

## Research paper

# Romanian nurses' process of adaptation to Italian nursing practices during their first six months in Italy: a qualitative study

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### ABSTRACT

The aim of this study was to understand the individual experiences of 17 Romanian nurses during their first six months in Italy. A phenomenological approach was used to capture the essence of their experiences. Interviews were carried out in 2004, after gaining the participants' consent and guaranteeing to respect their privacy and anonymity. Each interview, lasting 45 minutes on average, was carried out by two nurse researchers, one Italian and one Romanian. The participants could choose to speak either Italian or Romanian and half chose the Romanian language. The Romanian nurses found the experience of transition into their new roles during their first six months in Italy characterised by three processes: (a) staying with the patients versus organising nursing care; (b) satisfying nursing care needs versus guaranteeing the patient's independence; (c) managing the passive patient versus an active, participating patient.

Placements are important during this first six months because these are a basis for the nurses' future professional careers. Not only did the nurses have problems with the language, nursing practice and skills, technology and hospital organisation, but they also had to adapt to new professional roles, new nursing models and the different roles of the patients. International recruitment is positive when there is reciprocal growth in competence and it enriches nursing with new stimuli, but achieving this involves a long period of placement and adaptation and the possibility of confronting ways of managing nursing care.

**Keywords:** cultural diversity, international recruitment, nursing care, process adaptation, qualitative research

### Introduction

Migration to Italy from other European countries is a relatively new phenomenon. The number of foreign nurses working in Italy is around 1.4% of the whole nursing population. In 2002, of the tens of thousands

of applications received from nurses abroad, only 2554 were recognised: 1763 were from countries outside the European Union, 366 from Africa, 301 from South America and 104 from Asia. Overall, the

greater number came from Romania (936) where nursing education is a three-year course carried out in a college. Although there have been active debates between groups who are for and against this immigration (Martellotti, 2004), nothing has been documented in governmental reports or in professional journals. The immigrant nurses may practise their profession after having obtained (a) recognition of their qualifications by the Ministry of Health; (b) registration with the Nursing Board by passing an exam in the Italian language, knowledge of the deontological code and the laws that regulate practice of the profession in Italy. When they arrive in Italy, the foreign nurses' professional credentials are not evaluated as they are in other countries (Commission on Graduates of Foreign Nursing Schools, 2004). They are asked to be responsible for nursing care and to intervene on the basis of the deontological code as outlined by Law No 42/1996 which regulates the professional practice of Italian nurses.

To ease their placement into the workplace, the nurses are offered educational training programmes specifically including cultural topics, use of the language and specific courses in nursing practice, in terms of both organisational and technological aspects, similar to those documented in the literature (Maroun, 1991; Morton *et al*, 1992; Brown, 1999; Ryan, 2003). However, many of these courses do not deal with practical nursing models used in Italy or with explanations of what is expected of nurses in Italy. In fact, when the nurses arrive, they are expected to be able to function in the same way as the local nurses.

The process of adaptation for foreign nurses depends on many factors: it may take only a year but often a much longer period is needed (McNeese-Smith and Crook, 2003). According to Pilette (1989), nurses' aides go through four phases of adaptation in their first year. The first, defined as *gaining knowledge*, starts on arrival and continues with the orientation programme: the nurses need to be given information regarding board and lodgings and need to be able to put a social network into place to lessen cultural shock and isolation. The second phase is one of *indignation* which presents from about the third to the sixth month following their arrival: it is characterised by professional and psychological cultural discord. Having overcome this phase, *resolution* of the conflict appears, between the sixth and ninth months but often later, and finally, there is *integration* of the new approach to nursing for those nurses who decide to stay. In contrast Yi and Jezewski (2000) used a qualitative approach in documenting the long-term adaptation of 12 Korean nurses employed in hospitals in the United States. The study showed that the initial phase, 2–3 years following their arrival in the United States, was characterised by three processes: *coping with psychological stress*, *getting over the language barriers*

and *gaining the nursing skills required in the United States*. The next phase, which lasted 5–10 years, was focused on adopting the expected professional style. All the participants referred to the variations in nursing care, the roles of nurses, families and nurses' aides. The Korean nurses stated that they had had a positive experience and that the United States had become their second home, even if this had taken 10 years.

