience gained in New Zealand	
1–5 years	3
5–10 years	1
10+ years	2
Median years of New Zealand nursing experience	5
Employment settings	
Public hospital	2
Private hospital	3
Both public and private hospitals	1
Locations	
Urban	5
Both urban and rural	1

to strengthens the study's credibility and dependability.[53]

Participants were invited to review their interview transcripts. Five of the six participants completed this process within two weeks and confirmed that the transcripts were accurate and reflected their views[47, 54]. Member checking enhanced the credibility and dependability of the findings[54].

The first author is an internationally qualified operating-theatre nurse with extensive perioperative experience in China and, since 2017, in New Zealand, an insider position that aided rapport and interpretation. To limit bias, she maintained an ongoing reflexive practice (journaling/bracketing) and held regular supervisory debriefs where the supervisors would challenge the authors' thoughts around design, data collection, and analysis to surface assumptions and enhance rigour[55, 56].

Initial codes were established by the principal researcher, and all the authors were involved in robust discussions around the analysis of the raw data and the development of themes to ensure procedural fidelity and methodological rigour[54].

This study was conducted and reported in accordance with the SRQR guidelines[53].

Ethics

The Auckland Health Research Ethics Committee approved the ethical application of this study (Reference Number: AH24057). Māori consultation was conducted in conjunction with the ethics application.

All the data were kept confidential and de-identified (codes/pseudonyms), with consent forms stored separately on password-protected University of Auckland systems and access restricted to the researcher and supervisors. Interviews (audio-only, including Zoom) were transcribed by the researcher, securely stored with originals deleted after transfer, and archived at the University of Auckland for six years, and any potentially identifying details were removed from the transcripts and reports.

Prospective participants received a Participant Information Sheet (PIS) outlining the study purpose, data use, and potential benefits and provided written informed consent, and all participation was voluntary. A brief verbal explanation was given before each interview. Written consent (electronic or hard copy) was obtained, and consent to participate and audio-record was verbally reconfirmed. Participants could withdraw at any time. They were also offered the opportunity to review the transcripts to correct, clarify, or remove content.

Findings

The interviews were conducted with six IQNs working in OTs across New Zealand. The participants had varied levels of experience working as nurses in New Zealand and came from different levels of seniority, with two participants holding theatre management roles (Table 1). All participants were of Asian descent from North and Southeast Asian countries

Thematic analysis identified four key themes of adjustment and adaptation, working conditions, interpersonal relations and management. The themes were also separated into subthemes (Table 2).

Adjustment and Adaptation

Orientation and training

Orientation experiences varied, and most participants were dissatisfied with the limited support they received. Many felt that the programs were rushed and lacked structure. A participant mentioned the following.

> Orientation was really bad [...] after a week, [managers] expected you to know all these things.
>
> Participant 6

Participants described orientation as more focused on ticking boxes than genuinely preparing them for practice. Preceptors were often unavailable or untrained, and they were not familiar with key equipment. One participant mentioned the following.

> They gave me an orientation book, but it was very simple [...] nobody told you how to use [equipment]. I felt unsafe practising here. (Participant 3)

Many IQNs completed their Competency Assessment Program (CAP) in aged care settings, which they felt did not align with their theatre experience. They suggested that international nurses should be offered placements in their own specialties. A participant said the following.

Table 2: Themes and subthemes

Themes	Subthemes	Quotations
Adjustment and adaptation	Orientation and training	'Orientation was really bad [...] after a week [managers] expected you know all these things.'
	Adjusting to the operating theatre	'We need more time and more patience [for us as] international nurses.'
	Adjusting to a new language environment	'Back home, we use American English [...] some words were really new, [and] the accent [...] it took me a while.'
Working conditions	Better working conditions	'In [New Zealand] there is a huge [emphasis on] well-being [...] and the importance of family...'
	Opportunities for career pathways and progression	'In New Zealand, you get more opportunities [...] you can work in the ward, theatre, GP — you can try different things.'
Interpersonal relations	Team dynamics and Peer relationships	'Sometimes you really feel painful, particularly in the first three months [...] I feel upset.'
	Effects of interpersonal relations	'It definitely impacts on your personal life [...] your angry mood affects your family members.'
4. Management	Management styles	'There's always favouritism — some people don't work well, but they still get what they want.'
	Management considerations	'The pressure is too much [...] managers don't see the complexity of our roles.'

> [Local and international nurses] should get different orientations.
>
> Participant 4

The participants were generally positive about the cultural orientation they received on Te Tiriti o Waitangi. Te Tiriti o Waitangi (known in English as the Treaty of Waitangi), is an agreement made in 1840 between representatives of the British Crown and (ultimately) more than 500 Rangatira Māori.

Some have reported similarities between Māori culture (the indigenous people of New Zealand) and their own cultural values. One participant stated the following.

> Back home, we are so family-orientated. That still resonates for practice [...] family counts.
>
> Participant 6

Adjusting to the Operating Theatre

All the participants expressed their willingness to adapt to New Zealand OTs, and they commonly shared how hard they tried and how long it took to learn the local ways of working in the operating theatre. They spoke about requiring a period of adjustment. One participant commented the following.

> We need more time and more patience [for us as] international nurses.
>
> Participant 4

Most had prior operating theatre experience overseas, which helped them apply core surgical skills such as aseptic technique and scrub nurse procedures. This made the transition smoother. One stated the following.

> I had the experience in China in a big hospital, so I knew most of the policies in theatre.
>
> Participant 3

Despite familiarity with most clinical skills, adjusting to new protocols and expectations was still very stressful. The participants reported that they needed to learn surgeons' preferences and systems quickly, which was difficult.

One participant stated the following.

> You are not familiar with the system [...] I will write down the preference [he has] for which surgery, [...] particularly, the difference from another consultant.
>
> Participant 4

They often spoke about how they were impacted by the significant differences between the work environments and health systems in their home countries and in New Zealand. One participant commented the following.

> [W]e are overseas; we have a lot of practical experience. We focus more on the practical side of nursing.
>
> Participant 1

In New Zealand, there was more focus on holistic patient-centred care and respect for the patient's cultural and social context. One stated the following.

> I feel patients [here in NZ] gain more respect from health professionals.
>
> Participant 4

Some participants felt that their previous skills were not recognised and that they were frustrated by being restricted from performing tasks in which they were confident. One provided the following example.

> IV insertion, Foley catheter insertion, we're not allowed to do males. However, back home, we do all that.
>
> Participant 6

Adjusting to a New Language Environment

All the participants encountered language-related challenges. Medical jargon, New Zealand ('Kiwi') slang, and strong accents made communication difficult, especially in the OT.

Some of the participant highlighted the following.

> Back home, we use American English [...] some words were truly new, [and] the accent [...] it took me a while.
>
> Participant 6

> They say very specific words or just a half sentence [...] you could not get a clue.
>
> Participant 2

This often led to hesitation in speaking up, even when they understood what was happening. A participant stated the following.

> I want to say something [...] but I am not confident if I can explain in the right way, so I just shut my mouth
>
> Participant 5

Informal social conversations were also challenging. Some felt excluded during breaks or casual chats because of cultural differences in humour and slang. One participant stated the following.

