University of Strathclyde School of Education

Faculty of Humanities and Social Sciences

“Speak Slowly, I don’t Understand”. Communication and Cultural Competence in the ERASMUS + Experience in Nurse Education

By

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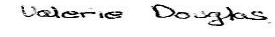
Declaration of Authenticity

This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

Signed: 

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Abstract

Two of the main objectives of ERASMUS+ are to enable students to develop language skills and cultural competence (European Commission, 2014a). Sweeney (2010) recommends that the ERASMUS experience should take place in the language of the host country as the underpinning belief of the 1999 Bologna agreement is that learning in a foreign language can provide cultural enrichment. Despite this recommendation the majority of 3rd year nursing students from the Scottish university where part of this study took place, have an ERASMUS clinical experience and are unable to speak the language of the host country.

The aim of this research was to explore how language constraints influence cultural competence and professional development in an ERASMUS placement for student nurses. A social constructivist, multiple case study was used to investigate each case individually and to illuminate the quintain (Stake, 2006). The quintain was students' clinical placement within four countries (Finland, Sweden, Italy and Spain). The research methods used were one-to-one interviews with 12 mentors and 13 students and interval contingent diaries (Thomas, 2016) to capture students' feelings about the challenges that they encountered in clinical practice and the perceived benefits of an ERASMUS placement on a day to day basis. NVivo 11 qualitative software was used for coding and thematic analysis.

Results showed that students had an expectation that most of the hospital staff in host countries would speak English. The inability to speak the host language led to constraints in clinical practice. Students were unable to speak to patients, read patients' notes and enter information in patient records. Consequently, mentors spent about 70 – 100 percentage of their time with students and acted as language and cultural brokers. Only with this kind of support were students able to have direct cultural encounters with patients. Despite the inability to speak the language, the findings indicated that the ERASMUS experience had personal and professional benefits for students. These benefits included a development of confidence in life and practice skills. In addition, critical thinking was developed through comparing the health care system and practices in the host country with the student's own country. Although students did develop professional and cultural knowledge the acquisition of the host language prior to the ERASMUS experience would have increased student independence. Consequently, many students felt they performed as 2nd year instead of 3rd year students and would have had more autonomy in patient care management in their home country.

Glossary

This glossary provides a list of terms, abbreviations and acronyms used within this thesis.

AEI's	Approved Education Institutions
Anglophone Countries	A country where English is the official language
EEA	European Economic Area
ECTS	European Credit Transfer System
EHEA	European Higher Education Area
ERASMUS	European Action Scheme for the Mobility of University Students
EU	European Union
EURASHE	European Association of Institutions in Higher Education
GATS	General Agreement on Trade in Service
HEI's	Higher Education Institutions
Nigerian Pidgin	A broken form of English with additional words belonging to the indigenous population
NHS	National Health Service
NMC	Nursing Midwifery Council
UKCC	United Kingdom Central Council
WTO	World Trade Organisation

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Chapter One: Introduction

This research was set within a nursing context. It explored how the constraints of language influence professional development and cultural competence in an ERASMUS placement for student nurses. To set the scene, a justification for this research inquiry was provided. This was followed by the overarching research question, the sub questions and the background to the research. The Camphina-Bacote's Model for the Process of Cultural Competence was described, and a rationale provided for using it as a theoretical framework for this research inquiry. Changes in nurse education programmes were discussed as these transformations have enabled student nurses to engage in clinical placements in host countries. The philosophy underpinning the Bologna agreement and the European Action Scheme for the Mobility of University Students (ERASMUS) was described. The chapter concludes by describing the role that mentors play in nurse education programmes.

1.1. Rationale for this Study

The reason for selecting this topic was both personal, educational and professional. From a personal perspective the motivating factor was my role as an ERASMUS site lead at the University of West of Scotland. This involved providing support for ERASMUS outgoing and incoming nursing students. My position as a nurse lecturer also involved the provision of induction programmes for incoming ERASMUS students. I observed how perfecting English linguistic skills was a priority for incoming ERASMUS students whereas learning the language tended to be given low priority for 3rd year nursing students going to host countries. Most of the Scottish students did not feel that there was a need to learn the language because they knew they would be allocated to a mentor who would be fluent in English. These observations stimulated me to carry out this research enquiry which considered the constraints of language skills for Scottish students going to the host country.

From an educational perspective, most student nurses undertaking a BSc in Adult Nursing at the University of the West of Scotland applied for ERASMUS clinical placements but were unable to speak the language of the host country. Indeed, Hughes (2008) suggests that educational achievement may be restricted due to the inability to function in a foreign language. Hughes (2008) applies this statement to students whose first language is not English and who are undertaking taught

programmes in this language. However, this statement is pertinent and can be linked to my study involving Scottish students who cannot speak the language of the host country. In contrast to educational achievements in taught programmes the students in my study must attain educational competences within a clinical setting. This has professional implications as students do not share a common language with patients in host countries. It is also noteworthy that the Nursing and Midwifery Council (NMC) (2010) stipulate that students should be able to initiate and maintain professional relationships with patients and communicate sensitively and effectively in different clinical settings. Despite these stipulations student nurses from the UK can go to a European country for a clinical experience without speaking the language of the country.

To support the students' experience and particularly their ability to communicate they are supervised by mentors in clinical placements. These mentors are registered nurses and chosen because they are fluent in English. Yet there is a dearth in current studies which examine mentors' views about student nurses who are unable to speak the language of the host country. Koskinen and Tossavainen's (2003a) study which explored intercultural mentoring in Finland is not contemporary yet revealed interesting findings. They found that the language barrier created problems when students were unable to participate in nursing procedures and this resulted in limited encounters with patients. Although mentors were classed as intercultural mediators in this study, Koskinen and Tossavainen (2003a) suggested that because direct encounters with patients are essential in the development of cultural competence, mentor strategies which encourage encounters with patients should be developed. My study will address this recommendation. Mentoring will be discussed in more detailed in section 1.7. (p.14) of this Chapter and in Chapter 4, section 4.7.3. (p.122-129).

1.2. Research Questions

The overarching research question arising from my professional experience is:

How does the constraints of language influence cultural competence and professional development in an ERASMUS placement for student nurses?

Cultural competence is associated with language (Sweeney, 2010) and linguistic skills are rooted in a cultural context (Risager, 2006). Language is moulded by

culture and it is reflected in it (Jiang, 2000). It was for this reason that culture and language have been embedded in my research questions.

To address the overarching question within this research enquiry, the following sub questions were posed:

1. How does the language of the student and the language of the host country influence the ERASMUS cultural experience?
2. What support mechanisms are presently in place for students who cannot speak the language in the four host countries (Finland, Sweden, Spain and Italy)?
3. How do mentors and students perceive the benefits of an ERASMUS experience?
4. What are the relationships between the process of cultural competence and professional learning?

1.2.1. Theoretical Framework - Campinha-Bacote Model

The Campinha-Bacote Process of Cultural Competence Model underpins this thesis, thus the reason for introducing it within this Chapter. Campinha-Bacote (2002, p.181) describes cultural competence as an ongoing process in which the health care worker strives to work effectively within the cultural context of the client, individual or community. Social constructivism is the basis of the Campinha-Bacote Process of Cultural Competence in the Delivery of Health Care Model (Hunter, 2008; Hunter and Krantz, 2010) and it was this that influenced my decision to adopt it as a theoretical framework for this research inquiry. Another reason for adopting this model is that culture competence is embedded in my research questions. The overarching research question and the sub questions 1 and 4 emphasise cultural competence and the development of cultural and professional learning. From a social constructivism perspective, cultural competence is an active process based on the development of knowledge, skills and behaviour and when combined leads to the delivery of congruent health care (Garneau and Pepin, 2015). Social interaction with people within a social cultural learning environment can facilitates this. Social constructivism will be discussed in more detail in section 2.3.1. (p.35-37).

The process of Cultural Competence Model includes five constructs: cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire

(Campinha-Bacote, 2002). The beliefs underpinning this framework are that each construct is of equal importance and must be experienced by health care workers in order to commence the process of cultural competence. Heath care workers can experience more than one construct at the same time. This is identified within the overlapping spheres. A diagram depicting the five overlapping spheres (constructs) within Campinha-Bacote (1998) Process of Cultural Competence Model (Campinha-Bacote, 2002) was displayed in Figure 1. Permission to use this diagram was provided by Camphina-Bacote (Appendix A). This diagram was reproduced in Chapter 5 in order to explain the application of the model to the ERASMUS experience.

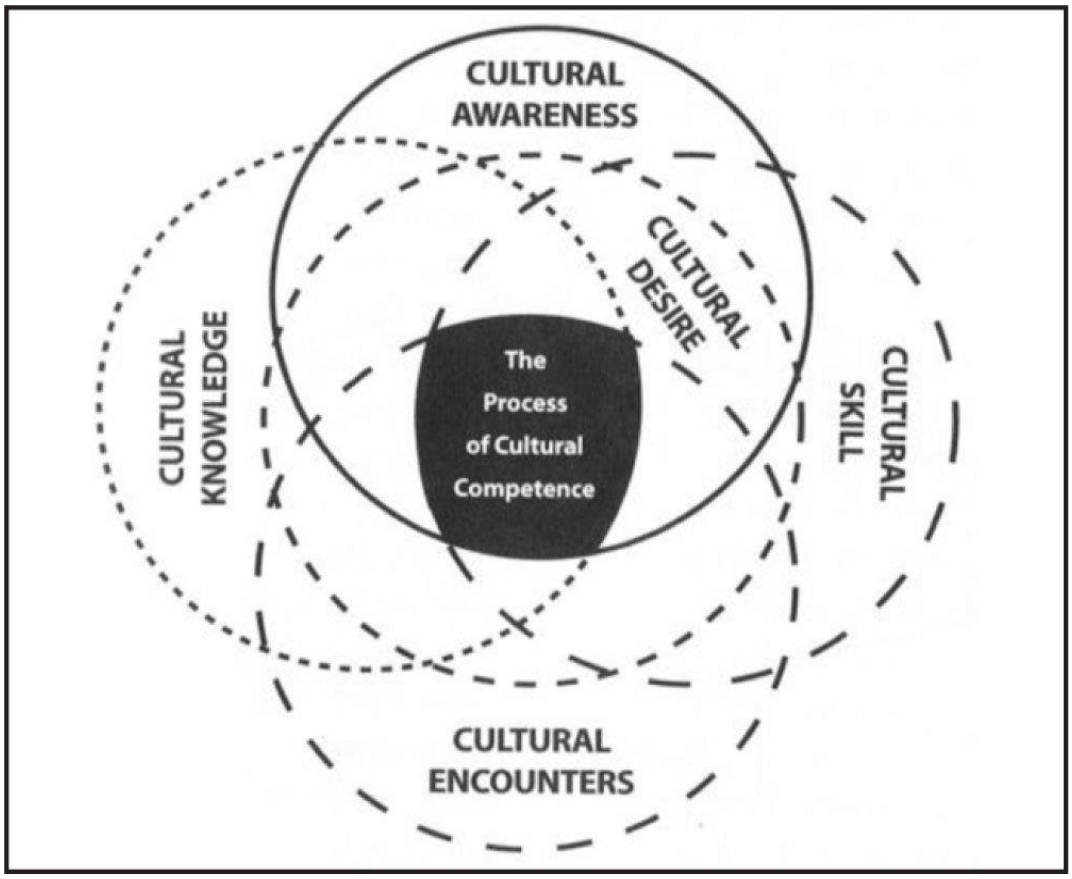

Figure: 1: Process of Cultural Competence in the Delivery of Health Care Services (Campinha-Bacote, 1998) Source: Reprinted with Permission of Transcultural C.A.R.E. Associates

As cultural competence is a pivotal part of this research inquiry, its relationship to the aims of ERASMUS programmes was discussed in more detail in section 1.5.1. (p.11-13). The Campinha-Bacote Process of Cultural Competence Model was revisited in Chapter 2 (p.31-35) to explain why it was judged as the most appropriate conceptual framework for this research inquiry. Furthermore, the Camphina-Bacote Model

focusses on clinical practice but the research findings which have been applied to this framework in Chapter 5, highlighted that in addition to the learning which took place within clinical placements in host countries, external factors also contributed to students' professional learning and cultural competence. Some of these external factors were linked to cultural encounters with people outside clinical practice. These encounters enabled students to develop cultural awareness and cultural knowledge. It was for this reason a pictorial diagram which takes these external elements into consideration was developed. This diagram was displayed in Figure 11 in Chapter 5, (p.154).

1.3. Background to the Research

Nursing is classed as a practice-based profession which is dependent on the development of caring and empowering relationships with patients and relatives (Boore and Denny, 2012). Communication is the basis of such relationships. Indeed, the NMC (2015) which is the regulatory body for Nursing and Midwifery within the United Kingdom puts emphasis on meeting the communication needs of patients and relatives. They recommend that nurses should communicate effectively in English and the language needs of all patients should be met (NMC, 2015). Although this recommendation applies to students within the UK it is also essential that the communication needs of patients within other European countries are met. The NMC (2015) also stipulate that registered nurses should be able to discern when language interpretation is needed. This recommendation can be related to my study due to students not speaking the language of the host country. Communication in a mutual language is imperative as studies have indicated that when patients perceive they are able to communicate effectively with health providers they are less anxious and have better clinical outcomes (Derksen, Bensing and Lagro-Janssen, 2013).

In addition, communication is an essential component of pre-registration nurse education programmes (Bramhall, 2014; NMC, 2015). The aim of the pre-registration programmes is to ensure that student nurses attain the necessary competencies for registration with the NMC before entry to the register as a qualified nurse. This includes competencies in communication and interpersonal skills. These competencies are identified in section 1.6. (p.14).

1.4. Changes in Nurse Education programmes

There have been many changes in nurse education which have contributed to student nurses being given opportunities to engage in an international clinical placement within their nurse education programme. This means that international clinical experiences for student nurses are increasing (Dobrowolska et al., 2015).

The reform which had a revolutionary impact on nurse training within the United Kingdom was the introduction of the Project 2000 Diploma of nursing programme (Watson, 2006). This reform involved the move from the NHS nurse apprenticeship model to a university based Higher Education nursing programme. The United Kingdom Central Council (UKCC) which was the governing body for nurses and midwives prior to the NMC believed that the professional status of registered nurses would be increased if there was a disengagement from the apprenticeship model (UKCC, 1986; Findlow, 2012). In addition, the apprenticeship model was criticised as it put emphasis on how to complete nursing 'tasks' rather than the theory underpinning these tasks (Elcock, Cutis and Sharples, 2006) from a holistic perspective. The apprenticeship model also meant that student nurses were employees of NHS hospitals and did not have access to the international activities which were offered within higher education.

Although colleges and schools of nursing were within NHS hospitals, there were exceptions to this approach to nurse training. For example, Edinburgh University developed a degree programme for nurses in the 1960's (Watson, 2006). However, the closure of the traditional NHS hospital-based schools of nursing and the move to higher education was classed as a means of educating student nurses to think at a higher level and respond appropriately to the needs of patients in different clinical settings, in a competent manner (Watson and Thompson, 2004; Watson, 2006). Moreover, students were given a UK government non-means tested bursary and were no longer counted as a salaried part of the NHS workforce (Findlow, 2012; Morrall and Goodman, 2013; Leonard, McCutcheon and Rogers, 2015). This meant that student nurses were granted supernumerary status and were additional to NHS staffing levels within clinical practice. The purpose of supernumerary status was to enable students to engage in learning opportunities, which were facilitated by a registered nurse in a supportive learning environment (McGowan, 2005). Alongside the transfer of nursing to higher education, clinical mentorship became an integral part

of the Project 2000 Diploma in nursing programmes (Donovan, 1990; Bray and Nettleton, 2007).

Consequently, following these reforms in nurse education, student nurses' clinical placements were no longer confined to the NHS sector. Student nurses had the opportunity of working in the private sector and spending time in clinical placements in another European country (Lee, 2004). This concept was implemented in the University of West of Scotland where I worked as a nurse lecturer and an ERASMUS site lead.

1.4.1. European Influence on Nurse Education

In addition to the United Kingdom changes in nurse education programmes, the Bologna Agreement also had a major impact on Nurse Education. The Bologna Agreement was developed by 29 European Ministers in Bologna in Italy in 1999 to encourage Higher Educations Institutions (HEI's) within each European Community (EC) country to construct a university system which was based on knowledge advancement and autonomy (Maas-Garcia and Maten-Speksnijder, 2009). Although, the Bologna process advocated university independence, the EC recommended that each European member country should have compatible and comparable degree programmes (Maas-Garcia and Maten-Speksnijder, 2009; Keeling, 2006). This recommendation applies to degrees at bachelor level, master's level and doctorates for advanced practice (Collins and Hewer, 2014).

The Bologna agreement has had an impact on the structure of pre-registration nurse education programmes within Europe. It resulted in the transfer of nurse education from vocational training to higher education and from a Diploma to a Degree programme (Collins and Hewer, 2014). Some European countries are at various stages in the transition from a Diploma in Nursing to a Degree in Nursing (Collin and Hewer, 2014). The transition to degree level of all pre-registration nursing programmes took place in Scotland in the year 2011 (RCN, 2012). A pre-registration degree level programme within the four countries of the UK was endorsed in the Willis Report (Royal College of Nursing (RCN) 2012). This Report was an independent inquiry commissioned by the RCN to investigate excellence in nurse education and preparing a workforce which is fit for practice (RCN, 2012). The Willis report claimed that the degree in nursing programme would equip nurses to develop critical thinking

skills, use evidence-based practice, and attain autonomous decision-making skills to meet the complex needs of individuals (Willis, 2012). These are classed as the core elements of nursing professionalism (Skela-Savic and Kiger, 2015).

Another factor which has contributed to the recognition of nurse education programmes throughout Europe is the EU directive about the minimum number of hours of theory and practice experience for nurses (Boore and Deeney, 2012). The directive stipulates that a nurse education programme should be at least three years in duration and comprise of 4600 hours of theoretical and practical experience (World Health Organisation, 2009). These hours should be split equally between theory and practice (Findow, 2012). It is advantageous to have comparable and compatible nursing qualifications within the European Community as it facilitates the free movement of registered nurses across borders to practice nursing within another EU member country (Lahitinen, Leino-Kilpi and Salminen, 2013). In addition, student nurses can have an international experience in a higher education sector in another European country which has a similar nurse education programme to their own country.

Two other dimensions of the Bologna agreement were to promote European cooperation in quality assurance and introduce a European element into higher education (Davies, 2008). Quality initiatives are dynamic and educational strategies are changing (European Association for Quality Assurance in Higher Education, (ENQA), 2015). For example, since the European standards and quality guidelines for the European Higher Education Area (EHEA) were published in 2005 there have been many changes in Higher Education. These changes include more emphasis on student centred learning, recognition of flexible learning pathways and a more transparent quality assurance initiative within the EHEA. The revised Standards and Guidelines for Quality Assurance in the European Area (2015) have addressed these strategies and were endorsed by the Bologna follow up group which included representatives from all EC countries. These standards were implemented within the higher education sector to ensure that there was an effective European network for Quality Assurance. HEIs in each of the European countries are responsible for internal and external accreditation and re-accreditation of programmes. Accredited programmes are reviewed periodically to obtain re-accreditation (Stanciu, 2014). This provides quality assurance for the HEI and the committee responsible for the European Higher Education Area. In addition, it also provides quality assurance to

students undertaking cross border degree programmes (Knight, 2006). A cross border degree is when a student completes part of their degree in another country.

The Bologna process established the European Credit Transfer System (ECTS) to facilitate mobility between Europeans universities (Veiga, Magalhães and Amaral, 2015; Keeling 2006). Student mobility is defined by the Organisation for Economic Co-operation and Development (OECD) (2009, p.308) as "International students who travelled to a country different to their own for study." During this period of mobility students are awarded ECTS and these are related to their learning outcomes and workload. For example, a typical workload could include attending lectures, exam preparation, compiling assignments (Collins and Hewer, 2014) and practice placement hours. In my study the student's workload load relates to practice placement hours and meeting the learning competences within their practice placement. These competencies were identified in section 1.6.(p.14) Collins and Hewer (2014) point out that most of the 47 countries in the European Area, award one credit (ECTS) for each 25 – 30 hours of student workload. This means that Higher Education students can be awarded ECTS for their engagement in an education programme in another European country under the auspices of an ERASMUS Mobility Exchange programme.

1.5. ERASMUS Mobility Programmes

ERASMUS programmes were established in 1987 by the European Commission as a 'civic experience' to develop or enhance a European awareness in participating students (Mitchell, 2012). As already indicated in section 1.4. the Bologna Process which was established in 1999 has enabled Higher Education including Nurse education to modernise and gain European recognition in other European countries (Collins and Hewer, 2014) and this has had a positive impact on ERASMUS. It has enabled Higher Education students to engage in a period of study at another institution in a host country (Vossensteyn et al., 2010) and gain European academic recognition. Likewise, the host university, who receive incoming ERASMUS students, send students to the partner university. Bilateral agreements are developed by partner universities (European Commission, 2014a). This agreement identifies the number of students which the university will send to the partner university, the number that the sending university will receive and the learning outcomes that students should achieve (European Commission, 2014a).

In 1987, the year in which ERASMUS was launched, a total of 3,244 students from eleven European countries engaged in an ERASMUS programme during a 12-month period (European Commission, 2015a). Since its inception, the numbers of students engaging in mobility programmes has gradually increased (European Commission 2015a). During 2013-2014, 272,497 students from across Europe participated in ERASMUS programmes (European Commission 2015a). This increase in ERASMUS participation has also been cited within the United Kingdom data. According to Vossensteyn et al. (2010, p.25) between the year 2007 and 2008, 7,382 students from the United Kingdom, engaged in an ERASMUS experience. This increased between 2012 and 2013 to 14,572 outgoing United Kingdom ERASMUS students (European Commission 2015b, p.41). During the same period there were 27,147 incoming ERASMUS students. Although there appears to be an imbalance in the number of outgoing and incoming students, the European Commission (2015b) do not give a reason for this. However, the lack of language skills could be a reason for this imbalance. A study by Vossensteyn et al. (2010) indicated that some UK students do not engage in ERASMUS placements due to insufficient information about ERASMUS and lack of linguistic skills.

The European Commission fund intensive ERASMUS programmes and these can range from ten days to six weeks. These programmes are subject related, and the aim is to bring teaching staff and students from different European countries together (European Commission, 2012, p.12). Vossensteyn et al. (2010) point out that shortening the period abroad can decrease the impact of the experience. In addition, students can also spend 3 months to 12 months in a host country (Vossensteyn et al., 2010) as part of a taught component of a degree programme or work experience. This study will focus on a 12-week ERASMUS experience in which at least seven weeks will be spent in a clinical placement. A clinical placement provides health care related services to patients.

The student mobility for 2012 - 2013 comprised of 212,522 who engaged in a study abroad experience and of this number 55,621 had a practice experience (European Commission 2014b, p.17). However, the European Commission (2014b) does not indicate the number of students who had health care practice or placements in nursing practice. In the School of Nursing in the University of West of Scotland where part of my study took place only 12 (3.7%) students had an 8-12-week ERASMUS

placement in 2015 and 11 (2.4%) students had an 8-12-week clinical placement in 2016.

The EC Higher Education Modernisation agenda have recommended that more opportunities should be made available for students to develop cultural awareness and language skills (European Commission, 2011). International student mobility can have a key impact in the development of cultural awareness (Kokko, 2011). Cultural awareness is described as sensitivity to the values, beliefs and practices of individuals from different cultures (Koskinen and Tossavainen 2003b).

An additional aim of the EC Modernisation agenda is to strengthen the knowledge triangle between Higher Education, Research and Business (European Commission, 2011). In my study, student nurses have the opportunity of developing knowledge in the host country which can enhance their professional practice in nursing. The European Commission recommend that 20% of the student population should have an ERASMUS placement yearly by the year 2020 (European Commission, 2013). The percentage of students from the University of West of Scotland, School of Nursing who engaged in a placement overseas during 2015 and 2016 was much less than what is recommended by the European Commission.

1.5.1. ERASMUS +

ERASMUS+ was introduced in January 2014. It is built on the philosophy of the 1987 ERASMUS programme (Marshall, 2017). The main aim of ERASMUS + is to give over 4 million Europeans the opportunity to gain work experience or participate in study abroad programmes (European Commission, 2014a). To facilitate this, the European Commission has allocated €14.7 billion (£13,89 billion) over a seven-year period to ERASMUS + (European Commission, 2014a). This funding is 40% more than what was allocated to previous ERASMUS programmes (European Commission, 2015b). Some of this funding goes towards EU mobility grants which university students can use for travel and subsistence in the host country (European Commission, 2014a). Whilst UK ERASMUS students can access EC mobility grants (European Commission, 2014a) EU members countries contribute to the EC budget and the UK at present is the fourth main contributor (British Council, n.d.). This may change if the UK leaves the EU (British Council, n.d.).

Presently, 28 countries are members of the European Union and 47 countries are in the European Higher Education area (EHEA). Some countries in the European Higher Education Area who are not members of the European Union participate in student exchange programmes. Participation in ERASMUS+ is subject to a joint European Economic Area (EEA) committee decision (European Commission 2014a). The EHEA was set up as an EU policy driver to steer educational policies (Viega, Magalhães and Amaral, 2015). Their responsibilities are to ensure comparability and compatibility of Higher Education Programmes throughout Europe. This was achieved partly by the Bologna Process which has helped to consolidate the EHEA into a dynamic and compelling force for enacting policies (Viega, Magalhães and Amaral, 2015) related to ERASMUS exchange programmes.

The main aims of the ERASMUS+ exchange programme mirrors those of the EC Modernisation agenda described in section 1.5. These are to increase knowledge of EU principles, develop cultural awareness and improve foreign language skills (European Commission, 2014a). Cultural awareness is the first step (construct) in the process to cultural competence (Campinha-Bacote, 2002). There are many definitions of cultural competence within the literature. Moreover, Wood and Atkins (2006) describe cultural competence in nursing as the ability to understand diversity and provide care which meets the cultural, social and linguistic needs of patients. Wood and Atkins (2006) do not stipulate if it is a nurse or an interpreter who is responsible for meeting the linguistic needs of the patients. Although, Campinha-Bacote's definition of cultural competence in section 1.2.1. (p.3), reflects a social constructivist stance which is an ongoing progress to cultural competence in health care, it does not put emphasis on the linguistic needs of patients. Whilst I have selected the Campinha-Bacote Model as a theoretical framework due to its emphasis on social constructivism, Wood and Atkins (2006) definition can also be linked to this research inquiry as Scottish ERASMUS students cannot meet the linguistic needs of patients if they are unable to share a mutual language. Social constructivist learning theories will be discussed in more depth in Chapter 2, section 2.3.1. (p.35-37).

Sweeney (2010) suggests that where possible the ERASMUS exchange should take place in a foreign language as the underpinning belief of the Bologna process is that learning a language is desirable and it can provide cultural enrichment. The EU has set a target for every European citizen to acquire a knowledge of at least two languages from an early age (European Commission, 2014a). However, Sweeney

(2010) does admit that the ERASMUS philosophy of acquisition of a foreign language during student mobility is weakened due to English becoming a lingua franca within most European Universities. A lingua franca is a common language which is used for teaching and learning during an international experience (Tsui, 2014). To facilitate language development, an on-line language assessment in six language has been constructed for ERASMUS+ students. These languages are English, Spanish, French, Italian, Portuguese and Dutch. Students have an online assessment prior to going to the host country and then on return from the host country (European Commission, 2014a). The purpose of this is to measure language acquisition and competence (European Commission, 2014a). Some student nurses from the University of West of Scotland had placements in other European counties such as Sweden and Finland but at the time of this study the European Commission had not developed online assessments in these languages.

1.6. Selection Criteria

Following completion of the ERASMUS application form within the School of Nursing at the University of West of Scotland, students were selected on the basis that they were 3rd Year Nursing Students and had successfully completed the first module in year 3. Student nurses had three clinical placements in Year 3 and had the opportunity of an international experience during their second placement. The rationale for this is that the final assessment in Year 3 is completed by a mentor in Scotland who has sign off status (NHS Education for Scotland, 2013). Mentors in the UK undergo additional mentorship training to enable them to sign off a student nurse as proficient and eligible for registration as a nurse (NHS Education for Scotland, 2013). This means their names can then be recorded in the NMC register for Nursing (NHS Education for Scotland 2013). Mentorship will be discussed in more detail in the following section, 1.7.

Another part of the ERASMUS selection criteria was that students must have good academic records. This was to ensure that students were not carrying fail grades as they had two academic assignments to complete whilst they were in clinical placement in the host country. Carrying a fail grade would have meant they had three assignments to complete during their ERASMUS experience. In addition, nursing students were also expected to achieve four sets of NMC competencies during their clinical placement in the host country.

The NMC's competencies included

- Communication and interpersonal skills
- Nursing practice skills and decision making
- Professional values
- Leadership, management and team working (NMC, 2010).

These competencies reflect the core values of professional nursing. They are central to caring relationships with patients and enable nurses to engage in decision making (Bailie and Black, 2015) with other professionals. Communication is the cornerstone of good nursing, yet knowledge of the language of the host country was not included in the selection criteria for nursing students at the University of West of Scotland. The European Commission (2014a) do not stipulate that students should have a knowledge of the language. They state that no matter what the result of the language assessment is that students undertake before departure, it will not preclude them from taking part in a placement abroad (European commission, 2014a).

1.7. Mentorship

Mentors are an integral part of a nurse education programmes in this country and in the host country. The NMC (2008, p.19) describes a mentor as a registered nurse who has completed an NMC recognised mentorship preparation programme within a higher education institution. This is a UK statutory body stipulation, but mentorship preparation is different in each EU country and not every EU country has a mandatory mentorship programme (Dobrowska, et al., 2016).

However, mentors in the host country are responsible for assessing the student in clinical practice. The role of the mentor includes instructing, supporting and assessing the performance of nursing students in clinical practice (Brown, Douglas, Shepherd and Gariety, 2012). Students are allocated to a named mentor during their clinical placements (Royal College of Nursing, 2007) in the United Kingdom and in a European host country. Mentors are integral to the education of nursing students in clinical practice (Heale, Mossey, Lafoley and Gorham, 2009) and helping students to link theory with practice. This view is held by the nursing profession in the United Kingdom and in other European countries (Jokelainen, Jamookeeah, Tossavainen and Turunen, 2011). Mentors are responsible for ensuring that students have

knowledge, skills and an appropriate professional attitude to deliver safe and effective nursing care (Elcock and Sharples, 2011; Dadge and Casey, 2009).

Furthermore, partnership working is necessary between the higher education institution (HEI) and the mentor (NMC, 2008). This statement applies to HEI's in Scotland and the host country. In the University of the West of Scotland where a component of my study was carried out, a lecturer in the School of Nursing acts as a link lecturer between the Scottish university and the partner university in the host country. The ERASMUS co-ordinator in the partner university in the host country is responsible for getting student nurses, clinical placements in the host country and ensuring they have a named mentor to supervise them. Should the mentors have concerns about the student's fitness to practice nursing during the student's clinical placement, these concerns are raised with the ERASMUS coordinator in the university in the host country and the link lecturer or ERASMUS coordinator in the school of nursing at the Scottish University. The NMC (2011) point out that learning outside the United Kingdom is dependent on the education provider in the host country having appropriate strategies in place to ensure the safety of students and clients/patients and to ensure that the educational experience is consistent with the student's pre-registration programme. Although mentors are accountable for the judgements they make about the student's competence and fitness to practice (NHS Education for Scotland, 2013) students also have a responsibility for ensuring that they do not work about their limitations and put patients' lives in danger (Fisher and Scott, 2013).

In addition, the NMC also stipulate that 40% of a mentor's time should be spent supervising a student (Walsh, 2014). They also specify that the level of supervision provided should reflect the mentor's assessment of the student's clinical competence (Walsh, 2014; NMC, 2015). Although the NMC (2015) state that registered nurses should ensure that individuals whom they delegate tasks to should understand the instructions, no reference is made to students who have difficulty speaking the language of the host country and if they require additional supervision.

1.8. Summary

The justification for exploring how the constraints of language influence cultural competence and personal development in an ERASMUS placement for student

nurses has been highlighted within this Chapter. Some of the changes which have taken place in nurse education since it was transferred from the NHS schools and colleges of nursing to Higher Education have been discussed. These changes include the cessation of the apprenticeship model of nurse training in which students were part of the NHS workforce and the introduction of supernumerary status in which the student nurse is classed as a learner, surplus to NHS workforce requirements.

This Chapter has highlighted how the European Union directives on nurse training coupled with the regulations on supernumerary status (NMC, 2010) and the Bologna Agreement Process (European Commission, 2010) have helped to shape, current nurse education programmes. These changes have now made it easier for student nurses to participate in study abroad programmes. Partnership working between the university in the sending (home) university and the host university enables the students to have a smooth transition into the host country. In order to facilitate this, ERASMUS coordinators in the host country are responsible for ensuring that students have a named mentor in clinical practice. Mentors play a vital role in supervising and assessing students in clinical practice and ensuring that students provide safe nursing care. This is imperative when students are unable to speak the language of the host country.

Chapter 2: Literature Review

The purpose of this review is to examine the literature in relation to student mobility programmes and the key issues associated with them. Globalisation is often associated with student mobility and being prepared to work in a globalised integrated world. It is for this reason that the literature review commenced by an appraisal of the economic, social and political dimensions of globalisation and how it is linked to Higher Education. This was followed by a review of the literature on internationalisation and why it has had an impact on education and nursing. Since English is the lingua franca during an international experience, it was imperative to explore why English has become a worldwide dominant language and its subsequent influence on internationalisation. Cultural competence is embedded in the overarching research question therefore an analysis of the theoretical frameworks of cultural competence and a rationale for selecting the Campinha-Bacote Process of Cultural Competence Model was discussed. To highlight some of the gaps in the body of knowledge on the students' cultural experiences, the literature on the inability to speak the language of the host country was then critically analysed. Some studies which contribute to the body of knowledge but are not part of ERASMUS+ EC programmes have been included within this literature review. Supervision of students by a named person in the host country is one of the stipulations of the NMC (2011) therefore this Chapter concluded with a review of the literature on students' experiences and clinical supervision in host placements.

2.1. Globalisation

Globalisation comprises of economic, social and political facets (Portrafke, 2015) and these have become engrained into higher education, the ERASMUS philosophy and nursing. Economic globalisation is a dynamic process and Mitchell and Nielson (2012) suggests that knowledge is a commodity which is traded globally within Higher Education Institutions. Another aspect of economic globalisation is the Bologna process, a borderless democratic Higher Education initiative which in some ways is responsible for the marketization of higher education and making it into a globalised commodity (Coleman, 2006). This has resulted in cross-border education activities which are subject to international trade agreements (Knight, 2008). Cross border higher education activities can be in the form of mobility programmes (Yousef, 2014) delivered face-to-face or education programmes through e-learning methods. Such

activities could be classed as the consequence of globalisation. Cross border education can be funded privately by students and families (Woodhall, 2002) or sponsors such as the national agencies for ERASMUS (European Commission, 2014a). A study by Parey and Waldinger (2010) found that it is advantageous to invest in ERASMUS student exchange programmes as many will remain or return to the host country as skilled workers. This is due to students developing language skills, ascertaining a knowledge of the labour markets and establishing personal contacts in the host country (Parey and Waldinger, 2010). This study indicates that there are many advantages of mobility programmes, but language skills are beneficial for job opportunities in a globalised economy.

Economic facets can be linked to ERASMUS mobility programmes. Higher Education institutions are provided with support grants from the European Commission to cover costs of activities such as selecting students for placements overseas and providing support for incoming and outgoing ERASMUS students (European Commission, 2014a). This is a relevant point and can be linked to this research study as grants from the European Commission can be used to orientate students to the host country and provide students with language tuition (European Commission, 2014a). Language tuition is pertinent as many of the outgoing ERASMUS students cannot speak the language of the host country.

Whilst, Altbach, Reisberg and Rumbley (2009) agree that globalisation is shaped by an integrated world economy and a global knowledge network they suggest that it is also facilitated by information technology. Instantaneous information technology, including faster internet connections have contributed to globalisation (Altbach, 2016; Mitchell and Nielson, 2012). This has had a global impact on higher education as international students can access course material worldwide from university websites and this provides a valid support mechanism in host placements.

Rizvi and Lingard (2000) provide another perspective of globalisation in the following statement.

> "The political rhetoric surrounding globalisation speaks of humanity's increasing interconnectedness across time and space and suggests that the means of instantaneous global communication and mass transportation have liberated us"
>
> (Rizvi and Lingard, 2000, p.419).

Rizvi and Lingard (2000) refer to interconnectedness, mass transportation and instantaneous global communication. Mass transportation can enable students and academics to have direct face to face communication with people in other countries and thereby engage in a knowledge exchange. Mitchell and Nielson (2012) also refer to transportation within their description of globalisation. They indicate that spatial awareness is a dimension of globalisation. This dimension takes into consideration transportation and the time it takes to get from one geographical place to another (Mitchell and Nielson, 2012). Advances in transportation have decreased geographical distances, making it easier for international students to travel across borders to other countries. Whilst advances in transportation can make it easier for students to cross international borders, some students can be deterred from applying for an ERASMUS experience due to lack of finance. A survey by Vossensteyn et al. (2010) found that some students felt that the ERASMUS grant was not enough to cover the cost of living in another country.

The second dimension of globalisation which Mitchell and Nielson (2012) refer to is the 'process of interaction dimension' of globalisation. Mitchell and Nielson (2012) place emphasis on social interactions with people. This involves interacting with people in other countries to create economic, technological, environmental and scientific inter-reliance (Marginson and van der Wende, 2007; Mitchell and Nielson, 2012). Social globalisation comprises of factors such as communication strategies and cross border information flow (Portrafke, 2015). These strategies can enhance cultural awareness as both academics and students can learn about each other's cultures.

An inherent feature of the process of the interaction dimension of globalisation is communication. The process of interaction dimension of globalisation can also be classed as the social element of globalisation. One of the advantageous of social globalisation is that it can bring professionals from diverse cultures and countries together (Mitchell and Nielson, 2012) for knowledge development and research. This is keeping with the aim of the Lisbon strategy which is to transform Europe into the greatest competitive knowledge economy within the world (Sursock and Smidt, 2010).

Rizvi and Lingard (2000) associate globalisation with the movement of capital, people and information across borders. This shows that globalisation is not a single facet, but it has many dimensions. Whilst Knight (2008) agrees that globalisation is the movement of people across borders, she also links it to knowledge, technology and

economics. The free movement of people within member states is the cornerstone of article 45 on the functioning of the European Union. Migration is linked to globalisation within the work of Pakulski and Marhowski (2014) and Doiz, Lasagabaster and Sierra's (2013). The participants (n=27) in the Doiz et al. (2013) study suggested that changes in the demography of society are the consequences of globalisation. This is a relevant point as migration has implications for governments and health policy makers who have a responsibility to respond to the diverse health and cultural needs of migrants (Mladovsky, Rechel, Ingleby and McKee, 2012).

Gunn (2005) refers to the movement of people across borders as cultural globalisation. This enables the transmission and sharing of ideas, attitudes and values with people from other cultures. Cultural globalisation is the producing and the reproducing of cultures within countries (Gunn. 2005). Gunn's description of cultural globalisation implies that the culture of countries can change. As already indicated in Chapter 1, (p.11) it is imperative that the nursing workforce develop a knowledge of the culture of a country and respond to the cultural needs of patients (Wood and Atkins, 2006). This can be linked to my research study as developing cultural competence is embedded in my research questions.

Another aspect of globalisation is the development of a common language. Doiz et al (2013) indicated that during focus group interviews some participants associated the English language with globalisation. Additionally, Albach and Knight (2007) also suggest that the escalation of information across borders and the use of English as a lingua franca to facilitates this, are the effects of globalisation. I agree that the use of English as a lingua franca is a response to globalisation rather than globalisation. English as a lingua franca will be discussed in more depth in section 2.2. (p.24-30).