More is being written about recruitment (International Council of Nurses, 2004). Leininger (2006) has argued that professional nursing is a culture, with its own set of values, beliefs and practices that are shared by nurses globally. However, no current data are available to compare practice values and roles among nurses from different cultures and countries of origin (Fynn and Aiken, 2002).

## Context and conduct of the study

In 2003 the Udine University Teaching Hospital in Italy recruited a group of 17 Romanian nurses to overcome staff shortages. The teaching hospital has 347 beds (76 in the day hospital), employs 259 nurses, and is the seat of clinical teaching for the faculties of medicine and surgery for all the healthcare professions. For the Romanian nurses the process of socialisation into the hospital environment was based on supervision by regular staff in the wards in which the Romanian nurses started working. To increase their confidence in performing tasks and fulfilling their responsibilities, the Romanian nurses were placed in wards that reflected their previous experience. A 'one-to-one' supervisor was guaranteed for each nurse during the first two months. After that the nurses started working on their own.

Given this situation it seemed appropriate to find out about the experiences of nurses who migrated to Italy, to compare their roles, the procedures nurses are allowed to carry out by law in the hospital, culture and relationships with other healthcare workers and physicians, and the Italian pattern of nursing care including the methods of patient care described in national guidelines, and the consequences of these concepts (see Table 1). Consequently, the aim of the study reported here was to understand individual experiences of Romanian nurses being confronted with different nursing roles and nursing care models during their first six months in Italy.

A phenomenological approach was used (Beck, 1994; Jasper, 1994; Rose *et al*, 1995) in order to capture the essences of the nurses' experiences. Before collecting data, the researchers consciously engaged in a process

**Table 1** A Comparison of Italian and Romanian healthcare cultures (Davanzo 2003)

	Italian healthcare culture	Romanian healthcare culture
Healthcare beliefs	Patients are actively involved. Some hold traditional beliefs. Most Italians are no longer superstitious or have a sense of fatalism linked to their health or healthcare.	Patients play a passive role. Prevalence of acute illness care. Health promotion is considered important but rehabilitation is not.
Healthcare relationships	Patients often complain about lack of communication between themselves and health professionals. Nurses are more aware of the importance of communication than doctors.	The doctor is the primary authority in the hospital setting, nurses are subordinate. Nurses are better respected when they are the only healthcare professionals present.
The family's role in hospital care	Many families are close and provide moral support to their relatives during hospitalisation.	Family members are expected to stay with patients, provide food, and assist in basic hygiene care. The family rallies around relatives who are sick and plays an important role in their care.

of bracketing (Elwyn and Gwyn, 1999; Polit *et al*, 1999). This required them to identify personal biases and to clarify any personal experiences or beliefs that could colour what they were going to hear and report. The project was presented to the hospital administration department, and permission to contact the nurses was obtained. A purposeful sample of Romanian nurses working at the teaching hospital was selected. Researchers explained the aims of the project to the nurses, and gave them a week to decide if they would like to be involved. A researcher met each of the nurses three times. At the first meeting the aims of the project were explained; at the second meeting the nurses were asked to give their informed consent and were given guarantees of respect for their privacy and anonymity. At the third meeting, at a time indicated by each nurse, the interview was carried out.

Each participant was interviewed (Polit and Hungler, 1999) about the following topics:

- how do you feel about Italian nursing practices?
- what is your experience with Italian nursing practice?
- how are you coping with Italian nursing practices?
- how would you describe the way nursing care is carried out in Italy?
- how do you feel about your practical nursing in this first six months?
- what major changes have you had to make regarding nursing practice?