> When they are making jokes sometimes, I didn't get it, and when I make jokes, they didn't get it
>
> Participant 2

Moreover, asking for clarification sometimes led to discomfort or judgment from peers. A participant said the following.

> It's really stressful and painful, because some colleagues [...] are not patient; they [behave] like you don't understand English
>
> Participant 4

Despite these struggles, many IQNs have made proactive efforts to improve. One participant used her time off to study instruments and stated the following.

> I'd spend time looking at pictures and Googling them [...] just use my hard-working attitude.
>
> Participant 4

Some used body language to overcome verbal gaps. A participant stated the following.

> Even if I couldn't pronounce the words correctly, I use my body language, and they can understand
>
> Participant 3

In addition, using their own language at work felt more comfortable for some, especially when asking questions or clarifying instructions. One participant stated the following.

> If I don't know something, I would go to a person [from the same background] first to gain information
>
> Participant 6

However, speaking in their own language sometimes created friction with others who felt excluded. One participant said the following.

> [Speaking home language] creates insecurities among the team members [...] you don't understand and feel disrespected
>
> Participant 1

Working Conditions

Better Working Conditions

All the participants described improved working conditions in New Zealand, especially in terms of work–life balance, fair pay, flexibility, and respect for staff well-being. Many noted how working hours in New Zealand allowed them to spend more time with their families, which was not possible in their home countries because of rigid expectations.

A participant stated the following.

> It is better for work-life balance in New Zealand [...] for a younger nurse, particularly with kids, you can choose a casual job, part-time [...] [back home] [...] you don't have a choice.
>
> Participant 4

Moreover, participants appreciated New Zealand's emphasis on wellbeing and mental health for staff. They had fair working conditions and paid sick leave that included caring for sick family members. These conditions were attributed to the 'special character' of New Zealand. This participant said the following.

> In [New Zealand], there is a huge [emphasis on] well-being [...] and the importance of family — which I really like.
>
> Participant 6

Workload was also seen as more manageable. Nurses recalled being required to cover multiple theatres back home, whereas New Zealand staffing levels allowed a better focus on patient care. Some participants stated the following.

> Back home, I had to work between two theatres [...] I had to run every day
>
> Participant 3

> Here, I feel nurses can do more proper theatre nursing jobs and focus on patient care more.
>
> Participant 5

Some noted that they were empowered to say 'no' to unreasonable demands, something not possible in their home countries. A participant said the following.

> I don't have to work overtime if I don't want to. Nobody will force you to work [which was impossible back home].
>
> Participant 3

However, this was not universal. A few felt burdened with heavier tasks and lacked support when they tried to speak up. A participant stated the following.

> [Other nurses] will withdraw from the [heavy] work [...] but we're getting paid the same. If I say 'no', it's going to be a big issue.
>
> Participant 6

The same participant also shared how cultural backgrounds influenced their response to pressure.

> We came from an oppressed country [...] you can't speak out; you just suck it up.
>
> Participant 6

Opportunities for Career Pathways and Progression

Many participants saw New Zealand as a place where nurses had access to career mobility and professional development. They described options to gain experience in different specialty areas. One participant made the following statement.

> In New Zealand, you get more opportunities [...] you can work in the ward, theatre, and the GP — you can try different things.
>
> Participant 3

This contrasted with their home countries, where they had little control over their placements. The same participant also stated the following.

> [Back home] you can't choose which ward you want to work in [...], [management] will decide for you.
>
> Participant 3

However, not all the participants had positive experiences. Some felt that local nurses had an advantage in terms of promotions and professional development. One participant revealed the following.

> I felt that [local] people have more privileges in career progression. I've done so much in my career [...] IQNs need to do more than other people to gain the same role.
>
> Participant 6

Another echoed a discouraging experience in the following.

> I applied [...] three times for different senior roles [...] the surgeons supported me, [they said to our theatre manager that they would like me] to be the charge because [they] trusted my communication skills, management skills [...] but the manager still didn't give it to me.
>
> Participant 2

Interpersonal Relations

Team Dynamics and Peer Relationships

Most participants described encountering negative behaviours from their colleagues, especially during the first few months. Some participants shared the experience of bullying.

> Sometimes you truly feel pain, particularly in the first three months [...] I feel upset.
>
> Participant 4

> People are very mean to new staff, and they like to bully the new staff as well.
>
> Participant 5

Many IQNs illustrated how body language, facial expression, and tone of voice could convey the feeling of arrogance or dislike toward their counterparts. One stated the following.

> [Y]ou see their eyes, eyes rolling to the ceiling [...] we are not stupid; we can figure out what they are talking about.
>
> Participant 2

Discrimination also surfaced in more insidious ways, such as racial stereotyping. One stated the following.

> She said, 'You know why I called you Susan? Because both of you are Asians.' This totally got me angry.
>
> Participant 3

In addition, some participants described being excluded from proper orientation or given responsibilities beyond their capabilities without guidance. One expressed the following.

> Some didn't teach you [...] some will just say something quite nasty [...] then give me two new staff to work with in theatre.
>
> Participant 3

The participants also discussed their concerns about cultural insensitivity, especially with respect to differences in communication styles and personal boundaries. One participant, when discussing the theatre environment, stated the following.

> Theatre is notorious in terms of culture.
>
> Participant 6

Others highlighted the following.

> The different beliefs of different cultures can also be a triggering factor for conflicts.
>
> Participant 1

Furthermore, expectations to share personal stories and express oneself openly sometimes clashed with more reserved cultural norms. One nurse described feeling pressured.

> [A Kiwi nurse] liked to talk about her life, but if I didn't tell her my story, she felt offended [...] and she reported it.
>
> Participant 5

Despite this, some participants praised the collaborative culture they experienced in certain teams.

> We respect each other, support each other [...] we can help each other.
>
> Participant 3

Furthermore, recognition from surgeons and managers contributed positively to self-worth; one participant stated the following.

> The doctors acknowledge your words within the theatre team — so really good experience.
>
> Participant 6

The impact of psychological pressure as a constant reality, particularly from operational demands and interpersonal tension, was highlighted in the following statement.

> I can tolerate physical stress, but the emotional and mental stress with difficult people can be overwhelming.
>
> Participant 1

Stress was intensified by poor handovers or a lack of preparation from colleagues. A participant commented the following.

> [Other people's mistakes] impact on you [...] the consultant was unhappy; it made you upset and annoye.
>
> Participant 4

Several participants shared stories of feeling undermined or micromanaged and feeling inferior and emotionally traumatised by senior colleagues. One participant stated the following.

> Senior nurse tries to micromanage everyone — that creates mental stress and conflict.
>
> Participant 1

In addition, negative behaviour by seniors sometimes led to a high turnover rate for the operating theatre nursing workforce; one explained with the following.

> She always made fun of others, putting others down [...] juniors tried to report it, but in the end, they [juniors] had to leave.
>
> Participant 2

Effects of Interpersonal Relations

Interpersonal challenges strongly affected participants' mental health, personal lives, and career decisions. One participant stated the following.