From reviewing the literature on globalisation, it is evident that it is multifaceted. Some literature associates the use of English with globalisation (Doiz, et al., 2013). However, the stance which I take is, the overarching facet of globalisation is economics, and establishing trade agreements with institutions and organisations is a core aspect of it. For example, the World Trade Organisation (WTO) member countries can negotiate a General Agreement on Trade in Service (GATS) which focuses on facilitating educational activities with another country. This can include distance learning, student mobility or a service provider (university) in one country having a branch campus in another country (Altbach and Knight, 2007). The social element of globalisation which includes face to face connectivity or instantaneous

communication via the internet (Portrafke, 2015; Mitchell and Nielson, 2012) is necessary for negotiating trade deals. Social globalisation can contribute to economic globalisation. Interconnectedness through social globalisation can contribute to both personal and knowledge development (Portrafke, 2015) and this is necessary for both academics and student nurses. A positive outcome of globalisation is that students from poorer countries can gain access to cross border higher education, if the correct financial support structures are in place for them. This can also be applied to ERASMUS students in poorer countries in Europe, who choose to have their ERASMUS experience in richer European countries. Although the globalisation of education has many positive outcomes, it remains a contentious topic as institutions including universities within some countries will benefit financially more than others (Yousef, 2014). This is due to some universities attracting higher numbers of international students than other universities (Yousef, 2014).

The literature reviewed also suggests that there are multiple views of globalisation (Beerkins, 2003) and it can be policy driven. These policies include the Bologna agreement, in 1999, a European higher agreement enterprise (Collins and Hewer, 2014) and the Lisbon Treaty in 2000 (de Wit, 2011a) which encourages a competitive European market. The driving force of globalisation in Higher Education has been the Bologna agreement. Globalisation and the knowledge economy, coupled with cross-border education initiatives can provide challenges (Yousef, 2014) and opportunities for higher education institutions (Iňguez, 2011). These opportunities and challenges can be related to the implementation of the principles of globalisation within higher education institutions and subsequently enhancing ERASMUS students' experiences.

2.1.1. Internationalisation

Internationalisation of Higher Education is often seen as a reaction or a response to globalisation (Mitchell and Nielson, 2012; Delgado-Marquez, Escudero-Torrez and Hurtado-Torres, 2013). This response involves institutions developing and implementing policies and initiatives with a global context (Albach and Knight, 2007; de Wit, 2011b). Knight (2008, p.21) defines the term internationalisation as the 'process of integrating global, international and intercultural or global dimensions into the purpose, function and delivery of post-secondary education'.

Knight (2008; 2015) points out that including the word 'process' within the description of internationalisation was intentional as it highlights that it is an ongoing venture which takes into consideration ever evolving standards. In addition, the word 'integration' was used in this definition as it puts emphasis on embedding international aspects and cultural diversity into higher education policies and programmes (Knight, 2008). This concept is in keeping with Albach and Knight's, (2007) view that embedding international issues into higher education is a response to globalisation.

From a higher educational perspective, the integration of global and intercultural dimensions within higher education curricula denotes internationalisation at home whereas mobility programmes signify internationalisation abroad (Trahar and Hyland, 2011). Mobility programmes are often referred to as cultural exchange programmes (Albach and Knight, 2007) between two institutions. This can be linked to the aim of ERASMUS+ which is to develop cultural awareness (European Commission, 2014a)

The term 'Internationalisation at home' denotes that for various reasons not every student in higher education can engage in a period of mobility in another country (Trahar and Hyland, 2011). Various strategies can be used to implement internationalisation at home. Chan and Nyback (2015) provide an example of one strategy using a virtual programme. This involved ten students in Hong Kong being paired up with ten students in Finland. Each student had a Skype conversation with a student in the other country. Because of this, they were able to develop an understanding of the beliefs, values and the cultural differences of a person in another country (Chan and Nyback, 2015). Although a virtual experience is not the same as a work placement experience in a host country, it has the potential to provide students with opportunities to develop an awareness of another culture within the cosmopolitan world.

Concepts of internationalisation at home and abroad are practiced throughout Europe (de Witt, 2011b) and in some Anglophone countries. This concept was highlighted in a qualitative study, carried out in Australia by Sawir (2013) involving academic staff (n=80). The results indicated that international students were a useful resource for learning and teaching and if they were used effectively in the classroom they can contribute to the intercultural learning of national (local) students (Sawir, 2013). On the other hand, the results of the study also indicated that some local and international students did not integrate with each other despite the efforts of academic staff (Sawir, 2013) and this diminished the effectiveness of using classroom workshops to

internationalise local students. In addition, de Wit, (2011b) concurs with Sawir (2013) and suggests that the quality of programmes in the Netherlands can be influenced by a disproportionate number of local versus international students. Having less than three international students in a classroom can present challenges for Dutch lecturers as some universities perceive Internationalisation is lecturing in English (de-Wit, 2011b). De-Wit (2011b) suggests that this can sometimes lead to pointless situations where Dutch lecturers communicate to Dutch students in bad English in the name of internalisation. This will be discussed in more depth in section 2.2.1. Sawir (2013) and de-Wit (2011b) focus on classroom-based programmes whereas the focus of my study is clinical practice in a host country, so more opportunities may be afforded for local and exchange students to mix.

Although teaching in English is a strategy often associated with internationalisation, Sweeney (2012) points out that this is a misconception and it has resulted in native English speakers not learning another language. This concept could be applied to students in some of the Anglophone countries including Scotland who do not have knowledge of the language of the host country before participating in mobility programmes. English is used in some European universities as a lingua franca in non-speaking English countries for a wide range of university programmes (Altbach, Reisberg and Rumbley 2009; Saarinen 2014) as a means of attracting students from overseas.

As already indicated mobility programmes are associated with internationalisation abroad. Furthermore, the results of a study by Doiz et al. (2013) indicated that academics and students in a Spanish university also concur that the term internationalisation is related to mobility. In addition, the findings showed that participants viewed internationalisation as the ability to use foreign languages (Doiz et al., 2013). Another interesting result was that English was viewed as an imposed lingua franca which can preclude having programmes delivered in the local language or another foreign language.

The terms globalisation and internationalisation are often used interchangeably within the literature. Knight (2015) has indicated that during the past number of years, emphasis has been put on avoiding the use of the phrase ‘globalisation of education’ and replacing it with the term ‘internalisation of education’. This is a valid point as some of the literature, class mobility as globalisation (Schőneck and Mau, 2015, p.1) whereas other literature, class it as internationalisation (Doiz, et al., 2013; Altbach, et

al., 2009). I concur with de Wit's (2011b) view that mobility is not internationalisation, but it is an instrument used to achievement it. However, internationalisation is a broad concept which includes embedding cultural and international issues into all aspects of an educational programme and the research agenda of the university. Although internationalisation is a response to globalisation (Mitchell and Nielson, 2012) it has helped to accelerate the process of globalisation (Maringe and Woodfield, 2013). This concept can be linked to Higher Education as it has played an important part in the acceleration of globalisation through international activities which include ERASMUS mobility programmes. One of the main points highlighted in this section is that often internalisation is viewed as European universities teaching in English. It could be argued that this can encouraged ERASMUS students who have English as a mother tongue to develop an attitude of complacency towards learning a second language.

2.2. A historical and global perspective of the English language

The global use of English is both historical and economic. From a historical perspective English is a North Germanic language derived from Anglo-Saxon's old English (Svartvik and Leech, 2006). It spread from England to Australia, New Zealand, Canada and the United States (Jenkins, 2015) and has now become the official language of 75 countries. Jenkins (2015, p.10) points out that the users of English can be divided into three categories: English as a native language (ENL) is often referred to as the mother tongue, English as a second language (ESL) and English as a foreign language (EFL). These terms can convey the way in which people learn English and use it for communication (Friedrich and Matsuda, 2010).

When English is used as a first language (ENL) it is underpinned by linguistic and cultural values (Jenkins, 2015). The countries in which English is used as a first language include the UK, USA, Canada, Australia and New Zealand (Jenkins, 2015). However, even though English is the 'mother tongue' of each of these countries, they have their own cultural identity. The concept of culture and language can be applied to other countries were English is not the mother tongue. This means when students are in placements in host countries, they can have an opportunity to learn the language and the underpinning culture. As indicated in Chapter 1, (p.2) language and culture are inextricably linked (Sweeney, 2010). For example, some areas in the United Kingdom have their own unique colloquial expressions.

On the other hand, in the past, individuals who used English as a foreign language (EFL) were from countries were English is not spoken within their borders, but they converse in this language with native speakers (Jenkins, 2015, p.11) from Anglophone countries. Moreover, it is estimated that 360 million people worldwide speak English as a second language. These people are from countries such as Singapore, India, Nigeria and Bangladesh who were once colonised by the British (Jenkins, 2015, p.11). When people used English as a second language to communicate with each other it is classed a lingua franca (Seidlhofer, 2005).

Originally, colonial powers were blamed for the proliferation of English. In fact, Macedo and Bartolome (2014) claim that colonialism enforced a distinction like an ideological benchmark which cultures and language are measured against. Maceedo and Bartolome (2014) point out that colonisers endeavoured to eradicate African languages in Nigeria and enforced an English educational system there. The legacy left by many of the colonisers was their superior attitude about the English language and the assumption that indigenous languages were inferior to it (Jenkins, 2015). There appears to have been the expectation that everyone should speak English in the colonised countries.

Changing a language policy is a common strategy when a country gains independence from colonial powers. It is worthy to note that after Malaysia got independence, Bahasa Malaysia (Malay) became the main language of instruction for education. When this became the official language, the status of English was decreased (Gill, 2005). Several countries have enacted language policies which indicate the official language and the language used for teaching specific subjects within different school grades (Okebukola, Owolabi and Okebukola, 2013). Following independence, the Nigerian national policy for teaching indicated, that the language of the mother tongue or the local area should be used (Okebukola, et al., 2013). The results of a focus group study by Okebukola, et al. (2013) involving 36 teachers indicated that 92% of teachers in rural areas used English and a mother tongue in science classes whereas in urban areas 88% of teachers used English alongside a mother tongue in science classes in primary school. The language of the mother tongue was used more in rural schools in comparison to urban schools. Okebukola et al. (2013) explain that there are many languages spoken in urban areas therefore the language of the pupil may not be the same as the teacher, but each ethnic group has a knowledge of Nigerian Pidgin which is a form of English with some additional words.

Okebukola et al. (2013) study indicates that although countries introduce language policies there are reasons for the indigenous population of a country using English.

In fact, Phan (2013) provides another reason for the use of English. Phan (2013) suggests that former British colonies such as India, Singapore and Malaysia promote English as a shared and historical heritage which has shaped their cultural identity (Phan, 2013). Moreover, Philipson (2008) argues that another reason for the proliferation of the English language was the cultural, military and economic impact of the USA worldwide. Coleman (2006) also suggests that it is not easy to separate the linguistic domination of English from other signs of power and ideology. Teaching in English and the subsequent proliferation of the language is viewed by some critics as a form of Anglo-American imperialist power for commercial purposes (Coleman, 2006). Dewi (2012) used a mixed methods approach comprising of a questionnaire and interviews to ascertain the views of academic staff and students in nine different universities in Indonesia about their views of 'imperialism and if English is influencing religion and national identities'. The results indicated that 236 people (77.89%) disagreed with the statement that '*English in Indonesia is a form of language imperialism'*. On the other hand, Dewi (2012) points out that 175 (58%) of people in this Muslim country agreed with the statement '*I learnt many values of Western Cultures via the English Language'.* However, Dewi (2012) did not identify what these values were. Some interview participants believed English was imposed on them but felt that the advantages of English outweighed the disadvantages of using this language. They suggested it was a vehicle for communication in a global language and it advanced knowledge. Some participants viewed English as '*positive imperialism' (*Dewi, 2012, p.11).

Dewi's (2012) study highlights the importance of English in the advancement of knowledge. Phan (2013) concurs with this concept and indicates that the language policies of higher education in the former colonies now assume that the English language is essential for the dissemination of academic knowledge (Phan, 2013).

The literature has indicated that historical events have had an impact on the use of English within former colonies of the USA and the UK. Initially, the people in the former British colonies wanted to establish their own identity and by doing so, discarded the colonial language (Gill, 2005). Language is central to the construction of national identities, but this can present difficulties when there are several languages spoken within a country. For example, in Nigeria there are 450 officially recognised

languages, but some Nigerians feel that there is a need for a common language and are using Nigerian Pidgin (Okebukola, et al., 2013). It is the governments of the former colonies who determine which languages should be taught in the school curriculum and the language for trading within a global economy (Gill, 2005). For a language to have recognition globally it must be used as the language of communication within different countries (Gill 2000; Okebukola, et al., 2013) and English has been granted this status. The literature supports my view that English has become the lingua franca of the former British colonies due to economic globalisation. In addition, English has now become the lingua franca of European higher education including ERASMUS.

2.2.1. The Influence of the English Language on Internationalisation

There is pressure for higher education institutions to implement international activities and for countries that do not have English as a first language to evaluate their language policies (Cots, Liurda and Garrett, 2014) and develop degree programmes in English. The evaluation of language policies not only applies to former colonies but countries in the European area that have a rich language heritage. However, using a lingua franca has many advantages in that higher education institutions can attract students from different countries. English is now the language used for instruction by some disciplines in universities in non-Anglophone countries. These universities are using English as a lingua franca. This is to enable speakers of different languages to converse in a common language (Friedrich and Matsuda, 2010). A survey involving both students (n=4524) and staff (n=668) at a Swedish university was carried out by Bolton and Kuteeva (2012) to ascertain the use of the English language and the attitudes to it. The findings indicated that 13% of undergraduate science students had all or almost all their lectures in English. English was used more in Masters' programmes than undergraduate programmes. It was found that 79% of science students used English compared to 66% of social sciences students. Some international students who do not have English as a first language may feel that it would be advantageous if they had a better knowledge of English than the language of the host country especially if most of the lectures are in English. The adoption of English as a lingua franca within European universities has been influenced by the Bologna Process and the standardisation of degrees within EU countries (Bolton and Kuteeva, 2012).

Bolton and Kuteeva's (2012) study highlight the wide use of English in higher education in Sweden. This can be related to my study as some of the undergraduate nursing students were undertaking an ERASMUS clinical placement in Sweden and were dependent on clinical staff speaking English. It is noteworthy that Bolton and Kuteeva (2012) found that some local students felt that the use of English as an international language was a threat to Swedish as an academic language. Although an English lingua franca can be viewed positively by people who use it as a mother tongue, Cots, et al. (2014) agree that it is a threat to national identity and language.

Apart from academics feeling that their language was under threat (Bolton and Kuteeva, 2012), some also raised concerns about a high proportion of textbooks used within Higher Education are in English (Kuteeva and Airey, 2013). Academics who lack proficiency in English view this as a disadvantage (Kuteeva and Airey, 2013). This view is not only held by academics in Sweden but also in Estonia. Phillipson (2006) points out that Estonia has reasserted their stance regarding English as a Global language. Academics in Estonia have indicated that they want to be able to use their own language for teaching and the publication of major research findings (Phillipson, 2006). In contrast to this finding, Ferguson, Perez-llantada and Plo (2011) found that most Spanish academics (n=252) agreed that there was a need for an international language and 62% felt more advantaged than disadvantaged using English as an international language for academic work. These findings can be applied to my study as Spain is one of the host countries which ERASMUS students have their clinical experience in, and they rely on English being the lingua franca. However, even though it is the lingua franca of Higher education it does not mean that it is the lingua franca of clinical practice in Spain as not every patient will be able to speak English. In addition, Ferguson, et al. (2011) also found that Spanish academics (n=300) strongly agreed (n=238) or agreed (n=52) that the dominance of English as an international language of Science and knowledge exchange gives native English academics an advantage. This would indicate that some academics feel that if they have not got a good knowledge of English, they may not have the same professional status as those who can speak the language.

On the other hand, the wide use of English does not provide an incentive to learn other languages. I agree with Jenkin's (2014) suggestion that students are aware that English has become the lingua franca of higher education and this possibly increases their unwillingness to learn foreign languages. It is now a matter of concern that a

selling point in recruitment events for Higher education mobility programmes is that students do not need to study the language of the European country where they have their cultural experience because programmes are taught in English (Coleman, 2006). Not having a knowledge of the language may be acceptable in a university setting, but Scottish student nurses are placed in clinical practice in host countries where some members of staff and patients do not speak English.

In addition, student nurses from countries where the official language is not English must pass an English proficiency exam before engaging in mobility programmes (Kokko, 2011), yet there is no requirement for students from Scotland to pass an exam in the language of the host country before their clinical experience (European Commission, 2014a).

Prior to engaging in a mobility programme, both academics and students should take into consideration that not every person within the European area speaks English. Although it is the most popular language in the EU, only one third of the EU population speak it well or very well. (Fidrmuc, Ginburg and Weber, 2009). It is understandable that some EU citizens including academics and students may feel disadvantaged when European higher education institutions adopt English as a lingua franca. In addition, if English was the core language in Europe it would result in a linguistic disenfranchisement of 62.6% of EU citizens (Fidrmuc, et al., 2009). A study by Olsson and Sheriden (2012) found that 63% of the academic staff (n=35) in a Swedish University felt disadvantaged by the dominance of English. Some felt disadvantaged in academic writing as research in Nordic languages were ignored in favour of English. One academic stated: that “native English speakers can use their energy to formulate arguments without having to think about it” (Olsson and Sheriden, 2012, p.41).

Hughes (2008) asserts that there is a tendency for Anglophone countries to take the lead in the delivery of institutional cross-country programmes and student mobility programmes. This is partly due to the demand for programmes in English (Hughes, 2008). Anglophone countries are also a popular choice for UK students. A survey involving UK students (n= 2856) in Higher Education indicated that 40% wanted to study in the US, 11% in Australia, 5% in Canada and 2% in New Zealand (British Council, 2015). Only 42% of the respondents wanted to study in a non-Anglophone country. In addition, UK students have now the opportunity of completing taught degree programmes in English in European countries (Gill and Kilpatrick, 2012; Garone and Van de Craen, 2017). This opportunity coupled with the knowledge that

English is the lingua franca of Higher education yet again may decrease the inclination of students to learn a foreign language during a work experience overseas. On the other hand, having nursing programmes in English for students from Anglophone and non-Anglophone countries provides great opportunities to live in a foreign country but it may pose difficulties during patient encounters in clinical practice if students are not proficient in the language of the host country.

2.2.2. Foreign Language Learning within the European Union

There are 24 official languages within the European Union, yet the English language has not only been given prominence in Higher Education, but it is also the most popular language taught in primary schools within the European Union (Eurostat, 2018). This means that student nurses from Anglophone countries would find this advantageous as they could converse with other people within the European countries in English. Another important statistic is that 99%-100% of primary school children in Malta, Cyprus, Austria, Spain and Italy learn English in primary school and 94% of secondary school pupils in the EU studied English (Eurostat, 2018). Spain and Italy are two of the Southern European countries where students in my study have clinical placements. However, in Sweden and Finland the two Nordic countries where students in my study have clinical placements, 100% of secondary school pupils learn English (Eurostat, 2018). There has been a notable increase in language learning in secondary schools across Europe (Coleman, 2009) whereas although there has been an increase in the number of pupils learning Spanish in Scotland there has been an overall decline in language learning in secondary schools at below Higher Grade (Scottish National Centre in Languages, 2018). Nevertheless, the EU recommends that young people should learn at least two foreign languages from an early age (European Commission, 2014a). To address this recommendation, the Scottish Government are promoting the 1+2 approach to language learning which is based on the 1 +2 European model (Scottish Government, 2012). This means that pupils should be encouraged to learn other languages in addition to English in primary school and in secondary school. Local authorities have been given the responsibility of identifying the languages which meets the local context. Some local authorities have identified Gaelic as one of 1+2 languages. Gaelic is a language which is used within some areas in Scotland but not in other European countries. On the other hand, if pupils learn to speak Gaelic in addition to their first language, they may find it easier to learn a third language. This can be linked to the results of a study by Abu-Rabia and Sanitsky

(2010) who found that students who are bilingual have an advantage over those who are monolingual. They found that Russian Israeli students who spoke Hebrew and Russian developed stronger English language skills than Israeli students who spoke only Hebrew. This would support the 1+2 approach to language acquisition.

The working party group for the Scottish 1+2 approach believe that the languages spoken by our nearest European neighbours should be taken into consideration when implementing the policy (Scottish Government, 2012). This may prove helpful for students who become trilingual and want to engage in an ERASMUS programme. The UK ranks the lowest in the table of language skills with just 65.4% of adults, monolingual and only 20% of adults aged 25 to 64 years with linguistic skills in one foreign language (Euronews, 2018).

Although English is presently a lingua franca for global business and European higher education, this may change post Brexit (Gazzola, 2016). Due to this it could be argued that the young people within the UK should become bilingual or trilingual instead of monolingual in order to compete in a competitive economic market and in the workplace. The British Council (2014) also asserts that understanding and trust between other countries and the UK could be enhanced if there was a better knowledge of each other's languages and cultures. This concept can be applied to ERASMUS coordinators and students who don't have a knowledge of the language of the host country.

2.3. Cultural Competence: Theories and conceptual frameworks

Taylor, Lillis Lettone and Lynn (2011, p.24) define culture as a "shared system of beliefs, values and behavioural expectations that provide structure for clarity in living". However, it could be argued that in a multicultural society people have different cultural beliefs and values. The UK immigrant population from different countries has increased and these people can present with culturally diverse health issues (Chambers, Thompson and Narayanasamy, 2013) and linguistic needs. Culture can influence lifestyle behaviours (Papadopoulos, 2006) and how individuals from each ethnic group describe their symptoms (Chambers et al., 2013). In addition, there can be a predisposition to specific diseases within some ethics groups (Chambers et al., 2013). Changes in global and multicultural societies indicate the importance of

developing student nurses who can deliver culturally congruent care to patients from different ethnic groups (Allan and Riner, 2014). Although embedding cultural issues about ethnic groups into the taught component of a nurse education programme can be helpful, Kulbok, Mitchell, Glick and Greiner (2012) argue that an appreciation and knowledge of diverse cultures can be achieved through students having international placements.

As culture is embedded in language (Sweeney, 2010) and cultural issues should be rooted within the nursing curricula (Alan and Riner, 2014) it was decided that a model of cultural competence should be used as a theoretical framework for this research inquiry. Models of cultural competence can also be used to promote and assess cultural awareness and knowledge (Papadopoulos, 2006). There are several transcultural theories and models of cultural competence, but I argue that the Campinha-Bacote Model of Cultural Competence (Campinha-Bacote, 2002) was the most appropriate conceptual framework for this research inquiry. To present this argument, three models were selected and reviewed for concise framework, a clear description of the concepts underpinning the framework (Brathwaite, 2003) and a structure which addresses a process to cultural competence. The rationale for selecting the three models was that a process of cultural competence was inherent within each framework. The frameworks selected were Papadopoulos, Tiki and Taylor Model for developing cultural competence (Papadopoulos, 2006), Purnell Model for Cultural Competence (Purnell, 2002) and the Camphina-Bacote Process of Cultural Competence Model.

The first model reviewed was Papadopoulos, Tilki and Taylor Model for cultural competence (Papadopoulos, 2006). Cultural competence is defined as “the capacity to provide health care to people, taking into consideration people’s cultural beliefs, behaviours and needs” (Papadopoulos, 2006, p.10). Although the process of cultural competence is not inherent in this definition, Papadopoulos (2006) asserts that the development of cultural competence is a process. This process is reflected in the four constructs of the Papadopoulos, Tilki and Taylor Model. The constructs are cultural awareness, cultural knowledge, cultural sensitivity and cultural competence (Papadopoulos, 2006, p.10). Papadopoulos (2006) provides a concise outline of the framework and a clear explanation of the meaning of the four constructs and the underpinning beliefs and values of the Model. This framework can be applied to different nursing settings. The concepts have also been used to develop cultural assessment tools (Vasilion, Kouta and Roftopoulos, 2013) for research purposes.

Papadopoulos, (2006) highlights the importance of taking the constructs, cultural awareness, cultural knowledge and cultural sensitivity into consideration when delivering nursing care. I concur with this as these constructs are the foundation of culturally congruent nursing care. However, a weakness in this framework is that the progression from cultural awareness to the development of cultural competence could have been more explicit.

The second model considered was the Purnell Model for Cultural Competence. Purnell (2002) developed this model to promote a cultural understanding about individuals during illness, wellness and whilst engaging in health promotion activities. The model was developed from a cultural assessment instrument and can be applied to nursing and research. Purnell (2002) provides a graphic representation of the model depicting it as a circle which is divided into twelve wedge shaped domains. A strength of this model is that it includes health behaviours, social and biocultural ecology domains. In addition, the concepts described within these domains can be used to assess individuals, families and communities. On the other hand, the information within its graphic representation tends to be complex and this reduces the visual appeal of the model (Xu, Shelton, Polifroni and Anderson, 2006). Cultural competence is described as a process which includes, unconscious incompetence, conscious incompetence, conscious competence to unconscious competence (Purnell, 2002). A more in-depth explanation as to what stimulates the care giver to move from unconscious incompetence to unconscious competence could have been provided.

In contrast to the Purnell Model, the Campinha-Bacote (1998) Model on the Process of Cultural Competence in the Delivery of Health Care does not include a wedge shape explicit pictorial schema to help guide health care workers in a cultural health assessment of patients (Campinha-Bacote, 1999; 2001). However, Campinha-Bacote (2001) draws on the work of Leininger (1978) to explain the meaning of cultural assessment in nursing. This is linked to cultural skills which is one of the five constructs in the Campinha-Bacote Model on the Process of Cultural Competence.

Campinha-Bacote (2002) provides an explicit narrative about the constructs related to the process of Cultural Competence. These five constructs are as follows:

- Cultural awareness is the ability to examine one's own culture

- Cultural knowledge is the ability to develop a knowledge of diverse cultures. This includes health beliefs.
- Cultural skills involve carrying out a culturally base assessment which takes into consideration a patient's cultural background.
- Cultural encounters are having direct interactions with individual from diverse cultural backgrounds
- Cultural desire is the yearning of an individual to 'want to rather than must engage in the process of becoming more culturally aware, culturally knowledgeable, culturally skilful and familiar with cultural encounters'

(Campinha-Bacote 2002, p.181)

Campinha-Bacote (2002) asserts that each of the five constructs should be experienced to enable health care workers to start the ongoing process of cultural competence. Papadopoulos (2006) agrees with Campinha-Bacote (2002) that cultural awareness involves scrutinising our beliefs and values and any prejudices unconsciously held about a different culture. The Papadopoulos, Tilki and Taylor Model includes a cultural sensitivity construct whereas the Campinha-Bacote omits this construct. On the other hand, it could be argued that health professionals should use cultural sensitivity during each cultural encounter. This includes using verbal and non-verbal communication which meets the cultural needs of patients (Papadopoulos, 2006).

After reviewing the three models and taking into consideration, if the concepts in each model were explicit (Brathwaite, 2003) and had a structure which addresses a process to cultural competence it was decided that the Campinha-Bacote Model of Cultural Competence (Campinha-Bacote, 2002) was appropriate. The rationale for this was that the constructs and underpinning beliefs and values were concise, and the process of cultural competence was explicit and easy to follow. Another reason for selecting the Campinha-Bacote Model was that it includes a construct of 'cultural encounters' which can be applied to ERASMUS students' encounters with patients. The other constructs in this model can be related to the cognitive, (knowledge) psychomotor (skills) and affective (attitudes) aspects of learning. This is relevant as the cognitive, affective and psychomotor domains are used in daily nursing practice. (Davis and Kimble, 2011). The psychomotor domain can be linked to the cultural skills

construct of the Campinha-Bacote framework. This is carrying out nursing activities or technical skills whereas the affective domain is demonstrating appropriate values and attitudes during the delivery of nursing care (Miller, 2010). The affective domain can be linked to the cultural awareness construct. It is through cultural awareness that nurses become sensitive to the beliefs and values of other people (Camphina-Bacote, 2001).

Each of the three models is grounded in empirical evidence. The concepts underpinning the Papadopoulos, Tiki and Taylor Model have been used in nursing research studies to assess cultural competence (Vasilion, Kouta and Roftopoulos, 2013) and the Purnell Model has been used to guide ethnographic research (Purnell, 2002). The Camphina-Bacote's model has been used as a framework for both Finnish research studies (Koskinen and Tossavainen, 2003b) and an Israeli research study (Noble, Engelhardt, Newsome-Wicks, and Woloski-Wruble, 2009). Despite the cultural differences in these two countries both the Finnish and Israeli studies indicate that the Campinha-Bacote model can be applied to the culture of different countries. The Campinha-Bacote Model is easy to understand and has been used as a framework for research studies within other countries and it was therefore deemed suitable for a theoretical framework for my research inquiry. This model is linked to the social constructivist learning theory (Hunter, 2008) and this was another deciding factor in selecting it as a theoretical framework. The application of the Campinha-Bacote Model will be discussed in more depth in Chapter 5.

2.3.1. Social Constructivism and Cultural Competence

Constructivism is a learning theory which describes how people learn. It is an umbrella term which embraces different types of constructivism (Adams, 2006). These include cognitive constructivism and social constructivism. Cognitive constructivism is based on Piaget's theories about how individuals use their mental processes to interpret the environment and assimilate new information about it into their existing schema. (Schcolnik, Kol and Abarbane, 2006; Bodmer, Klabuchar, and Gleelan, 2001). According to Piaget's theories, individuals cannot instantly understand and utilise the information provided by teachers, instead they need to construct their own mental blocks of knowledge (Powell and Kalina, 2009). Piaget believed that new knowledge is produced in the individual through a personal process (Powell and Kalina, 2009). In contrast to cognitive constructivism, social

constructivism which was derived from Vygotsky (Adams, 2006) a developmental psychologist puts more emphasis on social interaction with people within a social cultural environment. The belief is that the construction of knowledge takes place within a social cultural environment. This enables cultural meanings to be subjectively developed and internalised by the individual (Talja, Tuominen and Savolainen, 2005). This means that the learner has an active role in the learning process. Social constructivism also acknowledges the role that teacher plays in the co-construction of knowledge (Adams, 2006). This can be linked to mentors who stimulate discussion about clinical skills and cultural issues in host countries. In contrast, Piaget's theories on cognitive constructivism do not acknowledge the important role which teachers or mentors play in the learning process.

On the other hand, Vygotsky's belief that social interactions are an important aspect of learning within the social-cultural environment (Powell and Kalina, 2009; Thomas, Menon, Boruff, Roderiquez and Asmed, 2014) can be applied to ERASMUS students in clinical placement who are constantly interacting with people from different cultures. The social constructivism learning theory view language as an important factor in the sharing and the creation of knowledge about professional groups and their practices (Talia et al., 2005). This concept can also be linked to ERASMUS students in clinical practice who are working and interacting with the members of a multidisciplinary team within a social cultural environment. On the other hand, social interactions can be difficult for ERASMUS students who are unable to speak the language of the host country.

Students can experience cognitive dissonance in a different culture (Koskinen and Tossavainen, 2003b) especially when they do not understand the language or the culture of a country. Feelings of cognitive dissonance can be caused by students holding two conflicting views about the social-cultural environment (Festinger, 1957; Thomas, et al., 2014). Festinger (1957) suggests that these feelings of dissonance cannot be resolved until an individual's understanding and knowledge is altered. Cognitive dissonance is a valid theory and can be applied to an ERASMUS experience.

The Social constructivist learning theory has been linked to the process of cultural competence. The theory underpinning constructivism is that learning is a continuous and an active process which involves constructing and restructuring knowledge (Hunter, 2008). According to Hunter (2008) constructivist's learning theories and the

Campinha-Bacote theories share the belief that a learner's new knowledge enables existing knowledge to be modified. Hunter (2008) does not identify the type of constructivism which is linked to the Camphina-Bacote Process of Cultural Competence in the Delivery of Health Care Services Model. Nevertheless, Hunter's application of the model puts emphasis on cross-cultural interactions and cultural encounters which would indicate that the learning theory is social constructivism. Using the prefix 'social' places constructivism within a social cultural context (Ward, Hoare and Gott, 2015). Social Constructivism is an appropriate learning theory which can be applied to the Camphina-Bacote Model and this research inquiry. Garneau and Pepin (2014) concur that this learning theory is interconnected with the concepts of the Camphina-Bacote Process of Cultural Competence Model. The application of the Camphina-Bacote's Model was discussed in Chapter 5.

2.3.2. Application of Theories and Conceptual Frameworks

Some researchers have used cultural theories as a framework for their studies. A phenomenological study by Hagen, Munkhondya and Myhre (2009) describes how students developed cultural competence during an international cultural experience. Hagen et al. (2009) applied the five constructs of the Campinha-Bacote framework to the experiences of three host and two Norwegian guest students in Malawi. Campinha-Bacote (2002) suggests that the process commences with cultural awareness whereas Hagen et al. (2009) identifies cultural skills as the first construct. Students linked cultural skills to relational skills such as communication and language whereas Campinha-Bacote (2002) describes cultural skills as taking patient histories and carrying out culturally based assessments. Although Hagen et al. (2009) commented that when students were asked about the main outcomes of their experience, they did not refer to practical skills, yet the following direct quotation is about the skill of medicine administration. A Malawian student stated: "he (Norwegian student) noticed that the dose was too much for the baby and said why don't we go back and seek clarification". (Hagen et al., 2009, p.478).

The Norwegian student demonstrated diligence by identifying that the dose was too much for a baby. A recent co-produced publication by the Royal Pharmaceutical Society (RPS) (2019) and the Royal College of Nursing (RCN) (2019) point out that those who delegate another person to administer medicines must ensure that the person has been adequately trained and assessed as competent in medicine

administration. It is important that students do not work above their limitations and compromise patient safety during an international experience. Clinical supervision will be discussed in 2.4.1. (p.45-47).

Whilst the Norwegian students were unable to speak to the patients in a mutual language they worked with the Malawian students and this enabled them to have cultural encounters with patients. Hagen et al. (2009) claims that it was the cultural encounters with staff and patients which facilitated the development of cultural competence. This can be linked to Campinha-Bacote (2002) assumptions that there is a direct link between cultural encounters and the level of cultural competence. However, the manifestations of cultural competence in students could have been made more evident in the Hagen et al. (2009) study.

A similar study was carried out by Koskinen and Tossavainen (2003b) to explore the benefits/problems of enhancing students' (n=15) intercultural competence. Koskinen and Tossavainen (2003b) used the five constructs of the Campinha-Bacote (2002) model to organise the data obtained from group interviews, one individual interview and the observations of students in clinical practice. The findings of the Koskinen and Tossavainen (2003b) study are different from those identified in the Hagen et al. (2009) study. Koskinen and Tossavainen (2003b) found that not all the students whose first language was English integrated into the host country. Encounters with patients and healthcare workers were problematic for these students, due to not being able to speak the language. This presented a difficulty for some students when they were carrying out practical skills in clinical practice. Although, Koskinen and Tossavainen (2003b) indicated that students were unable to complete patient records they did not identify the practical nursing skills which students had difficulties practicing. The findings also indicated that some students could not overcome the culture shock to allow the process of intercultural competence to commence (Koskinen and Tossavainen, 2003b). Cultural shock appears to have presented an additional barrier to communication. Furnham (1993) suggests that due to a lack of familiarity with the host environment some students can be anxious and confused. Unlike some of the students in Koskinen and Tossavainen's (2003b) study, Furnburn (1993) points out that students can overcome cultural shock and develop an understanding of the cultural values and what is expected of them. This can be applied to my study as all students worked in host countries in which people had different cultural beliefs and values.

Although Koskinen and Tossavainen's (2003b) study was carried out sixteen years ago, there is no evidence of another study which emphasises the importance of direct communication with patients and the activities which students could not engage in, due to the inability to speak the language. The findings of the Koskinen and Tossavainen (2003b) study is relevant as the aim of my study is to uncover how the constraints of language influence cultural competence and professional development in an ERASMUS placement for student nurses. Koskinen and Tossavainen's (2003b) study provide a good example of how the Campinha-Bacote theoretical framework can be used to explore student nurses' cultural experiences in a host country.

In contrast to Koskinen and Tossavainen's (2003b) study, Jones, Neubrander and Huff (2012) used Cushner's (1986) Inventory of Cross-Cultural Sensitivity (ICCS) and a reflective diary. This inventory can stimulate individuals to critical reflect on their own views about culture and promote cultural awareness. The ICCS is a seven-point Likert scale, comprising of thirty-two items and includes five aspects: "cultural integration, behavioural scale, intellectual interaction, attitudes and empathy" (Jones et al., 2012, p.4). Jones et al. (2012) used the inventory to assess the impact that a ten-day international experience with a travelling medical unit in Ecuador, had on students' (n=14) cultural attitudes. A comparison group which did not engage in a cultural immersion was also included within the study. The inventory was administered to both groups three weeks after the experience, but the pre-and post-test results were not statistically significant.

Although this appears to be a good inventory for stimulating cultural awareness it is generic and does not illicit responses about communication within a health care setting. In the Jones et al. (2012) study a thematic analysis of students' diaries identified three themes related to heath care settings. These were classed as 'a new experience of being a minority' 'health disparities' in the host country and 'feeling helpless' due to not having the resources to treat patients. To support the theme 'new experience of being a minority,' Jones et al. (2012) referred to the language barrier. One student stated: *'t*he language barrier makes me nervous. How am I going to be effective in helping these people learn when I can't speak the language?' This is a very interesting question which remained unanswered within the study. Although this study does not focus on ERASMUS students, it does add to the body of knowledge about the feelings of apprehension when nurses are unable to communicate with patients in a common language.

Ruddock and Turner (2007) used a phenomenological approach to ascertain if an international learning experience as part of a nursing programme promoted cultural sensitivity. Although Ruddock and Turner (2009) refer to theories about cultural immersion and cultural sensitivity, a cultural competence framework was not used within their study. However, the data obtained by the semi-structured interviews from seven Danish student nurses revealed three main themes. These included "transition from one culture to another, adjusting to cultural differences, developing cultural sensitivity and growing personally" (Ruddock and Turner, 2007, p. 364). Students commented that their experiences in a host country had made them reflect on what a foreigner from a diverse cultural background must feel like within a Danish hospital. Although Ruddock and Turner (2007) stated that the students felt like foreigners in a strange land they did not mention if they had encountered any language difficulties in the host country.

These studies have indicated that the aim of a placement in a host country is for students to develop a cultural awareness and cultural competence. The Cushner (1986) inventory of Cross-Cultural sensitivity used by Jones et al. (2012) is generic and does not illicit responses about communication or cultural encounters within a health care setting. However, the Campinha-Bacote (2002) conceptual model used by Koskinen and Tossavainen (2003b) and Hagen et al. (2009) enabled these researchers to explore the development of cultural competence within a health care setting. Unlike the findings of Hagen, et al. (2009) which suggested students developed cultural competence even though they could not speak to patients in a mutual language, Koskinenen and Tossavainen (2003b) indicated that due to the insurmountable barrier of not being able to speak the language of the host country some UK students did not become culturally competent.

2.4. Students' Experiences including the inability to speak the language of the Host country

This section will include studies about students' inability to speak the language of the host country. Although many of the studies are related to student nurses and clinical practice, studies about the experiences of students from other disciplines will also be included in this review as they provide an insight into some of the perceived difficulties of not speaking the language.

A phenomenological study by Morgan (2012) explored student nurses' (n=10) perceptions of risks in international placements. Three themes emerged from the interview data. These were clinical-professional risks, socio-cultural risks and physical risks. Some students suggested that although they had an English-speaking mentor the language barrier was an increased risk. Morgan's (2012) findings did not uncover the reasons for students perceiving this as an increased risk and there is no evidence of other studies which suggest that the language barrier was a risk factor. One student was concerned about being unaccompanied whilst having direct contact with a patient. The student stated: 'it could create a problem if you went to them (patients) on your own' (Morgan, 2012, p.957). The types of problems which this student felt could be created due to not speaking the language were not identified within the study. However, a study by Divi, Koss, Schmaltz and Loeb (2007) found that adverse events including communication errors in six hospitals in the US are more likely to occur in patients who had limited English proficiency. The findings of this study could be linked to the ERASMUS experience where students do not speak the same language as the patients. Unlike Morgan's (2012) study which focused on student nurses, the Divi et al. (2007) study focused on patients who are unable to speak English in an Anglophone country. The findings of the Divi et al. (2007) study indicate that the patient's inability to speak the language can compromise their care. This study adds to the body of knowledge about patient safety issues due to language barriers. On the other hand, effective communication between the multidisciplinary team and patients has the potential to enhance the standards of patient care (Scottish Healthcare Strategy, 2010)

Morgan's (2012) study also identified social-cultural risks. Students felt they did not fit into the culture of the host country and this may result in people making negative comments about them or there was also a danger of becoming socially isolated. The students did not identify if it was their inability to speak the language contributed to feelings of social isolation. Personal risks included the poor infrastructure of the country and unsafe modes of transport. Students felt that exposure to perceived risks enhanced learning and personal and professional development. These results indicate that international experiences have benefits, in that students can develop professionally and personally but the inability to speak the language can present difficulties.