The interviews were carried out in February and March 2004. Each interview lasted 45 minutes on average, and was undertaken by two nurse researchers, one Italian and one Romanian. Participants could choose to speak either Italian or Romanian, and half chose the Romanian language even though the nursing board had evaluated the Italian language skills of all the nurses involved as good before they started working. For the nurses who chose to speak Romanian the interview was much shorter, only about 30 minutes.

Every interview was audiotaped, listened to and transcribed verbatim as soon as practicable. The interviews in Romanian were translated carefully. In conducting analysis the researchers used five steps:

- 1 *familiarisation*: all the transcripts were carefully read for complete understanding
- 2 *compilation*: researchers identified the most significant elements stated by each participant
- 3 *condensation*: researchers reduced the individual answers to find the crux of each dialogue, then identified the meaning of significant statements, phrases or other parts of the dialogue
- 4 *themes*: the researchers compared these statements, put them into categories and tried to establish borders between the categories. These formulated categories were organised into topics that emphasised the basic concepts

5 *contrastive comparison of categories*: the researchers identified the unique character of each category as well as comparing and contrasting between categories.

The researchers worked together on the first step, but then worked independently on the second and third steps. They then worked closely together on the fourth step to achieve consistency and agreement to validate their findings. This strategy was adopted to try to guarantee valid results.

## Findings

### Participants

All the newly arrived Romanian nurses working at the teaching hospital were interviewed (see Table 2). At the time of the interview they had been employed there for an average of 5.6 months (standard deviation (SD) 0.49). Ten nurses (58.8%) had obtained a nursing diploma through high schools offering nursing courses, seven (41.2%) gained their diplomas after doing some years at high school, that is to say a three-year nursing training course following two years of high school. One nurse had done a degree course in biochemical engineering.

Two nurses had done further studies in the management of haemodialysis and the home-nursing problems involved (a one-week course) and a course in cardiopulmonary resuscitation (four days). Two others had done courses on physiotherapy and

massage techniques (3–6 months). One nurse had done a nursing administration and management course (three weeks) and a course on medical/surgical emergencies (six months). These in-depth courses were done independently of the clinical areas in which the nurses were working before leaving for Italy.

The participants had worked as nurses for an average of 7.6 years prior to leaving Romania (SD 6.3; median 6; range: 2–29) and on average had gained experience in two different clinical areas (SD 1.3; median 2; range: 1–6). Immediately before leaving for Italy, seven nurses (41.2%) worked in specialised areas; four (23.5%) in specialised surgery; three (17.7%) in medical wards; two (11.8%) worked in home care, and one (5.9%) for Caritas (a charity organisation). They had worked in these areas for 3.4 years (SD 2.5, range 1–9). Eleven (64.7%) had been very satisfied professionally; five (29.4%) had been reasonably satisfied and only one (5.9%) had not been at all satisfied with his/her work.

Two participants (11.8%) out of 17 saw the move as a work opportunity; 15 (88.2%) saw it as a way to earn more money. None said that the move was to help with career advancement. Italy was chosen because:

- they were contacted by an agency (6 nurses)
- it was easy to have their qualifications recognised (4)
- they were influenced by Romanian colleagues already working in Italy (4)
- the language was easy to learn (3).

### Themes

The Romanian nurses we interviewed during transition into their new roles in the first six months found the experience characterised by three processes:

- staying with the patients versus organising nursing care
- satisfying nursing care needs versus guaranteeing the patient's independence
- managing the passive patient versus an active, participating patient.