> It definitely impacts on your personal life [...] your angry mood affects your family members.
>
> Participant 4

Several IQNs shared that sleep disturbances and emotional distress. One of the participants stated the following.

> I couldn't sleep for two weeks [...] only 1–2 hours a day. Therefore, I said I'll probably stop now [...] it drains me too much.
>
> Participant 2

Some participants reported leaving their roles or the theatre environment entirely. Some participants reported the following.

> I was trying to leave already, and I gave [manager] the resignation letter.
>
> Participant 5

> I'm not working in theatre anymore.
>
> Participant 6

In some cases, the cumulative impact of negative workplace experiences led to a complete career shift. One stated the following.

> So many disappointments — I'm changing my profession now.
>
> Participant 2

Management

Management Styles

IQNs described a mix of supportive and problematic management styles. Some IQNs praised open and empathetic leadership. One participant stated the following.

> You can feel [my new manager] really cares [...] she is honest. If the manager is honest and ethical, the team will be better!
>
> Participant 3

However, others described favouritism, where preferred staff received better rosters, easier work, or training opportunities. Some participants stated the following.

> No matter what I'm complaining about, [the manager] just keeps [defending] the other nurses. I felt hopeless.
>
> Participant 5

> There's always favouritism — some people don't work well, but they still get what they want.
>
> Participant 6

Power imbalances also shaped the experiences of IQNs. Senior staff were perceived to have influence over management, making it hard for others to speak up or resolve issues fairly. Some stated the following.

> What [senior RN] says always gets supported by other seniors or even management.
>
> Participant 2

> If you've got a connection with someone above, you can be rude or mean to anyone.
>
> Participant 5

Some participants felt silenced by their managers when reporting mistreatment. Others stated the following.

> '[Manager] emailed me, wanted me to shut up [...] said I'd be in trouble for breaking confidentiality.
>
> Participant 2

> [Senior nurse] blamed my English [...] [Manager] threatened me and thought I would be scared because I'm not local.
>
> Participant 3

In addition, participants used the words 'ignore' or 'don't care' to describe their experiences with managers. Some added the following.

> They blur the line between right and wrong [...] They turn a blind eye.
>
> Participant 3

> They can see it, but they're just brushing it off. Nothing is changing.
>
> Participant 6

Moreover, speaking up was perceived as risky. Participants feared backlash or being seen as troublemakers. Some participant stated the following.

> If you talk too much, they won't help you.
>
> Participant 4

> Managers feel like you're criticising them. People just withdraw complaints.
>
> Participant 6

Management considerations

Participants also reflected on structural challenges managers face, particularly staffing shortages and maintaining skill mix. They discussed the pressure felt by the perioperative service to complete a surgical quota and the implications for safe staffing given the shortage of theatre nurses available to cover shifts on a day-to-day basis, with limited acknowledgement of the complexity of the nursing role.

One stated the following concern.

> The pressure is too much [...] managers don't see the complexity of our roles.
>
> Participant 6

Some raised safety concerns over hiring inexperienced staff without proper training to work independently.

> They hired staff from rest homes without theatre experience [...] [without proper training] it was quite dangerous.
>
> Participant 3

With respect to long-term retention, participants called for greater cultural awareness and understanding. One participant stated the following.

> Managers need to improve [...] put them in a different culture for a few days to understand.
>
> Participant 2

Some IQNs suggested regular professional service meetings to foster a stronger team culture.

> Catch up meetings would be good — talk about what went well, set goals [...] give IQNs a picture of what's happening.
>
> Participant 6

Discussion

The findings of this study highlight both positive and negative experiences of IQNs that have migrated to New Zealand to work in the operating room setting. While participants generally found New Zealand working conditions better than those of their home countries and enjoyed the New Zealand lifestyle, significant challenges were captured for IQNs around cultural adaptation, orientation processes, communication challenges, and complex team dynamics. A conceptual framework summarised the findings (Figure 1).

The transition to the New Zealand healthcare system required nurses to go through an extensive period of orientation and adjustment. Although most were clinically competent and experienced, the transition required them to navigate new healthcare systems, cultural expectations, and communication styles.

Participants consistently reported dissatisfaction with the orientation processes provided on arrival. Many felt underprepared because of brief, generalised programs that did not accommodate their diverse backgrounds or previous experiences. The expectation to quickly learn from numerous surgical specialties and adjust to unfamiliar workflows created significant stress. These concerns align with international literature reporting that IQNs frequently feel unprepared for their new roles[28, 29, 37, 57]. Standardised approaches have been found not to accommodate the diverse learning needs and prior clinical experience of IQNs[30].

IQNs frequently reported that their clinical skills acquired in their home countries were underutilised due to the differing scopes of RN practice in New Zealand. Retraining and reassessment were often required despite prior proficiency. Similar findings in Australia and the UK reveal frustration among IQNs who are required to prove competence again[33, 57-59].

Nonetheless, some migrant nurses report positive aspects of working in Western healthcare systems. Work in countries such as New Zealand is often seen as more professionally rewarding because of increased autonomy, collaborative team environments, and a stronger emphasis on holistic care[32, 60]. For many, this cultural shift facilitates the development of non-technical competencies such as interprofessional communication and patient advocacy[32].

Another key finding of this study is related to how language poses a significant barrier for IQNs in both professional and social contexts. It impeded their ability to express clinical opinions, participate in discussions, and form relationships with local colleagues.

Many preferred to speak in their native languages to their peers when they could; however, they found that this would sometimes create friction and exclusion. Similar findings have been reported internationally, with studies reporting that IQNs often seek support from culturally similar peers because of shared language and understanding[37, 61-63]. However, exclusive reliance on them may hinder language development and integration, contributing to social divides and misinterpretation[60, 64].

Bullying and discrimination emerged as significant concerns for many IQNs in this study, contributing to distress, marginalisation and barriers to successful adaptation in the OT. Participants described unequal task allocation, limited access to development opportunities, dismissive managerial responses, and exclusion from decision-making. Their experiences mirror international evidence of widespread discrimination toward overseas-trained nurses[28, 37, 38, 65, 66].

An operating theatre's hierarchical and high-pressure environment can intensify these challenges[19, 21, 67]. Power imbalances, rapid workflows, and complex interprofessional dynamics often shape workplace culture in ways that heighten IQNs' vulnerability, particularly during early adaptation[15, 16, 24, 68]. Both formal authority and informal influence, such as seniority or established social networks within the teams, can contribute to behaviours that marginalise IQNs[69-71].

A reluctance to speak up further perpetuated these issues. Participants frequently hesitated to report bullying due to fears of retaliation or perceived managerial bias, which is consistent with the literature showing that organisational culture strongly influences reporting behaviours [72-74]. Although anti-bullying policies exist, many doubted their effectiveness, reflecting a wider 'culture of silence' documented across healthcare settings[16, 24, 38, 68, 75, 76].

Cultural background is also likely to play a role in how IQNs respond to bullying behaviours; for example, participants from collectivist cultures may be more likely to tolerate mistreatment or avoid confrontation, prioritising harmony over self-advocacy[60, 77-79].