Moreover, a quantitative study was carried out by Suanet and Van de Vijver (2009) to examine the acculturation and perceived cultural differences of international students (n=187) from eleven different countries who were doing a Masters' Degree in Russia. The term acculturation is when individuals modify behaviour patterns due to having contact with another culture. The results supported the hypothesis that a 'larger perceived cultural distance between the mainstream and immigrant culture (exchange students) is associated with less psychological and socio-cultural adjustment' (Suanet and Van De Vijver, 2009, p.182). Suanet and Van de Vijver (2009) suggested that students, who were from countries within the former USSR, spoke Russian fluently, shared the same religion and other traditions had the smallest perceived cultural distance. These students had more interactions with Russians, less homesickness and adjusted better to the host country. Although the participants in this study were not student nurses, the findings suggest that student nurses who are unable to speak the language of the host country will have a larger perceived cultural distance from the mainstream groups in a host country. However, it could be argued that there would be cultural similarities due to these students being from countries within the former Soviet Union therefore these results would have been expected. Santoro and Major (2012) also identified similar findings in a study involving fifteen Australian student teachers who had a short international study tour in either India or Korea. The results indicated that the student teachers experienced dissonance which hindered intercultural learning and communication practices (Santoro and Major, 2012). Although this study is not related to nursing, it adds to the body of knowledge about the value of speaking the language of the host country. The findings of both Suanet and Van de Vijver (2009) study and the Santoro and Major, (2012) study suggest that students' fears and anxieties could be reduced if they had a knowledge of the language of the host country.

In addition, the findings of a grounded theory study by McLauglin and Justice (2009) also identified that students (n=20) from various academic backgrounds had a transition shock during their international experience in the United States. The transition shock included feelings of isolation because of language difficulties, homesickness and loneliness. A network of friends was classed as a useful support strategy. The research findings also indicated that students developed confidence and independence and reported an 'increasing comfort and competence in the academic, cultural and the social aspects of their lives after 6-12months' (McLauglin and Justice, 2009, p.31). The students were from different countries and were

undertaking a taught programme in the US whereas my study involved nursing students on a work-based programme in clinical practice and they did not have as long to adjust to the culture. Nevertheless, McLaughlin and Justice's (2009) study adds to the body of knowledge about students' experiences and adjusting to a host culture. A hermeneutic study by Greatrex-White (2008) found that nursing students (n=26) diary accounts revealed feelings of exclusion and being an outsider due to not speaking the language of the host country. The findings indicated that students' feelings of worthlessness were magnified though being reliant on someone having to speak on their behalf and interpret the answers of the other person (Greatrex-White, 2008).

The Carpentner and Garcia (2012) study had a similar focus. They used a survey, reflective journals and individual and group interviews to assess the outcomes of American student nurses' (n=35) study abroad programme in Mexico. The results indicated that if students had knowledge of the language of the host country, it helped them develop a better knowledge of the culture and the social factors within it. This would indicate that there is a link between language and culture. In contrast to Carpetener and Garcia's (2012) study, Myhre (2011) carried out a hermeneutic study to explore the challenges that three non-Norwegian nursing students experienced during a three-month clinical placement in Norway. These students could not speak the language of the host country. Two focus group interviews were used to explore students' experiences. Two of the themes which emerged from the focus group interviews were 'development of self-confidence' and 'responsibility, trust and value'. Students felt that they could function well in clinical practice despite not having knowledge of the language and this had enabled them to develop self- confidence (Myhre, 2011). The type of skills or care that students provided for patients was not identified within this study. However, students commented they used non-verbal communication to convey meaning to patients. It is worthy to note that students did not identify any negative issues due to not speaking the language. It may have been that Myhre did not explore this. In addition, a study by Jirwe, Gerrish and Emani (2010) explored nurses' experiences of communication in cross cultural encounters. They also found that students (n=10) in Sweden used non-verbal communication when they were unable to share a common language with patients who were immigrants. Jirwe, et al. (2010, p.443) make a very important point in stating, 'even in situation where students were satisfied, they were able to communicate, it does not mean that patients were'.

The results of an exploratory study by Fernandez et al. (2004) involving Spanish speaking patients (n=116) and primary care physicians (n=48) within a large ethnic minority group found that physicians who are fluent in Spanish are more likely to elicit the problems and concerns of Spanish speaking patients than their less fluent counterparts. The findings also indicated that even when the physicians who were not fluent in Spanish used professional interpreters, they were unable to elicit patient's problems and concerns in the same way as physicians who were fluent in the language did.

Although the students in Myhre's (2011) study had a clinical supervisor and could not speak the language of the host country they were able to work independently and provided direct nursing care to patients. The students indicated that they felt valued and trusted due to working independently. The benefits of working independently was also identified in a qualitative study by Mattila, Pitkäjärvi and Eriksson's (2010). The data obtained from semi-structured interviews with international student nurses' (n=17) indicated that when the international students worked independently it increased their self-confidence and made them feel accepted as part of the ward team. A category named 'restricted learning' consisted of students' views about language problems. Some students had limited skills in the Finnish language, and they felt that staff could not tolerate this and advised them to speak in English, whereas other students were not allowed to use English in clinical practice. This is interesting findings and it implies that universities should identify the language which students will be supervised in, before the exchange takes place. In my study, the supervising language is English as students do not have a knowledge or understanding of the language of the host country.

In contrast to the findings of Mattila, Pitkäjärvi and Eriksson's (2010) study, about contradictory advise given regarding the use of two languages in clinical placement, the study by Koskinen and Tossavainen (2004) found that Finnish students (n=10) who had a placement in the United Kingdom had initial difficulties with speaking English. They were gradually able to adjust to speaking the language and communicated effectively in English in clinical placements. The findings of the Koskinen and Tossavainen (2004) study suggest that ERASMUS students achieved the aims of ERASMUS which is to develop linguistic skills. Unfortunately, these studies have not explored how the inability to speak the language restricts students' learning and direct encounters with patients in clinical practice.

2.4.1. Students' Experiences and Clinical Supervision.

English is usually the language used for supervising students in clinical practice unless the student has a good knowledge of the language spoken in the host country. This is often referred to as mentoring. A mentor is a registered nurse whose role encompasses supporting, assessing and supervising student nurses in clinical practice placement. Mentors are often referred to as "supervisors" "preceptors" or "clinical supervisors" (Mead, Hopkins and Wilson, 2011). The study by Myhre (2011) indicated that the three international students were from non-English speaking countries in central Europe and could not speak the Norwegian language therefore they were supervised in English by a named mentor. The term 'named mentor' is also used by the regulatory board for Nursing and Midwifery Council (NMC) in the United Kingdom. The NMC (2008) have recommended that student nurses should spend 40% of their time in placement with a named mentor. There is no evidence of a study which identifies if mentors need to spend more time with students who do not speak the language of the host country.

However, Green, Johansson, Rosser Tengnah and Segrott (2008) refers to the support provided by mentors in an international placement for student nurses. Green et al. (2008) used semi-structured individual, group interviews and documentary analysis to explore student nurses' (n=32) experiences in a host country. The support which students received in clinical practice varied from a total lack of support to overprotection. Green et al. (2008) did not identify if students who felt overprotected spoke the language of the host country. The UK professional body for nurses and midwives, the NMC recommend that mentors should assess the amount of direct supervision and support students will require in clinical practice. Although a minority faced challenges with the language, the findings indicated that students had developed practical skills, professional knowledge, self-reliance and confidence (Green et al. 2008). A similar study which was carried out by Keogh and Russel-Robert (2009) to explore the benefits of a German-Finnish exchange programme found that it had met both the personal and educational needs of students. The findings indicated that the seven students who spent five months in Finland felt that the supervision in clinical practice was outstanding and this had enabled them to develop both cultural competence and practice skills. Keogh and Russel-Robert (2009) point out supervisors spoke both English and German and students could communicate with them in both languages. Older patients spoke German, and this

was the language used to communicate with them. During their placement in Finland, students were able to learn an elementary form of the Finnish language (Keogh and Russel-Robert, 2009). There is no evidence of another study indicating that both German and English languages were used to supervise students or that they had developed a knowledge of the language of the host country albeit at a rudimentary level.

In contrast to the findings of Keogh and Russel-Robert (2009) regarding supervision the results of the qualitative study by Petrosoniak, McCarthy and Varpio (2010) indicated that some of the participants were asked to work above their competency level. The aim of this study was to explore the complexities of international electives. The findings indicated that participants (medical trainees (n=10) and other health care professionals (n=10) found that there were no clear educational objectives, ethical dilemmas were encountered, and some were asked to work above their competency level. One medical trainee was asked to close (suture) an abdomen when the surgeon walked out of theatre whereas another medical trainee was asked to do a lumbar puncture on a patient. The medical student who was asked to do a lumbar puncture expressed her anxiety about gaining experience at the expense of patients who did not speak the same language. (Petrosoniak et al., 2010) Although the participants in this study were not student nurses, it adds to the body of knowledge about the importance of providing the correct level of supervision when caring for patients who are unable to speak the same language as the student. This is important in order not to compromise the care of the patient. The NMC (2011) stress that the safety of patients and students is a prime concern therefore Approved Education Instructions (AEI's) need to have a formal arrangement with host partners for them to organise a named academic or practice person to support the student in the host country. As already indicated in section 1.7 (p.14), the practice persons who are responsible for supervising students in an ERASMUS clinical placement are mentors.

Jokelainen, Jamookeeah, Tossavainen and Turunen (2013) make some valid findings about supervision within their phenomenological study. They found that both British (n=17) and Finnish (n=22) mentors felt that it was important for a mentor to work closely with the student they are supervising. Mentors in both countries suggested that it is important to know about the student's present stage of training and their personal learning goals in order to assess if these are achievable and if so, help the student to attain them. Although this study does not focus on international

experiences, the same principles apply if mentors are facilitating an exchange students' learning. A study by Koskinen and Tossavainen (2003a) on the characteristics of intercultural mentoring found that there was an enormous language barrier and mentors had to act as language interpreters. The language barriers also reduced students' direct contact with patients. Although this is a relevant study which includes mentors' experiences it was carried out in 2003. The literature review indicates that there is a dearth of studies which explores mentors' experiences supervising ERASMUS students in a host country.

2.5. Summary

ERASMUS operates within a globalised world where Higher Education is viewed as a commodity. Whilst ERASMUS has helped to drive internationalisation through mobility programmes, it has also accelerated the social interaction dimension of globalisation due to students crossing borders for cultural experiences. Unfortunately, social interaction can be jeopardized through students relying on English being the lingua franca of everyone in Europe. Fidrmuc et al. (2009) points out that if English is the lingua franca of Europe it leaves 62.6% of Europeans disenfranchised. Despite this article being published in 2009, this statistic should not be ignored as it suggests that students will be unable to interact with some people in host countries owing to the inability to communicate in a mutual language. Lack of language skills can also present challenges for students communicating with staff and patients in clinical practice.

The aim of ERASMUS is to enable students to develop language skills, but it could be argued that this can be hindered through English being the lingua franca of European Higher Education and the language of supervision in clinical placements. This may decrease the motivation to learn the language of the host country. The second aim of ERASMUS is to develop an appreciation and knowledge of diverse cultures (Kulbok et al., 2012) and thereby develop cultural competence. It was decided that a cultural competence model would be used as culture is embedded in language (Sweeney, 2010). The Camphina-Bacote Model on the Process of Cultural Competence in the Delivery of Health Care was selected as a theoretical framework for this thesis. Koskinen and Tossavainen (2003b) used this framework to present her results on gaining intercultural competence. Their findings suggested that cultural shock and the language barrier prevented some students learning about the culture.

Although Koskinen and Tossavainen's (2003b) study was carried out several years ago their findings regarding the language barrier is relevant. In spite of this, there is no evidence of current studies on Scottish nurses' experiences of the ERASMUS experience in a host country. In addition, the literature review has shown that mentors play a valuable role in supervising students in clinical practice in a host country but there is no current evidence of research which explores their views about student nurses working in a clinical placement when they are unable to speak the language. Therefore, the aim of this research enquiry is to explore how the constraints of language influence cultural competence and professional development in an ERASMUS placement for student nurses.

Chapter 3: Methodology

This chapter will discuss the rationale for positioning this inquiry within the social constructivist paradigm. To do this, the ontological and epistemological assumptions underpinning the social constructivist paradigm will be explored. A justification will then be provided for selecting a qualitative case study methodology for this inquiry on, how the constraints of language influence cultural competence and professional development during an ERASMUS placement for student nurses. This will then be followed by a discussion about the rationale for purposive sampling and the research methods used within the study. Information will then be provided about the research population and how they were recruited. The reason for using reflexivity to demonstrate rigour during the research process will then be discussed. A critical appraisal of the data collection methods and a rationale for using the framework method for data analysis will be provided. Finally, the ethical principles which were taken into consideration in the planning and carrying out this study will be discussed.

3.1. Ontological and Epistemological Beliefs Underpinning Social Constructivism

All paradigms are based on the ontological assumptions about the nature of reality and epistemological beliefs about how knowledge is generated (Denscombe, 2010). Each research community have specific philosophical beliefs and practices, and these are the foundations of their paradigms (Bunniss and Kelly, 2010). The paradigm which underpins this research study is social constructivism, therefore the philosophical beliefs and values held by this research community were taken into consideration when planning this research inquiry. This sets the boundaries for the research inquiry and the type of questions worthy of investigation within this research community (Denscombe, 2010).

The terms constructivism and constructionism are used interchangeably within the literature and often no explanation is provided about the differences in both terms (Lee, 2012; Ward, Hoare and Gott, 2015). It was for this reason that the beliefs and values underpinning both constructionism and constructivism were taken into consideration before making the final decision about the paradigm which guided this research inquiry. Constructionism and Constructivism are regarded as learning theories and research paradigms. In section 2.3.1. (p.35-37) it was indicated that

Piaget developed cognitive constructivism. Piaget believed that knowledge is mentally constructed through activities and observation within the world (Talja, Tuominen and Savolainen, 2005) whereas Vygotsky (1978) who is associated with social constructivism emphasised that individuals live in a social cultural environment in which knowledge is subjectively and socially constructed and then internalised (Talja, Tuominen and Savolainen, 2005). However, it was Piaget's student, Papert who developed the theories of constructionism. Papert's aim was to challenge Piaget's theories of constructivism about the way knowledge is constructed (Kynigos, 2015) and in doing so develop a more pragmatic approach to the construction of knowledge. The underpinning beliefs of constructionism are that reality is created through using and working with artefacts and having ongoing interactions with people within the social world (Talja et al., 2005).

Constructionism and constructivism are embraced within the broad umbrella term of interpretivism (Williamson, 2018). Placing the prefix 'social' before the terms, constructionism and constructivism emphasises the social context of both paradigms. Interpretivists view reality as socially constructed and it is the individual who makes sense of it and attaches meaning to it (Tuli, 2010). Social constructionists agree with interpretivists that reality is socially constructed (Galbin, 2014). However, Parahoo (2014) suggests that some interpretivists hold a similar belief about critical realism to that of post-positivists. Critical realism encompasses both subjectivist and positivist beliefs (Taylor, 2018). Critical realism acknowledges the individual's subjective interpretation of reality, but it also takes into consideration objective reality which exists independently from the individual's perceptions (Taylor, 2018). According to Taylor (2018) critical realism would be placed in the middle of a positivist, subjectivist reality continuum.

Taylor (2018) points out that there are two forms of social constructionism, one is classed as weak and the other strong. The weak form of social constructionism is closer to a critical realism philosophical stance than the stronger form (Taylor, 2018). Some researchers who lean towards critical realism tend to 'sit on the fence' and not make decisions about the interpretation of data, in order to create the impression of an objective reality (Taylor, 2018, p.218). On the other hand, Taylor (2018) points out that social constructionism would be at the subjectivist end of a positivist subjectivist reality continuum. However, Stam (2001) is of the opinion that there are still controversial issues within the social constructionism paradigm regarding, if it

favours realism or anti realism. In addition, (Stam, 2001) also points out that it is now becoming more obvious that there is no single social constructionism position in relation to realism and anti-realism.

The social constructivist paradigm reflects a Vygotskian perspective which rejects the objective nature of social reality (Kim, 2014). The beliefs underpinning the social constructivism paradigm are relativism and multiple realities (Lee, 2012). Realism and relativism represent opposite sides of a reality continuum (Andrews, 2012). The philosophy underpinning relativism is that there is no universal truth. Social constructivism is also placed at the subjectivist end of positivist subjectivist continuum (Taylor, 2018).

Epistemology are the beliefs about the way in which knowledge about multiple realities are known (Cohen, Manion and Morrison, 2011). This includes assumptions about the basis of knowledge, how it is developed and the social location of the researcher and the one being researched (Cohen, et al., 2011). According to Kim (2014) the Vygotskian social constructivist paradigm concentrates on the construction of joint intersubjective knowledge. Social interaction is the basis of the social constructivism paradigm (Kim, 2014). The aim of the social constructivist researcher is to understand the research participant's construction of reality. However, it is through the researcher's active involvement with the research participant during the research process that understanding of reality and the construction of meanings are developed (Kim, 2014). In contrast some interpretivists' believe in subjectivity yet include elements of objectivity (Kim, 2014) in the interpretation of data (Taylor, 2018). This can involve researchers bracketing preconceived opinions about a phenomenon in order to give the impression of objectivity. On the other hand, the philosophy underpinning the social constructivist paradigm advocate that researchers should actively interact with research participants in order to develop a collaborative dialogue which results in the co-construction of meaning (Kim, 2014). Figure 2 provides a summary of the social constructivist paradigm.

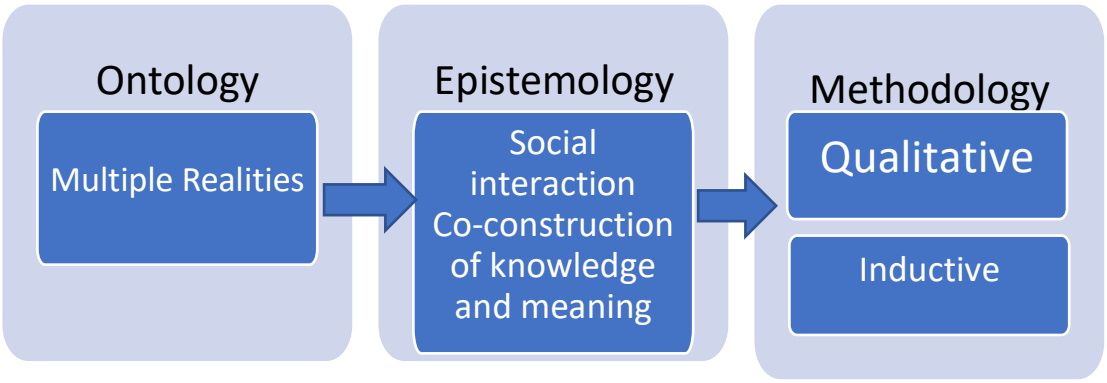

Figure 2: Social Constructivism Paradigm

After reviewing the social constructivism paradigm, I felt that it was suitable for this research inquiry. Ontological beliefs underpinning paradigms influence data collection methods. As already indicated social constructivists believe that knowledge is socially and subjectively constructed (Denzin and Lincoln, 2005; Talja, et al., 2005) therefore qualitative methods (Kim, 2014) utilising inductive reasoning was selected for this research inquiry (Parahoo, 2014). A qualitative methodology is appropriate for studies in which the ontological position is multiple realities (Cohen et al., 2011). The beliefs that a specific research community hold about the construction of knowledge influences how researchers interact with research participants during the data collection process (Welford, Murphy and Casey, 2011). The methodology selected for this research inquiry will be discussed in section 3.3. (p.53-57) and the data collection methods will be discussed in section 3.5. (p.64-69). The other reasons for selecting social constructivism will be discussed in the Research Stance section.

3.2. Research Stance

My research stance was influenced by my experience as a nurse and a nurse lecturer. During my career, I noted how the practice of nursing and nurse education was dynamic. Many people view the same phenomena from different viewpoints and some researchers can hold biases about specific phenomena (Parahoo, 2014). I was conscious that I had different experiences in nursing and education to that of mentors and student nurses and may therefore have different viewpoints about nursing practice. For example, I had studied nurse education and midwifery under the apprenticeship model in which students were part of the NHS workforce whereas these students had Higher Education student status and were supernumerary to the requirements of the workforce during clinical practice hours.

In addition, this study was carried out in four different countries therefore it was envisaged that there would be different perceptions about how the constraints of language influence the development of cultural competence and professional development in an ERASMUS placement. As a social constructivist researcher my opinion was that people construct their own view of reality. My view about multiple realities was strengthened though Denscombe's (2010) suggestion that different cultures may have different views of reality. This was deemed a suitable stance to take as my study embraced different cultural settings within four host countries.

In addition, Welford, Murphy and Casey (2011) suggest that when a researcher wants to explore how participants construct reality and attach meaning to the experience then the constructivist paradigm should be used. I felt that the social constructivist paradigm was suitable for this research inquiry as I wanted to explore, how the constraints of language influence cultural competence and professional development during an ERASMUS placement for student nurses in four different countries (Finland, Sweden, Spain and Italy). In addition, I wanted to gain an understanding of the meaning that participants put to their experiences in host countries and ascertain ways in which this experience could be improved (Welford, Murphy and Casey, 2012).

3.3. Research Design

Prior to finalising my choice of methodology, I took into consideration the research which had been done on international experiences from a quantitative and qualitative perspective. Studies on cultural competence and the experiences of students in host countries have been carried out from a quantitative perspective (Carpenter and Garcia, 2012; Suanet and Van de Vijver, 2008; Braithwait and Majumdar, 2006) but the majority have been qualitative studies (Keogh and Russel-Roberts 2008; Koskinen and Tossavainen 2003b; Koskinen and Tossavainen, 2004; Myer 2011; Morgan, 2011). Some studies (Koskinen and Tossavainen 2003a; Koskinen and Tossavainen, 2004; Myhre, 2011) have referred to students' inability to speak the language of the host country but this topic was not the focus of their research enquires. Furthermore, as indicated in Chapter 1, there is a dearth of current studies which examines mentors' views about student nurses who are unable to speak the language of the host country. The purpose of my research is exploratory, so a qualitative approach (Niewiadomy 2012), should enable me to gain an insight into the how the constraints of language can influence cultural competence and

professional development in an ERASMUS placement for students. This phenomenon will be examined from mentors' and student nurses' perspectives.

3.3.1 Case Study Design

Initially, I considered using phenomenology, which is a branch of qualitative research, but I felt that the data collected from participants who had experienced this phenomenon in the four countries would be grouped together whereas I wanted to look at each country separately. I also wanted to embed the research inquiry in an educational, social and cultural context and this is linked to case study methodology (Stake, 2006). It was for these reasons that I chose a case study methodology for this research inquiry.

Bryman (2008, p.60) suggests that the term 'case' is associated with a community, organisation or a location. In my study the term case relates to students and mentors in a clinical environment within the host country where the students had their ERASMUS placement. Stake (2006, p.6) uses the term 'quintain' to describe a phenomenon, community or organisation with branches. This is likened to an umbrella or framework. In my study quintain is the ERASMUS clinical placements for students and the cases or units are countries where the students are placed for their clinical placements.

Simons, (2009, p.21) defines a case study as 'an in-depth exploration, from multiple perspectives of the complexity of a particular project, policy, institution, programme or system in a real-life situation'. This definition puts emphasis on a real-life context in which the primary purpose is to generate knowledge and understanding from different perspectives (Simons, 2009). My study investigates contemporary phenomena and the real-life context is clinical placements in a host country for student nurses who are undertaking a BSc (Adult Nursing) programme. Yin's (2009, p.18) describes a case study as an empirical approach to investigate a current issue within its real-life context when the boundaries between the experience and the context are not evident. In addition, Thomas (2016, p.21) likens a case study to a 'rich picture with boundaries'. The boundaries are the edges of the case study and the route in which the researcher wants the case study to go (Thomas, 2016). The research aim of my study helps to define the boundaries of the research enquiry. The boundaries are the ERASMUS experience for students in the four countries and the related educational, cultural and social context. Stake (2006) concurs with this concept and points out that each case

has its own unique context or background. Each case is viewed as an entity and the context in which the experience takes place should always be taken into consideration (Gerrish and Lacey 2010; Baxter and Jack, 2008). Furthermore, case study methodology is useful when a researcher wants to ask 'why' and 'how' questions and investigate the contextual conditions believed to be relevant to the phenomenon (Yin, 2003). My research study investigates the 'how' question. It investigated, how does the constraints of language influence the process of cultural competence and professional development in an ERASMUS placement for student nurses?

3.3.2. Using Quantitative or Qualitative Perspective within case study design

According to Parahoo (2014) the case study design lends itself to both, quantitative and qualitative methodologies. For this reason, case study methodology can be viewed as an 'intellectual orphan' as it is not attached to one specific research community and this can present difficulties when trying to justify its credibility (Thomas, 2016, p.46).

Quantitative research has its roots in positivism. The term 'positivism' originates from positivist sciences and follows a tested, organised approach to data collection and analysis rather than relying on undisciplined assumptions (Parahoo, 2014). Quantitative research includes approaches such as experiments, randomised control trials, quasi experiments and non-experiment surveys (Welford, Murphy and Casey, 2012). Polit and Beck (2012) point out that positivists believe that knowledge is developed through the senses (smell, touch, hearing, taste and sight) whereas post-positivists challenge this because they believe it excludes issues such as well-being and life satisfaction. Post-positivists claim that although these issues cannot be observed, they can be studied using valid and reliable self-reporting tools (Parahoo, 2014). A criticism of positivism and post-positivism is that it only investigates small aspects of the human experience (Polit and Beck, 2012).

Boblin, Ireland, Kirkpatrick and Robertson (2013) points out that Yin (2009) and Stake (2006) have different approaches to case study methodology. Boblin et al. (2013) expands further on this comment by claiming that Yin's approach to research is underpinned by post-positivist theories which follows a more structured style whereas Stake's approach is underpinned by the constructivist paradigm (Boblin et al., 2013).

Boblin et al. (2013) does not identify the type of constructivism that is reflected within Stake's case studies. However, Stake's approach to case studies is rooted within a social-cultural environment.

The quantitative approach to case studies was viewed as inappropriate for my study as I wanted to explore the phenomenon from a holistic perspective, and this is more in keeping with a qualitative approach. In support of this decision, Thomas (2016, p.47) claims that the starting point in any case study is realising that phenomena is more than a number of parts which need to be understood as a whole rather than as a group of 'interconnected variables'. This statement reflects a holistic approach to case study research.

Stake's view of multiple realities and the relationship between the researcher and the research participant is in keeping with social constructivism whereas Yin's beliefs are that reality is predictable and the researcher remains independent from the researched (Boblin et al., 2013). I concur with Stake's views of multiple realities and this in keeping with the theories of social constructivism.

3.3.3. Different Types of Case Studies

There are many types of case studies, including the intrinsic case study, the collective case study and the instrumental case study (Stake, 2006; Thomas, 2016). The intrinsic case study focusses on one case and the aim is, to provide an understanding of it (Thomas, 2011) whereas a collective (multiple) case study focuses on more than one case. An intrinsic case study was not suitable as I wanted to look at cases in different settings. On the other hand, the instrumental case study is when the case is investigated to explore something beyond the case (Stake, 2006). I decided to use an instrumental case study to provide an insight into ERASMUS clinical placements for student nurses who cannot speak the language of the host country. Instrumental case studies provide a deeper understanding of the phenomenon and enable theoretical generalisations to be redrawn (Stake, 2006; Thomas, 2016). My intention was to build or contribute to the theories about the ERASMUS experience and therefore the instrumental approach was appropriate. According to Thomas (2011) the approach which a researcher uses to carry out a case study reflects the reason for the study and the process used to do this was multiple cases (Thomas, 2011). The route that the study took is illustrated in Figure 3.

Purpose	Approach	Process
Instrumental	Building a theory	Multiple cases

Figure 3: Case Study Process

Multiple cases are examined to explore a certain phenomenon. Stake (2006) suggests that each single case is valuable in a multi-case study because it belongs to a specific group of cases. Each case and the supporting theoretical principles can be compared and analysed (Thomas, 2016). On the other hand, Stake (2006) suggests that multiple case studies are designed in two distinct ways. Firstly, an embedded case study comprises of small cases, but the focus is on the quintain and this can restrict a detailed examination of each case. Embedded case studies can be done from a qualitative or quantitative perspective (Scholz and Tietje, 2002). Thomas (2016) points out that 'embedded' case studies can offer comparisons between cases whereas 'nested' case study designs are subunits which fit into a "larger unit." I decided not to use this term as nested case studies often use quantitative methods with control elements whereas my study uses qualitative methods (Keogh and Cox. 2014). The second type of design described by Stake (2006) is the qualitative multiple case study design, which enabled me to examine each case holistically and ascertain its uniqueness and complexities. I decided that a qualitative multiple case study process (Figure 3) would be more appropriate for my research as it allowed me to study each case individually and this would also enable me to get a broader view of the quintain. The justification for this was that my enquiry involved four cases which are countries (Finland, Sweden, Italy and Spain) and the context of each case would be different (Baxter and Jack, 2008).

3.3.4. Generalisation of Case Study Data

Generalisation is a term used to describe the degree to which the research findings can be applied to similar populations in a similar setting (Parahoo, 2014). This is referred to as scientific or empirical generalisation. Boblin, Ireland, Kirkpatrick and Robertson, (2013) inserts that the quantitative approach is rooted in positivism and this research community may feel uneasy using case study methodology as it may be difficult to generalise findings due to the small sample sizes. On the other hand, quantitative case studies involve a small number of cases and emphasis is not placed on generalising findings from an empirical perspective. Thomas, (2016) claims that although empirical generalisations cannot be made from case studies which are done

from both a quantitative or qualitative perspective, the data collected is good for providing rich pictures and analytical insights of the case or cases from many angles. As indicated in section 3.3.3 (p.56), this is often referred to as theoretical generalisations. Nonetheless, Flyvbjerg (2006) suggests that even though knowledge cannot be generalised scientifically it does not mean that it cannot contribute to a collective body of knowledge on a specific subject. Descriptive case studies can contribute to the pathway of scientific innovations (Flybierg, 2006).

Furthermore, Stake (2006) suggests that a multiple case study is incomplete if less than four cases are examined. Even though data was collected from four countries which had cultural and educational differences, the emphasis was not to compare the cases but to provide a more in-depth understanding of the phenomenon under examination (Stake, 2006: Thomas, 2016). Moreover, each case was selected carefully in order to provide a good understanding of the quintain. Flybierg, (2006) comments that generalisability is enhanced through strategic choosing of cases.

3.3.5. Strategies Used to Ensure Quality in Qualitative Research

Guba and Lincoln (1989) have suggested that in order to ascertain the trustworthiness of a research study it should fulfil the following four criteria: credibility, dependability, transferability and confirmability. There are different ways to achieve these criteria. Credibility attempts to confirm a true reflection of the phenomenon and the social reality of the research participants (Maher, Hadfield, Hutchings and de Eyto, 2018). Transparency is imperative in the research process in order to provide credibility and an endorsement of the research findings (Avis, 2005). This involves demonstrating an openness and honesty about the challenges and unexpected difficulties within the research design (Tracey, 2010). Reflexivity can help researchers to be more aware of challenges and potential difficulties. I used reflexivity during the research process (see section 3.6) and framework analysis (see section 3.7) to ensure rigour and enhance credibility.

Confirmability is being aware of any biases held which may influence the research process (Maher et al., 2018) and the research findings. I felt that reflexivity enabled me to be aware of any beliefs I held about the research phenomenon. Accurate data analysis is imperative. When any queries arose during the transcribing phase I asked research participants to confirm if the transcripts were accurate (Parahoo, 2014).

Dependability includes describing the research process accurately so that other researchers can use the same research design with confidence and repeat the work (Maher, et al., 2018). In order to do this, the research methodology and the use of framework analysis was described systematically to enable the transferability of this research inquiry to another setting (Maher, et al., 2018). Framework analysis was also used within this study to enhance the credibility of the research inquiry (Lacey and Luff, 2009).

3.4. Sampling

To select the research population purposeful sampling was used (Parahoo, 2014). Stake (2006, p.24) claims that this is an appropriate form of sampling in case study methodology. The research participants were selected on purpose because it was anticipated that they had a deep insight into the topic and would be able to provide the most comprehensive data (Hewitt-Taylor, 2011). Stake (2006) also indicates that participants should provide the researcher with good opportunities to learn about the complexities and the context of the case. All my participants had immersed themselves in an ERASMUS experience and were deemed suitable to answer the research questions. Stake (2006) also specifies that in a multiply case study, participants should offer diversity across the context. I felt that selecting mentors from four different countries and students who had a clinical experience in different countries would provide, a diversity across the context.

In this study, the inclusion criteria were, mentors should be registered nurses and had mentored student nurses during their ERASMUS placement in a host country. Another inclusion criterion was that mentors used the English language to mentor ERASMUS student nurses. The inclusion criteria for students was that they were in the 3rd year of a BSc in Adult Nursing programme and had participated in an ERASMUS experience which involved a clinical placement from 7 – 12 weeks in a host country.

The research population comprised of twelve mentors who supervised students during an ERASMUS clinical experience in a host country and thirteen student nurses. (More details will be provided in the following section about the research participants). The sample size in qualitative research is influenced by practical and theoretical factors (Robinson, 2014). I felt that a sample of 12 mentors and 13 students gave me a theoretical insight into how language constraints influence

cultural competence and professional development in an ERASMUS placement for student nurses. Hewitt-Taylor (2011) claim that whilst the sample sizes are small, the main aim in qualitative research is to ensure that the depth of enquiry has been achieved to bring about a better understanding of the phenomenon.

3.4.1. Participant Information – Mentors

The mentors were identified through senior lecturers and ERASMUS coordinators in the partner universities in host countries where the Scottish ERASMUS students had clinical placements. Sixteen mentors were recruited for the study, two mentors decided not to take part. One had acted as a co-mentor and felt that she had spent insufficient time with the students and therefore was unable to participate in the study and the other mentor provided no reason for not taking part in the study. Two other mentors were on maternity leave during the period of data collection and were unable to participate . Four mentors from Finland, two mentors from Sweden, four mentors from Spain and two mentors from Italy participated in the study. Table 1 (p 61) provides information about the mentor participants. It includes the number of years' experience mentoring ERASMUS students and the languages spoken by mentors. Pseudonyms were used to protect anonymity.

Table 1: Participant Information - Mentors

Pseudonym & country of origin	Languages Spoken	Year of graduation as a nurse	Number of years' experience as an ERASMUS mentor	Nursing Speciality
Astrid Sweden	Swedish, English & German	1984	8 months	A & E
Emelia Sweden	Swedish & English	1999	8 years	A & E
Samuel Finland	Finnish, Swedish, English & Hungarian	1999	10 years	Intensive Care
Nella Finland	Finnish, Swedish, English, Spanish & French	2006	8 years	Renal dialysis
Ella Finland	Finnish, Swedish, English, Spanish, Russian & French	2005	3 years	Ophthalmology (Eye) Clinic
Saara Finland	Finnish, Swedish, English, Spanish, Russian & French	1997	5 years	General Surgical Ward
Ana Spain	Spanish, English & Catalan	2012	2 years	Intensive Care
Felipe Spain	Spanish, English & Catalan	2015	1 year	Intensive Care
Antonio Spain	Spanish & English	2004	7 months	A & E
Patricia Spain	Spanish, English & Catalan	2009	2 years	Ophthalmology
Ricardo Italy	Italian & English	2009	3 months	Intensive Care
Sofia Italy	Italian & English	2004	3 months	Intensive Care

The twelve mentors met the NMC criteria that they must be qualified for more than one year before mentoring student nurses (Walsh, 2014). Although four of the mentors, Astrid, Antonio, Ricardo and Sofia, had less than one year's experience mentoring international students they were experienced nurses and had mentored national students. Astrid graduated as a nurse in 1984, Antonio in 2004, Ricardo in

2009 and Sofia in 2004. In addition, Astrid and Sofia had less than a year's experience mentoring ERASMUS students, but they had worked in the United Kingdom as registered nurses and were familiar with United Kingdom nurse education programmes. Most mentors spoke three or more languages fluently and mentored nursing students from various European countries. Table 1 (p.61) shows that mentors in Finland are fluent in more languages than those in Sweden, Italy and Spain. Mentors in Sweden, Finland, Italy and Spain spoke English and used this language to mentor ERASMUS students in clinical practice.

3.4.2. Participant Information – Students

I recruited the students through the ERASMUS coordinator at a university in the West of Scotland. The ERASMUS co-ordinator emailed me the names of the student nurses who had applied for an ERASMUS placement from the four university campuses. Students were recruited prior to going on their ERASMUS placement. The purpose of recruiting students prior to their ERASMUS placement was to provide them with a verbal explanation about the study and an opportunity to ask questions about their involvement in the study. Boulton, (2009) concurs with the concept of researchers meeting participants to answer any queries that they may have about the research.

Sixteen students agreed to participate but three withdrew from the study after returning from their ERASMUS experience. No explanation was given by two of the students for withdrawing from the study. One student was only able to complete one week of her ERASMUS experience due to personal reasons. She was withdrawn from the study as she no longer met the inclusion criteria.

The student nurses who participated in the study were aged 20 to 31 years. Four students had a placement in Finland, four students had a placement in Sweden, two had a placement in Spain and three students had a placement in Italy. The first language of the students was English. Some students had a knowledge of other languages but were unable to speak these languages fluently. Only two students spoke another language other than English fluently. None of the students spoke the language of the country where they had their clinical placement. All students had clinical experiences in highly specialised units such as intensive care and accident and emergency departments (A & E). Some students had one clinical placement

whereas other students had three placements within seven weeks. Table 2 displays a summary of information about student nurse participants.

Table 2 - Participant information – ERASMUS students

Pseudonym	Age	Languages Spoken	Languages students had knowledge of	Country of ERASMUS placement	Nursing Speciality
Jon	27	English	No other Language	Sweden	A&E Home Nursing
Gillian	21	English, Irish & German	No other Language	Sweden	Renal Dialysis A& E Home Nursing
Chloe	21	English	No other Language	Sweden	Renal Dialysis A & E Home Nursing
Louise	31	English	French & Spanish	Sweden	Renal Dialysis A & E Home Nursing
Kate	24	English	French & Spanish	Finland	Renal Dialysis, home care & surgical care
Margaret	21	English	French & Spanish	Finland	Renal Dialysis, home care & endocrinology
Heather	20	English	French	Finland	Emergency ward
Pamela	20	English	French	Finland	Intensive care & cardiology
Evelyn	20	English	None	Italy	Intensive care
Helen	20	English	None	Italy	Intensive care
Susan	20	English Gaelic	None	Italy	Oncology Intensive Care
Aileen	30	English	None	Spain	A & E Intensive Care
Linda	24	English	None	Spain	A & E Intensive Care

3.5. Data Collection Methods

Two data collection methods were used to enable me to gain a holistic understanding of the phenomenon. A trustworthy and comprehensive understanding of the phenomenon can be enhanced by using different research methods (Maltby, Williams, McGarry and Day, 2010). The research methods used in this research inquiry included reflective diaries and semi-structured, one-to-one interviews. Niewiadomy (2012) agrees that these are appropriate methods for data collection within a case study methodology. I had initially considered using unstructured observation (Parahoo, 2014) but this was rejected due to the time factor as it was not feasible to observe the constraints that students encountered through not speaking the language in four host countries. Other factors which were taken into consideration were, the possible difficulties I could encounter observing students' interactions with patients when I did not speak the language of the host country. I would have had to rely on a mentor's support whilst observing the students in clinical practice. I also considered the ethical implications of the intrusion into the patient's private space (Parahoo, 2014) and permission from gatekeepers. Good interpersonal and observational skills are necessary for unstructured observation (Polit and Beck, 2006). My interpersonal skills would have been limited in the host country due to the constraints of language. The time factor travelling to host countries to observe each individual student and the cost that this would ensue was taken into consideration. After much deliberation I decided to use a student recording diary.