#### *Staying with ill patients versus organising nursing care*

In Romania, it is the nurse who stays close to the ill patients. When speaking of their past experiences, the phrases most used were, 'nurses look after the patients' and 'they spend time with the patients'. On their arrival in Italy the situation was very different. In the first six months the Romanian nurses found their nursing experience limited to the main activities of Italian nurses: organising care and looking after the

**Table 2:** Participants: Romanian nurses working at the Udine Teaching Hospital

<i>n</i> = 17		
Females	14	
Males	3	
Average age	31.2 years	SD ± 6.02 (25–51)
Marital status		
Single	12	
Married	5	4 with children
Of these		
Average no. of children	2	(1–5)
Average age of children	2 years old	SD ± 6.3 (5–22)

bureaucratic aspects, which made them feel very distanced from the patients. For example:

'... in my experience, nurses have always been the ones to stay with the ill patients in hospital, while here [in Italy] we spend so much time on red tape and in organising the nurses' aides ...' (Female)

The Romanian nurses were adapting to a new role that was rather different from the one they typically had in Romanian hospitals. This process of adaptation was seen in a negative light because of language difficulties but also because of the different focus of nursing practice. In their view, only by staying close to the ill patients was it possible to completely fulfil their role which was:

'... to give hope and develop trust; to do the best for the patient and encourage and support him.' (Female)

In Italy, instead, they were expected to have a minor role in patient contact: they organised nursing care and bureaucratic activities which reduced the opportunities for nurse/patient relationships and increased contact with other staff, such as nurses' aides, and other departments, to which patients were transferred or discharged. A mainly organisational role was a new consideration for Romanian nurses, but not the only one. Their previous work experience involved being a figurehead of *giving* in a wider sense, giving spiritual help and acting as patient advocate in following medical decisions. For instance:

'... nurses in Romania are highly regarded by patients and get on well with them, they can encourage them with patience and understanding of their suffering.' (Female)

'... we were the doctors' right hand ... an intermediary between the doctors and the patients ...' (Female)

'... we made sure ... that everything was done properly ...' (Male)

'... everything was done for the patient's benefit ...' (Female)

In Italy the law stating that nurses must always act under medical supervision has been annulled; nurses nowadays are permitted to perform various activities excluding diagnosis and medical treatment, having gained competence through a university education and continuous updating (Law No 509/99). Consequently, the Romanian nurses had to be more self-sufficient in Italy, although they also worked with the doctors. In acting as patient advocates the nurses were able to make many nursing care decisions independently. According to one participant:

'... in Italy the nurses are prepared to take a lot of decisions on their own; they help the patients handle their affairs but in a different way.' (Female)

These findings suggest that the process of adaptation for Romanian nurses was focused on two nursing

roles: on developing bureaucratic and organisational skills, and in making independent clinical decisions.

### ***Satisfying nursing care needs versus guaranteeing the patient's independence***

In the first six months, Romanian nurses had to change from one nursing model to another. In Romania, the principal aim of nursing care was:

'to identify and satisfy nursing care needs while supporting the patient psychologically.' (Female)

That is to say it was based on the Virginia Henderson (1966) model. In practice and in Italian nursing training, however, the Dorothea Orem model (Hartweg, 1991) is more widely used. In this model nursing intervention is technical in nature, based on relationships and education, and promotes the encouragement of patient self-care. While the personal needs of the patient are cared for by nurses' aides, nurses concern themselves with patient education and supervision from a clinical point of view. Romanian nurses really noticed the differences in nursing care models; according to them:

'... here in Italy, nurses teach the patients, involve themselves with their clinical condition and are responsible for any procedures that are carried out ...' (Male)

These aspects seemed difficult for the Romanian nurses to cope with because whereas previously they had always had an active but guided role in nursing care, in Italy they had to act independently in developing patient self-care.

### ***Managing the passive patient versus an active, participating patient***

When talking about their experiences, all the Romanian nurses referred to the role of the patient. It was not easy for Romanian nurses to look after Italian patients whom they found to be better informed and aware of the evolution of their illness. Italian patients also wanted to have more information and to play a part in their care. For example:

'In Italy, patients ask for more information regarding their care; they are more reserved in Romania, they don't expect anything, they are happy to see the nurses who are their "little rays of sunshine, bringing care and hope".' (Female)

'In Italy, patients are more demanding, probably because there are more material goods here to help and look after them better. Romanian patients are easier to get along with, they don't expect anything because they know that we don't have these things (plenty of beds, linen, sufficient bathrooms, etc.). Romanians are very poor and don't expect anything ...' (Female)