Bullying had notable psychological and physical effects in this study, including stress, anxiety, sleep disruption, and emotional exhaustion, with flow-on effects on family and work lives. These outcomes align with global evidence linking workplace bullying to burnout, absenteeism, and reduced performance[16, 25, 80-83]. In severe cases, nurses feel compelled to transfer roles or leave the profession entirely, underscoring the long-term impact of bullying on professional identity, retention, and workforce stability[17, 84].

Management behaviours also played a central role in shaping these experiences. Several IQNs identified unsupportive or inequitable leadership as key factors influencing dissatisfaction or resignation. Effective leadership is known to enhance cohesion and staff well-being, whereas favouritism, intimidation, or managerial inaction can erode trust and morale[85-87]. In this study, perceived dismissiveness from managers compounded feelings of exclusion. When bullying is modelled

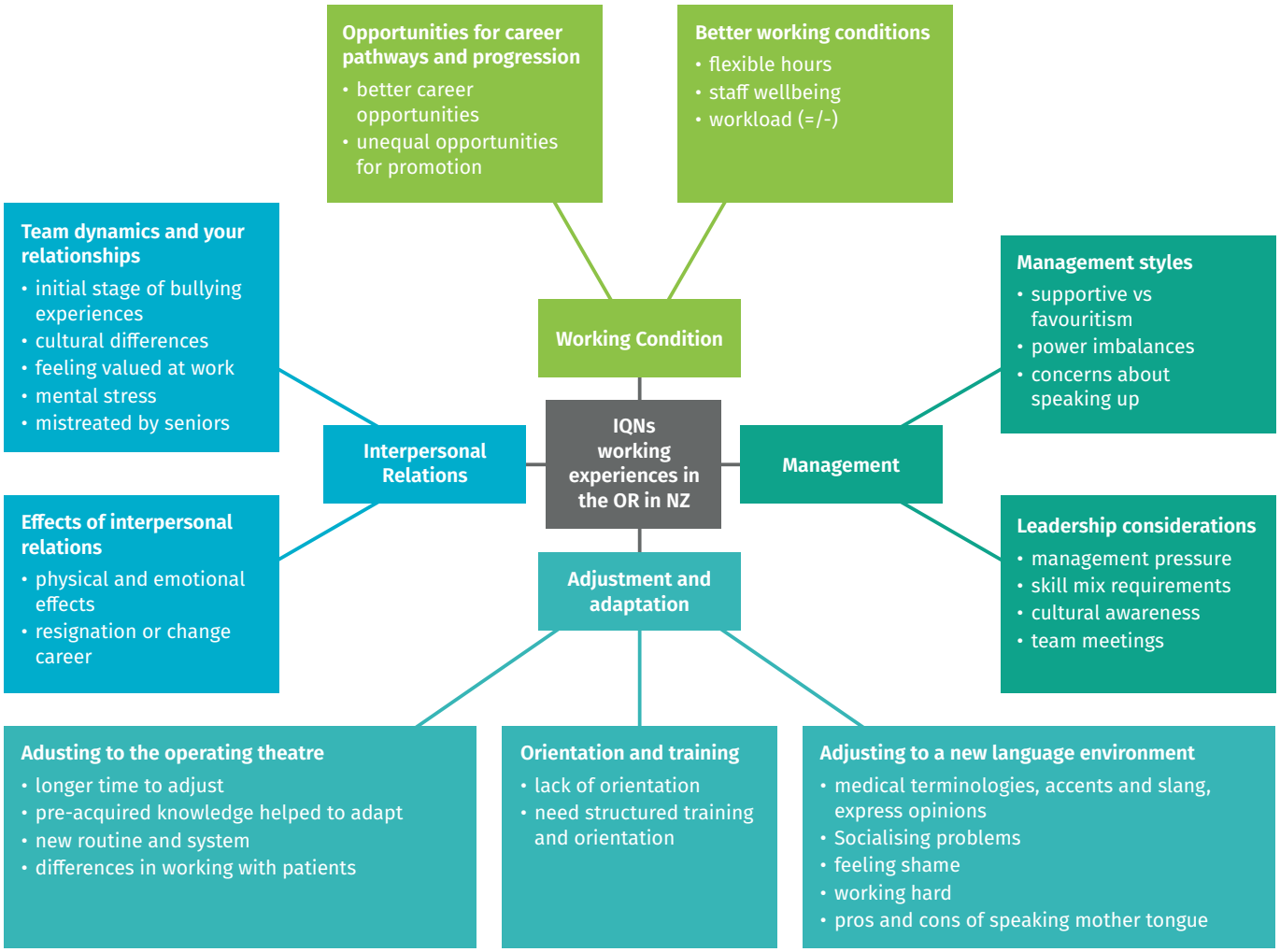


Figure 1: Conceptual Framework Illustrating the Themes and Subthemes

or tolerated by senior leaders, newer managers may adopt similar behaviours[17, 87], a pattern particularly evident in OTs where strong hierarchies and high-stakes decision-making can foster authoritarian leadership styles and reduced accountability[15, 18, 20].

Implications for Practice

This study reveals several practical implications for improving the workplace experience of IQNs, particularly in operating theatre settings. It underscores the need for enhanced orientation, culturally competent leadership, anti-bullying strategies, and stronger support systems that promote equity and well-being.

First, this research highlights the need for more tailored orientation for IQNs in the perioperative setting. In New Zealand, the New to Operating Room (NTOR) program is a 12-week initiative that supports nurses through a supernumerary model and consistent preceptorship[88]. This structure has been shown to enhance clinical integration and professional confidence[89]. However, a comparable structured program specifically for IQNs is lacking.

It is essential that perioperative leadership ensures that orientation programs are structured around the unique learning needs of IQNs, with consideration given to the country of origin and background of each new nurse. Furthermore, greater consideration of the quality of mentorship is needed, ensuring that it is ethical, culturally sensitive, accommodates language needs and includes mental health considerations[80, 90].

Language barriers also need to be actively addressed during the orientation process. A study from Ireland on migrant nurses in perioperative nursing advocated for increased English-language interaction to build confidence and improve communication, which is critical to teamwork and patient safety[91], and this opinion is also supported by a literature review about challenges faced by international nurses[60]. Seeking clarification should be framed positively, as it promotes safety and professional accountability[70].

Furthermore, structured conversations comparing healthcare systems and daily routines between IQNs' countries of origin and New Zealand can help with professional integration[31]. Orientation should also extend beyond the workplace to include settlement support, covering housing, transport, healthcare, schools, and employment for family members[92], all of which affect workplace performance and retention[93].

Second, the findings from this study underscore the importance of reciprocal adaptation. While IQNs must navigate new systems and cultural contexts, host organisations and local staff also need to develop cultural awareness and inclusive practices. Successful integration in multicultural teams relies on mutual

understanding and accommodation of cultural diversity[60, 91, 94].

While IQNs often expect to adapt to new workplace norms, mutual cultural understanding is vital. Creating inclusive workplace environments requires host nurses to actively engage with and respect the cultural values of their migrant colleagues. This reciprocal understanding helps reduce conflict, stereotypes, and cultural displacement[95, 96]. It is important that management foster multicultural awareness and facilitate staff engagement through ongoing cultural competence training and inclusive practices[97].