3.5.1. Rationale for using Diaries

Diaries are beneficial for recording day to day information of experiences (Niewiadomy, 2012) in nursing practice. The students' clinical experience in the host country was normally three or four days a week over a seven to nine-week placement. Although the students spend a twelve-week placement in a host country the recordings in the diary focused on issues related to clinical practice.

Diaries can be useful in qualitative research to capture aspects of participants' experiences and thought processes (Barbour, 2008). Students were asked to make entries in their diaries about the difficulties and challenges they encountered in clinical placement due to not speaking the language and identify the benefits of a clinical placement in a host country. They were instructed to spend no longer than 30 minutes a day writing down thoughts and feelings about their experiences (Polit and Beck,

2006) during their time in clinical practice. This is classed as an interval contingent diary (Thomas, 2016, p.191). I decided to use interval contingent diaries instead of an event contingent diary to capture students' feelings about the difficulties and challenges that they encountered in clinical practice and the perceived benefits of an ERASMUS placement on a day to day basis. Event contingent diaries can be useful, but entries may only be made when an event (Thomas, 2016) which is perceived relevant occurs. I felt that recording information on a day to day basis cultivated daily observation and reflection (Hyers, 2018) about the communication challenges and the perceived benefits of an ERASMUS clinical placement. This enabled me to answer research questions, 1 and 3 cited in section 1.2. (p.3). In addition, some students also provided information about mentor support within their diaries. This information was related to question 2 about the support mechanisms presently in place for students who cannot speak the language in the four host countries.

3.5.2. Rationale for Using Semi-structured Interviews

One-to-one semi-structured interviews were carried out with the student nurses who had an ERASMUS placement in Sweden, Finland, Italy and Spain and mentors who supervised ERASMUS students in host countries. I concur with Gerrish and Lacey (2010) that semi-structured interviews enable researchers to understand the context when little is known about the phenomenon. However, some researchers prefer using unstructured interviews when little is known about the experience (Parahoo, 2014). While, unstructured interviews are a suitable data collection method within qualitative case study methodologies (Houghton, Casey, Shaw and Murphy, 2013; Parahoo, 2014) they are often difficult to carry out when researchers want participants to concentrate on specific topics (Parahoo, 2014). On the other hand, Yin (2003) suggests that semi-structured interviews are a suitable method for a case study methodology. Semi-structured interviews are beneficial in that they enable researchers to cover a list of topics which they feel should be covered within the research inquiry (Polit and Beck, 2006). I felt that semi-structured interviews were suitable for this study and provided a degree of uniformity during each interview. More details regarding the challenges and advantages of the interviews is provided in section 3.5.6.

3.5.3. Administration

Prior to the interview students and mentors were sent participation information leaflets (Appendices B & C) and consent forms (Appendices D & E). Information regarding the content of the participant information leaflets is provided in section 3.8.1. Once informed consent was provided, arrangements were made for a suitable time to meet with the students prior to going to the host country. The reason for this was to provide a verbal explanation about the diaries and how they would be used as a data collection tool (Barbour, 2008) and as a memory aid during the interview (Denham, Taylor and Humprey, 2017)

On return from the host country arrangements were then made to interview the students. These interviews took place at a time and at a venue within Scotland, which was convenient for the student. Most of the interviews were carried out during the day, only three interviews took place when the students were doing a night shift in clinical placement. All interviews took place in a quiet room where there was no danger of being disturbed. The other staff on the ward were made aware that an interview was taking place. The same principle applied to the mentor interviews which took place in host countries.

An interview guide was developed for students and mentors (Appendices F & G). Although interview guides in semi structured interviews consist of topics which the researcher wants to cover (Thomas, 2016), I phrased these as open questions. These questions reflected the sub questions in this research inquiry. I felt that the interview guide was beneficial as it enabled me to ensure that the research questions were addressed (Polit and Beck, 2006). The mentors were asked about difficulties and challenges students encountered in clinical practice due to not speaking the language of the host country and the perceived benefits of an ERASMUS placement for students. They were also asked about the support mechanisms in place for student nurses who were on an ERASMUS placement. Both students and mentors were asked the same questions. In addition to the three questions in the interview schedule, students were asked which clinical placements they worked in during their ERASMUS experience. This was to enable me to gain an understanding of the environment where the experience took place. Both mentors and students were asked which languages they could speak fluently. This provided me with a deeper understanding of the educational context of the case (Stake, 2006). Moreover, the interview method

allowed me to answer the four research questions identified in Chapter 1, section 1.2. (p.3).

3.5.4. Triangulation

According to Polit and Beck (2010, p.497) triangulation is the use of several data collection sources to draw assumptions about what establishes truth about a phenomenon. Data and method triangulation were used. Data triangulation includes person, time and space (Polit and Beck (2010, p.497). I decided to use person and space triangulation. Person triangulation is a term used for collecting data from people of different ranks or positions (Polit and Beck (2010, p.497) and space triangulation is collecting data from different sites. In this study, person triangulation was the collection of data from student nurses and nurse mentors whereas space triangulation was the collection of data in four different countries.

Gerrish and Lacey (2010) point out that method triangulation is the use of different methods from the same paradigm or different paradigms. The use of different methods enhances the credibility of the research findings (Gerrish and Lacey, 2010). In this study, I used two data collection methods from the same paradigm. These were semi-structured interviews and unstructured diaries. Casey and Murphy (2009) recommend collecting data from multiple sources to enable a complete picture of the phenomenon to be revealed. Furthermore, Stake (2006) also suggests that varied sources of data collection can provide a holistic view of the phenomenon. Triangulation within multiple case studies is valuable as it helps the researcher to ascertain multiple realities and diverse opinions regarding a quintain (Stake 2006, p.38). Figure 4 illustrates the types of triangulation used within this study and identifies the research questions answered by each data collection method.

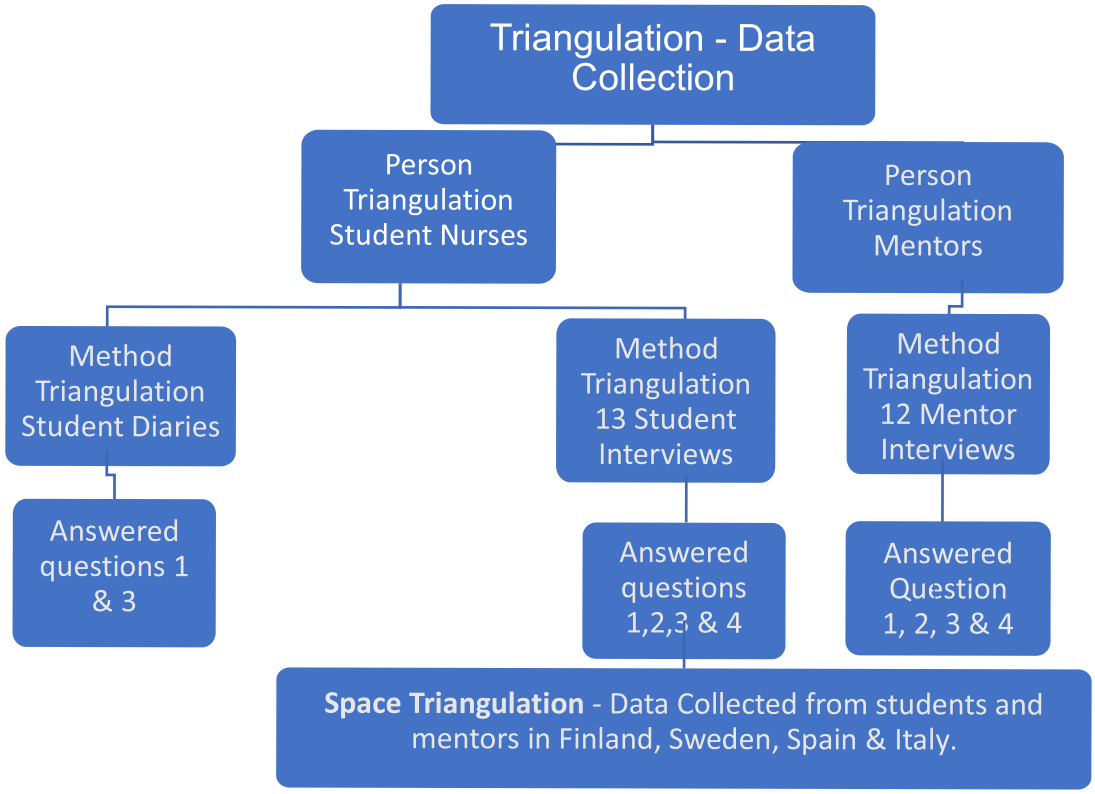

Figure 4: Data Collection & Questions Answered by Each Research Method

3.5.5. The Challenges and Advantages of diary entries as a research method.

Diaries were used as a data collection method as well as a means of facilitating recall during the interviews. Denham, Taylor and Humprey, (2017) suggests that this method improves recall and can enhance the quality of the data collected. Although thirteen students were asked to make diary entries four days a week over a seven-week period, only eleven students recorded information about the difficulties they experienced and the benefits of an ERASMUS placement. Whilst diary entries can provide reliable data one of the disadvantages is that participants may become less diligent in making diary entries if it used for extended periods of time (Bryman, 2008, p.228). While, most students were very meticulous in their diary entries over the seven weeks period, one student only made one entry in her diary on the first day of her ERASMUS placement and another student made one detailed entry after the experience. However, I felt that interval contingent diaries were a valuable research method in that, it enabled me to ascertain how the students' views of the experience changed from the first day to the last day of their clinical placement. In addition, the

diaries allowed me to get an insight into the students' emotions when they made the diary entry.

3.5.6. Challenges and Advantages of Interviewing as a Research Method

Although the mentors were from Finland, Sweden, Spain and Italy, the interviews were carried out in English. I gave mentors the choice of carrying out interviews through Skype or face to face in their own country. The choice of face to face interviews were offered in the host country so that it would not alienate mentors who could not participate in Skype interviews. Seven interviews with mentors were carried out by Skype. Skype interviews are a viable alternative to face to face interviews in a person's normal habitat (Hanna, 2012). Participants can sit in the comfort of their own home during a Skype interview without a researcher invading their personal space (Hanna, 2012; Seitz, 2016). The Skype interviews proved less time consuming than travelling to the host country. However, some technical problems were encountered during one of the Skype interviews. After reconnecting to the Skype number, the sound quality improved. I concur with Seitz (2016) that poor internet connections can have a negative impact on the interview flow. To maintain the interview flow, I summarised what the participant had said and used her own words as much as possible (Seitz, 2016). This also helped to established understanding of the participant's responses (Seitz, 2016) and maintain continuity of the interview.

Two mentors who were interviewed via Skype asked if another person who had a good knowledge of English could be present during the interview as they were apprehensive that they may not understand the questions. In one interview the manager of the unit where the mentor worked was present during the interview and in the other interview the nephew of the mentor was present. This proved beneficial as they were able to translate some questions into the language of the host country for the research participants. Three interviews were carried out face to face with mentors in Finland due to a lack of access to Skype in the hospital. Two interviews were also carried out face-to-face with mentors in Italy. Studies carried out in the natural habitat of participants is a feature of naturalistic case studies (Abma and Stake, 2014). I found it beneficial carrying out interviews in mentors' normal habitat as it enabled me to gain an understanding of the environment where some of the students' experiences took place. It also enabled me to appreciate the difficulties

students may encounter following directions to the different departments within the hospital as the signs of the clinical areas were in the language of the host country.

3.6. Reflexivity in the Research Process

To ensure rigour during the research process, many qualitative researchers use reflexivity. Reflexivity is described as the steps taken to examine one's own beliefs, prejudices and choices in order to ascertain how these may have influenced data collection and the interpretation of the results (Parahoo, 2014, p.253). Jootun, McGhee and Marland (2009) suggests that engaging in reflexivity to understand how one's own beliefs and values can influence the research process can enhance the credibility of the research findings. Jootun et al. (2009) elaborates on this by suggesting that an exploration of beliefs can made the researcher more aware of the potential dangers of presenting one's views instead of those of the participant. To avoid this, I was careful not to ask leading questions during the semi-structured interviews. In addition, Dwyer and Buckle (2009) expands on this by suggesting that the position researchers have as an insider or outsider can have an impact on the research process. Although I had coordinated induction programmes for international students and had participated in an ERASMUS experience for lecturers, I had not had an ERASMUS experience as a nursing student or mentored international students in clinical practice. Due to this I was conscious that I may be viewed as an outsider by mentors in host countries. I was also aware that students may view me as an insider due to my status as a university lecturer. Dwyer and Buckle (2009) suggest that some research participants are more willing to share their experiences with insiders because they feel that they have a better understanding of the situation. However, Bonner and Tolhurst (2002) warns that familiarity with a setting carries risks for insiders of assuming the meaning of the experience rather than seeking clarification of the meaning of it from the research participant's perspective. I was careful not to make assumptions about the meaning of data and if I had any doubts about the meaning of statements in the interview transcripts or diaries, I sought clarification from research participants. This validation process was useful and prevented misinterpretation of the data (Parahoo, 2014).

Allen (2004) provides two different views of the insider and outsider's positions. From an insider's perspective those who are fully immersed in the experience can obtain a reliable and valid account of the phenomenon. In contrast, the data collected from an

outsider's stance is free from potential bias due to the researcher's proximity as an outsider to the research participants (Allen, 2004). I felt that I was able to immerse fully in the experience through having an insider's position as a nurse lecturer within the university. However, the Hawthorn effect was also considered during the interviews (Gerrish and Lacey, 2010). This is where individuals may alter their behaviour or interactions in the presence of the researcher (Moule, 2011) and the danger is that a true view of the phenomenon may not be obtained. In my study, all of the research participants (mentors and students) were very willing to share their views about the difficulties and the benefits of their experiences, unreservedly.

3.7. Data Analysis

Qualitative analysis includes organising the data, identifying themes and patterns in the data and providing an interpretation of the findings (Cohen, et al., 2013). It is imperative that the process of data analysis in qualitative studies is outlined in order that the results are verifiable (Maltby, et al., 2010). I selected framework analysis because it provides a systematic approach and it helps to enhance the transparency of the data analysis (Ward, Furber, Tierney and Swallow, 2013). Ward et al. (2013) indicates that framework analysis comprises of five interrelated stages. These are displayed in Figure 5.

Stages
Stage 1 - Familiarisation – reading the transcripts to became familiar with the data
Stage 2 - Developing a thematic framework – this involves the identification of recurrent themes
Stage 3 - Indexing – applying the thematic framework to the data and using codes or numbers which correspond to the themes
Stage 4 - Charting the data – using themes from the data to develop thematic and case charts
Stage 5 - Mapping and interpretation – this involves identifying patterns in the data and interpreting it

Figure 5: The Stages of Framework Analysis (Ward et al., 2013)

The first stage in framework analysis commences with becoming familiar with the data. Some researchers may get other people to transcribe interviews. I felt that transcribing the interviews was valuable as it enabled me to immerse myself in the data. Transcribing the recorded interviews is a crucial step in data analysis as there is always a danger that valuable data will be lost or distorted in some way (Cohen et al., 2011). The interview data was transferred from a digital voice recorder to the computer. The benefit of this was that I could stop and start the voice recorder during the transcribing process without going back to the beginning of the interview. To become familiar with the data, the interview transcripts and diaries were read and reread several times (Crabtree and Miller, 1999). I felt that this was beneficial in the coding process and it enabled me to crystallise my understanding of the cases (Crabtree and Miller, 1999).

The term codes and themes are the terms used in framework analysis (Ward et al., 2013) thus the reason for using them within my analysis section. Identification of recurrent themes relates to the second stage of framework analysis. Frequently the terms ‘themes’ and ‘codes’ are used interchangeably within research studies (Parahoo, 2014). Codes are labels which are used to describe chunks of data (Miles, Humberman and Saldana, 2014). These labels are in the form of a word or phrase (Parahoo, 2014). On the other hand, a theme is classed as a concept or patterned response which emergences from the data with consistent regularity (Polit and Beck, 2006).

Prior to the first interview and during the interview process a ‘start list’ of provisional codes was developed (Miles, et al., 2014). These were ascribed to chunks of data (Cohen, et al., 2011). The provisional codes or first cycle codes were formulated from the literature review and the subsequent research questions. The first three broad questions were, how the language of the student and the host country, influence the ERASMUS experience, the support mechanisms which are currently in place for students in the host country and the benefits of the ERASMUS experience. It was envisaged that the fourth question which focussed on the relationships between the process of cultural competence and professional learning would be addressed under the provisional code ‘benefits’. The provisional or first cycle codes were ‘communication’, ‘difficulties’, ‘limitations’, ‘strategies’, ‘benefits’ and ‘support’. These codes were revised during the data analysis (Miles, et al., 2014).

Both the manual coding method (Crabtree and Miller,1999, p.168) and NVivo 11 computer software package were used to identify codes. Crabtree and Miller (1999, p.168) indicate that several researchers recommend initial hand coding of printed versions of transcripts. It can be mind-numbing spending hours identifying codes (Crabtree and Miller, 1999), so I found combining both the hand and computer approach to the identification of codes beneficial. Hand coding enabled me to use coloured highlighters to distinguish the different codes within the printed version of the interview transcripts and diaries (Parahoo, 2014). An example of the preliminary analysis is displayed in Appendix H. This demonstrates how colour can be used to identify themes related to the challenges/difficulties of an ERASMUS placement, the benefits of an ERASMUS placements and mentor support. The NVivo 11 computer software package was also beneficial as it enabled me to import my interview and diary transcripts, identify nodes (themes) and do text searches including word frequency queries. This allowed me to count the regularity of the themes within the transcripts. I felt that this enhanced transparency and justified the labels given to each theme. An example of the themes (Nodes) identified through the use of NVivo 11 Computer Software is displayed in Appendix I. Codes and Themes will be discussed in more detail in section 3.7.1.

In Vivo coding was used for second cycle coding. This is a word or a small phrase from the data which reflects the language of the participant (Miles, Huberman and Saldana, 2014). For example, an in vivo phrase could be ‘feelings of frustration’. In vivo coding is suitable for all qualitative studies, but it is particularly suitable for novice researchers (Saldana, 2013). Similarities and differences in codes and themes within each of the four cases were then examined (Miles, et al., 2014).

Although, stage four of framework analysis indicates that the data should be used to develop case charts, this was omitted and a more informal approach to data charting was taken. Instead of developing a chart for each individual case, the four cases became part of the interconnected broader picture (Thomas, 2016) and were presented as themes and sub-themes within a flow chart (Figure 8) in Chapter 4.

I found that stage two and five are interrelated. Stage two is the identification of recurring themes whereas in stage five similarities and differences in each of the cases and themes were identified, interpreted and then amalgamated. This is a strategy recommended within framework analysis (Ward et al., 2013). It enabled me to get a better understanding of the quintain or phenomenon (Stake, 2006).

Framework analysis was also applied to the narratives from the diaries. Verbatim quotations from the narratives in the diaries and the interview transcripts helped to illuminate the themes (Cohen, et al., 2011). An example of the verbatim quotes is displayed in Figure 6. Accents Inhibit Comprehension. Pseudonyms were used to protect anonymity.

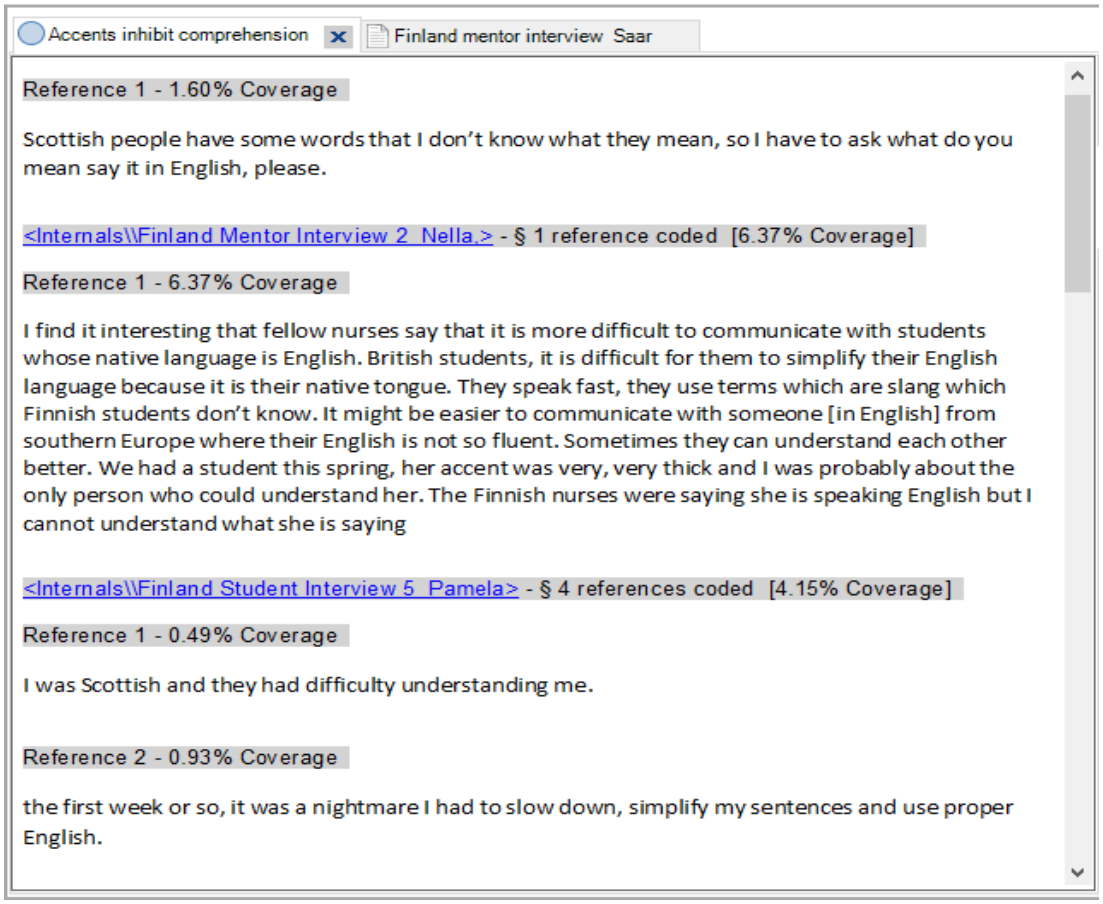

Figure 6: Verbatim quotations within the theme 'Accents inhibit Comprehension'.

3.7.1. Codes and Themes

Following data analysis, the provisional codes were modified. The words from the participants' own language which was repeatedly used within the data was classed as codes (Miles, Huberman and Saldana, 2014). The codes were 'communication,' 'snippets,' 'strategies,' 'support' and 'benefits.' As indicated in vivo coding was used. One word which was from participants' own language was 'snippets.' An example of this has been provided.

> *"*It was time consuming [for mentors] to translate everything for me. Therefore, the most I could get was a snippet of information before we went into the room"

I felt that term 'snippets' may have different connotations so the term 'minimal information' was used instead. This can be classed as a descriptive code as it summarises the topic discussed (Miles et al., 2014) by the participants in the interviews or diary entries.

Six main themes were identified. Themes are salient or common phrases which occur repeatedly within the data (Polit and Beck, 2006). The first theme was 'communication challenges' and the three sub-themes were 'communication with staff', 'accents inhibit comprehension', and 'difficulty communicating with patients'. An example of the quotations related to 'accents inhibit communication' was displayed in Figure 6.(p.74). The second theme was 'minimal amounts of patient information' and the supporting sub-themes were 'handover reports' and the 'inability to read and document patient information'. Communication challenges was identified as the first theme as it was related to direct verbal communication between the student and another person. The second theme is related to the first theme as it focusses on communication difficulties which resulted in some students obtaining minimal amounts of information. This was due to being unable to participate in staff handovers reports (Meum and Ellingsten, 2011) about patients' care and being unable to read patients' documentation. The third theme was 'isolation' and the sub-themes were 'feeling like an outsider' and developing 'a sense of belonging.' This was identified as the third theme as it is linked to communication challenges and difficulties.

The fourth theme was 'strategies used to communicate' and the sub-themes were 'speechless communication' or non-verbal communication and the use of 'search engines and apps' to overcome difficulties during interactions. This theme was a natural progression from themes one, two and three. Frequently students had to send wordless cues when they realised that individuals did not share a common language with them. Another reason for including it as a fourth theme was the fact that during each social interaction non-verbal cues are sent to the recipient (Leathers and Eaves, 2016) and verbal and non-verbal communication can be used during each social encounter.

The fifth theme is ‘support mechanisms’ and the sub-themes were ‘induction programmes’, ‘coordinator support ‘and ‘mentor support.’ This theme was placed fifth as the support mechanisms enabled students to overcome the difficulties encountered during their placement and subsequently become part of the nursing team. The sixth and final theme was ‘benefits’ of an ERASMUS experience. The two sub-themes which emerged were ‘personal development’ and ‘professional development’. This theme, ‘benefits’ was placed last as it focussed on the outcome of students’ ERASMUS experiences.

3.8. Ethical Approval

Ethical approval was sought from the School of Education Ethics Committee (University of Strathclyde, 2013). Research Ethics committees ensure that ethical principles will be adhered to during the research process (Moule and Goodman, 2009) and the dignity, wellbeing, and safety of all the participants who will be involved in the study is considered. Following ethical approval from Strathclyde University, the chair of the ethics committee in the university where I worked was also informed about the study as I was using students from the University of West of Scotland as research participants. Cohen et al. (2011) points out, that researchers have an ethical responsibility to inform gatekeepers of their study. Gate keepers in, Finland, Sweden, Spain and Italy were informed about the study and permission was sought to interview mentors in these countries. Participant information sheets and consent forms were sent to the gate keepers by email. Gate keepers can be a useful resource in publicising the study within their organisations (Robinson, 2014). In my study the gate keepers included university ERASMUS coordinators and nurse managers in the host country. The ERASMUS liaison lecturers in Finland, Sweden, Spain and Italy forwarded the participant information sheet (Appendix C) to the managers in clinical placements in the host countries. In Italy approval had to be sought from the director of health and the director of nursing.

3.8.1. Ethical Issues

Ethical principles should be applied from the initial planning, data collection, storage of the data to the dissemination of the research findings (Moule and Hek, 2011). According to Polit and Beck, (2006) the three principles which are the foundations for ethics in research are justice, respect for the dignity of research participants and

beneficence. The principle of justice includes treating individuals in an equal way and not discriminating against individuals due to their lifestyle, age or culture. It also includes treating people who wish to withdraw from a project fairly (Polit and Beck, 2006, p.91). This is an issue which I had to take into consideration as the students who were recruited were from the university where I was employed. To address this issue, students were reassured that participation or non-participation in the research study would not influence their grades or progress within the BSc in Adult Nursing Programme or any aspect of their ERASMUS status. The British Education Research Association (BERA) 2011) also point out that one of the potential difficulties is that students may feel under duress to participate in a research study because the person carrying out the study is a lecturer from the university where they are presently studying. It was for these reasons I decided not to invite my personal students, or the students I was teaching and who had applied for an ERASMUS experience to take part in this study. I also took into consideration that mentors may also feel under duress to participate in the study as the university where I was employed had a bilateral agreement for student exchange with universities in the host countries (European Commission, 2014a).

Participant information forms (Appendices B & C) were sent to the mentors and students to enable them to make an informed decision to participate or not to participate in the study (Parahoo, 2014). Polit and Beck, (2010) point out that individuals who participate in research studies should have the right of self-determination and be able to make a voluntary decision to participate in a research study without having a penalty imposed on them. Mentors were informed that participation or non-participation would have no effect on their involvement in mentoring student nurses from the University of West of Scotland.

Both students and mentors were assured that confidentiality would be maintained during the research process. Participants were given a pseudonym to ensure that they would not be linked to the data (Moule and Hek, 2011). Thomas (2016) also recommends that the names of the organisation where participants work should not be disclosed. To protect anonymity, the names of the hospitals where the mentors worked were not disclosed within my thesis. Another aspect of confidentiality which was taken into consideration was data protection and the storage of data. (de Chesnay, 2015). The participants were assured that the interviews transcripts and any other data linking them to the study would be stored in a locked cupboard and

only the person carrying out the research and her supervisors would have access to this data.

3.9. Summary

This chapter highlighted the underpinning ontological and epistemological beliefs of social constructivism and provided the reason for using this paradigm for this research inquiry. As multiple realities and inductive reasoning are inherent features of the social constructivism paradigm, an outline was provided as to how this paradigm is linked to qualitative methodology. The reason for using qualitative multiple case studies was then discussed. Each case was classified as a location (country) where the Scottish ERASMUS students had their clinical placement. The chapter provided a justification for using semi-structured interviews and interval contingent diaries as research methods. The pros and cons of using face to face interviews in the host country and Skype interviews were then discussed. Skype can be a useful resource, but technical problems and the sound quality presented difficulties during one of the interviews.

The Chapter highlighted the rationale for using framework analysis and discussed first and second level coding. It also indicated how the combination of both the manual approach to identifying themes and the NVivo 11 computer software package had specific advantages. The manual approach helped me to become fully immersed in the data. This included reading and rereading the transcripts and highlighting the themes in colour whereas the NVivo data management tool, enabled me to retrieve data, create themes and identify the frequencies of reoccurring themes. This Chapter concluded by highlighting the ethical principles which were applied to each step of the research process.

Chapter 4: Findings and Discussion

This chapter answers the research question: How does the constraints of language influence cultural competence and professional development in an ERASMUS placement for student nurses?

To address the overarching question within this research enquiry, the following sub questions were posed.

- How does the language of the student and the language of the host country influence the ERASMUS cultural experience?
- What support mechanisms are presently in place for students who cannot speak the language of the host country?
- How do mentors and students perceive the benefits of an ERASMUS experience?
- What is the relationship between the process of cultural competence and professional learning?

The research findings for this research inquiry were obtained from students' diaries and one-to-one interviews with twelve mentors and thirteen students. As already indicated in Chapter 3, a case study (Stake, 2006) methodology was selected for this study. The term case was classed as a country where the students had their ERASMUS placements. These countries were Finland, Sweden, Italy and Spain. This Chapter provided an outline of the educational, social and cultural context of the cases. This was followed by a presentation of the research findings obtained from the data collected from each of the research participants. Each case focused on student nurses' clinical experiences in both hospital and community settings in each of the four countries.

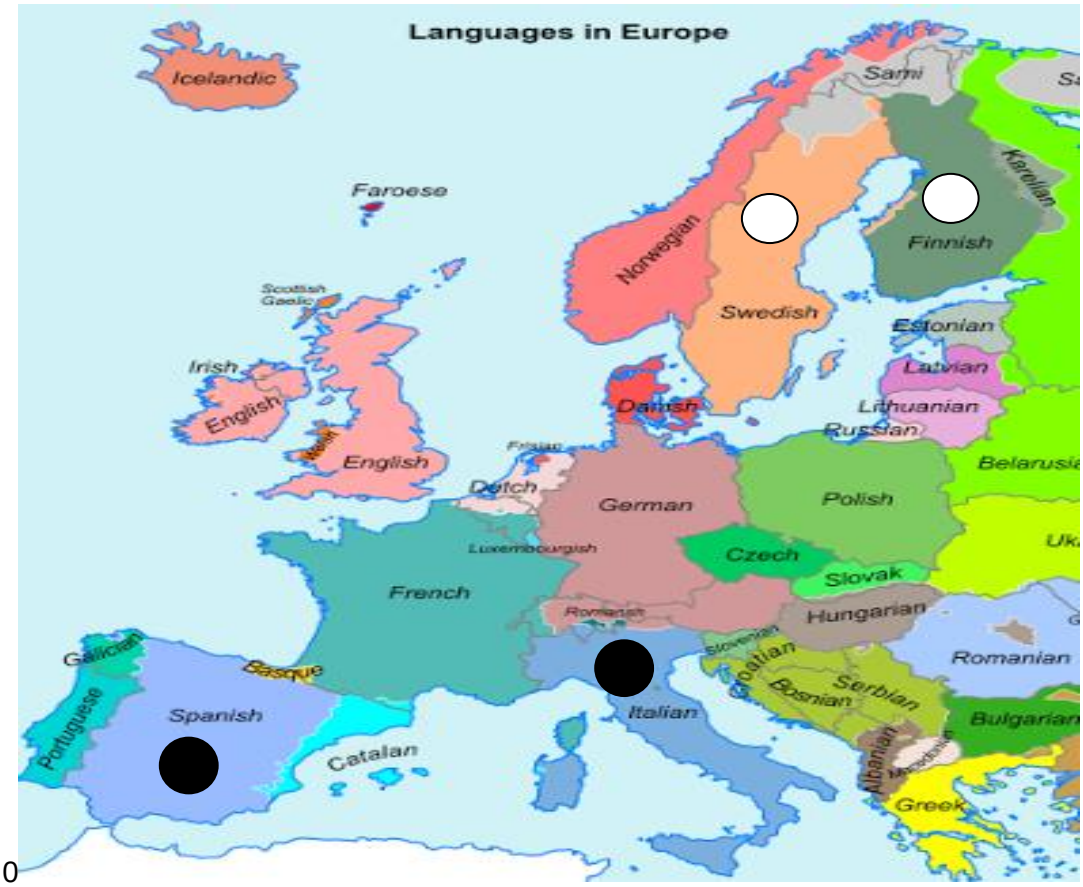

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Figure 7: Nordic and Southern European Countries

The white circles indicate the two Nordic countries the students were placed in and the black circles indicate the two Southern European countries the students were placed in. The map also shows the languages spoken in these countries. Eight students had their ERASMUS experience in two Nordic countries. Five students had placements in Southern European countries. The pseudo names of the students and mentors in each of these countries were cited in Tables 1 & 2 in Chapter 3.

4.1. Context of Cases

According to Stake (2006) each case investigated is a complex, multifaceted unit located in its own setting. The context or background of a case can include educational, social and cultural elements. These elements were reflected in the research findings. The cases are clinical practices in two Nordic countries (Finland and Sweden) and two Southern European countries (Spain and Italy). Although most people in Finland spoke Finnish, one student claimed that some patients over 60 years of age spoke Swedish. Swedish and Finnish are the two official languages

of Finland. However, a Eurobarometer survey carried out in 2012 indicated that 44% of Finnish respondents could have a conversation in Swedish and 70% spoke English fluently (European Commission, 2012). Likewise, the ERASMUS students who had a placement in Sweden commented that mentors had a very good knowledge of English. This is supported by the Eurobarometer survey which indicated that 86% of respondents in Sweden could hold a conversation in English (European Commission, 2012).

In the two Southern European countries, Italy and Spain students reported that most of the hospital staff could not speak English. This finding could be linked to the Eurobarometer survey which found that only 22% of Spanish respondents could have a conversation in English whereas 34% of Italian respondents could have a conversation in English (European Commission, 2012). This survey shows that the Nordic respondents in this survey had a higher English proficiency than Southern Europeans. My research findings regarding the communication challenges which students encountered in Nordic and Southern European countries will be discussed in more depth in section 4.3.

4.1.1. Educational Context

The educational context which influenced the cases were online language assessments and the skills learnt during clinical practice. Three students undertook an online language assessment prior to going to the host country. Two of these students had a placement in Spain and one had a placement in Italy. As stated In Chapter 1, the online language assessment was developed by ERASMUS+ to facilitate language development (European Commission, 2014a**)** because language learning is one of the aims of an ERASMUS experience (European Commission, 2017). At the time of carrying out this study, the online language assessment was available in six languages but Swedish and Finnish were not included (European Commission, 2014a). This study was commenced in the year 2015 and language testing did not commence at the university where this study took place until 2016.

Two of the students who had an ERASMUS placement in Italy during 2015 did not undertake a language test. The three students, who did the language assessment, claimed that they achieved the lowest grade, but they increased it by one level when they had a post test. Two students in Finland attended Finnish language classes but did not undertake a language test before leaving the country to ascertain if their

language skills had improved. Students in Italy, Sweden and Spain did not attend language studies at the university. However, Gillian a student who had a placement in Sweden stated that she was offered Swedish language studies at the university, but she was unable to attend these classes due to clinical placement commitments. Table 3 identifies the students who had language testing prior to going to the host country and those who engaged in language studies in the host country. Language learning will be discussed in more depth in section 4.8.1.

Table 3: Educational Context – Students' Language Development

Pseudonym	Year	Country	Pre-Language Testing	Engaged in Language Study at the University
Jon	2015	Sweden	No	No
Gillian	2015	Sweden	No	No
Chloe	2016	Sweden	No	No
Louise	2016	Sweden	No	No
Kate	2015	Finland	No	Yes
Margaret	2015	Finland	No	Yes
Heather	2015	Finland	No	No
Pamela	2015	Finland	No	No
Evelyn	2015	Italy	No	No
Helen	2015	Italy	No	No
Susan	2016	Italy	Yes	No
Aileen	2016	Spain	Yes	No
Linda	2016	Spain	Yes	No

The Scottish ERASMUS students indicated that student nurses carried out more clinical skills in the two Nordic countries and the two Southern European countries

than students in Scotland. This was an interesting observation as tuning has taken place through the Bologna agreement to standardise nurse education programmes within each country in Europe (Davies, 2008; Collins and Hewer, 2014). A participant in a study carried out by Keogh and Russel-Roberts (2009) also refers to students putting up blood for transfusions in Finland but implies in Germany this would not happen. However, the number of participants in Keogh and Russel-Roberts (2009) study are too small to generalise findings. On the other hand, it highlights the possibilities of students working above their limitations in host countries. Reference was made to clinical skills in section 4.8.2.

4.1.2. Social Context

Another external influencing factor was the supportive networks. Nine students were placed in the University Halls of Residence in host countries whereas two students (Chloe and Louise), who had a placement in Sweden and two students (Linda and Aileen) who had a placement in Spain stayed with families in private homes for the duration of their ERASMUS experience. The family which the two students stayed with in Spain, taught the students Spanish. On the other hand, the Swedish family who provided accommodation for the other two students, wanted to perfect their English linguistic skills so they communicated with the students in English. Another social factor which influenced the ERASMUS experience was that some students had an induction in the host university whereas other students had a hospital-based induction/orientation. This was discussed in more detail in section 4.7.1.

As already stated in Chapter 3, the clinical specialities which the student nurses were placed in were accident and emergency department, intensive care unit, surgical unit, and home care. The duration of these placements varied. Some students had three clinical placements whereas other students had only one placement in the host country over a period of seven weeks. This meant that the time spent in each placement varied. Some placements were less than two weeks in duration. Although one student claimed she was happy with short placements, a study by Levett-Jones, Lartman, Higgins and McMillan (2008) indicated that students took at least two weeks to settle into a ward and to develop a sense of belonging. This was highlighted within section 4.5.2.

4.1.3 Cultural Context

Although the four countries are within the European Union they are embedded in diverse cultures. Mentors and ERASMUS students in Finland indicated that Finnish people are shy and reserved and were initially reluctant to speak English but once they gained confidence in speaking this language, they could speak it fluently within a few days. Another attribute perceived was Finnish nurses were unruffled in clinical practice and had patience with the ERASMUS students. Student Heather compared her Finnish placement to clinical experience in Scotland:

> "In Finland they have more patience with you as a student and because they are so laid back, they don't run around feeling stressed. I feel you must have patience to make the learning experience beneficial whereas here [in Scotland] the nurses can be too busy to go through things with you".

Interview - student nurse Heather, Finland

It is noteworthy that a study carried out in Finland by Kaihlannen, Lakanmaa and Salminen (2013) also found that students perceived understanding, patience and clinical expertise to be the qualities of a good mentor. A student who had a placement in Italy also commented about the Italian stereotype being friendly and this was obvious in clinical placement. Although students in the other two countries (Spain and Sweden} did not identify that staff were more relaxed in practice than in the UK, they spoke very highly of their mentors. This was discussed in more detail in section 4.7.3.

Students who had an ERASMUS placement in Sweden indicated that Swedish people were very health conscious. They commented that nurses took proper breaks during working hours and ensured that other members of the ward team did likewise. Tea and coffee machines and fruit were provided free of charge for the staff in a room beside the nurses' station. Students also claimed that the patient's food in Swedish hospitals is better than the UK. Chloe referred to this in the following comment.