'Patients here want to know more ...' (Male)

The patient who actively participated in his own care created problems for Romanian nurses, above all with the language barrier creating difficulties in the nurse-patient relationships:

'Here I feel that about 50% of the patients keep their distance, probably because I don't speak the language well... In Romania, I felt very close to the patients because I was able to communicate effectively with them.' (Female)

The differences in the role of the patients and their different attitudes to illness seemed to be related to the economic conditions of the country. In the nurses' view:

'Italian patients are very calm and optimistic, they have great faith in the staff looking after them.' (Male)

'In comparison, Romanian patients seem depressed because they know it is difficult to improve their clinical situation; when they need to go to a doctor they are unhappy because it puts financial pressure on the family.' (Female)

These findings suggest that Romanian nurses found it difficult to cope with patients who wanted a more active part in managing their illness.

## Discussion

This study describes the transitional experiences of a small sample of nurses, homogenous in culture and work placement, from their role in Romania to the role necessary in Italy. It appears to be the first to examine the experiences of nurses who migrate between European countries (Fynn and Aiken, 2002) although some UK studies have addressed the subject (Alexis and Vasso, 2004; Matiti and Taylor, 2005).

According to Pilette (1989) and Yi and Jezewski (2000), the Romanian nurses were entering a phase in which they were becoming aware of the major cultural and professional differences between the two health services concerned, and were learning to progressively integrate these differences into their nursing practice. Change was difficult: it was not easy for a nurse with many years of experience and who was professionally qualified to move to another country with vast cultural and linguistic differences (Ludvigsen, 1997; Brown, 1999). These factors put the abilities of even the best nurses in serious difficulty (Bola *et al*, 2003) as was the case with the nurses we interviewed.

The Romanian nurses highlighted three crucial processes during the transition period: learning to manage the organisation of nursing care and the bureaucratic practices, learning to develop the patient's self-care and being able to make clinical decisions

independently, and learning to manage a well-informed patient who wants to assist in his own treatment. Looking closely at the main differences in their roles in nursing care and at the type of patients offers important considerations for Italian nursing practice. There are about 340 000 trained staff now in the workforce, an estimated 60 000 fewer than are actually needed. The skill mix in Italian wards has changed greatly, and so has the nurse's role. At present Italian nurses spend very little time with the patients. As an example, in a general medical ward they can be responsible for 17 to 20 patients. The hospitals expect nurses to be able to organise and supervise nurses' aides, who after only one year of training are supposed to manage most of the patients' basic needs. The Romanian nurses were used to getting to know the patients well and giving a great deal of emotional support. They stated that this was very difficult in Italy where nurses spent so little time together with the patient. This finding should help Italian nurses critically analyse the changes in nursing in the last few years, which focus their attention more on organisation and bureaucracy and less on the patient.

Romanian nurses felt that on the whole, Italian nurses have a more independent role. While the Romanian nurses had undergone three years' training following high school, nurses in Italy developed independence through a university education. Before 1992 when the university course was introduced, nurses in Italy played an auxiliary role to the doctors and had done so for more than a century. In recent years, many decisions regarding treatment have been taken independently by the nurses while in the past the doctors always gave directions and made the final decisions.

The Romanian nurses' practice was based on Virginia Henderson's model (1966): satisfying the patient's needs was the focus of their experience. In Italy, the Romanian nurses were faced with a different conceptual reference based on Orem's model in which patients' independence and the development of self-care strategies are central. These differences generated different approaches: Italian nurses allocate less complex general nursing care to the nursing aides so that they have more time to spend in patient education. It can be very difficult in the first few months for the Romanian nurses to delegate nursing procedures to nurses' aides and to think about education, at least until they have completely overcome any language difficulties (Vore *et al*, 1991).