Finally, the findings highlight the pressing need to address workplace bullying. Bullying not only affects the well-being of IQNs but also compromises patient care[20, 75]. Many IQNs struggle to recognise or report bullying because of a normalised 'toughen-up' culture[98, 99]. These findings reflect global patterns and reinforce the need for effective anti-bullying policies, inclusive workplace cultures, and leadership accountability[16, 17, 75].

The negative experiences of the IQNs in this study with their immediate managers contributed to half of the participants' resignation or career change. Perioperative leaders require not only specialised clinical knowledge but also strong communication, coordination, and conflict-resolution skills[18]. A New Zealand Nurses Organisation (NZNO) survey revealed that only 22.5 per cent of charge nurses had received full people management training prior to taking up the role[100]. This is concerning, as nurses are ideally positioned to detect early signs of workplace distress and intervene effectively[85, 101, 102]. Therefore, it is essential that they receive the necessary skill set while they are orienting to the role.

Despite legal and ethical obligations, many employers fail to deliver the wellbeing support they claim to provide[103-105]. Therefore, the implementation of wellbeing policies, mental health initiatives, and forums for open communication is crucial[106, 107]. Improved reporting systems, clear escalation pathways, and assurance of non-retaliation are essential to encourage staff to raise concerns[75, 108].

As more IQNs move into management roles in OTs, targeted support is essential. Leadership training that addresses intersectionality, communication, and conflict resolution can strengthen their ability to manage diverse teams. Additional education on handling bullying complaints, promoting equity, and maintaining an ethical workplace culture is crucial.

Overall, these findings underscore the need for robust leadership development programs tailored to the New Zealand operating theatre environment. Empowering managers with the skills to foster equitable, inclusive, and psychologically safe workplaces is essential to improving IQNs' experiences and ensuring long-term staff retention.

Strengths and Limitations

To the authors' knowledge, this pilot study is the first in New Zealand to specifically explore the experiences of IQNs working in an operating theatre setting. It offers foundational insights into the challenges and strengths of IQN integration among perioperative teams.

A key strength of this study is its qualitative design, which enabled an in-depth exploration of participants' lived experiences. Limitations include the small sample size, which limits generalisability, however, the study's purpose was to illuminate underexplored experiences, not to produce statistically representative findings. Importantly, data saturation was achieved, reinforcing the credibility of the recurring themes.

Additionally, self-selection bias is a notable limitation that may have affected the sample characteristics[109, 110,] and the study's demographic scope was limited, with all participants originating from Asian backgrounds. Future studies should incorporate a broader ethnic range to better reflect New Zealand's diverse IQN population.

Finally, it is important to note that the absence of charge nurses from the sample may have limited the study's insight into leadership perspectives. Future research should consider triangulating perspectives from both staff and leadership to better understand systemic and interpersonal challenges.

Recommendations for Future Research

1. There is considerable evidence emphasising peer-to-peer violence in the hospital environment [20, 75, 111]. Further research is needed to understand the extent of lateral violence (peer-to-peer), including non-verbal bullying behaviours, in the operating theatre among IQNs in the New Zealand context.
2. Little is known about how IQNs understand, recognise, and manage bullying behaviours in New Zealand. Future research should investigate the levels of awareness among both victims and managers, the effectiveness of existing support systems, and the barriers to reporting in the theatre environment.
3. Further research into the experience of IQNs from a wider range of ethnic groups would be beneficial, as well as exploring variations between ethnic groups.
4. A nationwide cross-sectional survey is recommended to gather data from a larger sample across New Zealand with the inclusion of nurse managers.

Conclusion

To the best of the authors' knowledge, this is the first study of its kind in New Zealand to explore the experiences of IQNs in OTs, revealing how cultural adaptation, communication, and team dynamics shape their professional integration.

The findings highlight a dual reality. While IQNs face significant challenges, they also report benefits such as improved work–life balance and greater autonomy.

The insights from this study underscore the need for culturally responsive orientation and leadership practices among perioperative teams. Targeted leadership interventions that foster inclusivity, equity, and mutual understanding are essential for strengthening IQN retention and enhancing the quality of perioperative care.