> "In Sweden staff would sit in the morning and have a piece of bread with loads of vegetables on top like cucumber and things like that. The patient's meals are so much better in Sweden in comparison to here"

Interview - student Nurse Chloe, Sweden

This is an interesting observation made by Chloe. It is a well-documented fact that good nutrition in hospital can improve patients' clinical outcomes (Tappenden, et al., 2013). Furthermore, students also commented there was not the same hierarchical structure in hospitals in Sweden, Finland, Italy and Spain as what there is in Scotland. Hierarchical culture is described as an ordered organisation which has a leader. It is bounded by policies, rules and predictability (Wager et al., 2014). In contrast to this depiction of a hierarchical structure, the students described Scottish organisations as having a top down structure in which emphasis is put on the rank of individuals and their perceived importance. The ERASMUS students agreed that not having a hierarchical structure had a positive impact on patient care as different points of view about patient care can be voiced and respected. This view is supported by Lancaster, Kolakowsky-Hayner, Kovacich and Greer-Williams (2015). Their study found that doctors view themselves as the principle decision maker. On the other hand, Lancaster et al. (2015) suggests that a conductorless orchestra model in clinical practice which values the opinions of care assistants, nurses and doctors enhances patient safety. This model was evident in the European countries where students had placements. In addition, some students commented that doctors, nurses, physiotherapists and care assistants had tea together but in Scotland, this is not common. They felt that this helped to improve multidisciplinary relationships in clinical practice. It also helped to enhance their ERASMUS experience as they got to know members of the multidisciplinary team.

Differences in the British and Spanish culture were also noted by both mentors and students in Spain. They commented that families in Spain stay for extended periods of time with patients in hospital. The Spanish culture value family interdependence whereas other cultures such as Anglo Americans value personal independence (Galanti, 2014). Students had to adapt to having patients' families around in the wards for longer periods of time than what they would do in Scotland. All the students indicated that they became more aware of culture through their ERASMUS experience. This is one of the elements of cultural competence in nursing (Camphina-Bacote, 2002). Cultural elements will be discussed in more detail in section 4.8. of this Chapter and in the application of the theoretical framework in Chapter 5.

4.2. Themes and Subthemes

The sequence of the five themes and subthemes identified within student diaries and mentor and student interviews was discussed in section 3.7.1 of the Methodology Chapter. Figure 8 in this Chapter provided an overview of the themes and sub-themes. The arrows were positioned from left to right and indicates the sequence of the themes and the order in which they were discussed within this Chapter. The arrows at the bottom of each theme identify the sub-themes.

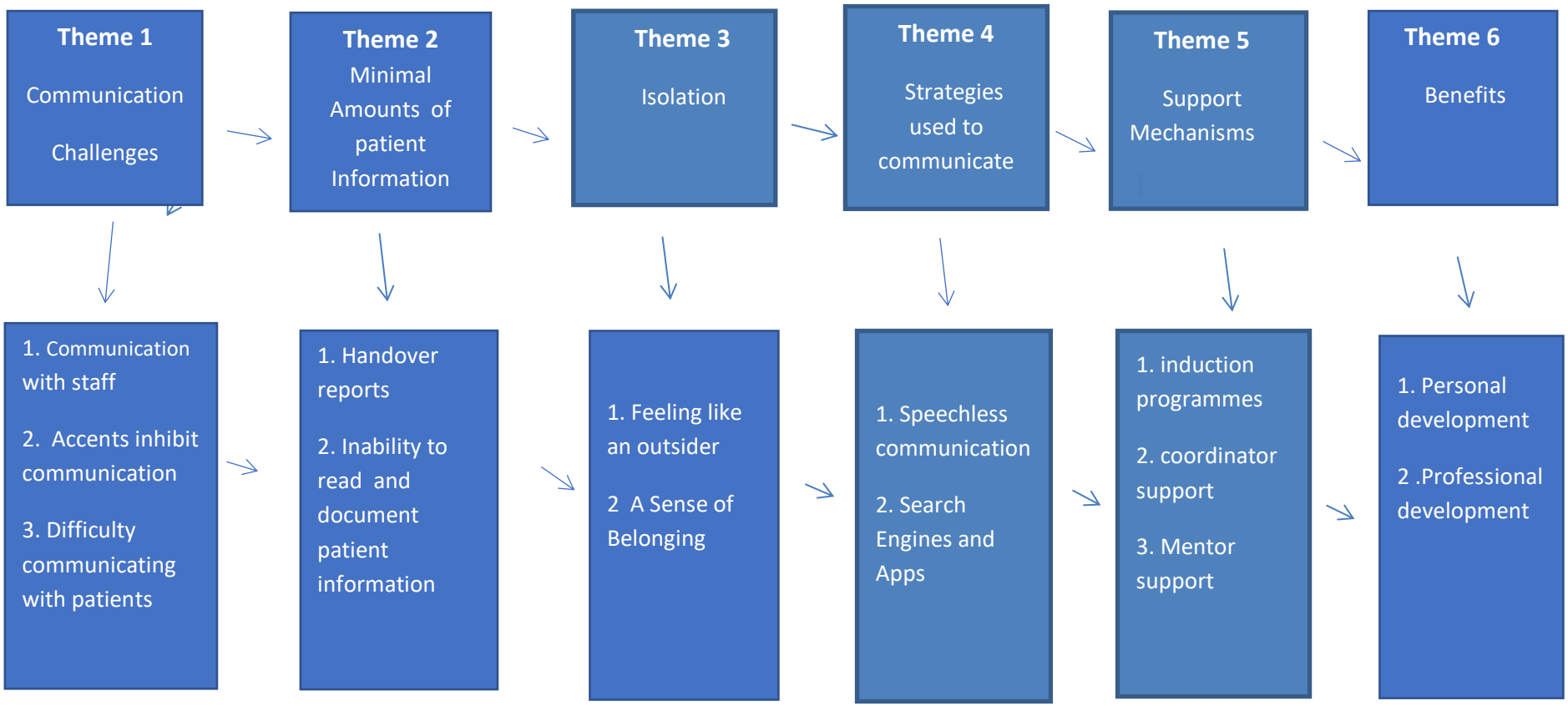

Figure 8: Themes and Sub-themes

4.3. Communication Challenges

The word ‘communicate’ was used 57 times and the word ‘communication’ was identified 169 times within the interview transcripts and students’ diaries. These words were cited in phrases about students’ communication with mentors, other members of hospital staff and patients. The three sub-themes are communication with staff, accents inhibit communication and difficulty communicating with patients.

4.3.1. Communication with staff

Although the students had a mentor who spoke English, some students who had ERASMUS placements in Spain, Italy, Finland and Sweden indicated that they had difficulty communicating with other members of the hospital staff. During an interview Linda who had a placement in Spain stated:

> “With regards to the placement it was difficult ... in the whole hospital I could count on my fingers the number of people who could speak English”.

Interview - student nurse Linda, Spain

Students who had placements in Spain and Italy appeared to have the expectation that more hospital staff would speak English. This was confirmed by the comments made by Aileen, a student who had a placement in Spain.

> “I hadn’t learnt Spanish before I went to Spain and I was naive and under the impression that everyone would speak English”.

Interview - student nurse Aileen, Spain

The students’ comments could be construed as a form of linguistic imperialism (Phillipson, 2016). This is an assumption that the English language should be transferred to people in other countries. On the other hand, English has become the lingua franca of higher education and students may not perceive it necessary to learn a foreign language (Jenkins, 2015). The NMC (2011) have indicated that students should have essential language skills for participation in learning activities and direct patient care. They don’t stipulate that the language skills should be the language of the host country during a student’s ERASMUS experience. As already indicated in Chapter 1, student nurses who come to the UK to engage in an ERASMUS

programme must be proficient in English whereas there is no requirement for outgoing student nurses to be proficient in the language of the host country during an ERASMUS experience. This can foster a form of language complacency.

During an interview a student who had a placement in an intensive care unit where doctors were always present, stated:

> "I couldn't collaborate with the doctors because of the language barrier. The doctors couldn't speak English. I found the way to overcome that was to give the information to my mentor who was English speaking and she would give the information to the doctors".
>
> Interview -student nurse Helen, Italy

Helen made the correct decision informing her mentor about concerns or new information about the patient's condition (Standing, 2017) as a breakdown in communication or incomplete information can compromise the patient's well-being (Bucknall et al., 2016)

Students in Spain and Italy commented that some hospital staff did not have knowledge of English and therefore could not converse in this language whereas in Finland, most of the staff had knowledge of English but did not have the confidence to speak in this language. This sentiment was reflected in a comment made by student nurse Heather during an interview.

> "Sometimes staff wouldn't speak at all. There were only a few who didn't speak at all. Then there were some [staff] who would say 'bad English, bad English'. I had one person who said that and then my mentor said to her, can you take Heather [with you] when you cannulate that patient? She ... was able to teach me how to do it in English yet she had said her English was bad".
>
> Interview - student nurse Heather, Finland

Heather commented that this nurse who was not her mentor was able to use English to teach her how to cannulate a patient. Margaret who had a placement in Finland also spoke about a similar experience in a renal dialysis unit and an endocrinology unit. She stated:

> “Initially they [the nursing staff] were worried that their language skills were not up to scratch and they would embarrass themselves, but as they came out of their shell, they proved to be chatty, confident and excellent friends”.
>
> Diary - student nurse Margaret, Finland

Two students and two mentors in Finland suggested that Finnish people are reserved and shy and this was a reason for their initial reluctance to use English. However, within a few days the nursing staff felt confident to converse in English. Although, students who had their ERASMUS experience in Sweden, commented that most of the staff spoke English, one student asserted in her diary that one member of staff appeared not to understand her. Chloe stated:

> “She [the registered nurse] was lovely but was limited in English. I offered my help, but she declined, I don’t think she understood what I meant, or she didn’t have confidence in me”.
>
> Diary - student nurse Chloe, Sweden

This student did not identify the nursing procedure that she had offered to help the registered nurse carry out and did not provide additional information about the reason for suggesting that this member of staff was limited in English. This is another example of how students had an expectation that all nursing staff would have a good knowledge of English. Chloe implied in her diary that this was her first day working with this registered nurse. Another explanation for refusing the student’s offer of help could be that the registered nurse had not had the opportunity to assess the student’s clinical competence to carry out the procedure. Prior to delegating a procedure to another person, it is important that an individual’s skills acquisition, knowledge and experience to carry out the task are taken into consideration (Hasson, McKenna and Keeney, 2012). Chloe’s diary a few days later indicates that she was working with mentors in a more permanent basis and began to feel part of the ward team. Despite initial communication difficulties all students attained their practice competences. These competences were identified in section 1.6.(p.13-14).

4.3.2. Accents inhibits comprehension

Accent is classed as the phonological features and patterns in speech (Derwing, Fraser, Kang and Thomson, 2014). The geographical location and social class can

play a part in the phonological features of an individual's speech (Derwing et al., 2014). Some people in the host countries were not familiar with the Scottish accent and could not understand what some students were saying when they conversed in English. Difficulties in comprehending what students were saying was identified in 12 sources (diaries and interviews).

Sofia mentored ERASMUS students in the ITU in Italy. She was an experienced nurse who had worked in England. During an interview, she suggested that the English spoken by students was different to that which she had learnt in school. Sofia stated:

> "There were some difficulties with the student's accent. It was very strong, so it was difficult for me and other people to understand what she was saying. The students spoke English but not the type we study at School.... not only could they [the students] not understand Italian I couldn't understand them".

Interview- mentor Sofia, Italy

Ricardo also expressed difficulty understanding the Scottish accent

> "I speak Italian and I speak English but not so well. It was difficult for me to understand what she was asking me. The student I had was from Scotland and she had a strong accent. She spoken so fast and I was always saying 'speak slowly, I don't understand".

Interview- mentor Ricardo, Italy

Students who had placements in Italy also commented that mentors had difficulty understanding them. Mentors in Finland also reported difficulties understanding what students were saying. One mentor who was a fluent English speaker summed up the communication challenges in the following statement.

> "I find it interesting that fellow nurses say that it is more difficult to communicate with students whose native language is English. It is difficult for them to modify their English because it is their native tongue. They speak fast, they use terms which are slang, and which Finnish people don't know".

Interview - mentor Nella, Finland

Nella's comment about the difficulties conversing with a person whose first language is English is supported by a Scottish student who had a placement in Finland. The student stated:

> "We had an ERASMUS class and there were about thirty International students in it. They were from Spain, Italy and everywhere in Europe. We had to speak in English to each other and whenever I spoke in class my friend, a student I became friendly with from Belgium had to say in English what I was trying to say".
>
> Interview- student nurse Kate, Finland

Kate had a strong Scottish accent and it was a student nurse from Belgium who had to interpret what she said. A study by Ockey, Papageorgiou and French (2016) found that strong accents and one which the listener is not familiar with can result in comprehension difficulties. The student from Belgium could have become familiar with Kate's Scottish accent and therefore developed an understanding of it. Furthermore, Ana, a mentor in Spain pointed out that she had difficulty comprehending the accents of students from some regions in Scotland.

In my study only one mentor in Sweden identified that accents could present difficulties. She referred to a student from Ireland who had a strong Irish accent and was doing her BSc in Nursing in a Scottish university. None of the students who had placements in Sweden commented about communication difficulties due to accents. However, the research findings indicated that communication difficulties were not just due to accent, but the rate of speech and the use of colloquial phrases. Two students indicated that they modified their language by not using Scottish slang words, softening their r's and slowing down their rate of speech. When people with strong accents slow their rate of speech it can enhance listener comprehension (Matsuura, Chibia, Mahoney and Rilling, 2014). These factors should have been taken into consideration prior to the ERASMUS experience and this may have reduced some communication difficulties.

4.3.3. Difficulty communicating with patients

Communication is an essential part of nursing care and plays an important part in the nurse patient relationship (Bramwell, 2014). Difficulty communicating with patients was identified in twenty-five sources (diary entries and interviews). Students who had their ERASMUS placements in each of the four countries experienced similar difficulties communicating with patients in a common language.

One student who had a placement in Finland commented in her diary how she was restricted in answering patient call buzzers due to not speaking Finnish.

> "It was difficult for me to answer the buzzers as older people couldn't speak any English and they [the patients] were often quite elderly".
>
> Diary - student nurse Margaret, Finland

These students were in year 3 and at this stage of their nurse education programme; emphasis is put on learning to become an autonomous practitioner. Most students felt that they were operating as a second-year student due to total dependence on mentors for communicating with patients. Heather, a student who had a placement in Finland expressed her frustration in one of her diary entries about being unable to communicate with patients and relatives in a common language. She stated:

> "Patients and relatives are trying to talk to me, it makes me feel hopeless. I look for someone to assist and to help the patient/relatives with their problem. They think I am rude. I am sick saying, I don't speak Finnish, or can you speak English. Most people say that they can speak a small amount of English".
>
> Diary - student nurse Heather, Finland

Students claimed that older patients in Finland and Sweden did not speak English. Students who had placements in Sweden commented if patients were over fifty years of age their English tended to be poor. Some younger patients had a knowledge of English and students conversed with them in this language whilst carrying out nursing procedures. In Finland, students tended to have similar challenges with the language

and had to rely on Finnish nurses to speak to the patient on their behalf. Pamela commented about this in the following statement:

> "As a third-year nurse, I was quite independent in Scotland, but it was difficult for me to do anything without someone there to say she is going to do this or that".
>
> Interview - student nurse Pamela, Finland

This sentiment about relying on someone to explain to the patient about the type of procedure that was going to be carried out was also expressed by a student who had a placement in an accident and emergency department in Sweden. She stated:

> "I always had to wait for someone to come in before I was able to do anything...I had to wait for them to explain to the patient".
>
> Interview - student nurse Louise, Sweden

Explaining the procedure to the patient is essential as it enables them to make an informed decision for the health professional to carry out the procedure or not. Gaining informed consent demonstrates a respect for patient autonomy which is an essential ethical principle underpinning nursing actions (Griffith and Tengnah, 2017). ERASMUS students in Spain and Italy also relied on mentors to explain the procedures to patients. A mentor in Italy stated:

> "I had to tell the patients what we are going to do … the students could not understand a word the patient was saying".
>
> Interview - mentor Sofia, Italy

A mentor in Spain also commented about ERASMUS students being unable to interact with patients. Antonio stated:

> "I feel the main problem is that they cannot understand the main conversation with the patient. They cannot interact with us when we are having discussions with the patient".
>
> Interview - mentor Antonio, Spain

It is obvious from Antonio's statement that mentors took both the needs of patients and the learning needs of students into consideration. One mentor verbalised this

and indicated that she did not want to compromise patient care through students not being able to give instructions to patients in a language that they could understand. Mentors asserted that students cannot practice nursing without communicating with patients. It was for this reason that 3rd year ERASMUS students required more supervision from the mentors than 3rd year national students who could speak to the patient in a common language.

All students spent part of their clinical experience in highly specialised areas. Six students were placed in intensive care units for part of their experience and seven students were placed in accident and emergency or an emergency ward. For this reason, students required an increase in clinical supervision during direct encounters with patients. The mentor of a student who had two placements, one in intensive care and the other in accident and emergency contacted the nurse manager to ask if the student could stay in intensive care. During the interview Ricardo stated:

> *"*The ERASMUS student was to go to the emergency room (A & E) but we felt it was not suitable for a student that could not speak Italian. We preferred to keep her here because here it is easier for someone who does not speak the language".

Interview - mentor Ricardo, Italy

In the emergency room (accident and emergency department) there can be communication challenges because patients are in a clinical placement for a short period of time (Pun, Mattieson, Murray and Slade, 2015). Due to these short-term episodes it can be difficult to build up relationships with patients. Although mentor Ricardo felt that intensive care was easier for someone who did not speak the language, two students in Spain, four students in Sweden and one student in Finland had placements in accident and emergency departments and enjoyed this experience. Furthermore, two students indicated that some patients in intensive care unit were sedated and communication with patients in ICU was different to a ward where all patients are conscious and relied on verbal communication. However, the students did acknowledge that patients required explanations when coming out of a coma. This is a valid comment as some studies have indicated that patients in ICU can experience feelings of frustration and anxiety through communication difficulties (Magnus and Turkington, 2006; Happ et al., 2011). It is therefore important that

nursing staff communicate with patients in a language they can understand in order to reduce fear and anxiety. Patients in the four countries appeared to accept that ERASMUS students did not speak the language of the host country. Some patients who had a knowledge of English tried to converse with the students in this language. Kate who had a placement in Finland was the only student who indicated that one patient appeared annoyed because he could not understand what she was saying. Other patients may have the same views but did not verbalise these.

4.4. Minimal amounts of Patient Information

Sixteen sources and forty-eight references were made to obtaining minimal information about patients. This was due to students' inability to comprehend patient information when it was given in the language of the host country. Secondly, another reason students' obtained minimal amounts of information was due to their inability to read patient documentation.

4.4.1. Handover Reports

Patient information is transferred between nursing staff at the end or the beginning of shifts through handover reports (Meibner et al., 2007). The aim of a handover is to facilitate the continuity of patient care (Meibner et al., 2007). The British Medical Association (BMA) (2004) point out that handover reports are the transfer of professional accountability to another professional or to a multidisciplinary team. There are different approaches to handovers. Some handovers are given verbally at the nurses' station or office and individual patients' reports can be given at the bedside (Meibner et al., 2007; Bruton, Norton, Smyth, Ward and Day, 2016).

Some student nurses in Finland spoke about silent handovers. During this type of handover, no words were spoken and information about patient care was obtained from computerised patient records (Meum and Ellingsen, 2011). Margaret who had a placement in Finland commented in her diary about this type of handover. She stated:

> "As a student nurse, it was difficult as I never received a handover for the patients as they followed a procedure of silent handover, meaning that they spent the first thirty minutes or so reading notes from the computer. All of this was in Finnish. It was time consuming to translate everything for me.

> Therefore, the most I could get was a snippet of information before we went into the patient's room".
>
> Diary - student nurse Margaret, Finland

Margaret comments about only receiving a snippet of information due to nurses using a silent handover. This meant that Margaret would have been totally dependent on her mentor to provide relevant information about the patient. Student nurse Kate who had a placement in Finland also referred to silent handovers in which nurses read computerised nursing notes and care plans. A care plan includes an overview of the patient's problems and relevant interventions or actions (Meum and Ellingsen, 2011).

Both students (Margaret and Kate) did not indicate if the nurses from the previous shift were present during the silent handovers or if discussion followed the silent handover. Silent handovers are often referred to as electronic handovers and frequently this is followed by a staff meeting a few hours later to discuss management of care (Meum, Wagenstein, Soleng and Wynn, 2011). These meetings can enable nurses to clarify any queries that staff may have regarding the computerised patient information.

Meum and Ellingson (2011) suggest that this new electronic approach to handovers encourage staff to reflect on the patient's problems and interventions whereas oral handovers can be a recitation of patients' care plans. Margaret and Kate are the only students who spoke about a silent handover. They pointed out that they could not read Finnish and therefore the mentor had to provide them with a summary of patients' diagnosis and nursing interventions before each patient encounter.

Other students in Finland and Sweden indicated that if all the nursing staff spoke English then the handover would be given in that language. Heather who had a placement in Finland commented that during the oral handover, the person giving it would ensure that all the staff understood English and if not, some explanations about the patient's care would be given in Finnish. Using English may seem a useful strategy in providing students with a good understanding of patient care, but it may foster English imperialism. (Phillipson, 2008).

Linda and Aileen who had placements in Spain indicated that the verbal handover was given in Spanish, but the mentor provided an overview in English. This is evident in a comment made by Linda during interview.

> *"*After the handover report the mentor would say [in English] this is what is wrong with the patient and this what we are going to do".
>
> Interview- student nurse Linda, Spain

This statement identifies the main issues which Linda was told about the patient. Both Linda and Aileen who had placements in Spain felt that they were provided with adequate information about patient care. Two students who had placements in Italy experienced a different approach to handovers. They were encouraged to be present when a multidisciplinary handover was given in Italian. An extract from the diary of a student who had a placement in an Intensive Care Unit in Italy, highlights her feelings about the multidisciplinary handover.

> "The staff all gathered in a circle and a very brief handover was given to all the staff. On the first week, my mentor would translate but after a week my mentor felt it would be beneficial to listen only to our patients. On this handover, it was very strange as nurses and doctors would exchange patient information and what was happening. I was unable to be involved due to the language barrier. I just didn't feel part of the staff. I was an onlooker".
>
> Diary- student Nurse Helen*,* Italy

Helen did not provide a reason for the mentor requesting that she should listen whilst the handover was given in Italian*.* However, Renukadevi (2014) indicates that listening to a language being spoken is pivotal in developing language awareness and it contributes to language proficiency. The mentor may have been encouraging the student to learn a second language which is one of the aims of ERASMUS programmes (European Commission, 2014a).

Some students in Finland and Sweden were encouraged to give handover reports in English. Jon a student who had a placement in Sweden was asked by his mentor to give the handover report for the group of patients which he and his mentor had delivered nursing care to. Jon stated:

> *"*The patient handover reports were usually in Swedish, but I was able to do three to four handover reports in English. The registered nurse I was handing over to, was a fluent English speaker. Usually it was when there were younger members of staff on, I did the handover in English. The younger members of staff were very good with English".
>
> Interview - student Nurse Jon, Sweden

Malone, Anderson and Manning (2016) suggest that to develop confidence and proficiency in this skill, student nurses should be given the opportunity to give handover reports. Jon's comment demonstrates how the nursing team were willing to use a second language to provide a student with an opportunity to do a patient handover. Moreover, in the interest of patient safety it is vital that students provide the nurse receiving the handover report with the correct information (Bruton et al., 2016; Malone et al., 2016). This is reiterated by Samuel a mentor in Finland when he spoke about an ERASMUS student giving a handover report.

> *"*The student gave the handover in English. I was sitting beside the student listening to everything and I was 100% sure that he gave all the information correctly".
>
> Interview - mentor Samuel, Finland

The research findings indicate that in Finland, Sweden and Italy if the staff can speak English then the handovers took place in English. In other occasions, when some staff were unable to speak English the handover was in the language of the host country and the mentor summarised the handover for the ERASMUS students. It was during these occasions that students felt they were only getting small amount of information about the patient. None of the students or mentors in Spain indicated that handovers took place in English.

4.4.2. Inability to Read and Document Patient Information

Patient documentation includes patients' medical history, admission details and care plans (Jefferies, Johnson and Nicholls, 2012). It is vital for nurses to read and understand patient documentation in order to promote continuity of care and patient safety. Eight references were made during interviews and two references were made in students' diaries about the inability to read information about the patient. The

challenges associated with reading patient information were highlighted by both mentors and students. A mentor in Italy compared the differences in supervising an Italian student in clinical practice and an ERASMUS student who could not speak Italian. She stated*:*

> "I can say to an Italian student go and read up about that and tomorrow we will discuss it. With students who cannot understand the language I have to explain it immediately".
>
> Interview- mentor Sofia, Italy

This mentor indicated that because the student did not have knowledge of Italian, she could not ask her to go and read the patient's medical history. Mentors in Sweden, Finland and Spain also identified similar challenges due to students being unable to read patients' medical histories and care plans. A mentor in Finland indicated that patient information was computerised ten years ago, but older files are not computerised. The mentor stated:

> *"*Frequently information has to be obtained from patients' old files. The ERASMUS students could not read the information in patients' health files or document information in patients' files*".*
>
> Interview - mentor Ella, Finland

In addition to the inability to obtain information from files, this mentor also identified that students were unable to document patient information. This information was related to the care provided and patient observations (Jefferies et al., 2012). Eleven participants made comments about documenting information in patients' records. Students in Italy and Spain indicated that mentors encouraged them to provide a summary of the patient's condition in English and then they translated it. This was echoed during an interview by a student who had a placement in Italy. She stated:

> "I told my mentor in English and she documented it in Italian for the other staff".
>
> Interview - student Nurse Susan, Italy

This mentor used a useful strategy of getting the student to think what information should be recorded about the patient and then translated it into Italian. Koskinen and

Tossavainen (2003b) also found that student nurses could not read progress notes about patients' conditions or document information in patients' records. However, Koskinen and Tossavainen (2003b) indicated that mentors encouraged students to provide information in English and the mentor documented the information in the patient's nursing notes. Although students in my study could not read patient information, three students claimed they could document vital signs. Vital signs comprise of blood pressure, pulse rate, respirations and oxygen saturation levels. It is essential that this type of information is recorded timely and correctly to identify any signs of deterioration in the patient's condition (Stevenson, Israelsson, Nillsson, Petersson and Bath, 2016). Some students described how they used strategies to enter vital signs into the patients' computerised records. This is reflected in an extract from an interview with a student who had a placement in Finland.

> "I remembered where (the icons) to click. Sometimes the buttons were pictures instead of words. The observation chart was a little chart button you had to click…the blood pressure had a dash in the middle and the saturation level had the percentage sign, the pulse was a funny word, but I remembered it".
>
> Interview - student nurse Heather, Finland

Although this student could not read patient documentation in Finnish, she was able to memorise the symbols for specific vital signs and this enabled her to record them. Jon a student who had a placement in Sweden stated:

> "I could carry out tasks such as blood pressure, temperature, pulse, respirations, complete fluid balance charts … I learnt the numerical values in Swedish and then recorded them".
>
> Interview- student nurse Jon, Sweden

Three students in Italy, one student in Finland, one student in Sweden and one student in Spain claimed that they could enter vital signs into patients' computer records if the data was numerical. Although some ERASMUS students could record numerical data in patient records none of the students were able to document information about patient care due to not having a knowledge of the language. Good patient record keeping is a basic skill which student nurses must develop (Griffith and

Tengnah, 2017) at an early stage of their nurse education programme. The information entered in patient records must be clearly written, dated and signed (NMC, 2015) in order to provide a vehicle of information for other nurses, protect patient safety and meet the legal requirements of documentation. The students in both the Nordic and Southern European countries were unable to read patient care plans and therefore depended on their mentors to provide additional information about patients and make entries in patients' records about the care provided. Mentor support was discussed in more detail in section 4.7.3.

4.5. Isolation

Cultural loneliness and isolation can be caused by the absence of a familiar cultural or linguistic environment (Sawir, Marginson, Deumert, Nyland and Ramia, 2008). Three references were made by mentors regarding students feeling like outsiders and five students also made comments about feeling like an outsider and feelings of isolation. The two sub-themes are 'feeling like an outsider' and developing a 'sense of belonging'.

4.5.1. Feeling like an outsider

A mentor in Finland provided examples of situations in clinical practice when students may feel like an outsider. Ella stated:

> "There are difficulties …when students cannot participate in conversations. For example, on coffee breaks or discussions with the patient. I feel that students get frustrated and feel like outsiders if they cannot speak the language".
>
> Interview - mentor Ella, Finland

Ella identified two reasons for students' feeling isolated. These included not being able to converse with patients in clinical practice and language isolation during coffee breaks. Student nurse Heather who had a placement in Finland made a comment in her diary about feelings of isolation. She stated:

> "sitting in the staff room with the nurse who was looking after me (that day my mentors weren't in). Everyone was chatting or laughing in Finnish. I couldn't understand one word … I felt very isolated and I thought, is it going

to be like this for seven weeks".

Diary - student nurse Heather, Finland

This comment was made on Heather's first day in clinical practice. However, with the help of staff who spoke English she began to feel part of the nursing team. A study by McLachlan and Justice (2009) found that students from four different continents had feelings of language isolation when they arrived in the US. The first six months was challenging for these students due to cultural differences and social and language isolation. However, the students who participated in the McLachlan and Justice (2009) study had a longer period to integrate into the US whereas the students who participated in my study had only nine to 12 weeks to integrate into the clinical area in the host country.

Although some students felt like outsiders when staff spoke in the language of the host country, Louise who had a placement in Sweden commented that she would not expect meetings regarding patient care to be in English as it was not the first language of this country. During her interview she stated:

> "When I was in community the meetings were in Swedish… I think it makes you feel a little bit left out, but you also realise I don't speak Swedish and you don't expect every meeting to be in English".

Interview - student nurse Louise, Sweden

Although Louise felt isolated on these occasions her mentor acted as a language broker (Weisskirch, 2017) and summarised what had been discussed during the meeting. Mentor support and their role in language brokering will be discussed in section 4.7.3 (p.122-129). Louise was the only student who commented that she did not expect every member of staff to speak to her in English.

A study by Mattila, Pitkäjärvi and Eriksson (2010) found that Asian and African students who had a placement in Finland felt restricted in clinical practice as staff were unaware of their learning needs and their language difficulties. This made them feel like outsiders in clinical practice and some experienced low self-esteem due to this (Mattila, et al., 2010). My findings indicate that although some students felt like

outsiders, no one identified a decrease in self-esteem due to this. Unlike the findings of Mattila et al. (2010), mentors who participated in my study were aware of students' professional learning needs and their language difficulties. In order to enable students to feel like 'insiders' mentors and other members of the ward team used English when possible. This was discussed in more depth in the following section 4.5.2.

4.5.2. A Sense of belonging

Students commented that after their initial feelings of isolation they began to develop a sense of belonging and became part of the ward team. This sense of belonging was developed through nursing staff and other ERASMUS students involving them in conversations in a language which they understood. Two students who had placements in Finland looked at the sense of belonging from different perspectives. Margaret related the sense of belonging to feeling more European. This is reflected in the following statement.

> *"*When I was there, I stayed in the Halls of Residence with so many students from all over Europe. I felt that sense of belonging. I felt more European. I felt as if I belonged".

Interview- student Nurse Margaret, Finland

Margaret's statement could be linked to a survey by Osborune (2013) on the impact of ERASMUS programmes. They found that mobile students felt more European than non-mobile students. A survey by Sigalas (2010) also found that studying and socialising with other Europeans can have a positive impact on European identity. Some of the other students who had placements in Finland also suggested that the sense of belonging was strengthened through socializing with other European students. Susan who was the only student nurse from Scotland in the Halls of Residence in Italy stated:

> "It was great living in the Halls. I met so many other ERASMUS students. They spoke two or three languages … we spoke English together".

Interview - student nurse Susan, Italy

Susan made friends with the other ERASMUS students and a strong bond of friendship developed between the students. This was strengthened by sharing a

common language. Some students who had initial feelings of isolation began to feel part of the team. This is highlighted in an extract from a student's diary.

> *"*Today during lunch break everyone spoke in English, so I wasn't left out of the conversation. I thought it was nice of them and I felt part of the team. We were able to discuss how the morning went and plans for the afternoon were discussed as a group".
>
> Diary - student nurse Kate, Finland

A diary entry by Chloe indicated that she had initial feelings of isolation but her diary entry a few days later indicated that those feelings had changed. Chloe stated:

> "They included me in the team throughout the day and this made me feel at ease".
>
> Diary - student nurse Chloe, Sweden

Chloe suggests that being included as a member of the nursing team diminished her feelings of isolation. It is noteworthy, that Koskinen and Tossavainen (2004) found that student nurses' intercultural adjustment was enhanced through team membership. Some studies have indicated that students had feelings of isolation and difficulty adjusting to the host country due to the culture (Koskinen and Tossavainen 2004; Ruddock and Turner, 2007). A qualitative study by Ruddock and Turner (2007) found that some students felt alone in a different culture but social networks in the form of other students and nursing staff, helped them to adjust to the culture (Ruddock and Turner, 2007). Although the ERASMUS students who participated in my study felt isolated due to language, they did not indicate they had difficulty adjusting to the culture. However, my findings suggest that nursing staff helped the Scottish ERASMUS students develop a sense of belonging by integrating them into ward teams and speaking to them in English. ERASMUS students from other European countries also helped the Scottish students develop a sense of belonging through forming strong interpersonal relationships with them.

The sense of belonging was also attributed to longer placements. This suggestion is supported by student nurse Heather who had a seven-week placement in an accident and emergency department. Heather stated:

> “I got to know the staff a lot better due to a longer placement. If I had gone to another placement, they wouldn’t speak to you because you would just be another face. When my mentor was off sick, I had someone, who took me for the whole week. If I had been somewhere else, I would not have got to know the nursing staff so well. I think it was beneficial having a longer placement rather than a shorter one”.
>
> Interview - student nurse Heather, Finland

Heather indicated that she had formed good relationships with members of the ward team. This can be linked to a study by Levett-Jones et al. (2008) who found that staff-student relationships are enhanced through longer placements and this contributes to a sense of belonging and a reduction in the feelings of isolation. My data confirms that longer placements for ERASMUS students can enhance the sense of belonging due to being part of a ward team within a supportive learning environment.

4.6. Strategies Used to Communicate

Although the word ‘strategy’ was only used in five sources, students described common methods to communicate with patients who did not share their language. There are multiple definitions of the term strategies (Cohen, 2012; Riding and Rayner, 2012). Cohen’s (2012) definition is concise and it is applied to language learning.

> “Thoughts and actions consciously chosen and operationalised by language learners to assist them in carrying out a multiplicity of tasks from the very onset of learning to the most advanced levels of target language performance.” (Cohen, 2012, p.136).

In addition to applying this definition to language development it could be applied to ERASMUS students’ communication with patients in clinical practice. This definition can be applied to the actions that were selected by learners to enable them to deliver nursing care to patients who did not speak English.

The two main sub themes were ‘speechless communication’ and ‘search engines and apps’. Thirty-two references were made to non-verbal communication (speechless communication) and eleven references were made to apps and search engines.

4.6.1. Speechless Communication

Speechless or non-verbal communication includes the use of facial expression, touch, body posture and noises such as moans or grunts (Boyd and Dare, 2014). These features are reflected in some of the comments made by both students and mentors. Some students related speechless communication to assisting patients with eating and drinking, A student who had a placement in Finland stated:

> 'the patients would put their hands up to indicate that they did not want any more. I would point to the cup to indicate if they wanted a drink. I used non-verbal gestures, but I got on fine. I don't think I had problems with any of the patients".
>
> Interview - student Nurse Margaret, Finland

It is interesting that Margaret perceived that there were no problems with this situation. Jirwe, Gerrish and Emami, (2010) believes when student nurses are satisfied with intercultural communications with patients who cannot speak a common language it does not mean that patients are also satisfied. Student nurse Margaret's comment suggests that both she and the patient used speechless gestures as a means of communicating information to each other. It is noteworthy that a study by Stevenson (2014) found that speechless communication can facilitate a direct connection between pharmacists and patients who do not share a common language. Although simple English words were used during the communication between the pharmacist and patients, Stevenson (2014) pointed out that the pharmacy assistant was multilingual and could interject in the patient's own language if necessary. Props such as medicine bottles and tablets were used to facilitate understanding (Stevenson, 2014). Margaret who had a placement in Finland used a cup as a prop to help the patient understand that she was offering her a drink. The student did not identify the physical condition which prevented this patient from eating and drinking independently. Jirwe, Gerrish and Emami (2010) also found that Swedish student nurses used non-verbal communication and props when they tried to convey a message to patients who did not speak Swedish or English. The props included equipment to convey messages to patients that they were going to carry out nursing procedures (Jirwe, Gerrish and Emami, 2010). This strategy was used by student nurse Louise whilst carrying out nursing procedures in Sweden. Louise stated in her diary.

> "My non-verbal communication skills were used again today when taking blood pressure. I would show them the cuff and point to their arm. Patients understand when I pointed or showed them what I needed to do. I have realised a smile can go a long way*".*
>
> Diary- Student Nurse Louise, Sweden

Louise indicated that patients demonstrated they understood her non-verbal communication by putting out their arm to enable her to apply the cuff of the sphygmomanometer. The patient's action implied that consent was given (Cole, 2012). A widespread practice of implicit consent is when patients roll up their sleeves to allow health practitioners to apply a cuff and thereby take their blood pressure (Cole, 2012). On the other hand, failing to give adequate information about procedures such as this could be construed as a form of battery (Johnson and Bradbury, 2016). Battery is a term used to denote, touching patients without consent (Johnson and Bradbury, 2016). Patients' understanding of procedures and the implications of consent is something which must be considered by ERASMUS students who do not share the same language as the patient.

Susan who had a placement in Italy commented during her interview that if patients did not understand her non-verbal gestures, she got her mentor to explain the procedure to the patient. Susan stated:

> "They allowed me to take bloods and do observations. I could gain non-verbal consent if I was showing the patient what I was going to do and pointed to the blood pressure monitor. If there were patients that could not understand, I would get my mentor".
>
> Interview - student nurse Susan, Italy

This is another example of how a mentor acted as a language broker for a student. Students in the four counties commented that due to not being able to use verbal communications they became more aware of patients' non-verbal communications such as facial expressions and posture. This is reflected in a statement made by student nurse Linda during an interview. She stated:

> "In my placement, I picked up a lot of non-verbal's. Due to not being able to communicate verbally you were more aware of looking for signs which

indicated if the patients had any pain".

Interview - student nurse Linda, Spain

Linda identified she was looking at body language to ascertain if the patient was in pain. A student who had a placement in Finland made a diary entry regarding this. Margaret stated:

> "About halfway through my time in Finland, there was one instance where a patient buzzed for a nurse and I went to see if I could be of assistance. When I arrived, it was clear she was in distress; she was clutching her throat and chest and appeared to be in pain. I called for the Finnish student as I couldn't see a staff nurse. I asked her if the patient had any significant cardiac history and she replied she did. I asked her to get help immediately and I began taking the patient's blood pressure, heart rate and setting up the ECG machine. It turned out she had angina and tachycardia (140 beats per minute). Although this was an obvious example, I feel opportunities like this helped me to develop a high standard of non-verbal communication".

Diary-student nurse Margaret. Finland

Margaret identified that the patients' non-verbal communication indicated the classic manifestations of cardiac vascular disease and took appropriate actions (Webster and Thompson, 2012). Despite taking appropriate actions, the student was unable to reassure the patient in a common language. It is noteworthy that a study by Hart and Mareno (2013) indicated that due to a verbal language barrier there can be difficulties establishing trust and a connection with patients.

The ERASMUS students who participated in this study developed confidence in identifying the speechless communication of patients and using non-verbal communication to convey messages to them. This is a skill which can be transferred to clinical settings in Scotland. Unlike the findings of my study which indicated that ERASMUS students developed confidence in the use of non-verbal communication, a survey by Rodriguex, Spring and Rowe (2015) found some nurses lacked confidence in using non-verbal communication and detecting the needs of patients who became suddenly speechless due to trauma. On the other hand, a study by Jirwe, Gerrish and Emani (2010) found that students in Sweden used non-verbal

communication when they were unable to share a common language with patients who were immigrants. Some patients had difficulty understanding some non-verbal gestures (Jirwe et al., 2010). However, the students who participated in my study were able to get mentors to clarify information if they thought that patients had difficulty understanding their non-verbal gestures.