For all the participants, nursing care was closely connected to practical tasks and their relationship with the patient. In Italy instead, nursing care appears to focus more on the clinical side of nursing and patient education. Similar difficulties were observed with Filipino nurses working in America, highlighting the differences in values between collectivist and individualist cultures which contribute to differences

in assertion, autonomy and nurse–doctor relationships (Fynn and Aiken, 2002). Romanian nurses have difficulty with these differences because in Romania they had precise tasks and here in Italy, because there is no written job description, they cannot understand what they have to do. Existing placement programmes include learning about the specific culture and language differences, nursing practice, organisation and technology required locally (Maroun, 1991, 1992; Ryan, 2003). It could be a great help to add the study of nursing care models and teach these nurses the skills that they might need in their first few months.

Nurses who come from different cultures are not always able to inform the patients, involve them and encourage them to participate and make decisions, because of language difficulties and cultural differences. This may also be due to different concepts of nursing, the patient and his role (Pizer *et al*, 1992; West *et al*, 2004). The nurses participating in this study also reported differences between Italian and Romanian patients: Italian patients were seen to be optimistic and well informed yet demanding. The Romanian nurses thought this was due to the economic resources available to the Italian patients. Romanian patients apparently participate less in their treatment and are not well informed. They were said to have a more resigned attitude to their illness. Any patient who asked a lot of questions and wanted to participate in his treatment increased the pressure on Romanian nurses, especially if they were having difficulty with the language or were confronted with a patient from a different culture.

The international recruitment of nurses has been debated for more than 30 years: hospitals that employ foreigners have expected these nurses to be competent and self-sufficient and thus able to reduce the workload of permanent staff (Sweeney, 1973; Davitz *et al*, 1976). However, in reality, the cultural differences need to be recognised (Jein and Harris, 1989; Pacquiao, 2002) and confronted over a long period, supported by an expert tutor (Williams, 1992) who can ease the learning and changing processes and help to develop progressive self-sufficiency. To design effective placement career paths it is important to interview the foreign nurses (Dijkhuizen, 1995) to find out their previous working roles, the nursing models they used and the expected role of the patients. This is the only way to change the nurses' very difficult experience of immigration to an experience that confronts and enriches nursing as a whole. Many authors (Burner *et al*, 1990; Edward, 2000) have accentuated the importance of employing foreign nurses and of accepting with interest their professional experiences, their culture and their working practice. Acting in this way would facilitate placement experiences and reduce the effects of 'culture shock'. Unfortunately, this does not happen often (Allan and Larsen, 2004).

## Conclusions and implications for practice

The foreign nurses' first few months of placement are important because they form a basis for their future professional careers in Italy. Not only do they have problems with the language, nursing practice and skills, technology and hospital organisation, but they have to adapt to a new role, new nursing models and different roles of the patients.

Romanian nurses who have worked for about six months in Italy in the same hospital say two positive and one negative thing about Italian nursing. On the positive side, Italian nurses are seen as being self-sufficient in their work and the patients as active participants in their own care. The main focus of practice on bureaucracy and so little contact with the patients is seen in a negative light. This is an interesting aspect that the Romanian nurses have pointed out and is closely related to the nursing shortage. We are looking at something that should be monitored in the future: not being involved in direct patient care does not help to develop clinical competence or good nursing care.

International recruitment is positive when there is reciprocal growth in competence and it enriches nursing with new stimuli. To absorb these values needs a long time for placement and adaptation and the possibility of confronting new ways of managing nursing care. It is important to understand the foreign nurses' points of view; their observations are very useful when analysing nursing care critically. Above all, this is only possible if there is a working environment where there is occasion to include all the staff in friendly, open discussions (Taylor, 2005) and if career paths are organised that take the various roles, proven models of nursing and patients into account.

## AUTHORS' CONTRIBUTIONS

Study design: AP, MB, GB, MM; data analysis AP, MB, GB, MM, SB; manuscript preparation: AP, MB; literature review: AP, MB.

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#### CONFLICTS OF INTEREST

None.

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