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Conflict of interest

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References

1. Shuttleworth A. A history of nursing in Britain: the 1930s [Internet]. Nurs Times. 2021 Aug 26 [cited 2023 Apr 11]. Available from: https://www.nursingtimes.net/history-of-nursing/a-history-of-nursing-in-britain-the-1930s-26-08-2021/
2. Keeling AW. Nursing in the Great Depression, 1930–1940. In: Keeling AW, Hehman MC, Kirchgessner JC, editors. History of professional nursing in the United States: toward a culture of health. New York: Springer Publishing Company; 2017. p. 235–256.
3. Bryder L. Hospitals. In: Te Ara: the Encyclopedia of New Zealand [Internet]. Wellington: Ministry for Culture and Heritage; 2022 [cited 2026 Sep 16]. Available from: https://teara.govt.nz/en/hospitals
4. Flood ME. The troubling expedient: general staff nursing in United States hospitals in the 1930s, a means to institutional, educational and personal ends [dissertation]. Berkeley (CA): University of California; 1981.
5. Organisation for Economic Co-operation and Development. Recent trends in international migration of doctors, nurses and medical students. Paris: OECD Publishing; 2019.
6. Socha-Dietrich K, Dumont JC. International migration and movement of nursing personnel to and within OECD countries 2000 to 2018: developments in countries of destination and impact on countries of origin. Paris: OECD Publishing; 2021.
7. North N. Can New Zealand achieve self-sufficiency in its nursing workforce? J Clin Nurs. 2011;20(1-2):40–49. doi:10.1111/j.1365-2702.2010.03380.x.
8. Nursing Council of New Zealand. Internationally qualified nurses [Internet]. Wellington: Nursing Council of New Zealand; 2024 [cited 2026 Sep 16]. Available from: www.nursingcouncil.org.nz/IQN
9. Tom B. Impact of nursing registration process revision on healthcare migrants [Internet]. Indian Weekender. 2024 Apr 24 [cited 2024 May 17]. Available from: https://www.indianweekender.co.nz/news/impact-of-nursing-registration-process-revision-on-healthcare-migrants
10. Nursing Council of New Zealand. Annual report 2023. Wellington: Nursing Council of New Zealand; 2023.
11. Ministry of Health. Recruitment of new graduate registered nurses. Wellington: Ministry of Health; 2019.
12. Stats NZ. New Zealand's population reflects growing diversity. Wellington: New Zealand Government; 2019.
13. Walker L, Clendon J. New Zealand's migrant Asian nurses: recent trends, future plans. Labour Employ Work N Z. 2015 [cited 2024 Feb 5]. doi:10.26686/lew.v0i0.2221.
14. Rogers D, Lingard L, Boehler ML, Espin S, Klingensmith M, Mellinger JD, et al. Teaching operating room conflict management to surgeons: clarifying the optimal approach. Med Educ. 2011;45(9):939–945. doi:10.1111/j.1365-2923.2011.04040.x.
15. Ahmed I. Staff well-being in high-risk operating room environment: definition, facilitators, stressors, leadership and team-working—a case study from a large teaching hospital. Int J Healthc Manag. 2019;12(1):1–17. doi:10.1080/20479700.2017.1298228.ouci.dntb.gov
16. Tekin YE, Bulut H. Verbal, physical and sexual abuse status against operating room nurses in Turkey. Sex Disabil. 2014;32(1):85–97. doi:10.1007/s11195-014-9339-7.
17. Bentley T, Catley B, Cooper-Thomas H, Gardner D, O'Driscoll M, Trenberth L. Understanding stress and bullying in New Zealand workplaces: final report to OH&S steering committee [Internet]. Wellington (NZ): Health Research Council of New Zealand; New Zealand Department of Labour; 2009 [cited 2024 Feb 5]. Available from: https://www.massey.ac.nz/massey/fms/Massey%20News/2010/04/docs/Bentley-et-al-report.pdf
18. Gillespie BM, Wallis M, Chaboyer W. Operating theater culture: implications for nurse retention. West J Nurs Res. 2008;30(2):259–277. doi:10.1177/0193945907303006.
19. Reyka ME. The impact of disruptive behaviour on operating room nurse satisfaction [dissertation]. Indiana (PA): Indiana University of Pennsylvania; 2015.
20. Bigony L, Lipke TG, Lundberg A, McGraw CA, Pagac GL, Rogers A. Lateral violence in the perioperative setting. AORN J. 2009;89(4):688–696. doi:10.1016/j.aorn.2009.01.029.
21. Higgins BL, MacIntosh J. Operating room nurses' perceptions of the effects of physician-perpetrated abuse. Int Nurs Rev. 2010;57(3):321–327. doi:10.1111/j.1466-7657.2009.00767.x.
22. Sadler D. Staffing shortages and nurse burnout [Internet]. OR Today. 2024 May 1 [cited 2024 Jun 1]. Available from: https://ortoday.com/staffing-shortages-and-nurse-burnout
23. McClenathan B. Mitigating the nursing shortage in perioperative services: causes, impact and retention strategies. Chicago: Surgical Directions; 2024.
24. Skehan J. Why do we still eat our young? Strategies and interventions to decrease workplace bullying. Prof Case Manag. 2014;19(4):196–199. doi:10.1097/NCM.0000000000000047.
25. Lögde A, Rudolfsson G, Runesson Broberg R, Rask-Andersen A, Wålinder R, Arakelian E. I am quitting my job: specialist nurses in perioperative context and their experiences of the process and reasons to quit their job. Int J Qual Health Care. 2018;30(4):313–320. doi:10.1093/intqhc/mzy023.
26. Nursing Council of New Zealand. Refreshing our English language competence policy [Internet]. Wellington: Nursing Council of New Zealand; 2022 [cited 2026 Sep 16]. Available from: https://nursingcouncil.org.nz/IQN/IQN/IQN_News/English_Language_Competence_Policy_Refresh.aspx
27. Nursing Council of New Zealand. Nursing Council of New Zealand quarterly data report. Wellington: Nursing Council of New Zealand; 2025.
28. Pittman P, Davis C, Shaffer F, Herrera CN, Bennett C. Perceptions of employment-based discrimination among newly arrived foreign-educated nurses. Am J Nurs. 2014;114(1):26–35. doi:10.1097/01.NAJ.0000441794.09592.1d.
29. Ho YY-C. Investigating internationally educated Taiwanese nurses' training and communication experiences in the United States. J Contin Educ Nurs. 2015;46(5):218–227. doi:10.3928/00220124-20150420-02.
30. Covell CL, Primeau MD, Kilpatrick K, St-Pierre I. Internationally educated nurses in Canada: predictors of workforce integration. Hum Resour Health. 2017;15(1):26. doi:10.1186/s12960-017-0201-8.
31. Eriksson E, Berg S, Engström M. Internationally educated nurses' and medical graduates' experiences of getting a license and practicing in Sweden: a qualitative interview study. BMC Med Educ. 2018;18(1):296. doi:10.1186/s12909-018-1399-4.