In addition, mentors in Finland and Sweden commented they were impressed with ERASMUS students' non-verbal communication and their ability to pick up patients' non-verbal cues and carry out accurate clinical assessments. A mentor in Sweden stated:

> "The student was very good at picking up what was going on even though she did not speak the language. It was fascinating seeing her doing a patient assessment and see how accurate she was".

Interview- mentor Astrid, Sweden

Astrid felt that students developed this aptitude of identifying cues during their ERASMUS placement. Ella, a mentor in Finland also observed that students developed speechless communication during their ERASMUS placement. Ella stated

> "Their (ERASMUS students') non-verbal communication is sometimes better than Finnish nurses".

Interview - mentor Ella, Finland

Although, Ella suggested that ERASMUS students' non-verbal communications were sometimes better than Finnish students, it has to be taken into consideration that ERASMUS students depended solely on their non-verbal skills whereas Finnish students could use both verbal and non-verbal communication skills in clinical practice. The ERASMUS students in the four countries commented that their non-verbal communication had improved during their ERASMUS experience. This included using props such as equipment to convey messages to patients and observing facial expressions and body language to identify the emotional and physical needs of patients. Mentors were always nearby when there was a breakdown in this communication channel. It is evident that mentors became language brokers through interpreting what patients and ERASMUS students said during these three-way

conversations (Weisskirch, 2017). The role of mentors as language brokers will be discussed in section 4.7.3. of this Chapter and in Chapter 6.

4.6.2. Search Engines and Apps

The search engines used by students were Google translate and online dictionary apps. These devices have led to revolutionary ways in which students learn languages (Rahimi and Miri, 2014). Google translator can be used to translate words and phrases from one language to another. It can also help in the pronunciation of words. This strategy was used by both mentors and ERASMUS students. Student nurse Heather who had a placement in Finland made a comment in her diary about using Google translate if she did not understand the meaning of words. This also included the names of medication. Heather stated:

> "I used Google translate in the ward. If the nurse said to me, we are going to give out medication now and I felt that I didn't know what the medication was, I put it into Google translate and would have found that it was something simple like paracetamol or Ibuprofen".
>
> Diary -student nurse Heather, Finland

Heather indicated that the medication was written in the medication chart in Finnish and Google translate enabled her to find the name of the drug in English. Although mentors supervise students during medication administration, it is imperative that the student knows the name of the drug, the reason for giving the drug, the side effects and contraindications (Bourbotonnais and Caswell, 2014). This student demonstrated initiative in deciding to use Google translate to find information about the medication.

Google translate was also used by mentors. Saara, a mentor in Finland commented:

> "The computers were good because I could use Google translate if I didn't know what they (the students) were saying or if they didn't know what I was saying".
>
> Interview - mentor Saara, Finland

This form of technology served a dual purpose for mentors and students. Another mentor in Finland also commented about the benefits of using an online dictionary and Google translate. Samuel stated:

> “Nowadays we use a good internet dictionary. It is called Kopla translator. If we didn’t find the word immediately; we use Google translator”.
>
> Interview -mentor Samuel, Finland

Samuel commented that both he and the student used this technology if they did not understand the meaning of some words. A Spanish mentor and two ERASMUS students who had placements in Spain also commented that Google translate was beneficial when they experienced difficulties understanding the meaning of words. However, Sheppard (2011) suggests that frequently longer sentences may not be translated accurately. Groves and Mundt (2015) also point out that although Google translate is a valuable tool in the academic community, grammatical errors can be present in some translations. Although students in Finland, Spain and Sweden used Google translate they did not indicate that they encountered errors in translation.

One student who had a clinical placement in Sweden commented that she downloaded an app to her phone to ascertain what people were saying.

> “I had an app on my phone for the Swedish Language and I used it. You slowly pick up things. I couldn’t have a conversation in Swedish but when they were speaking, I could understand what they were saying”.
>
> Interview - student nurse Chloe, Sweden

Chloe claimed that this app was helpful as it enabled her to develop a knowledge of the language. This is a proactive stance and one that should be encouraged prior to students commencing an ERASMUS experience. Another student, Helen who had a placement in Italy also commented in her diary that she had used a language app on her phone to learn Italian. She stated:

> “I feel there is an expectation that ERASMUS students should have a basic knowledge of Italian, I used apps on my phone and DVD’s and books to learn the language”.
>
> Diary - Student Nurse Helen, Italy

Although the ERASMUS coordinator informed Helen before her ERASMUS experience that she would have a mentor who spoke English, Helen felt that there was an expectation that she should have a basic knowledge of Italian. Having the

knowledge that there would always be a mentor who spoke English present in clinical practice can be reassuring but it could foster laziness in learning the language of the host country. However, the nurses' expectation that Helen would have a basic knowledge of Italian gave her an incentive to download Italian language apps unto her mobile phone and use DVD's to learn the language.

Mobile language apps can be a helpful resource for language development. A study by Rahimi and Miri (2014) involving 34 students who were equally divided between an experimental and a control group explored the value of using a mobile dictionary. The experimental group used a mobile language dictionary whereas the control group used a printed copy of a language dictionary. The results indicate that the experimental group achieved better results in a post language test. Although this is a noteworthy study the research population in Rahimi and Mira (2014) study are too small to make concrete generalisations about the results. However, only three students in my study did a post-test after their language experience and even with the use of mobile apps these students' post language test was only increased by one grade.

ERASMUS students in Finland, Sweden, Spain and Italy claimed that they developed a better understanding of the language of the host country and were able to communicate with people at a very basic level. However, it could be argued that apps and Google translate may not have been entirely responsible for this. Other factors such as language classes, immersion in the culture inside and outside clinical placement and mentor support may have contributed to this. Nevertheless, the fact remains, these students took a proactive stance by using computer and mobile language technology to learn another language.

4.7. Support mechanisms

Students and mentors provided examples of the support mechanisms which were beneficial. These included induction and orientation programmes and the support provided by ERASMUS coordinators and mentors.

As already stated in the social context section (4.1.2.) some students participated in a university induction programme whereas other students had a more informal type of orientation programme. Both types of programmes were organised by ERASMUS

coordinators. Each student had a named mentor who supervised them in clinical practice. This met the requirements of the NMC (NMC, 2008; Rooke, 2014) as mentor supervision is vital for facilitating learning, assessing students' competences and protecting patients' safety**.** This will be discussed in more depth in section 4.7.3. (p.122-129).

4.7.1. Induction and Orientation Programmes

Prior to going to the host country, the Scottish ERASMUS students were provided with the same information about bursaries and travel insurance in their home university (MacMillian, 2015). However, my findings indicated that there were similarities and differences in the content of the induction/orientation programmes in Finland, Sweden, Spain and Italy. For example, the duration of the induction programmes at one university in Finland was five days whereas in the other countries it was one day.

The terms induction and orientation are used interchangeable but Marquis and Houston (2009) identify differences in both terms. Induction is the first phase of a programme and includes policies and procedures related to clinical practice (Marquis and Houston, 2009). This can be followed by an orientation programme. Orientation is the provision of more specific information about the student nurse's position in practice and it also involves a tour of the clinical placement (Marquis and Houston, 2009) and an introduction to the staff who work there.

In my study the students distinguished between induction and orientation. This is reflected in a statement made by Gillian who had a placement in Sweden. She had an orientation to the hospital and met her mentors before commencing clinical practice but felt that it would have been beneficial to have a more structured induction programme in the host country. This is reflected in a statement Gillian made during interview. She stated:

> Prior to our arrival in Sweden all of the other ERASMUS students had the welcome dinner. I felt it would have been beneficial if we had been sent to the host country at the start of the semester …. From the student's point of view, you miss the induction programme and you miss that bonding with the

other (ERASMUS) students".

Interview -Student Nurse Gillian, Sweden

Gillian indicated that if she had been able to attend an induction programme with the other ERASMUS students, she would have developed friendships that would have enhanced her cultural experience. This is a relevant point and one which should be taken into consideration by the sending and host universities when planning for the reception and integration of students in the host country (European Commission, 2014a)

In contrast, two Scottish ERASMUS students (Chloe and Louise) who had a placement in Sweden didn't attend an induction programme, but the ERASMUS coordinator gave them an induction pack. Induction packs are a useful learning resource and provides details about the local area and the people to contact in an emergency. The pack which Cloe and Louise received included information about the local area and instructions about how to join the university international group. This enabled the Scottish students to meet other ERASMUS students and participate in social events during their twelve-week placement in Sweden. These events can help to facilitate cultural immersion.

Kate and Margaret who had placements in Finland were the only two students who had a five-day formal induction programme. Kate stated:

> "Our first week was induction. The first week the support was brilliant. The class was made up of 30 international students studying nursing or physiotherapy. The students were from the UK, Spain, Italy, Greece, Poland, Belgium, Austria, France and Finland. The coordinators' mentality was if the whole class bonded, we would help each other. We were foreign students and they wanted the whole class to bond. They did an excellent job, by the end of the week we were the best of friends".

Interview - student nurse Kate, Finland

This induction programme provided the two Scottish students with the opportunity of forming strong relationships with other ERASMUS students. The programme included studies on cultural variations between their own country and the host country and an introduction to the Finnish language. These subjects are beneficial as students should

be encouraged to obtain information about the culture of the host country (Koskinen and Tossavainen, 2003b) as this can enable them to commence the process to cultural competence (Campinha-Bacote, 2002). Cultural competence will be discussed in more depth in Chapter 5. Kate and Margaret were introduced to the language of the host country, this is in keeping with the European Commission's (2014a) recommendation that HEI's should provide linguistic support for incoming ERASMUS students.

Kate commented that two Finnish students attended the induction programme. These students acted as buddies to the international students and took the students on a tour of the town. Host buddies can be helpful in creating a positive experience for international students during their transition into a host country (Campbell, 2012). The two ERASMUS students (Kate and Margaret) indicated that the buddy system proved beneficial as they could contact their buddies if they had queries about the local area. Kate and Margaret also felt that good social networks were formed through the induction programme. The buddies were introduced to the students during the induction programme whereas in Spain, Italy and Sweden the Scottish students were given contact details about local students after their orientation programme, but this was not classed as a buddy system. All students indicated that the local network of students helped in the integration into the host country. Local students have a valuable role to play in helping students adjust to the culture and language of a country (Kokko, 2011; Kent-Wilkinson, Leurer, Luimes, Ferguson and Murray, 2015).

Students in Italy, Spain and Sweden and two of the other students who were placed in another area in Finland had an orientation to the university and hospital. Student nurse Chloe made comments in her diary entries about meeting the university lecturer who was responsible for her ERASMUS orientation to clinical placement.

> "Today we met T our university lecturer at the university. She showed us around our local hospital and the local town. T introduced us to various mentors for each placement. All of them spoke very good English. We got guided tours of each of the wards we will be working in".
>
> Diary - student nurse Chloe, Sweden

Five days later Chloe stated:

> *"*Today I knew where I was going as we had a welcome tour the previous week therefore finding my ward was not an issue".
>
> Diary - student nurse Chloe, Sweden

Chloe referred to the hospital orientation as a welcome tour. She felt that the welcome tour helped to reduce the anxiety of trying to find the ward on her first day of placement. Four other students commented about initial feelings of apprehension about the language and clinical practice. The ERASMUS students' feelings of apprehension can be linked to DeLuca's (2005) findings that during the initial stages of Jordanian nursing students' sojourn in America, they felt anxious about cultural adjustments, language and the unknown academic expectations of the university. An orientation to the culture and student life in the host country is important (DeLucia, 2015) to alleviate feelings of apprehension which students may have about the cultural experience. Chloe's statement indicates that she had a week to adjust to the culture before clinical practice. Students in Finland, Sweden, Italy and Spain had a similar period to enable them to adjust to the country before commencing their clinical practice. This period enabled them to get to know the area where they were living and develop personal confidence. Personal confidence was discussed in section 4.8.1.

Students who had placements in Spain attended a university-based orientation programme. The coordinator arranged a day trip to the university town for the two Scottish students and two Italian ERASMUS students. The following is an extract from the diary of student nurse Aileen.

> "We met the two Italian students at the train station. The four of us got the train and then a bus to visit the university and sign (ERASMUS) paperwork. The coordinator suggested somewhere to eat and encouraged us to learn Spanish".
>
> Diary - student nurse Aileen, Spain.

In addition to signing the ERASMUS paperwork, Aileen and the other Scottish student (Linda) were provided with information about the local area and their clinical placements. Although the ERASMUS coordinator did not arrange linguistic support,

for the students at the host university he encouraged them to learn the language. Both students were motivated to learn the language and received Spanish lessons from their host in their living accommodation. This enabled them to develop a rudimentary knowledge of the language. This proved beneficial in their practice placement when they were communicating with patients.

All students were provided with relevant information about clinical placements during their orientation to clinical practice. This included information about support networks in the university and in clinical practice, uniform policy and off duty rotas. Information about the uniform policy was beneficial as students noted there were difference between the uniform policies in the host countries and Scotland. Reference was made to uniform policy in section 4.8.2.

My findings indicate that although students' experienced language challenges, the transition into the host country was smooth due to induction and orientation programmes and the supportive networks that were established during or after these programmes. Inadequate preparedness can lead to students having a difficult transition into the host country (Koskinen and Tossavainen, 2004; Ruddock and Turner, 2007). In contrast to my findings about the induction and orientation programmes, Koskinen and Tossavainen (2004) indicated that student nurses who had an ERASMUS placement in the United Kingdom felt that the preparation they received in Finland and the United Kingdom was inadequate, delayed or non-existent. Although the Scottish ERASMUS students received relevant information to prepare them for their clinical experience, it is noteworthy that only two students were encouraged to think about culture during their induction/orientation programme yet developing cultural knowledge is one of the aims of ERASMUS. As indicated in section 1.2.1. (p.3-4) cultural knowledge is one of the constructs in the process to cultural competence (Campinha-Bacote, 2002) and this is an essential aspect of cultural congruent nursing care (Papadopoulos, 2006). This will be discussed in more depth in Chapter 5.

4.7.2. Support provided by ERASMUS Coordinators

Host universities provide accommodation or assist students in finding a suitable place to live (MacMillan, 2015). My findings indicated that it was the ERASMUS coordinator who provided information about accommodation in the host country. As indicated in

the Social Context section (4.1.2.), ERASMUS coordinators in Spain and Sweden arranged accommodation for four students in private homes. The ERASMUS coordinators' position in the host country had many facets. This included providing educational support, social support, arranging placements and identifying mentors to supervise students during their clinical placements.

Some students referred to the ERASMUS coordinator in the host country as link lecturers whereas other students referred to them as coordinators. Seventeen references were made to the support students received from link lecturers or ERASMUS coordinators. Although the sending university and host university provide support for ERASMUS students (Milne and Cowie, 2013) the Scottish ERASMUS students referred more to the support provided by the link lecturer at the host university.

Susan, who had a placement in Italy referred to the link lecturer at the host university during interview. She stated:

> "I had a link lecturer who organised my placements and I met her a good few times. She was great. She explained everything to me, the shifts, and the wards and if I had any problems she was there. I didn't have any problems, but I knew I could always go to her if I needed help".

Interview - student nurse Susan, Italy

Susan's statement indicates that she was pleased with the ongoing support provided by the link lecturer at the host university. Both link lecturers and ERASMUS coordinators are responsible for ensuring that the students' individual learning needs are met. The thirteen students who participated in my study attained their learning competencies in the host country.

In some host universities, link lecturers and ERASMUS coordinators provided ongoing support for the ERASMUS students. Louise who had a placement in Sweden commented about meeting the coordinator for coffee. She stated:

> "The ERASMUS coordinator was good; she emailed us to ask how we were getting on. She picked us up at the house and we went for fika (coffee break). We would also meet her every couple of weeks in the university and she

would ask how things were going".

Interview -student nurse Louise, Sweden

This is another example of how some ERASMUS coordinators provided social support for students. Educational support is vital in host countries but Button et al. (2005) also suggests that social support is pivotal for students. Some ERASMUS students may experience social challenges through separation from friends and family (Milne and Cowie, 2013) or cultural shock in clinical practice (Koskinen and Tossavainen, 2003b) so this type of support can be valuable. Only one student who had a placement in Spain commented about the separation from her family. Linda stated:

> "The student who was with me didn't get homesick, but I did. I got homesick the first few weeks, I think that was because I just wanted to speak to somebody that understood me".

Interview -student nurse Linda, Spain

With the help and support from the ERASMUS coordinator and the other Scottish ERASMUS student who had accompanied her, Linda was able to overcome the feelings of homesickness. This can be linked to the findings of Koskinen and Tossavainen (2003c) study on the link tutor or lecturer's relationships with exchange students. Koskinen and Tossavainen (2003c) findings indicated that this relationship was pastoral. This type of relationship was valuable in that it helped to reduce some ERASMUS students' stress levels and enable them to integrate into the culture of the host country (Koskinen and Tossavainen (2003c). In addition, my results indicated that the ERASMUS coordinator acted as a liaison between university and practice. Chloe who had a placement in Sweden provided an example of how she contacted the coordinator when she was ill. Chloe stated:

> "I was sick when I was abroad, and the coordinator contacted the people in clinical practice for me because I didn't have the telephone number".

Interview - student Nurse Chloe, Sweden

Chloe informed the ERASMUS coordinator that she was ill and asked her to contact her placement to let her mentor know she would be unable to go to clinical practice. The coordinator has the overall responsibility for arranging placements, ensuring that

students complete their placement hours, signing ERASMUS documentation at the end of placements and confirming that students attained their practice competencies.

Koskinen and Tossavainen (2003c) also highlights that another facet of the link lecturer's role is to encourage students to think about the cultural differences between their own country and the host country. Only two students in my study commented that the link lecturers or coordinators asked them to reflect on their clinical placements. Kate and Margaret who had placements in Finland, commented that their lecturer at the university encouraged them to reflect on their clinical practice in Finland. This enabled the students to think about alternative ways of doing things in clinical practice (Howatson-Jones, 2016) and compare it with their practice in Scotland. Reflection stimulates critical thinking (Price and Harrington, 2016) which is an essential component of professional development. Professional development will be discussed in section 4.8.2. of this Chapter.

Students in the four countries were happy with the support they received in the host countries. Aileen who had a placement in Spain compared it with the support received in the UK. Aileen stated:

> "The support mechanisms were very good from the Spanish side. The host university was in contact with us every other day. The coordinator would arrange to meet us. He also arranged for us to meet other students. They were more involved with you. There is more support over there [in Spain]. It would have been nice if the university in the UK found out if we had arrived in Spain safely".
>
> Interview - student nurse Aileen, Spain

Aileen compared the support she got in Spain to that in Scotland. She is the only student who commented about the university in Scotland not contacting her to find out if she had arrived safely in a host country. Nevertheless, MacMillan (2015) points out; students are responsible for getting a certificate of attendance form signed by the lecturer responsible for their ERASMUS placements at the host university. The student is also responsible for signing the form and returning it electronically to their home university within the first two weeks of arriving in the host (receiving) university (MacMillan, 2015). This form verifies that the student has arrived safely in the host country.

Both Linda and Aileen who had placements in Spain claimed that the coordinator from the host university contacted them on alternate days, but still felt that the ERASMUS coordinator from the sending university should have also contacted them. Both students commented that there was an air traffic control strike in France, and this had affected their return journey. Linda and Aileen commented that ERASMUS coordinators in the sending universities should contact students to ensure that they had no concerns about their travel arrangements. Other students indicated that they valued the contact they had with the academic staff in their home university during their ERASMUS experience. My findings indicated that some students valued a tripartite support. This included support from the ERASMUS coordinator at their home university, the receiving ERASMUS coordinator in the host university and the mentor in clinical practice. Although this tripartite support may indicate that students felt less confident when they were abroad, my findings indicate that students developed personal confidence during their ERASMUS experience. Personal confidence was discussed in section 4.8.1.

4.7.3. Mentor Support.

Thirty-three references were made by students to mentor support. Mentors supervised students carrying out nursing skills and acted as language brokers (Weisskirch, 2017), interpreting what students and patients were saying. The NMC (2008) stipulate that a mentor should provide direct or indirect supervision for the student nurse. The type of supervision depends on the mentor's assessment of the student's clinical competencies (NMC, 2008; Walsh, 2014).

Four mentors claimed that they spent 100% of their time with ERASMUS students. One student indicated that she spent 60% of her time with a mentor and the remainder of the time would be spent with registered nurses. However, the time that other students spent with their mentors ranged from 70 to 100%. Pamela who had a placement in Finland claimed:

> ***"***Mentors spent 100% of their time with me. They did not leave my side".
>
> Interview - student nurse Pamela, Finland

Pamela spent one week in an intensive care unit where one would expect a higher level of supervision as it is a specialist area. In other clinical placements which were

less specialised, Pamela received the same level of supervision. It is noteworthy that the NMC (2008) recommend that the mentor should be available for at least 40% of the student's time in clinical placement. The ERASMUS students spent well above this minimum requirement of time with their mentors.

Gillian who had a placement in Sweden commented about mentor supervision in the following statement:

> "I spent about 90% of time with my mentors. The mentors apologised several times for providing so much mentor supervision. I thought their mentor supervision was great. You developed a good rapport with the mentor".

Interview - student nurse Gillian, Sweden

Despite being in their 2nd placement of year 3 and due to complete their nurse education programme within five months of returning from their ERASMUS experience, the students felt that their level of supervision in the host country was very good. My findings indicated that the students were not perturbed about having a higher level of mentor supervision than what they would have had in Scotland. In contrast, Keogh and Russel-Robert's (2009) study on a German Finnish exchange programme found that students desired supervision but they also wanted to engage in self-directed clinical practice. Keogh and Russel-Robert's (2009) study did not indicate what this self-directed practice was. In my study none of the students indicated that they wanted to engage in more self-directed practice or make autonomous decisions about patient care. The students recognised that there was a need to work with their mentor whilst carrying out patient care due to the constraints of language. This is reflected in a statement made by Pamela.

> "As a third-year nurse in Scotland I was quite independent, but it was difficult for me to do anything without someone there to say, she is going to do this or going to do that".

Interview - student Nurse Pamela, Finland

The NMC (2012) have stated that nurses should be able to "work independently and as a member of a team" before registration. Moreover, the safety needs of the patients and students should take precedence (NMC, 2011) in any clinical setting but it is a priority in clinical settings where students do not speak the same

language as the patient. Some of the ERASMUS students indicated that they worked independently whilst taking patient observations. They were introduced by their mentor to the patient or on some occasions the patient spoke English. This enabled students to introduce themselves to the patient and carry out some clinical procedures. Jon a student in Sweden stated:

> "I worked 80% of my time with my mentor…the other 20% of the time it would have been when my mentor asked me to check a patient's blood pressure … I worked as a level 2 student who did venepuncture, although in Finland, Year 2 students do venepuncture. It was a bit of a step back, but I don't regret it".
>
> Interview - student nurse Jon, Sweden

Although Jon was in year 3 of his nurse education programme, he indicated that he worked as a 2nd year student nurse. Despite this, Jon commented that the ERASMUS experience enabled him to develop personally and professionally. Personal and Professional development will be discussed in section 4.8. All ERASMUS students commented how mentors engaged in a two-way process of interpreting what patients and student nurses said. This indicates that mentors in each of the four countries acted as language brokers or interpreters conveying verbal statements between two or more parties (Lee, Sulaiman-Hill and Thompson, 2014). Kate a student who had a placement in Finland commented about the mentor interpreting during interactions with patients. Kate stated:

> "My mentor and I would go around the patients and she would interpret for me. I could only speak to the patients in that way. Sometimes there was a mix up in translation. My mentor sometimes didn't know the word in English. Sometimes she struggled how to put it into English. It was so quick. I would say something and then she would say it in Finnish and then back in English. Most of the time it was fine".
>
> Interview - student nurse Kate, Finland

Kate indicates that most times this two-way process of interpreting for her and the patient worked. This process necessitates the ability to rapidly reconceptualise what a person has said in another language (Elderkin-Thompson, Silver and Waitzkin,

2001). Although two students commented that their mentors could not remember the odd words, none of the students indicated that there were errors which lead to misunderstandings in communication. This is reflected in a statement made by Louise who had a placement in Sweden. She stated:

> I didn't really have great difficulties because the mentors could speak such good English. As soon as the patient would say something in Swedish then they would translate the information into English for me. Perhaps there was the odd word that they could not remember but then they would start describing it and I would say I know what you mean".
>
> Interview - student nurse Louise, Sweden

In health care settings there are trained and untrained interpreters. My study did not identify if any of the mentors were trained or untrained interpreters. A study by Elderkin-Thompson et al. (2001) found that there was minor miscommunication when bilingual nurses translated for patients during twenty-one medical encounters. Nurses who are not trained in the art of interpreting tend to use a proximate-consecutive approach (Elderkin-Thompson et al. 2001). This is when the interpreter is in the same room as the patient and waits until the primary speaker finishes speaking before interpreting what has been said (Gany et al., 2007). Simultaneous interpretation is like a voice over which is a word for word rendering of the speech within milliseconds of the primary speech (Gany et al., 2007). Although simultaneous interpretation can be more accurate (Elderkin-Thompson et al., 2001) this would not have been an appropriate method for the mentors in my study as they were often engaged in a direct conversation with the patient. From the students' description of the mentors' role as language brokers consecutive interpreting was used. This is sometimes referred to as a back and forth type of interpreting. The mentor interpreted what the patient said and then what the student nurse's verbal response was.

This study has identified that mentors had a dual role to play. They were responsible for the delivery of high standards of patient care and acted as language brokers for Scottish ERASMUS students. A study by McDowell, Messias and Estrada (2011) on the experiences of twenty-seven formal and informal interpreters found that the 12 informal carers who worked within the health care system had extra demands made on their time for language brokering. Mentors did not comment about the extra time

spent on language (Interpreting) brokering. In addition to acting as language brokers some students who had placements in Spain, Finland and Italy also indicated that their mentors took on the role of language teachers.

> *"*Our mentor would also teach us to say certain phrases {in Spanish] such as I am going to give you an injection and so forth".
>
> Interview - student nurse Linda, Spain

> *"*My mentors taught me to ask questions [in Finnish] such as, can I take your blood pressure? It meant that they (mentors) didn't have to follow me around and gain consent each time the patient's blood pressure needed checked*"*
>
> Interview - student nurse Margaret, Finland

Although Margaret perceived that the learning of these questions in Finnish was beneficial some mentors commented that when patients started to engage the students in conversation, they were unable to answer. Similar issues were also identified in a study by Magnusdottir (2005) on the lived experience of eleven foreign nurses in Iceland. The nurses indicated when they started to speak in the Icelandic language their fluency of it was overestimated and they encountered difficulties due to their limited vocabulary (Magnusdottir, 2005).

Felipe a mentor in Spain provided a rationale for teaching students Spanish phrases. He commented that he taught ERASMUS students Spanish phrases before they carried out nursing procedures because he felt that patients were more relaxed when the student spoke to them in Spanish. Felipe stated:

> *"*Even though students cannot speak properly, or they are embarrassed to speak, I make them try to talk. For example, a few weeks ago I had a student from the UK, and I said, can you remove the patient's catheter? I gave her some phrases to say in Spanish. One was 'I am going to remove your catheter'. I always teach the student to do this. When the students speak in Spanish and even though it is not the best pronunciation the patient will feel more relaxed".
>
> Interview - mentor Felipe, Spain

This is an interesting observation which the mentor made regarding patients feeling more relaxed when their own language is spoken. None of the students made comments about this. However, a study by Ardial, Sulman Fuller-Thompson (2011) found that 8 mothers whose babies were hospitalised had feelings of helplessness and isolation due to not speaking the same language as health care workers. The language barrier contributed to feelings of isolation but when someone spoke to them in their own language, the feelings of isolation were reduced (Ardial et al., 2011). Although this study does not involve patients or student nurses, feelings of isolation can be applied to patients who do not speak the same language as the student nurse. In addition, to teaching the language of the host country, mentors taught the students how to use medical equipment and supported them in learning new clinical skills in the renal dialysis unit. Louise commented about this in her diary. She stated:

> "My mentor was very good at explaining the dialysis machines to me and how they worked. I was able to get everything ready for the afternoon patients coming in. The only thing that was hard was trying to read the machines due to the titles not being in English. I was able to get my mentor to explain it to me".
>
> Diary - student nurse Louise, Sweden

Five students had placements in renal dialysis units. The time spent in these placements ranged from one to three weeks. Kate who had a three-week placement in a dialysis unit claimed she learnt to care for patient during renal dialysis. She experienced the same difficulties as Louise due to not being able to read in Finnish. This is reflected in the following statement:

> "My role in the dialysis unit was to help my mentor set up the equipment and ensure people were alright during the treatment. I couldn't read Finnish and the machines were all set up in the Finnish language. I did not know what the word meant on the screen ... I felt silly because it was simple to them [the Finnish nurses] and it was hard for me. My mentor or the other members of staff would tell me when I asked them what this word meant. My mentor was brilliant…. I had never seen dialysis before".
>
> Interview - student nurse Kate, Finland

Renal dialysis is specialised nursing (Coyne and Needham, 2012) and students had not worked in this type of speciality in Scotland. In the renal dialysis unit, students were able to practice other nursing skills such as monitoring observations and doing venepunctures. Mentors also encouraged students to learn about the life changes which some patients had encountered through dialysis. They acted as interpreters when students asked the patients questions about their lifestyle changes. Subsequently, students were able to gain a holistic perspective of the patient's care needs and culture. This is supported by Coyne and Needham (2012) who suggest that students develop clinical reasoning about the holistic needs of the patient in specialist units.

Two students spent seven weeks in intensive care. This is a specialist unit for patients requiring critical care (Coyne and Needham, 2012). Student nurse Helen made some comments in her diary about the learning opportunities in this clinical placement. The following is an extract from Helen's diary.

> "My mentor is explaining things to me. I am learning loads. Basic nursing care is universal, and I can carry it out…. My mentor is so knowledgeable".
>
> Diary - student nurse Helen, Italy

Students in each of the four countries commented that their mentors were knowledgeable and taught them new skills. These findings can be linked to a study by Gidman, McIntosh, Melling and Fisher-Smith, (2011). They found that 65% (n=113) of first year students and 71% (n=69) of students in their final year of a nurse education programme ranked teaching and support as the most important responsibilities of a mentor.

In addition to teaching the students new skills, Louise and Kate's mentors acted as translators. They translated the written information (Lee, Sulaiman-Hill and Thompson, 2014) on the dialysis machine and explained the concepts of care for patients having renal dialysis. Good mentor support enabled the students to learn new aspects of patient care. This is echoed in the words of Jon who had a placement in Sweden

> “The language barrier did give me some difficulty but with the help of mentor, I was able to overcome this and learn in clinical placement”.
>
> Interview - student nurse Jon, Sweden

Both Jon and the other ERASMUS students expressed how they developed clinical knowledge and skills and they contributed this to their mentors. This new knowledge and skills enabled the students to develop professionally. The personal and professional benefits of the ERASMUS experience will be discussed in more depth in section 4.8.

The different types of support discussed in this section answered the second research question: What support mechanisms are presently in place for students who cannot speak the language in the four host countries? The findings indicate that there were various forms of support such as orientation programmes, student buddies and ERASMUS coordinators or link lecturers but the main support mechanism for students who could not speak the language of the host country was their mentor. Mentors in the four countries helped students to overcome the language barrier and facilitated a smooth entry into clinical practice. This enabled the students to learn about the theory and practice of nursing in another country.

4.8. Benefits

The benefits of ERASMUS placements were identified by all participants. The sub themes included professional and personal benefits. The European Commission (2014a) have indicated that personal and professional development can be enhanced through ERASMUS programmes. My results support the views of the European Commission about personal and professional development. The terms personal and professional development are often used interchangeably within some studies. However, an integrative review by Kelleher (2013) differentiated between personal and professional development. Kelleher (2013) refers to the development of confidence, an increase in self-efficacy and cultural sensitivity as personal development. Professional development includes knowledge and practice development, technical and interpersonal skills (Kelleher, 2013).

4.8.1. Personal Development

In my study, personal development included confidence, self-efficacy, independence, language learning and cultural awareness which is one of the constructs of cultural competence. Although cultural awareness can be linked to personal development, it can have an impact on professional development. This will be discussed in more depth in Chapter 5.

Despite not having a knowledge of the language students commented that they had developed confidence. Confidence can be multifaceted, and this is reflected in Linda's statement.

> "I developed confidence in practice and in life skills. You are being pushed out of your depth to do something you would not do in everyday life".

Interview - student nurse Linda, Spain

Linda comments that she developed confidence in life skills. She related this to personal confidence. Ponomarenko, (2017) suggests there is a link between personal or self-confidence and professional confidence and professional confidence is linked to self-efficacy. Individuals who have professional confidence view themselves competent to carry out practice skills (Ponomarenko, 2017). The acquisition of practice skills was discussed in section 4.8.2. Magnus (2017) claims that self-confidence or personal confidence are closely associated with the words self-esteem and self-efficacy. Kate, a student who had a placement in Finland provides an example of how she developed confidence.

> "I didn't know the language and was in a different country, yet I was going to the bus stop on my own. I even would be walking about the city on my own, yet I would not do that in Glasgow. It was just what I needed to increase my confidence".

Interview – student nurse Kate, Finland

It is obvious that Kate had developed self-efficacy as she had a belief in her own abilities to walk around the city alone. This can be linked to a qualitative study by Unlu (2015) who found that students from an educational faculty in Turkey developed self-confidence and a sense of being able to succeed during their ERASMUS experience.

Although the students in my study did not identify the term self-efficacy, they indicated that despite not being able to speak the language of the host country they were able to manage the challenges of going to a new country.

Student nurse Jon's statement signifies that he developed confidence and self-efficacy during his ERASMAS placement in Sweden. Jon stated:

> "it is one thing phoning your Mum and Dad if you miss the last train in Glasgow and they can drive to you. In another country you are completely responsible. You must cope on your own. It made me realise I can do it".

Interview - student nurse Jon, Sweden

Self-efficacy is embedded in Jon's comment that that the experience made him realise he could cope on his own. Jon's comment can be linked to the findings of a qualitative study by Lee (2004). The findings indicated that students' developed independence and personal confidence following an international experience (Lee, 2004). My findings also indicated that the ERASMUS students who were placed in the two Nordic countries and the two Southern European countries developed a sense of independence.

Another personal benefit which students identified was being able to immerse themselves in a different culture and develop a knowledge and understanding of it. Linda referred to cultural immersion in the following statement.

> "the benefits are learning about diverse cultures. You are intertwined with the culture. It makes you more independent. Sometimes people from diverse cultures come into hospital here [in Scotland] but you don't have the time to talk about their culture. Over there you are immersed in that culture. Obviously in Spain, I didn't fully understand what was going on. It makes you think about patients who come into hospital in Scotland and don't speak the language".

Interview - student nurse Linda, Spain

Although knowledge of diverse cultures can be applied to personal development the concept can also be applied to clinical practice. In fact, a knowledge of diverse cultures is necessary for nursing practice (Repo, Vahlberg, Salminen, Papadopoulos

and Leino-Kilpi, 2016). Linda provided an example from clinical practice. Linda's comments indicate that it was a good learning experience because it heightened her awareness of what patients may feel when they are unable to speak English in a Scottish hospital. On the other hand, Linda admits that she did not understand fully what was going on in clinical practice. This demonstrates how the constraints of language can influence professional learning. Despite the language constraints, Linda achieved that sense of independence through travelling and working in another culture.

Susan who had an experience in Italy indicated that immersion in the Italian culture made her more culturally aware. She stated:

> "the experience has made me aware about other cultures. Although there is diversity in the population in this country. I feel I got more experience working with a different culture for a longer period. Here there could be someone from a different culture in the ward for a week or three weeks at the most, but I feel having a longer period helped me to gain a better understanding of the culture".
>
> Interview - student nurse Susan, Italy

Susan indicates that having a longer period working in the Italian culture enabled her to get a better understanding of it. The development of cultural awareness is one of the aims of ERASMUS+ (European Commission, 2014a). As already indicated in section 2.3. cultural awareness is defined as the ability to examine one's who beliefs and culture (Camphina- Bacote, 2002). Cultural awareness for the students in my study was the awareness of the beliefs held by other cultures. In addition to developing cultural awareness, Susan developed a knowledge of the culture through culture encounters and this enabled her to commence the process to cultural competence. All students developed professionally through cultural encounters with patients. As indicated in Chapter 1 (p.3) cultural encounters is one of the constructs in Camphina-Bacote's framework in the process to cultural competence (Camphina-Bacote, 2002). My findings indicate that cultural encounters are a crucial factor in the development of cultural competence and professional learning. This relates to the fourth question and it will be discussed in more depth in Chapter 5 which focusses on the application of the Campinha-Bacote theoretical framework.

In addition to becoming more culturally aware, some students also became more aware of their lack of language skills and tried to learn some words and phrases in the language of the host country. Louise stated:

> "My ERASMUS experience encouraged me to learn another language. There was a student from Belgium. He spoke French, English, Dutch, Spanish and Swedish. I was standing there and could only speak English. It made be aware that in the European countries how many languages they speak".

Student Nurse Louise. Sweden

Louise's statement suggests her interest in learning another language was stimulated through other ERASMUS students' linguistic abilities. As already indicated in Chapter 1, language acquisition is one of the aims of ERASMUS+ (European Commission, 2014a). The two students who had placements in Spain claimed that they were able to have a basic conversation in Spanish. Linda stated:

> "if I had not gone there, I would not have picked up the language…by the end of the placement we could have a conversation and I could understand what people were saying… that was a deep sense of achievement".

Interview - student nurse Linda, Spain

As already indicated in section 4.7.3. some mentors taught the students useful phrases for nursing practice. Linda stayed with a Spanish family who taught her the language. However, some students were more interested in learning practice skills than in language acquisition. This is reflected in a comment made by a student who had a placement in Italy. Evelyn stated:

> "My mentor gave me a book which was good. It was clinical phrases in Italian. I was trying to learn what was going on with the patient rather than learn Italian, trying to learn about ECMO machines and do essays".

Interview - Student Nurse Evelyn. Italy

Evelyn had a placement in an Intensive Care Unit where ECMO machines were used and felt she should learn about the function of these machines instead of spending time studying Italian. ECMO is an acronym for extracorporeal membrane oxygenation

(Stulak, et al., 2009). It is a machine which provides cardiac and respiratory support for critically ill patients.

Evelyn was also concerned that she needed to spend time doing an academic assignment. Louise another student commented that she was unable to attend some events with other ERASMUS students due to having two essays to write. Assignments had an impact on the time spent in language development and prevented some students from engaging in cultural encounters outside practice. Although Evelyn was more concerned with developing practice knowledge in the host country, since returning to Scotland she has commenced Italian lessons. My findings indicated that it can be difficult to separate the personal benefits from professional benefits. For example, one of the personal benefits for some students was to understand a basic form of the language but they found that this was a transferrable skill and they could use their newly learnt phrases to introduce themselves to patients in clinical practice.

4.8.2. Professional Development

According to Charania, et al. (2017) professionalism consists of nursing practices, behaviours and effective communication. As already indicated in section 4.3. (p.88-96) students experienced challenges through their inability to speak the language of the host country. Although some students learnt phrases in the language of the host country it was not enough to engage in a conversation with patients. My findings indicated that the professional benefits were the development of practice knowledge, practice skills, critical thinking and confidence in practice.

Some mentors described how ERASMUS students developed professionally during their ERASMUS placements. Astrid, a mentor in Sweden, provided an example of how an ERASMUS student had developed practice skills and knowledge. She stated:

> "it was fascinating to see how the ERASMUS student did her patient assessment and how she described it to the first-year Swedish nurse. The difference between the two students was fascinating. What I mean I thought the ERASMUS student wasn't going to make an impression, but she did even though she couldn't speak the language. I thought about what this ERASMUS student was like when she first came to our placement and what

she was like now. This student developed in practice and it was good to see it".

Interview -mentor Astrid, Sweden

Astrid indicated that there was an improvement in the student's clinical practice between her first day in placement and when she carried out the patient's assessment. This ERASMUS student was able to carry out a nursing assessment, internalise the information gained through this and impart the results of the patient assessment to her mentor and a first-year Swedish student in a systematic way. This could be linked to one of the NMC's (2010) competencies for nurses. The NMC (2010) stipulate that nurses must be able to carry an accurate patient assessment before entry to the professional register.

Evelyn who had a placement in Italy commented in her diary that her mentor felt that her nursing practice skills had improved. This is highlighted in the following statement.

"Last week my mentor did my mid-term review. He informed me that he was quite worried about my skill set. This surprised me as I thought my skills were brilliant. Today my mentor informed me that I was a quick learner and my skills had improved".