32. Zhong Y, McKenna L, Copnell B, Zhao W, Moss C. Professional adaptation experiences of Chinese migrant nurses in Australia: a qualitative study. West J Nurs Res. 2023;45(7):626–633. doi:10.1177/01939459231167711.
33. Zhupaj A. Working in the NHS as an immigrant nurse: a personal experience. Br J Nurs. 2021;30(7):440–441.
34. Liou SR, Cheng CY. Experiences of a Taiwanese nurse in the United States. Nurs Forum. 2011;46(2):102–109. doi:10.1111/j.1744-6198.2011.00211.x.
35. Okougha M, Tilki M. Experience of overseas nurses: the potential for misunderstanding. Br J Nurs. 2010;19(2):102–106. doi:10.12968/bjon.2010.19.2.46293.
36. Healee D, Inada K. Working with difference: thematic concepts of Japanese nurses working in New Zealand. Nurs Health Sci. 2016;18(1):91–96. doi:10.1111/nhs.12246.
37. Alexis O, Shillingford A. Exploring the perceptions and work experiences of internationally recruited neonatal nurses: a qualitative study. J Clin Nurs. 2012;21(9–10):1435–1442.
38. Alexis O. Internationally educated nurses' experiences in a hospital in England: an exploratory study. Scand J Caring Sci. 2013;27(4):962–968. doi:10.1111/scs.12014.
39. Kishi Y, Inoue K, Crookes P, Shorten A. A model of adaptation of overseas nurses: exploring the experiences of Japanese nurses working in Australia. J Transcult Nurs. 2014;25(2):183–191. doi:10.1177/1043659613515716.
40. Patton MQ. Qualitative research and evaluation methods. 3rd ed. Thousand Oaks (CA): Sage Publications; 2002.
41. Rudnick A. A philosophical analysis of the general methodology of qualitative research: a critical rationalist perspective. Health Care Anal. 2014;22(3):245–254.
42. Bradshaw C, Atkinson S, Doody O. Employing a qualitative description approach in health care research. Glob Qual Nurs Res. 2017;4:2333393617742282. doi:10.1177/2333393617742282.
43. Nursing Council of New Zealand. The New Zealand nursing workforce: a profile of nurse practitioners, registered nurses and enrolled nurses 2022–2023. Wellington: Nursing Council of New Zealand; 2023.
44. Terry G, Hayfield N, Clarke V, Braun V. Thematic analysis. In: Willig C, Stainton Rogers W, editors. The SAGE handbook of qualitative research in psychology. 2nd ed. London: SAGE Publications; 2017.
45. Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qual Res Sport Exerc Health. 2019;11(4):589–597. doi:10.1080/2159676X.2019.1628806.
46. Faulkner SL, Trotter SP. Data saturation. In: Matthes J, Davis CS, Potter RF, editors. The international encyclopedia of communication research methods. Hoboken (NJ): Wiley; 2017. p. 1–2.
47. Creswell JW. Qualitative methods. In: Creswell JW, editor. Research design: qualitative, quantitative, and mixed methods approaches. 4th ed. Thousand Oaks (CA): SAGE Publications; 2014. p. 183–213.
48. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. Qual Health Res. 2016;26(13):1753–1760. doi:10.1177/1049732315617444.
49. Braun V, Clarke V, Hayfield N, Terry G. Thematic analysis. In: Liamputtong P, editor. Handbook of research methods in health social sciences. Singapore: Springer; 2019. p. 843–860.
50. Srivastava P, Hopwood N. A practical iterative framework for qualitative data analysis. Int J Qual Methods. 2009;8(1):76–84. doi:10.1177/160940690900800107.
51. Ryan F, Coughlan M, Cronin P. Step-by-step guide to critiquing research. Part 2: qualitative research. Br J Nurs. 2007;16(12):738–744. doi:10.12968/bjon.2007.16.12.23726.
52. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101. doi:10.1191/1478088706qp063oa.
53. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245–1251. doi:10.1097/ACM.0000000000000388.
54. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. Educ Inf. 2004;22(2):63–75.
55. Dwyer SC, Buckle JL. The space between: on being an insider-outsider in qualitative research. Int J Qual Methods. 2009;8(1):54–63. doi:10.1177/160940690900800105.
56. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–357. doi:10.1093/intqhc/mzm042.
57. Efendi F, Pradipta RO, Makhfudli M, McKenna L, Houghty GS, Rahayu FK, et al. Experiences of internationally qualified nurses in adapting to the Australian healthcare system: a scoping review. Int J Nurs Stud Adv. 2025;9:100399. doi:10.1016/j.ijnsa.2025.100399.
58. Brunero S, Smith J, Bates E. Expectations and experiences of recently recruited overseas qualified nurses in Australia. Contemp Nurse. 2008;28(1-2):101–110. doi:10.5172/conu.673.28.1-2.101.
59. Davda LS, Gallagher JE, Radford DR. Migration motives and integration of international human resources of health in the United Kingdom: systematic review and meta-synthesis of qualitative studies using framework analysis. Hum Resour Health. 2018;16(1):27. doi:10.1186/s12960-018-0293-9.
60. Pung LX, Goh YS. Challenges faced by international nurses when migrating: an integrative literature review. Int Nurs Rev. 2017;64(1):146–165. doi:10.1111/inr.12306.
61. Mpando D, Zhao Y, English M, Leckcivilize A. Experiences of EU and non-EU internationally educated nurses and midwives in the UK: a scoping review. BMC Nurs. 2025;24:1459. doi:10.1186/s12912-025-04080-y.
62. Magnúsdóttir H. Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse. Int Nurs Rev. 2005;52(4):263–269. doi:10.1111/j.1466-7657.2005.00412.x.
63. Philip S, Woodward-Kron R, Manias E. Overseas qualified nurses' communication with other nurses and health professionals: an observational study. J Clin Nurs. 2019;28(19–20):3505–3521. doi:10.1111/jocn.14916.
64. Xu Y, Gutierrez A, Kim SH. Adaptation and transformation through (un)learning: lived experiences of immigrant Chinese nurses in US healthcare environment. ANS Adv Nurs Sci. 2008;31(2):E33–E47. doi:10.1097/01.ANS.0000319570.99254.e5.
65. Allan H, Tschudin V, Horton K. The devaluation of nursing: a position statement. Nurs Ethics. 2008;15(4):549–556. doi:10.1177/0969733008090515.
66. Gerrish K, Griffith V. Integration of overseas registered nurses: evaluation of an adaptation programme. J Adv Nurs. 2004;45(6):579–587. doi:10.1046/j.1365-2648.2003.02947.x.
67. Keller S, Tschan F, Semmer NK, Timm-Holzer E, Zimmermann J, Candinas D, et al. Disruptive behaviour in the operating room: a prospective observational study of triggers and effects of tense communication episodes in surgical teams. PLoS One. 2019;14(12):e0225323. doi:10.1371/journal.pone.0225323.
68. Association for Perioperative Practice. Nationwide survey highlights bullying as a concern in the perioperative workplace [Internet]. J Perioper Pract. 2020 Sep 9 [cited 2024 Mar 10]. Available from: https://japractice.co.uk/2020/09/nationwide-survey-highlights-bullying-as-a-concern-in-the-perioperative-workplace/
69. New Zealand Human Rights Commission. Experiences of workplace bullying and harassment in Aotearoa New Zealand. Wellington: New Zealand Human Rights Commission; 2022.