Diary- student nurse Evelyn, Italy

The psychomotor (practice) skills which Evelyn had difficulty with were not identified. A multiple case study by Green, Johansson, Rosser, Tenhnah and Segrott (2008) found that students developed an increased awareness of practical skills during their ERASMUS experience. However, Green et al. (2008) does not specify the practice skills which students developed. Nevertheless, student nurse Gillian specifies the skills she developed during her placement:

"I was able to practice skills such as taking bloods, cannulation and catheterisation. When I say about taking bloods in this country, they will say the phlebotomist, or the junior doctor does that".

Interview - student nurse Gillian, Sweden

Gillian indicates that she did not get the opportunity to develop these skills in Scotland as other members of the multidisciplinary team did them. Moreover, students in each of the four countries commented that they had developed practice skills. This type of professional development was experiential learning. This is learning through experience in a naturalistic environment (Kolb, 2015). All students who participated in my study indicated that they had learnt new clinical skills in the host countries.

Mentors and students indicated that the ERASMUS experience enabled students to compare nursing practice and organisational management in their own country with the host country. Some mentors linked this to critical thinking. This is reflected in the comments of a mentor who supervised Scottish students in Finland.

> *"*The ERASMUS experience develops critical thinking. For example, they are doing things differently here. The students then think, is it possible to do things in clinical practice in another way from what I have been taught".
>
> Interview - mentor Nella, Finland

Nella links comparing practices to critical thinking. Yildirim and Özkahraman (2011, p.257) define critical thinking as *"*an active process of searching, obtaining, evaluating, analysing, synthesizing and conceptualising information." Pamela, a student who had a placement in Finland displayed some of the elements of critical thinking described by Yildirim and Özkahraman's (2011). During her interview she evaluated infection control procedures in Finland. She stated:

> "I think infection control is better over there with regards to uniforms. They don't take them home to wash. You went and got a …scrub (uniform) there … I loved that".
>
> Interview - student nurse Pamela, Finland

Pamela evaluated the procedure of taking uniforms home to wash and suggested; to minimise infection it is better to have a uniform washed and supplied by the hospital. By reflecting on this practice, Pamela was able to analysis the two methods of laundering and then make a logical conclusion which one she preferred.

Some of the elements of critical thinking identified by Yildirim and Özkahraman (2011) can be linked to Bloom's Taxonomy of higher order thinking. Bloom's taxonomy was developed in 1956 to identify major acts of thinking (Dwyer, Hogan and Stewart,

2014). The taxonomy comprises of six categories, knowledge base, comprehension of facts, application of prior knowledge, analyse care, synthesize information, compile a plan of action and finally evaluate the plan (Dwyer et al., 2014). The students who compared nursing and organisational practices in Scotland and the host country used prior knowledge to do it. Blooms taxonomy can be applied to deeper cognition and critical thinking (Adams, 2015). It highlights the importance for higher levels of cognition which can lead to in-depth learning and the transfer and application of skills and knowledge (Adams, 2015) to professional learning. The Scottish ERASMUS students were able to do this in clinical practice.

Nella, a mentor who worked with student nurse Margaret and Kate commented that the ERASMUS students constantly compared the equipment used in Scotland and Finland. They also compared how the nursing procedures were carried out in each country and then evaluated the best method to use for the nursing procedure. This could be classed as critical thinking. Alfaro-LeFevre (2017) suggests that critical thinking is using prudence to evaluate practice and the evidence underpinning it.

In addition, Felipe a mentor in Spain indicated that the ERASMUS students had the confidence to challenge why practice is carried out in diverse ways. Felipe stated:

> "the students ask, 'why are you doing it like that, and we do it like this in our country? They develop a more open mind. They are learning diverse ways of doing the same thing. This encourages critical thinking and the learning process is increased".
>
> Interview - mentor Felipe, Spain

Felipe commented that the Scottish ERASMUS student tended to ask questions about practice and developed a more open mind. A study by Davies, Curtin and Robson (2016) also found that nine students who had an international experience were more open minded and developed the ability to think outside the box. Furthermore, Yildirim and Ōzkahraman (2011) links open mindedness with critical thinking. Yildirim and Ōzkahraman (2011) suggests that critical thinking involves being a creative thinker, open minded and inquisitive. However not every student demonstrated a questioning attitude. A student who had a placement in Italy stated:

> “I don’t know why the patient requires a specific type of equipment. I didn’t really want to ask my mentor who is lovely any questions. He tells me the information about the patients in the morning or when my shift starts. He does all the talking, trying his best to explain everything in English, so I feel bad if I have to ask questions as half the time, he does not understand everything I say, so I really feel bad and don’t ask questions”.
>
> Diary - student nurse Evelyn, Italy

As already indicated in section 4.3.2. some mentors had difficulty comprehending what some students were saying due to their accent. This extract from Evelyn’s diary indicates that she was reluctant to ask her mentor questions and therefore missed good learning opportunities. On the other hand, Evelyn could have used other strategies to enable her mentor to understand what she was saying such as putting the questions into a written format. Evelyn’s account of this experience provides an example of how the inability to speak or understand the language of the host country can have an impact on professional learning.

Although mentors agreed that students developed professionally during their ERASMUS experience, they indicated that this experience could have been enhanced if students had a knowledge of the language. This sentiment is highlighted in a comment made by Ricardo a mentor in Italy. He stated:

> “Professionally they can compare a health system in a different country, but I feel if they had a basic knowledge of the language it would be better for them”.
>
> Interview - mentor Ricardo, Italy

Ricardo’s comment is valid in that it would be much better if students could speak the language. Some mentors suggested that professional learning could be enhanced if students had a knowledge of the language. A mentor in Spain pointed that although ERASMUS students have direct cultural encounters with patients, it would have been much better if they had a knowledge of the language as it is difficult to learn about culture without a knowledge of the language. I agree that knowledge of the language would have enhanced the process of cultural competence (Camphina-Bacote, 2002) and professional learning. However, mentors facilitated cultural encounters and this

enabled students in the four countries to develop professionally. Cultural encounters and cultural competence will be discussed in more depth in Chapter 5.

In addition, some students viewed not having a knowledge of the language from a positive perspective. Kate stated in a diary entry.

> "because I was always working with my mentor, I found that this enabled me to gain more practice knowledge".
>
> Diary - student nurse Kate, Finland

Kate identified that she gained practice knowledge even though she could not speak the language. She associated the development of practice knowledge to additional mentor supervision. This can be linked to Keogh and Russel-Roberts' (2009) findings that seven nursing students who participated in a German Finnish exchange developed new competencies in clinical nursing and this was related to mentor supervision.

My findings indicated that students learnt about the cultural differences in host countries which had an impact on the organisational management of the ward. Both student nurses and mentors indicated that one of the cultural differences was that nurses had more autonomy in each of the four countries than what they do in Scotland. A study by Green et al. (2008) also indicated that ERASMUS students who had a placement in Sweden found that nurses had more autonomy than their nurse counterparts in the UK. Although Scottish students who participated in my study observed that the registered nurses in Finland, Sweden, Italy and Spain had more autonomy than registered nurses in the UK, the students had a high level of mentor supervision and were not asked to work above their limitations.

Two students (Margaret and Kate) who had placements in Finland equated the ERASMUS experience with leaving their comfort zone in Scotland. Comfort zone theories are frequently associated with adventure education (Brown, 2008). Prazeres (2017) suggests that leaving a comfort zone can result in a critical self-reflection and self-discovery. The concept of self-discovery can be applied to the Scottish ERASMUS students in the two Nordic countries and the two Southern European countries as they commented how they had developed both personally and professionally. Kate commented about leaving her comfort zone. She stated:

> *"*I feel it is good to leave your comfort zone. I feel it is a confidence booster and it is a good for the transition from student to staff nurse. It is good for professional development, there were difficulties, but the benefits outweigh the difficulties. Definitely".
>
> Interview - student nurse Kate, Finland

Kate suggested that the experience was good for the transition from student to staff nurse and linked this to her increase in personal and professional confidence. She was the only student who identified the transition from student to staff nurse. Students did acknowledge that there were challenges and difficulties due to not speaking the language of the host countries. However, despite not having a knowledge of the language students developed confidence in practice. The Scottish ERASMUS students in the four countries developed professionally through this cultural experience.

4.9. Summary

The research questions identified at the beginning of this chapter have been answered. The findings indicated that there can be constraints in clinical practice due to students not having a knowledge of the language. These constraints included the inability to speak to patients, read patients' notes and enter information into patients' records. Lack of language proficiency can have an impact on professional practice therefore students relied on mentors to enable them to have direct encounters with patients and develop a knowledge of the culture. Some students felt isolated due to language, but these feelings were resolved through nursing staff speaking to them in English and including them as members of the ward team. Communicating in English and team membership enabled ERASMUS students to develop a sense of belonging. Support mechanisms were classed as beneficial. These included: induction programmes, ERASMUS coordinators, local student networks and mentor supervision. Mentors had a patient case load and therefore had to take into consideration the needs of the patients as well as the language constraints of the ERASMUS students and the learning competencies that they had to attain during their clinical placement. Students estimated that they spent 70 – 100 percentage of their time with mentors and were happy with this level of supervision.

The findings also showed that the ERASMUS experience can provide both personal and professional benefits. There was a link between cultural encounters and the development of practice knowledge and skills. Eleven mentors felt that there were benefits in having an ERASMUS experience despite not speaking the language. These benefits included the development of critical thinking, practice knowledge and psychomotor skills.

Chapter 5: Application of Theoretical Framework

This chapter provided an analysis of the Campinha-Bacote theoretical framework. As indicated in Chapters 1 and 2, the Camphina-Bacote framework is known as a Process of Cultural Competence Model in the Delivery of Health Care Services. The reason for selecting this Model as a theoretical framework is that the constructs reflect the cognitive, affective (attitudes) and psychomotor elements of student nurses' daily clinical practice (Davis and Kimble, 2011) and it is based on social constructivism. Some of the research findings discussed in Chapter 4 will be applied to the five constructs of the Campinha-Bacote framework. As indicated in Chapter 1 (p.3), the five constructs of this framework are cultural awareness, cultural knowledge, cultural encounters, cultural skills, and cultural desire. Although the constructs were valuable in exploring the cultural aspects of students' ERASMUS experiences, the framework was found to have limitations when it was applied to my study. This led to the development of a pictorial diagram on the application of students' ERASMUS experience cited in Figure 11 (p.154). The modified diagram takes into consideration the mentor's role and the external factors which contributed to student nurses' cultural experiences and their process to cultural competence during the ERASMUS experience.

5.1. Cultural Competence

In Chapter 2, it was highlighted that there are several definitions of cultural competence. The one which was adopted for this research study was that of Wood and Atkins (2006). They describe cultural competence in nursing as the ability to understand cultural diversity and provide care which meets the linguistic, cultural and social needs of patients. This description of cultural competence can be related to my study because students did not share the same language as most of the patients. For this reason, the linguistic needs of most patients were not met unless a mentor was present when students were interacting with patients. In my study, the mentor played a key role in the student's journey to cultural competence.

As indicated in Chapter 2, the Campinha-Bacote's Process of Cultural Competence Model was used as a conceptual framework as it indicates a progression to cultural competence (Campinha-Bacote, 2002; Ingram, 2012). This progression can be applied to students' experiences in host countries as they are exposed to an unfamiliar culture which had a transformation potential (Brown, 2009). As specified in Chapter 1, Campinha-Bacote (2002) believes the five constructs should be experienced by health professionals as the constructs have an interdependent link with each other. Each of the five constructs were experienced by the ERASMUS students in my study. The five constructs are reproduced in Figure 9.

As already stated in Chapter 2, the Camphina-Bacote conceptual framework is associated with the social constructivist learning theory (Vygotsky, 1978). This is based on the theory that new knowledge developed within a social cultural environment is internalised and assimilated into a student's existing knowledge and beliefs (Garneau and Pepin, 2015). This concept can be applied to my data as all students developed new cultural knowledge through their social interactions within a social cultural environment. This will be discussed in more detail in section 5.2.2 of this Chapter.

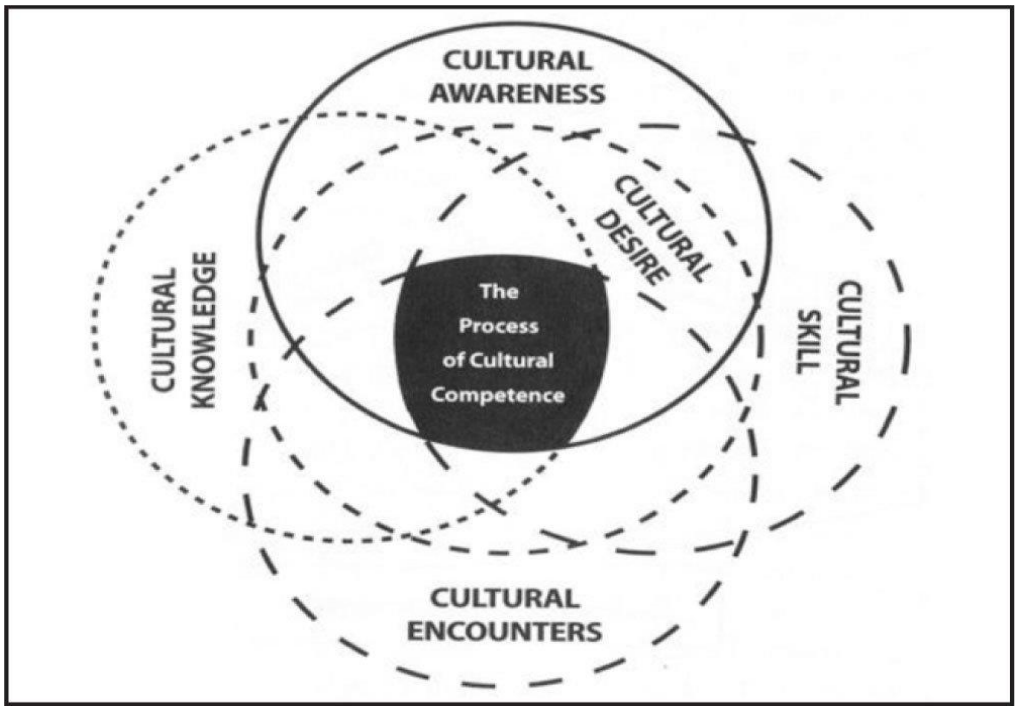

Figure: 9: Process of Cultural Competence in the Delivery of Health Care Services (Campinha-Bacote, 1998) Source: Reprinted with Permission of Transcultural C.A.R.E. Associates

5.2. Constructs

Although each of the constructs are discussed in sequential steps in this Chapter there is a relationship between each construct. This was identified in Figure 9. Campinha-Bacote (2002) describes her pictorial diagram as concentric circles and claims as the intersections become bigger it symbolises that health professionals have developed a deeper internalisation of information within each of the constructs. Campinha-Bacote (2002) does not identify how these intersections can be measured. On the other hand, Campinha-Bacote developed a self-administered Inventory consisting of 25 items for Assessing the Level of Cultural Competence in Health Care Professionals (Campinha-Bacote, 2002) but there is no evidence of literature on alterations to the pictorial diagram (Figure 9) following an immersion in a cultural exchange programme. The inventory was not used within my study as it was not part of the aims and objectives of the research inquiry. The European Commission's (2014a) outcome for the ERASMUS experience which is promoting intercultural awareness can be linked to the conceptual theories of the Campinha-Bacote Process of Cultural Competence in the Delivery of Health Care Services Model.

Furthermore, although Campinha-Bacote depicts her pictorial diagram as interlinking concentric rings in Campinha-Bacote's (2001) publication, she describes the constructs as sequential steps and places cultural encounters before cultural skills. However, in the Campinha-Bacote (2002) publication, cultural skills are placed before cultural encounters. I argue that when the Campinha-Bacote model is applied to clinical practice then cultural encounters with a patient comes before carrying out cultural skills. My findings indicate that students frequently carried out skills during cultural encounters with patients. It is for this reason that, I have placed cultural encounters before cultural skills in this Chapter.

5.2.1. Cultural awareness

Cultural awareness is reflecting on one's own professional background and culture (Camphina-Bacote, 2002)**.** This includes the recognition of one's beliefs and biases about people from unfamiliar cultures (Camphina-Bacote, 2002)**.** Although students did not identify any biases, some students who had placements in the Southern European countries tended to be judgemental regarding the English proficiency of

hospital staff and local people outside clinical practice. Interestingly, students appeared unaware that they were being judgemental about people who could not speak English fluently. For example, two students commented about the receptionist in the University Halls of Residence lack of English language proficiency. This could be classed as fostering ethnocentric attitudes towards their English mother tongue. Ethnocentric attitudes are present in people who are unaware that other people may have diverse cultural beliefs and values to themselves (Campinha-Bacote, 2001). All of the students were able to integrate into the cultural practices of their clinical placements and local communities. These findings could be linked to a quantitative study by Lee, Crawford, Weber and Dennison (2018) who found that an immersion experience with another culture had a greater impact on students who had high levels of ethnocentrism.

As already indicated, an imperative aspect of cultural awareness is reflecting on one's own personal culture (Campinha-Bacote, 2001). My research findings indicated that it was the cultural experience which stimulated students to reflect on their own culture. This is highlighted in the following statement made by Margaret who had a placement in Finland: *"*my eyes were open to their culture and ours".

This is an interesting statement, especially the point where Margaret's eyes were open to her own culture and the culture of the host country. This can be linked to Garneau and Pepin's (2015) suggestion that from a constructivist perspective, cultural competence is orientated towards critical reflection and it is this which develops understanding of the culture. My findings indicate that cultural awareness was reinforced by mentors who acted as cultural brokers (Gerrish, Chau and Sobowale, 2004) and encouraged students to reflect on the differences in their culture and the culture of the host country. Through reflecting on the culture of the host country, students developed cultural understanding and knowledge.

Furthermore, it was obvious that most students had reflected on their cultural experiences by the content of the narratives within their diaries. However, one student claimed that she had only become aware of culture during the research interview when she was speaking about the benefits of the ERASMUS placement. Nevertheless, this student had no difficulty discussing the cultural aspects related to clinical practice and the culture of the family she lived with in the host country.

Hunter (2008) applied four of Campinha-Bacote's constructs to a graduate course on culture, diversity and cultural competence and encouraged students to read a book on American culture to create an awareness of it. The constructs which Hunter (2008) focused on were cultural awareness, cultural knowledge, cultural encounters and cultural skills. Hunter (2008) highlighted how students developed an in-depth knowledge of their own culture and how personal experiences had influenced their own view of it. Reading a book about American culture acted as a stimulus for students to reflect on their own culture. Campinha-Bacote does not indicate that individuals require a stimulus to encourage reflection. Hunter's (2008) course was online, or classroom based so unlike my study, students were unable to develop personal awareness of another culture through direct encounters in a host country.

As already indicated, my findings suggest that critical reflection is an important aspect of the Cultural Awareness Construct. Two students who had placements in Finland had a cultural reflection session with the other ERASMUS students each week. From a constructivist perspective group discussion is critical to the understanding of new knowledge (Schcolnik, Kol and Abarbanel, 2006). This can be linked to social constructivism as this educational theory puts emphasis on the development of knowledge through interacting with other people in the social environment (Adams, 2006). The other students tended to reflect on their cultural experience with their mentors and ERASMUS coordinators in an ad hoc way.

5.2.2. Cultural Knowledge

Cultural knowledge is the process of searching and obtaining an in-depth cognitive understanding or world view about diverse cultures (Camphina-Bacote, 2002). In addition to Camphina-Bacote's description of this construct, Koskinen and Tossavainen (2003b) suggest that it also includes the ability to learn languages and develop intercultural knowledge. In my opinion when this framework is applied to an international experience then language ability is entwined with cultural knowledge. This is also reflected in the results of my study which indicate that poor language proficiency can restrict some students from obtaining cultural knowledge in the host country. This can also be linked to Koskinen and Tossavainen (2004) findings which indicated that Finnish students who had an ERASMUS experience in the UK avoided theoretical instruction at the university due to the language barrier. However, these

Finnish students were gradually able to become attuned to the English language and engage in intercultural learning in clinical practice (Koskinen and Tossavainen, 2004).

Koskinen and Tossavainen (2004) identified that students received cultural information from the host university and clinical practice. My findings indicated that students received cultural information from ERASMUS coordinators at the host universities, clinical practice and through interaction with people in the local community. As indicated in Chapter 4, some students stayed with families in the host country and gained general knowledge of the culture and language. These families became the cultural brokers for students (Gerrish, Chau and Sobowale, 2004).

In addition, Campinha-Bacote focuses on clinical practice and does not identify external factors which could influence clinical practice. A reason for this could be that she focuses on nurses providing care for patients from diverse cultural backgrounds and not on ERASMUS students who had clinical placements in a host country.

Prior to the experience students were unaware of the cultural practices in the host country. Camphina-Bacote (2001) links this to unconscious cultural incompetence. This is when individuals are unaware that they lack knowledge about the culture (Campinha-Bacote, 2001). Some mentors felt that prior knowledge of the culture and the health care system of the host country would have been beneficial prior to the ERASMUS experience as students would be more prepared for practice. However, two students were introduced to the culture in the host country during a five-day induction programme. This was beneficial as it helped to prepare students for their cultural experience.

In my study, students were able to gain cultural knowledge from their mentors and observing cultural practices within clinical areas and outside clinical areas. For example, some students identified the wide use of saunas in Finland and the health beliefs associated with it. Students in the other Nordic country and the two Southern European countries were able to identify the cultural beliefs about family and diet. As identified in Chapter 4, section 4.1.2. these cultural beliefs and values had an impact on the organisational culture of the hospital. Organizational culture is a set of beliefs, values and attitudes shared by people in an organisation and these can have an impact on the organisational routine (Wagner et al., 2014) of a hospital. Mentors in Spain indicated how ERASMUS students learnt the importance of providing bed

chairs beside patients' beds as relatives are involved in their care. Relatives in Spain provide help with patient hygiene and eating and drinking when required (Mora-López, Ferré-Grau and Montesó-Curto, 2016). These are classed as culturally responsive actions (Campinha-Bacote, 2001) and students were able to facilitate these actions.

Campinha-Bacote (2002) suggests that cultural knowledge includes incidence of disease, treatments, health beliefs and health education. Some students were able to develop a knowledge of the lifestyle factors in the Nordic countries and the positive attitude to promoting health and independence. These lifestyle factors were identified within the research findings in Chapter 4. Students also indicated that there was diversity in the population due to immigration which meant that people in the host countries had different beliefs and values. This is an important observation as it is imperative that everyone in a country is not put into a stereotype (Campinha-Bacote, 2002).

5.2.3. Cultural Encounters

Cultural encounters are classed as having direct interactions with patients from diverse cultural backgrounds (Campinha-Bacote, 2002). Although, Campinha-Bacote (2002) suggest that during these cultural interactions, health professionals can assess the linguistic needs of the patients, in my study it was the linguistic needs of students which presented the difficulties. Student had difficulties with face to face encounters with patients and as indicated in Chapter 4, had to rely on mentors to act as language brokers (McDowell, Messias and Estrada, 2011). This mediated communication between student and patient proved successful most of the time. However, as indicated in Chapter 4, some students had strong accents, and this compromised communication with health professionals on some occasions. My findings indicated that students had feelings of anxiety before going to their clinical placement in the host country, but these feelings were diminished when someone greeted them in English.

Whilst, Campinha-Bacote (2001) and Campinha Bacote (2002) focuses on health professionals' communication with patients whereas in my study cultural encounters included students' interactions with members of the multidisciplinary team and people outside the clinical environment. My results indicated that cultural encounters in the clinical environment and outside the clinical environment were pivotal to the

development of cultural awareness and knowledge. This finding can be linked to the Campinha-Bacote's (2010) revised pictorial diagram (Figure 10) which places cultural encounters, central to the other four constructs: cultural awareness, cultural knowledge, cultural skills and cultural desire. This diagram was replicated with permission from Camphina-Bacote (Appendix A). It was obtained from the Transcultural Care Associates Website.

Patient encounters with diverse populations enable nurses to develop good skills sets such an understanding of patients' linguistic terms (Ingam, 2012). Most students took the opportunity of learning linguistic terms to enable them to function within the clinical setting. However, one student indicated that she preferred to learn about patient care rather than focus on learning Italian phrases. This student spent her entire clinical experience in intensive care where half of the patients were unconscious, so she may have felt that it was not necessary to learn Italian phrases to speak to patients. Another Scottish ERASMUS student had the same clinical experience but did not vocalise her preference to focus on learning about patient care and not the language of the host country. However, as indicated in Chapter 1, the competencies which students should attain during their clinical placement include nursing skills and decision making, communication and interpersonal skills (NMC, 2010). This would indicate that both sets of competencies have equal importance.

On the other hand, having an entire experience in an intensive care unit where half the patients are unconscious may reduce the opportunity to communicate with patients and may lessen the impact of this aspect of the exchange programme and therefore deplete the motivation to learn the language of the host country. Albeit, one of the main aims of the ERASMUS programme is to develop language skills (European Commission, 2014).

The results of Koskinen and Tossavainen (2003b) found that some students remained outsiders during their ERASMUS experience. They were uncertain what was expected of them during direct encounters with patients and some were unable to cross the language barrier. My results in Chapter 4, indicated that due to the language barrier some students felt like outsiders during their first week of placement but with the help provided by mentors, students crossed the language barrier and were involved in cultural encounters with patients and members of the multidisciplinary team.

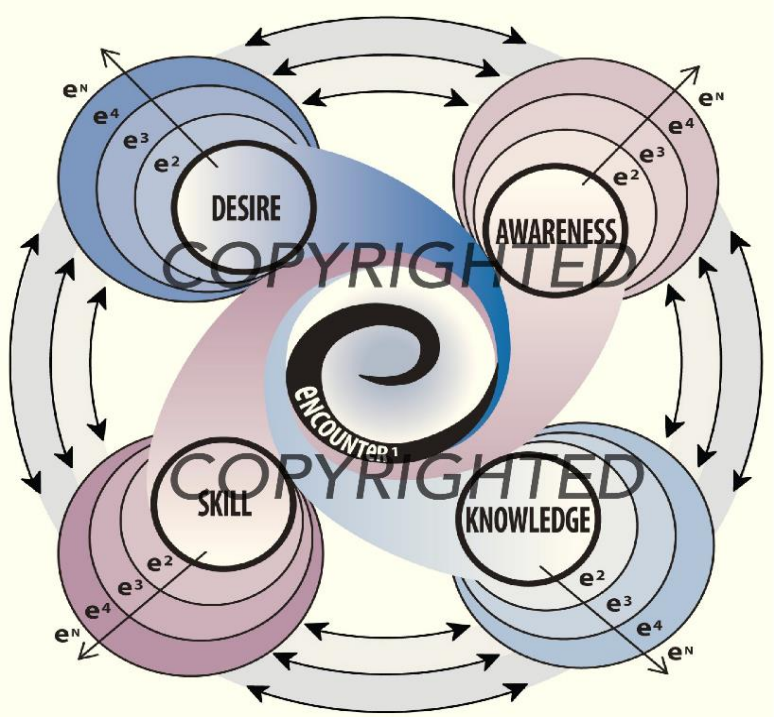

Figure 10: Process of Cultural Competence in the Delivery of Health Care Services (Campinha-Bacote, 2010) Source: Reprinted with permission from Campina-Bacote, Transcultural C.A.R.E. Associates

5.2.4. Cultural Skills

Campinha-Bacote (2001) suggests that this construct focuses on the ability to collect culturally relevant data about the patient's history, presenting problems as well as doing a culturally based physical assessment. Camphina-Bacote, (2002) and Ingram (2012) imply that cultural skills are related to cultural assessment. This is the identification of a patient's health needs, based on relevant cultural information (Giger, 2017). Assessment provides a baseline for interventions on which to plan nursing actions (Dougherty and Lister, 2015). Although my results indicate that students were able to carry out patient assessments they did not identify if these included cultural elements. The assessment carried out by the ERASMUS students was an overall physical assessment which included monitoring vital signs (temperature, pulse, respirations and blood pressure). A limitation of this assessment was, students could not ask culturally based questions, if patients were unable to speak English. These are questions related to the patient's illness, their health beliefs, culture and dietary habits. Such questions are part of a cultural assessment (Weber and Kelly, 2013). Nevertheless, some students commented that they became aware of the dietary and

religious practices of both the host country and the immigrant population in their clinical placement.

My findings indicated that when students were carrying out assessments or other nursing skills mentors were always available during these patient encounters. They ensured students did not work above their limitations, therefore patient safety was maintained. This is keeping with the NMC (2011) recommendation that the safety of both patients and students should be taken into consideration during ERASMUS placements.

Although, Campinha-Bacote (2002) framework focuses on cultural assessment within this construct, my findings indicated that in addition to patient assessment this construct included other technical (psychomotor) skills which was underpinned by knowledge of the subject and knowledge of the patient's culture. These psychomotor skills included washing and dressing patients, doing wound dressing, administering medication, doing venepucture and taking vital signs. Patient assessment is ongoing even whilst carrying out psychomotor skills and all nursing actions (Dougherty and Lister, 2015).

This could be linked to the Koskinen and Tossavainen's (2003b) study in which the Campinha-Bacote framework was applied to their research findings. Although, Koskinen and Tossavainen (2003b) commented about students having difficulty practicing skills due to the language barrier they did not identify if these skills were related to collecting assessment information. Furthermore, my findings indicated that some students took cultural and religious issues into consideration whilst carrying out psychomotor skills. This can be linked to cultural sensitivity (Papadopoulos, 2006) and ethnorelativism (Campinha-Bacote, 2001). This supports Davis and Kimble's (2011) view that psychomotor skills, attitudes and knowledge are part of each nursing action. It can also be linked to the cultural skills construct of Camphina-Bacote's conceptual framework.

In addition, some students learnt phrases in the language of the host country to help them carry out patient assessment and other psychomotor skills but if the patient responded with more than a one-word answer, it presented difficulties for students if a mentor was not present. As indicated in Chapter 4, the mentor's role as a language broker (Lee, Sulaiman-Hill and Thompson, 2014) was invaluable. It was the cultural

encounters which enabled the Scottish ERASMUS students to commence the process to cultural competence and develop professionally. This addresses the fourth research question regarding the relationship between cultural competence and professional learning.

5.2.5. Cultural Desire

Cultural desire is the aspiration of health professionals to care for patients from diverse cultures (Campinha-Bacote, 2001). Camphina-Bacote's revised pictorial diagram in 2010 suggests cultural encounters are pivotal to the development of cultural competence whereas her pictorial diagram in 2002 identifies cultural desire as the construct which kindled the aspiration of cultural awareness, cultural knowledge, cultural encounters and cultural skills (Campinha-Bacote, 2015). Her pictorial diagram in 2010 (Figure 10) now places Cultural Encounters as the key construct. This was based on the results of studies which used her inventory tool for assessing cultural competence (Campinha-Bacote, 2015).

The constructs of cultural desire and cultural encounters can be related to the results of my study (Campinha-Bacote, 2015). The Scottish ERASMUS students had a desire to engage in an ERASMUS programme to develop cultural and practice knowledge in host countries. This also relates to the findings of Bohman and Borglin's (2014) qualitative study. They found that the reason students applied for an ERASMUS exchange programme was to get an insight into the culture and go beyond that of a tourist. However, I found that the overarching desire to learn more about a culture was stimulated through cultural encounters and caring for people from diverse cultures. This is reflected in the following statement. Louise who had a placement in Sweden stated: "in Sweden they have a big influx of refugees ...I never had experience of asylum seekers in Scotland …if I could I would work there." This statement can be related to Koskinen and Tossavainen's (2003b) belief, that cultural desire should be a genuine impetus 'to want to' rather than 'need to' care for people from diverse cultural groups.

In addition, Louise spoke very enthusiastically about her exposure to people from different nationalities. Louise and three other students commented that they would like to work in the host country or spend a longer period of time there. Nevertheless,

these students were aware that at present the inability to speak the language would inhibit their desire to work in any of the four countries as a registered nurse.

5.3. Limitations of the Campinha-Bacote Model

Although the Campinha-Bacote Model for the Process of Cultural Competence in Health Care is an excellent framework and can be applied to health professionals' journey to cultural competence, it was found to have limitations when applied to my study. The main reason for this was that my findings indicated that although the mentor was the key to cultural encounters in practice there were several influencing factors outside clinical practice which contributed to the students' process to cultural competence. The Campinha-Bacote (2002) theories and the pictorial diagrams do not identify the external factors which influence the health professional's journey to cultural competence. As already indicated these influencing factors included meeting people in the host country, living with families or meeting other students in the halls of residence in the host country. It could be argued that becoming familiar with the culture of the host country and transcending the boundaries of clinical practice can enhance the cultural experience (Upvall 1990; Button, Green, Tengnah Johansson and Baker, 2005) and the process to cultural competence. Some of the influencing factors outside practice had an impact on practice. For example, in addition to gaining cultural knowledge, some students learnt language skills from the families they lived with or by attending classes at the university. Students were able to use these skills in practice.

Even though my study focussed on clinical practice, during one-to-one interviews most students spoke about the factors outside practice which contributed to their cultural experience. It was for this reason that it was decided to develop a pictorial diagram which identified the five cultural constructs and the other external influencing factors which contributed to the ERASMUS students' process to cultural competence. This was shown in Figure 11: which is an application of the students' ERASMUS cultural experience.

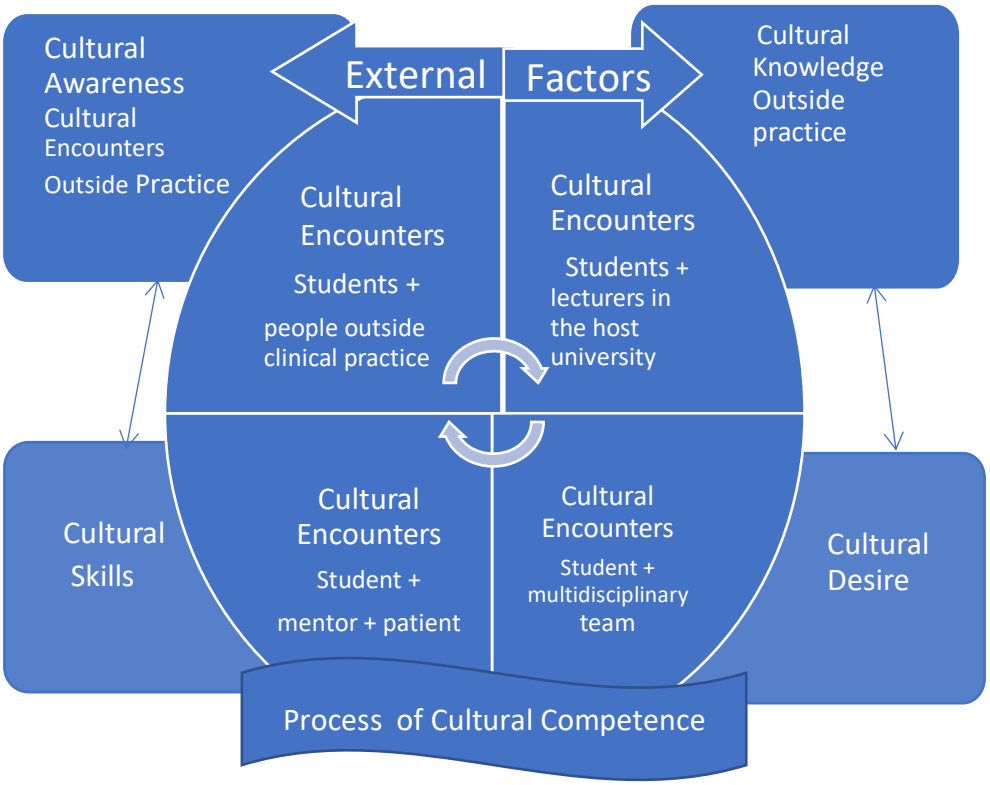

Figure 11: An Application of the Students' ERASMUS Cultural Experience

5.4. Pictorial Diagram Depicting the Student Nurses' Cultural Experience

The banner at the top of the diagram relates to the external factors which contributed to the cultural process to cultural competence. These include living with families or meeting other students in the halls of residence. The banner encircles the cultural awareness construct and the cultural knowledge construct because students spent time engaging in cultural activities outside clinical practice. They also engaged in cultural encounters and this contributed to the conceptual elements of cultural knowledge. Another justification for including External Factors in this diagram is that there is a dearth of literature which indicate how external influencing factors can contribute to the student's cultural experience. However, Morgan's study (2011) indicates that external factors can contribute to personal and professional development. Although Morgan (2011) explains how social-cultural risk factors outside the clinical environment and risk factors within the clinical environment contributed to professional and personal development and self-actualisation, little emphasis is put on cultural knowledge or cultural competence.

Cultural encounters have been placed in the middle of the diagram as this was the key to the cultural experience. Even though the mentor was the main cultural broker (Gerrish, Chau and Sobowale 2004) other sources contributed to cultural brokering through direct encounters with students, therefore the cultural encounters with these cultural brokers was placed in the centre of the diagram. The arrows in the middle of the diagram (Figure 11) indicate that there is a relationship between the encounters with different people and the development of cultural awareness, cultural knowledge, cultural skills and cultural desire. In addition, the diagram indicates that it was the combination of these cultural encounters which contributed to students' process of cultural competence.

5.5. Summary

This chapter has shown that the five constructs of the Campinha-Bacote conceptual model for the Process of Cultural Competence in the Delivery of Healthcare Services was applied effectively to the ERASMUS experience. It was also found that there was a link between each of the five cultural constructs in that students frequently engaged in each of the five constructs simultaneously. However, the findings indicate that the process of cultural competence is not just confined to clinical practice. External factors such as the host university and living with families and meeting students in the Halls of Residence contributed to the students' process of cultural competence and language development. These social interactions with families and other students in the host university were crucial in the development of cultural knowledge. This type of knowledge development can be linked to social constructivism. The chapter has also identified that stimulus is the main factor in promoting cultural awareness. In my study the main factor in stimulating cultural awareness was the students' cultural encounters in the host country. As a result of this, students not only became aware of their own culture but the cultural beliefs and values of people within the host country.

Although the main cultural broker (Gerrish, Chau and Sobowale 2004) was the mentor other internal and external sources contributed to the students' development of cultural knowledge. It for this reason that a pictorial diagram was developed which recognised these valuable sources which contributed to the students' process of cultural competence. Cultural encounters were found to be the key to cultural awareness, cultural knowledge, cultural skills and cultural desire.

Chapter 6: Conclusions and Recommendations

This concluding chapter analysed to what extend the aim of this research inquiry was met. In order to do this, reference was made to the four research questions. The aim of the inquiry was to explore how the constraints of language influence cultural competence and professional development in an ERASMUS placement for student nurses.

The chapter commenced with a summary of the key findings. An analysis of how these findings contributed to the body of knowledge was then provided. This was followed by recommendations about how the ERASMUS experience can be enhanced. These include recommendations for students who participate in ERASMUS programmes, recommendations for coordinators, mentors and programme leaders and finally suggestions for future research studies. These recommendations are based on the research findings in Chapter 4 and the summary of the key findings in section 6.1 of this Chapter. The Chapter concluded with an analysis of the strengths and limitations of the research inquiry and my concluding thoughts about the study. This includes a review of my personal and professional learning during this research journey.

6.1. Summary of Key Findings

The key findings demonstrated that the four research questions have been answered. The first research question was as follows: how does the language of the student and the language of the host country influence the ERASMUS cultural experience? Research findings indicated that the language of the student and the language of the host country influenced the ERASMUS cultural experience in many different ways. These were as follows:

- The inability to read patient documentation in the language of the host country and listen to a handover report unless it was given in English meant that some students felt that they received limited information about patients.
- Students were not able to make entries in patient progression notes because of their inability to write in the language of the host country.

- Some Scottish students' verbal communications with mentors and ERASMUS students from other European countries were inhibited due to their strong accents.
- Students experienced initial feelings of isolation due to the language barrier but when the nursing staff spoke to them in English and they became part of a nursing team, they developed a sense of belonging.

In addition, another key finding was the use of strategies to overcome communication difficulties. These strategies were as follows:

- Students memorised symbols in the computerised patient documentation to enable them to record vital signs (Waterhouse, 2011). They found this easy as it was numerical information.
- Students used non-verbal communication which included the use of gestures and props when taking vital signs.
- Kopla translate, Google translate, and other language apps proved beneficial when students had trouble understanding the meaning of words.

The following findings answered the second research question: what support mechanisms are presently in place for students who cannot speak the language in the four host countries, Finland, Sweden, Spain and Italy? The support mechanisms which were in place in the four host countries for ERASMUS students were as follows:

- The induction/orientation programmes were valuable, but the length of these programmes varied within the four countries from one to five days. Students indicated that the hospital orientation programmes helped to reduce anxiety as it enabled them to meet the clinical staff before their first day of clinical practice.
- Language classes were provided by some host universities whereas other universities did not provide language classes.
- Host families in Spain and Sweden were cultural and language brokers for student nurses.

- Students valued a tripartite support (ERASMUS coordinators from their home university, ERASMUS coordinators from their host university and mentors in clinical practice) during their cultural experience.
- Students spent about 70% to 100% of their time with mentors in clinical practice. This was a higher level of supervision than what they received in the UK.
- The role of the mentor included teaching psychomotor skills, supervising students carrying out nursing care, language brokering (McDowell, Messias and Estrada (2011) and cultural brokering (Strouse and Nickerson, 2016).
- ERASMUS students who had placements in the Finland, Sweden, Italy and Spain appreciated the support of local students who acted as buddies.

Students valued all these support mechanisms. Furthermore, some students stated that they felt like a European in the host countries due to mixing with students from different countries. This is noteworthy as one of the aims of ERASMUS+ is to raise awareness of culture and develop a sense of 'European citizenship and identity' (European Commission, 2014a, p.33)

The following findings answered the third research question: how do mentors and students perceive the benefits of an ERASMUS experience? Both mentors in the four countries and ERASMUS students believed that despite the language constraints there were benefits for student nurses who participated in an ERASMUS experience. The benefits were both personal and professional. The personal benefits were as follows:

- Students developed self-efficacy, personal independence and self-confidence.

The professional benefits were as follows:

- Students developed new clinical skills and confidence in clinical practice.
- Students developed prudence in evaluating practice in the home country and host country. Mentors indicated that this facilitated critical thinking.

- Students became more astute in observing patients' general appearances and non-verbal communication and were able to link these diagnostic clues to care needs.

The fourth research question was: what are the relationships between the process of cultural competence and professional learning? The findings indicate that there were relationships between cultural competence and professional learning. These are as follows:

- Cultural encounters which is one of the constructs of cultural competence (Campinha-Bacote, 2002) were imperative. It was through cultural encounters that students developed cultural awareness, cultural knowledge, cultural skills and cultural desire.
- Cultural encounters facilitated the commencement of cultural competence and enhanced professional learning.
- Cultural encounters with patients enabled students to develop clinical skills and practice knowledge.

The findings indicated that there was a link between the general culture of the country and the organisational culture of the ward. For example, the students indicated that people in Sweden and Finland embraced healthy lifestyle behaviours and this was reflected in the organisational culture of the ward. Other findings regarding the organisational culture are as follows:

- Students developed a knowledge of the general culture of the country and the organisational cultural of the ward in the host country.
- Students commented that there was not the same hierarchical structure in clinical practice in the four countries as what there is in Scotland. They felt that not having a hierarchical structure helped to encourage communication between disciplines.
- Despite the language barrier, students felt part of the organisational culture of the ward.

Although an ERASMUS immersion experience has many benefits, students can be inhibited through lack of language proficiency. The findings indicated that students'

lack of language proficiency can have an impact on both professional development and cultural competence. Students were not able to question practice if staff in clinical placements were not proficient in the English language.

6.2. Contribution to the Body of Knowledge

This study has provided a current contribution to the body of knowledge about how the constraints of language influence cultural competence and professional development in an ERASMUS placement for student nurses. The findings indicate that students developed both personally and professionally during their ERASMUS experience, but this was only achieved through the assistance of the mentor who acted as a language broker.

These mentors were language mediators in that they interpreted for students during interactions with patients and translated information in patients' records from the language of the host country to English. This enhanced students' understanding of the patient's medical history and their care plan. In contrast to Koskinen and Tossavainen's (2003a) findings that the language barrier minimised direct contact with patients, all ERASMUS students in my study had direct contact with patients on a regular basis throughout their clinical experience. This intercultural contact with patients enabled the students to start the process to cultural competence (Campinha-Bacote, 2002).

My research inquiry found that students spent 70% -100% of their time in clinical practice with their mentors. One student indicated that she was supervised by her mentor for 60% of her time in clinical practice and during the remainder of the time she received supervision from another registered nurse. This exceeds the 40% recommended by the NMC (2008). The length of time spent in placements varied, two students spent one week in some placements whereas other students had one or two placements within a seven-week period. My results indicated that longer placements were better for continuity with the mentor and it also enhanced the students' feelings of belonging to the ward team. The longer placements also enabled students to develop good relationships with members of the multidisciplinary team.

In addition, mentors maintained the safety of students (NMC, 2011) through direct supervision when students carried out nursing procedures but in doing so, they

protected the safety of patients. This is echoed in the statements of two mentors who indicated that they don't like to leave the student unsupervised as it may compromise the safety of student and patient. The students' which mentors referred to, did not share a common language with the patients. This study demonstrates how mentors have a dual responsibility first to their patients and then to the student nurse. Figure 12 shows the diverse roles of the mentor within an ERASMUS clinical placement for student nurses.

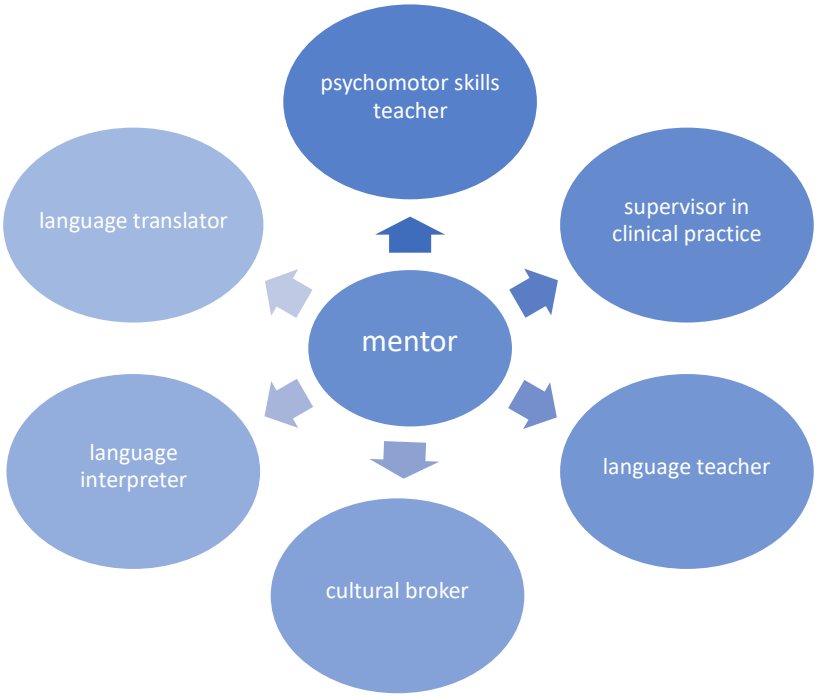

Figure: 12: The Role of the International Mentor

Most students commented that patients were delighted to have foreign student nurses. As indicated in Chapter 4, only one student who had a placement in Finland indicated that one of the patients was annoyed because she could not understand what he wanted. Although this patient expressed his feelings, other patients may have had similar feelings about students not speaking their language but did not express these.

From an educational perspective, my research findings indicated that students used mobile language apps or google translate when they had difficulty comprehending what people were saying. There is no evidence of a research study which indicates

that ERASMUS student nurses used technology inside and outside clinical practice as a strategy to understand the language of the host country. Some mentors helped students in clinical practice to access online dictionaries and Google translate. This demonstrates another facet of the invaluable support provided by mentors within a clinical placement.

Data collection for this study commenced in the year 2015 and language testing did not commence at the university where this study took place until 2016. Students are required to take a language assessment based on the language of the host country before departure (European Commission, 2014a). Three students did the assessment in 2016, two students who had placements in Spain and one in Italy. These three students achieved the lowest grade but when they had their language assessment following their ERASMUS experience, they were able to increase their score by one grade. Acceptance for an ERASMUS exchange does not depend on the grade awarded (European Commission, 2014a) but ERASMUS students who have placements in the UK are required to be proficient in English. However, the pre and post language testing may help to motivate students on return to the sending country to learn another language. Two students who had placements in Spain were keen to continue language studies and a student who had a placement in Italy enrolled in an Italian course on return to Scotland. Language testing for students in Sweden and Finland was not available when this study was carried out.

Although some students learnt some phrases in the host country, it was not enough to have a conversation in a foreign language. Some patients spoke English in the two Nordic countries, and this enabled students to engage in a conversation with them. The results of my study indicated that Scottish ERASMUS students concentrated on the practice competences identified in Chapter 1, and language learning in the host country was given a lower priority. Language classes were available in some universities but shift patterns or compiling assignments for their home university prevented students from attending these classes. It could be argued that language learning is the aim of ERASMUS+ (European Commission, 2014a), yet the fact remains Scottish students depend on English being the spoken language in clinical placements. This is complicated by the fact that English remains the lingua franca of Higher Education in Europe (Bolton and Kuteeva, 2012; Kuteeva and Airey, 2014) and this may discourage students from learning a second language.

6.3. Recommendations

This section provided recommendations for ERASMUS students and ERASMUS coordinators. As identified in Chapter 4, this case study included an educational, social and cultural (Stake, 2006), context and this has been reflected within the recommendations.

6.3.1. Recommendations for students

My results indicated that some students who had placements in Spain and Italy were surprised that not more of the hospital staff spoke English. It was evident that students did not believe they had a responsibility to learn the language of the host country. As indicated in Chapter 4, a student who had a placement in Italy commented that she wanted to focus on nursing practice skills rather than learning another language. There is no doubt that a clinical placement is an integral part of a nurse education programme and provides students with opportunities to learn nursing practice skills and knowledge (Donnelly and Wiechula, 2012). On the other hand, one of the aims of ERASMUS + is to the is to develop language skills (European Commission, 2014a). The results indicated that some students' colloquial expressions and accents inhibited communication. As good communication is central to high quality nursing care (Bramhall, 2014: Healthcare Quality Strategy, 2010) it is therefore recommended that:

- Students should be aware of strong accents before going to the host country, slow their rate of speech and refrain from using colloquial expressions during their ERASMUS placement.
- Students should learn the language of the host country at least a year before going on their ERASMUS exchange programme.
- As cultural awareness is one of the aims of ERASMUS+ (European Commission, 2014a), students should be encouraged to compare their own culture with the general culture in the host country.
- Students should also be encouraged to examine how the general culture of a country impacts on the organisational culture in clinical practice.

6.3.2. Recommendations for ERASMUS Coordinators

A student who could speak German had a placement in Sweden. She stated: 'if I had an ERASMUS placement in Germany, I would have had a knowledge of the language and would have had a higher level of independence'. Three students who also had placements in the Northern European countries (Sweden and Finland) had a knowledge of Spanish but could not speak it fluently. It is therefore recommended that:

- ERASMUS coordinators in sending universities identify the students with second languages or who have a knowledge of another language and if possible, place these students in a host country in which this language is spoken.
- The country where the student is going to for their ERASMUS experience should be identified at least one year before departure. This would enable students to have a longer period of time to learn the language.

ERASMUS coordinators in the host universities were in contact with the student via email, prior to students embarking on their ERASMUS experiences. They arranged accommodation, organised induction/orientation programmes and identified named mentors to supervise the students in clinical practice.

Two students missed the induction programme in Sweden because the programme started before their module in the sending university finished. Although these students had an orientation to their clinical placements, one student commented that she had missed the initial bonding with the other ERASMUS students which normally takes place during an induction programme. The European Commission (2014a) recommends that host Higher Education Institutions integrate mobility students into the host country, but it does not identify the form that this should take. It is therefore recommended that the sending university and receiving university:

- Arrange for students to arrive in the host country in time to participate in an induction/orientation programme if one is available.

Shift patterns in the host country prevented some students from engaging in ERASMUS activities and language classes. Taking this into consideration and the European Commission's (2014a) suggestion that both the sending and receiving

university have a responsibility to provide linguistic and intercultural preparation for outgoing and incoming ERASMUS students, it is therefore recommended that:

- Students should be encouraged to attend language classes (if available) within the host university.

Students valued the support they received in the host country; it is therefore recommended that:

- Tripartite support from ERASMUS coordinators in sending and receiving universities and mentors in the host country should be maintained.

6.3.3. Recommendations for Mentors

Some students had one or two clinical placements in the host country whereas other students had a different placement each week within the first four weeks of a hospital placement. It is therefore recommended that:

- Students should have no more than two clinical placements in the host country. This would enable mentors to get to know the student and carry out an accurate clinical assessment with the student and/or contribute to the assessment carried out by the ERASMUS coordinator.
- Mentors should know what their role in supporting ERASMUS students entails before students go to the host country.
- If language classes are available in the host country, mentors should encourage students to attend these classes.
- Mentors should continue to provide the aspects of student support identified within Figure 12.

6.3.4. Recommendations for Programme Leaders

The findings indicated that all students developed a good knowledge of the organisational culture in clinical practice. Some students were impressed by the healthy lifestyles in the Scandinavians countries, family related policies in hospitals in Spain and a friendly relaxed culture in clinical practice in Italy. These cultural traits had an impact on professional practice. It is therefore recommended that:

- Students should be encouraged to share areas of good practice which they encountered in the host country within meetings and student conferences in their home university. This would facilitate intercultural learning.

Students commented that they had two academic assignments to complete in the host country during their ERASMUS experience. This meant that some students could not engage in certain ERASMUS activities due to completing assignments. It is recommended that:

- Students should have no more than one academic assignment to complete in the host country. This assignment should be linked to the cultural experience.

6.3.5. Recommendations for Future Research

This study has found that in addition to mentors having a case load of patients they provided ongoing support for the ERASMUS students. It is therefore recommended that:

- A qualitative study could be carried out to explore if the support provided for international mentors is beneficial and adequate.

This study has demonstrated that external factors can influence the ERASMUS clinical experience. Taking this into consideration and the dearth of research on how external factors can contribute to the ERASMUS student nurses' clinical experience, it is therefore recommended:

- A study should be done to investigate student nurses' perceptions of the external factors which influenced their ERASMUS clinical experience.

This study has focused on two Nordic countries and two European countries. It is therefore recommended:

- A research study should be carried out in other European countries to explore mentors' and students' views on the effectiveness of an ERASMUS programme for students who cannot speak the language of the host country.

My research study was carried out in four countries which are part of the European Union. In the light of Brexit (Gazzola, 2016) it is recommended that the research

inquiry should focus on ERASMUS participating countries which are not part of the European Union. For example, countries such as Norway and Switzerland, participate in ERASMUS+ but are not part of the European Union (European Commission, 2014a). As indicated in section 1.5.1. (p.12), the decision for these countries to participate in ERASMUS+ is subject to a joint European Economic Area Committee's decision (European Commission, 2014a). This implies that even though the United Kingdom leaves the European Union there is still the possibility that students will be able to participate in ERASMUS programmes. However, as highlighted in section 2.2.2. English is the lingua franca for Higher Education and global business, but this may change post Brexit (Gazzola, 2016).

6.4. Strengths and Limitations

The strengths of this research inquiry were the use of multiple case study analysis (Stake, 2006). This enabled an analysis of each case and the development of new knowledge about the quintain (Stake, 2006). This supports the philosophy of the instrumental case study which is to develop new theories and knowledge and to contribute to the improvement of a situation ((Thomas, 2016) or a phenomenon. As already indicated in Chapter 3, Stake (2006) likens the term quintain to a phenomenon, community or organisation with branches. In my study the quintain was the clinical placements for students and the four cases were the countries (Finland, Sweden, Spain and Italy) in which students had their ERASMUS experience.

The overarching question and the four sub-questions generated rich data from students' diaries and one-to-one interviews with both mentors and students. Another strength of the study was that respondents were able to answer the research questions from a common and specific perspective (Cohen, Manion and Morrison, 2011). The common and specific elements were related to the educational, social and cultural context of each case (Stake, 2006). For example, the findings indicated that there were similarities and differences in the ERASMUS experience within each of the four countries. Some of the differences identified by students were that in the two Nordic countries most of the staff were fluent in English whereas in the two Southern European countries, students were surprised that most of the clinical staff could not speak English. However, these differences and similarities helped to provide a broader picture of the quintain.

On the other hand, a possible limitation could be that data was obtained from only five participants in Italy whereas in the other three countries six to eight individuals participated in the study. Then again, the three students in Italy provided an in-depth holistic account of their ERASMUS experiences in their diaries. In addition, what added value to this case was that data was collected from mentors in clinical practice in Italy and this enabled me to observe some of the challenges which students may encounter if they could not speak the language. On the other hand, another limitation was I did not observe the students in clinical practice in the host countries, so I relied on the information obtained from diaries and interviews.

Furthermore, interviews with mentors in Sweden and Spain were carried out via Skype, a telecommunication software system which provides video links to enable a two-way communication process (Deakin and Wakefield, 2014). Although these two approaches were used to collect interview data from mentors there were no differences in the quality of data obtained from each of these participants. I felt that this flexible approach to data collection worked well and it did not alienate mentors who wished to participate in the research inquiry but were unable to use Skype.

6.5. Concluding thoughts about the research inquiry

The Bologna process was introduced as a borderless, harmonised democratic European Higher Education initiative (Coleman, 2006) to facilitate the mobility of students. This intergovernmental initiative can be related to political globalisation. Social globalisation can be linked to mobility and the interconnectedness between students and people in different countries (Portrafke, 2015). The findings indicate that this interconnectedness can be impaired if students are unable to speak the language of the host country.

As identified in Chapter 1, my reason for embarking on this research journey included personal, educational and professional factors. My personal reasons were that Scottish ERASMUS students were not able to speak the language of the host country and I felt that they would be unable to integrate into the clinical setting in the same way as students who spoke the language of the host country. On the other hand, due to English being the lingua franca (Philipson, 2008) of European Higher Education, students did not feel that there was a need to learn the language prior to going to the host country. My research findings addressed these issues. Although,

the main priorities of students were to attain their practice outcomes, most students had a desire to learn phrases in the language of the host country. This was to enable them to engage with patients. Only one student who had a placement in Italy commented that she wanted to focus on practice learning instead of learning phrases in the language of the host country. As already indicated in section 6.4 students who had placements in the two Southern European countries were surprised that not many hospital staff spoke English. It was this which stimulated them to learn some phrases in the language of the host country in order to communicate with patients. My results indicated that some students were challenged by the linguistic skills of other European students who could speak two or more languages. This is reflected in a statement made by one of the Scottish students. She stated: 'there was one student from Belgium. He spoke English, Dutch, Spanish and Swedish. I was standing there and could only speak English.'

From an educational perspective, I was also concerned that the inability to speak the language would influence educational achievement. However, English was the language that was used during discussions with mentors, national students and ERASMUS students from other European countries. Mentors indicated that students worked alongside national (local) students in clinical practice and in doing so they were able to support each other in knowledge development. Despite the inability to speak the language, students were able to develop a knowledge of the culture of the host country.

As indicated in Chapter 2, the study by Sawir's (2013) found that international and local students in Australia did not integrate, despite the efforts of academic staff whereas my findings indicated that the Scottish ERASMUS students and national students shared their professional experiences and discussed their cultural differences. Student buddies were also allocated by some host universities to help the students if they encountered difficulties outside practice. Although this source of support proved beneficial for Scottish ERASMUS students, it is also beneficial for local students as this interconnection with ERASMUS students can facilitate internationalisation at home (Sawir, 2013). The ERASMUS students' clinical experiences in the four European countries is associated with internationalisation abroad (Sawir, 2013).

My professional reason for this study was that communication is the cornerstone of good nursing care and these students did nor share a common language with patients. As indicated in Table 2 (p.63), eleven Scottish ERASMUS students were monolingual. However, students developed a good knowledge of nursing practice through being with mentors for approximately 70-100% of their time in clinical placements. The mentors acted as language brokers for students and patients in each of the four countries. A noteworthy reason for the high levels of supervision was provided by one of the mentors. She claimed: “I did not want to leave the student and compromise the patient”. However, one must also take into consideration that this mentor worked in a unit where patients received intensive nursing care.

However, even though these students could not speak the language they all viewed their time spent in the host country as a positive experience. This positive attitude is reflected in the words of one of the students who states: ‘the benefits outweigh the difficulties”. Although students had constraints and challenges in clinical practice due to their inability to speak the language, they acknowledged that there were professional and personal benefits to be gained during an ERASMUS experience. Some Scottish ERASMUS students expressed the desire to work in the host country, but they recognised that their inability to speak the language would restrict them in finding employment within the European labour market. They realised that even though English is the lingua franca of Higher Education in Europe, it was not the lingua franca of clinical placements in host countries.

6.5.1. Personal and Professional Learning

Just as the ERASMUS experience enabled students to develop personally and professionally, my doctoral journey also provided opportunities for both professional and personal development. Burnard, Dragovic, Ottewell and Lim (2018) point out that professional doctorate students commence this journey as experienced practitioners, but the development of new skills is essential in order to navigate through the many difficulties that arise during the doctoral journey. Albeit, I had carried out a previous research study, the taught component of the professional doctorate and my supervisory discussions made me realise that doctoral research was different to what I had previously undertaken. I realized that research at doctorate level must be original and extend the body of knowledge. In order to do this, I had to demonstrate a strong

engagement with theory, a critical evaluation of research studies and a self-evaluation of my own research inquiry (Hodgson, 2017). I found this challenging. These challenges were both psychological and educational. On some occasions I had periods of self-doubt about completing the doctorate. As a full-time lecturer and a part-time student, I was anxious about my ability to devote time to data collection. Although I developed a sense of perseverance and a course of action in relation to time management, there were still educational challenges during my research journey in relation to developing a deeper level of critical analysis and synthesis within the thesis. I felt it was beneficial to relate synthesis to Bloom's Taxonomy which is linked to higher-level thinking and originality (Dwyer et al., 2014).

There have been many occasions during my doctorial research journey when I have had to step out of my comfort zone to learn new technical skills such as NVivo qualitative data analysis and travel to host countries to collect data. This enabled me to relate to some of the ERASMUS students' comments that it was through stepping out of their comfort zone they were able to develop personally and professionally (Prazeres, 2017).

As already indicated in section 3.5.6.(p.69) some interviews were carried out through Skype (Seitz, 2016) whereas other interviews were face to face with mentors in host countries. I was apprehensive about using Skype for research interviews but after my first one I developed a sense of self efficacy in carrying out my newly acquired technical skills. Both types of mentor interviews enabled me to develop a more conscious style approach to communicating with mentors from the four host countries. I felt this was imperative when carrying out interviews with mentors whose first language was not English. On some occasions this included slowing my rate of speech to enhance listener comprehension. I felt that I could relate to some of the ERASMUS students as they had used similar strategies to enhance listener understanding.

Although the doctoral journey has necessitated a huge investment of my time it has had had many rewards. These include a broadening of my professional and research knowledge base. It has also enabled me to develop a professional insight into educational policies in relation to nursing and ERASMUS+ and explore how ERASMUS+ programmes are delivered in other countries. As a pragmatist the professional doctorate has suited my learning style (Honey and Mumford, 1982) as I

could envisage how these policies, theories and research findings can be applied to practice. From a personal perspective, the professional doctorate journey has enabled me to develop a sense of self-efficacy and fulfilment.

I look forward to sharing the knowledge acquired through my doctorate studies with ERASMUS students and international mentors and engaging in more academic writing in order to disseminate my research findings.

6.6. Summary

My research findings have indicated that the Scottish ERASMUS students had cultural encounters with patients and were able to provide direct nursing care to them. This enabled them to develop professional knowledge, cultural knowledge and cultural skills. The findings revealed that there was a link between the process of cultural competence and professional learning. This was mainly achieved through direct encounters with patients and members of the multidisciplinary team. However, some mentors and ERASMUS students commented that professional and cultural learning could have been enhanced if students had a knowledge of the language of the host country. Students indicated that they performed as second year students and would have had more autonomy in clinical practice in their own country. However, all students valued the time spent in the host country as it stimulated critical thinking and encouraged most of the Scottish ERASMUS students to learn a second language. Two of the main recommendations are that students should commence learning the language of the host country at least a year before their ERASMUS experience, to enhance professional learning and the process of cultural competence. It is also recommended that students who have a knowledge of a foreign language should be placed in the country where this language is spoken in order to develop their linguistic skills in this language.

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Appendix A: Consent to Use the Camphina-Bacote Diagrams

TRANSCULTURAL C.A.R.E.

Clinical, Administrative, Research
& Educational Consultation
in Transcultural Health Care

J. Campinha-Bacote,
PhD, MAR, PMHCNS-BC, CTN-A, FAAN

Transcultural Healthcare Consultant

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meddir@aol.com

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11108 Huntwicke Place
Cincinnati, Ohio 45241

Date: July 24, 2018
To: Ms. Valerie Douglas
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates
RE: **Contractual Agreement for Limited Use of Campinha-Bacote's Models of Cultural Competence in a Dissertation**

This letter grants one-time permission to Ms. Valerie Douglas to copy my 1998 and 2010 models of cultural competence as they appear on my website at http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/ in her dissertation/thesis only.

TIME FRAME: Permission to use my model is a one-time use in July - August 2018 when she submits it to her professor in this paper.

RESTRICTIONS OF COPYING: This permission only allows the copying/ reprinting of my model in this academic paper. Ms. Valerie Douglas **agrees that my models cannot be copied for any other reason outside of this paper.** This includes, but not limited to, not being copied in another formal or informal publication, handouts, Power Point presentations, Poster presentations or in any hard copy or electronic formats for presentations or for any other purpose.

Ms. Valerie Douglas will use the following citation when citing my models in his dissertation:

The Process of Cultural Competence
in the Delivery of Healthcare Services (1998 & 2010)
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Transcultural C.A.R.E. Associates

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of Campinha-Bacote's Models of Cultural Competence is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Dr. Josepha Campinha-Bacote — Date 7/24/18

Ms. Valerie Douglas — Date 12/11/18

Appendix B: Participant Information Sheet for Student Nurses

Name of department: School of Education - Faculty of Humanities and Social Sciences

Title of the study: An exploration of mentors and student nurses' views regarding student nurses' inability to speak the language of the host country during an international clinical experience.

Introduction

I am a lecturer in nursing at the University of West of Scotland (UWS) and presently undertaking an EdD at Strathclyde University. I am the site lead within the School of Health Nursing & Midwifery at Ayr Campus for ERASMUS.

What is the purpose of this investigation?

The purpose of the study is to investigate mentors and students' views of students' inability to speak the language of the country where they have a clinical experience in a hospital setting. Although there have been several studies done on the experiences of ERASMUS students, they don't focus on students who are unable to speak the language of the country where they have a clinical placement. This study will uncover how students perceive the benefits of an ERASMUS experience when they cannot speak the language and the difficulties students may experience in clinical placements if they are unable to speak the language of the host country. You are invited to participate in this study because you have had the experience of working in a country where you have been unable to speak the language. Your views regarding this experience are valuable as it may help prepare future students for international placements.

Why have you been invited to take part?

You have been chosen to take part in this study because you are a student nurse participating in an ERASMUS programme and will have experience working in a clinical environment in a host country. I have obtained your contact details from the ERASMUS coordinator for the School of Nursing Health and Midwifery at UWS

Do you have to take part?

Your participation in this study is entirely voluntary. If you consent to participate and then decide to withdraw from the study, you can do so without any consequences. Participation or non-participation will not influence your grades or progress within the BSc in Adult Nursing Programme or any aspect of your ERASMUS status. If you choose to take part and at a later stage come to a decision to withdraw data, you can do so before the interview data is analysed.

What will you do in the project?

The study may entail you using a diary for four days each week over a seven-week period. Students are advised to spend no longer than thirty minutes each day,

recording information in their diaries. The information which you should record in your diary are experiences in clinical practice which you have found beneficial and any difficulties you encountered as a result of not speaking the language. A notebook will be supplied for you to record the information in. The diaries can be used to facilitate recall during interviews.

You will be invited to participate in a semi-structured interview at a time when it is convenient for you on your return to Scotland. The interview will last about 45 – 60 minutes. You will be asked for consent to audiotape the interviews. The focus of the interview will be your experiences in the host country. You will be asked about the benefits of the experience, language comprehension and if you were restricted in any aspect of clinical practice due to not speaking the language.

What happens to the information in the project?

Interviews will be recorded provided that you give your consent and then transcribed verbatim. A password protected computer will be used to word process the transcripts. The information which you provide will be analysed along with the information provided by other students. Quotations from the transcript may be used to support aspects of the data. The information obtained by interviews will be presented in a way that will not link you to the data. The diaries are a data collection method and a memory aid for you during the interview and will be returned to you following the interview. Interview transcripts will be anonymised and stored in a locked cupboard. Only my research supervisors and I will have access to the transcripts.

Data will also be collected from mentors. Should your mentor be involved in the study they will be focusing on their experiences working with several international students who have been unable to speak the language of the country. There will no matching of the data collected from students and mentors.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 1998. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 1998.

What Happens Next?

If you decide to participate in the study complete the consent form and return it by email to val.douglas@uws.ac.uk. I will post the notebook to you prior to leaving for your ERASMUS experience. I will then arrange a time when it is convenient for you to be interviewed following your ERASMUS experience.

Thank you for reading this information

Please ask any questions if you are unsure about what is written here. My contact details are Valerie Douglas T/N 01292 886339 email address: val.douglas@uws.ac.uk

This investigation was granted ethical approval by the School of Education Ethics Committee. If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed, or further information sought, please contact:

Dr Eleni Karagiannidou
Ethics committee Chair
School of Education
University of Strathclyde
Lord Hope Building
Glasgow

Appendix C: Participant Information Sheet for Mentors

Name of department: School of Education - Faculty of Humanities and Social Sciences

Title of the study: An exploration of mentors and student nurses' views regarding student nurses' inability to speak the language of the host country during an international clinical experience

Introduction
I am a lecturer in Nursing at the University of West of Scotland and presently undertaking an Ed. D at Strathclyde University. I am also the lead within the School of Health, Nursing & Midwifery at Ayr Campus for ERASMUS

What is the purpose of this investigation?
The purpose of the study is to ascertain how effective is an ERASMUS experience for student nurses' who are unable to speak the language of the host country. There have been studies done on the experiences of nurses who have participated in ERASMUS, but they have not focussed on language comprehension issues facing ERASMUS students in clinical placements. Another gap in the body of knowledge is that studies have been done from student nurses' perspectives but there is no evidence of studies about mentors' experiences supervising students who cannot speak the language of the host country. This qualitative study will uncover how mentors perceive the benefits of an ERASMUS experience when student nurses cannot speak the language and the potential difficulties students may experience in clinical placements if they are unable to speak the language. The study will also examine the support mechanisms available for students who are unable to speak the language.

Do you have to take part?
Your decision to take part in this study is entirely voluntary. If you consent to participate and then decide to withdraw from the study, you can do so without any consequences to your involvement in mentoring student nurses from the University of West of Scotland.

What will you do in the project?
The study will entail you participating in a semi-structured interview at a time which is convenient for yourself. The interview will be conducted in the English language via Skype or face-to-face (in the host country) and will last for about 45 minutes. The main focus of the interview will be on your experience mentoring student nurses who cannot speak the language of the host country in clinical practice.

Why have you been invited to take part?
You have been chosen to take part in this study because you have had the experience of supervising student nurses who cannot speak the language of the host country.

What happens to the information in the project?

Interviews will be recorded, provided that you give your consent and then transcribed verbatim. The information which you provide during the interview will be analysed along with the information provided by other mentors. Student nurses who are on ERASMUS placements will also be involved in this study but there will be no matching of the data collected from students and mentors.

Verbatim phrases which some mentors have stated may be used to illustrate some facts. The sample size is sixteen mentors from four different countries. Due to the small number of participants there is a possibility that you may recognise a verbatim quote as yours. In order to protect your anonymity, the name of your institution/hospital where you work will not be disclosed. The information which you provide will be presented in a way that will not link you to the data. A password protected computer will be used to word process the transcripts and the names of mentors will not be identified within these transcripts.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 1998. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 1998.

What happens next?

If you are happy to be involved in the study, sign the consent form and return it to Valerie Douglas at val.douglas@uws.ac.uk I will then contact you to arrange a time which is convenient for you to be interviewed.

Thank you for reading this information

Please ask any questions if you are unsure about what is written here. My contact details are Valerie Douglas T/N 01292 886339 email address: val.douglas@uws.ac.uk

This investigation was granted ethical approval by the School of Education Ethics Committee. If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed, or further information sought, please contact:

Dr Eleni Karagiannidou
Ethics committee Chair
University of Strathclyde, School of Education
Lord Hope Building
Glasgow

Appendix D: Consent Form for Student Nurses

Name of department: School of Education – Faculty of Humanities and Social Sciences

Title of Study: An exploration of mentors and student nurses' views regarding student nurses' inability to speak the language of the host country during an international clinical experience

- I confirm that I have read and understood the information sheet for the above project.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time without having to give a reason and without any consequences. If I exercise the right to withdraw and I don't want any data to be used, any data which has been collected will be destroyed.
- I understand that I can withdraw from the study any personal data (i.e. data which identified me personally) at any time (up to publication).
- I understand that anonymised data which identified me personally (i.e. data which does not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publically available.
- I agree that anonymised verbatim quotes may be used in reports or presentations
- I consent to be a participant in the above study

PRINT NAME _____

Signature _____ Date _____

Appendix E: Consent Form for Mentors

Name of department: School of Education – Faculty of Humanities and Social Sciences

Title of Study: An exploration of mentors and student nurses' views regarding student nurses' inability to speak the language of the host country during an international clinical experience

- I confirm that I have read and understood the information sheet for the above project.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time without having to give a reason and without any consequences. If I exercise the right to withdraw and I don't want any data to be used, any data which has been collected will be destroyed.
- I understand that I can withdraw from the study any personal data (i.e. data which identified me personally) at any time (up to publication).
- I understand that anonymised data (i.e. data which does not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publically available.
- I agree that anonymised verbatim quotes may be used in reports or presentations
- I consent to being audio recorded as part of the study
- I consent to be a participant in the above study

PRINT NAME_____

Signature of Participant _____ Date_____

Appendix F Interview Schedule – ERASMUS Students

Introduction

Thank you for agreeing to participate in this interview. Discuss elements of informed consent

State the purpose of the Interview

The purpose of the interview is to ascertain how effective an ERASMUS experience is for students who cannot speak the language of the host country.

Prior to the interview students will complete a diary over a seven-week period about the difficulties they encountered through not speaking the language and the benefits of an ERASMUS placement.

Preliminary questions

Do you speak any foreign languages? Which languages do you speak?

1. What difficulties or challenges did you encounter in clinical practice due to not being able to speak the language of the host country?

   Reference can be made to any diary entries. These included difficulties encountered through not being able to speak the language of the host country and the benefits of an ERASMUS placement.

2. Were you restricted in the delivery of any aspects of nursing care due to not being able to speak the language? If so, which aspects of care were you restricted in carrying out?

3. What do you feel the benefits of your ERASMUS experience were? Reference will be made to any diary entries about the benefits of an ERASMUS placement.

4. What support mechanisms did you feel were beneficial?

Summary: End of the interview

Appendix G: Interview Schedule – Mentors

Introduction

Thank you for agreeing to participate in the interview. Discuss elements of consent.

State the purpose of the Interview

The purpose of the interview is to ascertain how effective an ERASMUS experience is for students who cannot speak the language of the host country.

Preliminary questions

How long have you been a mentor for ERASMUS students? Which languages do you speak?

1. What are the difficulties or challenges that student nurses experience when they cannot speak the language of the host country?
1. Were the students restricted in the delivery of any aspect of nursing care due to not being able to speak the language?
2. What are the benefits of an ERASMUS placement for students who cannot speak the language of the host country?
3. What support mechanisms are presently in place for students who cannot speak the language?

Summary: End of the interview

Appendix H: Example of Preliminary Data Analysis – Diary Extract

Tuesday, 1st March Today, I had my first day of placement in Sweden and what a great experience it was. Everyone was so welcoming. All the staff knew I was coming and had a mentor for me. She was very nice and spoke excellent English.	Support Mechanisms: Mentor Support
Wednesday, 2nd March I encountered some problems being able to speak to patients as 1 out of 12 patients spoke English. I wish Swedish was an easier language to pick up. However, even the nursing staff has said it is a difficult language to understand. I am enjoying the experience and seeing how the Swedish Health care system works. Although there are language barriers I am still learning and interacting with staff and patients. I was working with N who has been a qualified nurse for over a year. Today, I helped with patients coming into the clinic and doing blood pressures and taking bloods. It was good to be more involved today with practical skills and to see how they do things differently. I found it easier today to interact with patients as most of them spoke English so they could understand a basic conversation. I did find that I had to try and talk a lot slower and use words that were easy to understand. I have found that I have started to use a lot of non-verbal communication when I am carrying out tasks. Patients understand when I point or show them what I need to do. I have picked up some words in Swedish words like 'hi' and 'thank you' and 'please'. I also got to use a different cannula which I needed help with. It is different from the ones used in the UK, but it was good practice and I hope to do more now that I have practiced. I also worked with a nursing assistant who was Welsh, so it was nice being able to communicate with her. I had really a good day and it nicer being able to communicate a bit more with patients.	Communication Challenges: with patients Professional Benefits Communication Challenges Support Mechanisms Professional Benefits Strategies used to communicate: Speechless Communication Professional Benefits Support Mechanisms Communication with patients
Monday, 7th March 'M' was able to go into a lot of depth with me about things and explain all the processes. M was very good when the patients arrived and explained to them, I spoke English. Most of the patients today didn't speak a lot of English so M translated for me. I am finding it amazing how all the staff speak English. My non-verbal communication skills were used again today when taking blood pressure. I would show them the cuff and point to their arm. I have realised a smile can go a long way. Although there is still a language barrier with patients, I am still able to practice my skills and feel confident speaking non-verbally to patients.	Professional Benefits Support Mechanisms Mentor support Strategies used to communicate: Speechless Communication
Thursday, 10th March I am picking up Swedish words but also noticing myself watching people's gestures and body language when they are doing handovers. The ambulance staff were excellent at translating for me and would explain to me before we went out on a call what we would be doing. I was able to help in the back of the ambulance taking blood pressure and pulse and counting respirations. One of the young girls we picked up with stomach pain was very anxious and gripped my hand. It really showed me that although I don't speak the language a little gesture and compassion can really put some at ease.	Speechless Communication Support mechanisms Professional Development Speechless Communication
Friday, 11th March My mentor was very good speaking to the patients and telling them where I was from. She would get their permission for taking blood and carrying out tasks. I was very lucky today as we had a few patients who could speak English and were able to speak to me and understand me. This made it easier for me to take bloods and let the patients know what I was doing. The one thing that had been difficult for me is not being able to write notes for patients or read their past medical history. The staff (mentor) have been very good letting me know about the patient's past medical history Today I was working in the dialysis unit. It was interesting seeing dialysis as I have not seen it at home [Scotland]. It is interesting to see how the patients are taught to take part in their own care. There were a couple of patients who spoke good English so that was helpful for me as I was able to ask questions. My mentor was very good at explaining the dialysis machines to me and how they worked.	Support mechanisms: mentor support Professional Benefits Communication Challenges: Inability to read patient information Mentor Support Professional Benefits Sense of Belonging Support Mechanisms: Mentor Support

Appendix I: An Example of the Nodes (Themes) identified, using NVivo 11 Computer Software

Nodes

Name	Sources	References
communication with patients in Italy	4	7
communications with patients in Sweden	7	10
Coordinator support	9	10
Culture	11	24
culture desire	3	4
Feeling Isolated	9	11
Finland - documentation	2	3
Finland - vebal communication with staff	5	9
handover - sweden	3	3
handover reports - Finland	4	6
Handover reports - Italy	2	2
Handover Report Spain	2	3
induction programme	9	10
Italy - documentation	2	2
Italy - verbal communication with staff	4	8
limitations - written communication	7	10
Personal development	10	20
Search engines and apps	10	11
snippets of information	3	3
Spain - verbal communication with staff	2	4
Speechless - non verbal communication - Finland	7	9
Support of mentor	21	34
Sweden - documentation	3	3