70. Bezemer J, Korkiakangas T, Weldon SM, Kress G, Kneebone R. Unsettled teamwork: communication and learning in the operating theatres of an urban hospital. J Adv Nurs. 2016;72(2):361–372. doi:10.1111/jan.12754.
71. Einarsen S, editor. Bullying and emotional abuse in the workplace: international perspectives in research and practice. London: Taylor & Francis; 2003.
72. Fast I, Villafranca A, Henrichs B, Magid K, Christodoulou C, Jacobsohn E. Disruptive behaviour in the operating room is under-reported: an international survey. Can J Anaesth. 2020;67(2):177–185. doi:10.1007/s12630-019-01511-6.
73. Lainidi O, Jendeby MK, Montgomery A, Mouratidis C, Paitaridou K, Cook C, et al. An integrative systematic review of employee silence and voice in healthcare: what are we really measuring? Front Psychiatry. 2023;14:1111579. doi:10.3389/fpsyt.2023.1111579.
74. Van Dyne L, LePine JA. Helping and voice extra-role behaviors: evidence of construct and predictive validity. Acad Manage J. 1998;41(1):108–119. doi:10.2307/256902.
75. Parke R, Bates S, Carey M, Cavadino A, Ferguson A, Hammond N, et al. Bullying, discrimination and sexual harassment among intensive care unit nurses in Australia and New Zealand: an online survey. Aust Crit Care. 2023;36(1):10–18. doi:10.1016/j.aucc.2022.08.010.
76. Einarsen S, Hoel H, Notelaers G. Measuring exposure to bullying and harassment at work: validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised. Work Stress. 2009;23(1):24–44. doi:10.1080/02678370902815673.
77. Sherman RO. Transitioning foreign nurses: develop your cultural diversity. Nurs Manage. 2007;38(9):14–16. doi:10.1097/01.NUMA.0000289283.54804.17.
78. Wesołowska K, Hietapakka L, Elovainio M, Aalto AM, Kaihlanen AM, Heponiemi T. The association between cross-cultural competence and well-being among registered native and foreign-born nurses in Finland. PLoS One. 2018;13(12):e0208761. doi:10.1371/journal.pone.0208761.
79. Thomas DC, Au K. The effect of cultural differences on behavioral responses to low job satisfaction. J Int Bus Stud. 2002;33(2):309–326. doi:10.1057/palgrave.jibs.8491015.
80. Efendi F, Hadisuyatmana S, Malik G, Ramdani WF, Has EMM, Erfina E, et al. Mental health challenges faced by foreign nurses: a scoping review. Int J Migr Health Soc Care. 2024;20(4):657-681. doi:10.1108/IJMHSC-03-2024-0036.
81. WorkSafe New Zealand. Bullying at work: advice for workers [Internet]. Wellington (NZ): WorkSafe New Zealand; 2019 [cited 2024 Mar 10]. Available from: www.worksafe.govt.nz/topic-and-industry/bullying/bullying-at-work-advice-for-workers/
82. Johnson AH, Benham-Hutchins M. The influence of bullying on nursing practice errors: a systematic review. AORN J. 2020;111(2):199-210. doi:10.1002/aorn.12923.
83. Topp MC. New Zealand nurses' alcohol and other drug use [doctoral dissertation]. Darwin (AU): Charles Darwin University; 2016. Available from: https://ris.cdu.edu.au/ws/portalfiles/portal/22706905/Thesis_CDU_61432_Topp_M.pdf
84. Spence Laschinger HK, Leiter M, Day A, Gilin D. Workplace empowerment, incivility and burnout: impact on staff nurse recruitment and retention outcomes. J Nurs Manag. 2009;17(3):302–311. doi:10.1111/j.1365-2834.2009.00999.x.
85. Blackwood KM. Workplace bullying in the New Zealand nursing profession: the case for a tailored approach to intervention [doctoral dissertation]. Albany (NZ): Massey University; 2015.
86. Zori S, Nosek LJ, Musil CM. Critical thinking of nurse managers related to staff RNs' perceptions of the practice environment. J Nurs Scholarsh. 2010;42(3):305–313. doi:10.1111/j.1547-5069.2010.01354.x.
87. Salin D, Goel H. Organisational causes of workplace bullying. In: Einarsen S, Hoel H, Zapf D, Cooper CL, editors. Bullying and harassment in the workplace: developments in theory, research and practice. 2nd ed. London: Taylor & Francis; 2011. p. 227–239.
88. Wu G, Taylor B. Successful training programmes for nurses new to the perioperative environment. Dissector. 2020;48(3):25–28.
89. Roth C, Berger S, Krug K, Mahler C, Wensing M. Internationally trained nurses' and host nurses' perceptions of safety culture, work-life balance, burnout and job demand during workplace integration: a cross-sectional study. BMC Nurs. 2021;20(1):77. doi:10.1186/s12912-021-00581-8.
90. Allan H. Mentoring overseas nurses: barriers to effective and non-discriminatory mentoring practices. Nurs Ethics. 2010;17(5):603–613. doi:10.1177/0969733010368747.
91. Cummins T. Migrant nurses' perceptions and attitudes of integration into the perioperative setting. J Adv Nurs. 2009;65(8):1611-1616. doi:10.1111/j.1365-2648.2009.05034.x.
92. Immigration New Zealand. Integrating staff into the workplace and life in New Zealand [Internet]. Wellington (NZ): Ministry of Business, Innovation and Employment; [cited 2026 Sep 16]. Available from: https://www.immigration.govt.nz/employ-migrants/settle-migrant-staff/supporting-migrant-staff
93. Villamin P, Lopez V, Thapa DK, Cleary M. Retention and turnover among migrant nurses: a scoping review. Int Nurs Rev. 2024;71(3):541-555. doi:10.1111/inr.12861.
94. Kurup C, Burston A, Miles S. Transition of internationally qualified nurses in Australia: meta-synthesis of qualitative studies. Collegian. 2023;30(2):357-366. doi:10.1016/j.colegn.2022.10.002.
95. Javanmard M, Steen M, Vernon R, Newnham E. Experiences of internationally qualified midwives and nurses in Australia and other developed nations: a structured literature review. Evid Based Midwifery. 2017;15(3):95–100.
96. Kamau S, Koskenranta M, Isakov TM, Kuivila H, Oikarainen A, Tomietto M, et al. Culturally and linguistically diverse registered nurses' experiences of integration into nursing workforce: a qualitative descriptive study. Nurse Educ Today. 2023;121:105700.
97. Hu Y, Tung WC. Workplace violence experienced by immigrant nurses: types, contributing factors and strategies. Home Health Care Manag Pract. 2025;37:10848223251367403. doi:10.1177/10848223251367403.
98. Deans C. Who cares for nurses? The lived experience of workplace aggression. Collegian. 2004;11(2):32–36.
99. Blackwood K, Catley B. Workplace bullying in the nursing profession: a call for secondary intervention research. Bus Rev. 2013;60(4):91–106.
100. New Zealand Nurses Organisation. Charge nurse survey. Wellington: New Zealand Nurses Organisation; 2012.
101. Rayner C, Lewis D. Managing workplace bullying: the role of policies. In: Einarsen S, Hoel H, Zapf D, Cooper CL, editors. Bullying and harassment in the workplace: developments in theory, research, and practice. 2nd ed. Boca Raton (FL): CRC Press; 2011. p. 327–340.
102. Einarsen S. The nature and causes of bullying at work. Int J Manpow. 1999;20(1–2):16–27. doi:10.1108/01437729910268588.
103. Roth C, Breckner A, Krug K, Mahler C, Wensing M, Berger S. Integrating internationally qualified nurses: a qualitative exploration of nurse managers' influence from nurses' experiences. BMC Nurs. 2025;24(1):233. doi:10.1186/s12912-025-02875-7.

104. Employment New Zealand. Bullying at work [Internet]. Wellington: New Zealand Government; 2020 [cited 2026 Sep 16]. Available from: https://www.employment.govt.nz/resolving-problems/types-of-problems/bullying-harassment-and-discrimination/bullying/
105. Deligiannis N. Mental health at work: who is responsible? [Internet]. Hays; 2020 [cited 2026 Sep 16]. Available from: https://www.hays.net.nz/blog/insights/mental-health-at-work-who-is-responsible
106. Hays. How to improve mental health and wellbeing in your workplace [Internet]. 2020 [cited 2026 Sep 16]. Available from: https://www.hays.net.nz/employer-insights/management-issues/improving-mental-health-and-wellbeing-in-your-workplace
107. Ministry of Business, Innovation and Employment. Why a health and wellbeing policy is important [Internet]. Wellington: New Zealand Government; 2024 [cited 2026 Sep 16]. Available from: https://www.business.govt.nz/wellbeing-support/wellbeing-in-your-business/workplace-wellbeing-policy-builder
108. Chambers C, Frampton C. Bullying in the New Zealand senior medical workforce: prevalence, correlates and consequences. Health Dialogue [Internet]. 2017 [cited 2026 Sep 16];(14). Available from: https://asms.org.nz/wp-content/uploads/2022/05/Health-Dialogue-Bullying.pdf
109. Galloway A. Non-probability sampling. In: Kempf-Leonard K, editor. Encyclopedia of social measurement. New York: Elsevier; 2005. p. 859-864.
110. Nikolopoulou K. What is self-selection bias? Definition and example [Internet]. Scribbr; 2022 [cited 2026 Sep 16]. Available from: https://www.scribbr.com/research-bias/self-selection-bias
111. Bambi S, Guazzini A, De Felippis C, Lucchini A, Rasero L. Preventing workplace incivility, lateral violence and bullying between nurses: a narrative literature review. Acta Biomed. 2017;88(5 Suppl):39–47. doi:10.23750/abm.v88i5-S.6838.