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Research into the factors influencing
the quality of care of Western nurses to
non-Western immigrant patients and
their relatives

A general literature review

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“We are sun and moon, dear friend; we are sea and land. It is not our purpose to become each other; it is to recognize each other, to learn to see the other and honour him for what he is: each the other's opposite and complement”.

(Hesse, 1968, p. 248-249)

Abstract

Introduction: During the past years the amount of global immigrants have increased due to many reasons. Nurses were challenged when providing care to immigrant patients and the need for cultural competent nurses increased. The level of their quality of provided care was influenced by many factors.

Aim: To illuminate the factors influencing the quality of care of Western nurses to non-Western immigrant patients and their relatives.

Method: A general literature review was done. Ten qualitative and two both qualitative and quantitative research articles were used from the period between 2005 and 2013.

Results: Nurses possessed cultural competences, which were divided in knowledge, attitude and skills. Challenges for nurses were; communication difficulties, difficulties related to differences in culture and external factors influencing the quality of care.

Discussion: The results were discussed by using relevant theories and researches.

Conclusion: The level of the nurses' quality of care was influenced by many factors. Organizations should be more supportive towards nurses. More research should be done into effective methods to improve the nurses' cultural competence.

Key words: nurses, immigrant patients, quality of care, cultural competence, barriers, challenges.

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Introduction

Since 1990, most countries of the world experienced an increased number of international migrants. In 1990 there were 154 million individuals living in another country than their country of birth. Ten years later, this number had increased up to 175 million and in 2013 it has even grown up to 232 million migrants worldwide. The majority of those migrants (59%) have moved to developed regions, which include Europe, Northern America, Australia, New Zealand and Japan. In 2013, Europe was hosting the majority of the international migrants (72 million), followed by Asia hosting 71 million migrants and Northern America as the third largest hosting country; 53 million (United Nations, Department of Economic and Social Affairs, 2013).

Migration takes place due to many different reasons. As described by Lee (1966), push and pull factors influence the immigration of individuals. Push factors are reasons that make individuals leave their home country hoping for better quality of life. A lack of jobs, poverty, political fear or persecution, war and natural hazards are, among others, examples of those push factors. Pull factors, on the other hand, are factors that make people want to live in another country. Those factors include; more job opportunities, better services, political stability, more wealth and a lower risk on natural hazards. Usually people migrate because of a combination of those factors (Lee, 1966; Polanco, 2013).

Migrants are seen as a vulnerable population with special needs (Derose et al., 2007; Hirani, 2008; Ottosson, 2000; Södergard & Ekblad, 1998). According to Derose et al. (2007) a vulnerable population can be defined as: *“a group at increased risk for poor physical, psychological, and social health outcomes and inadequate health care”* (p. 1258). Their vulnerability is influenced by different factors, such as the *“socioeconomic background, immigration status, limited English proficiency, welfare reform, residential location and stigma and marginalisation”* (Derose et al., 2007, p. 1258).

According to numbers of Eurostat (2015), the 28 European member states have experienced a major growth of the amount of asylum seekers. While in 2006 200 000 asylum applications were done by non-European migrants, in 2014 this amount has greatly increased up to 626 000. Almost 80% of the applications were from asylum seekers younger than 35 years. Most applications were done by Syrian citizens (20%), followed by Afghani citizens (7%), Kosovans and Eritreans (both 6%) and Serbians (5%).

Health care services are being challenged when meeting the health needs of migrants and ethnic minorities (Devillé et al., 2011; Jirwe et al., 2010). Nurses for example, are being challenged because of; difficulties related to different behaviour, language barriers, contact with relatives

and the use of natural remedies (Hjelm & Ozolins, 2003). Those differences could even increase, as immigrants often *“seek comfort in an even stronger bond to the country of origin and its founding values”*, as described by Festini et al. (2009, p. 221).

In addition, inequalities in health care use are seen between migrants and autochthones. The use of health care services of migrants is lower, but at the same time migrants are using emergency services more often than autochthones. In addition, antenatal and paediatric care have a lower utilization rate among immigrants. Reasons for those striking facts were found as barriers for migrants to access health care services. Those barriers were found to be *“education, cultural differences, language difficulties, lack of complimentary voluntary health insurance and legal issues”* (Mladovsky, 2007, p. 1).

Nurses can meet migrants as their patients in many ways. First of all, there is the nurses working in asylum centres and refugee camps. A nurse practitioner in an asylum seeker centre can be responsible for the assessment of the health needs of asylum seekers. Subsequently, he or she is responsible for the follow-up care during the immigrants' stay at the centre. If necessary, she can refer her patients to other disciplines (Suurmond et al., 2010). Of course nurses can also meet migrants in all different wards in the hospital, health centres or infant welfare centres, for example.

Health care providers who are culturally competent are able to provide a higher level of care as stated by Adams et al. (2004), Giger et al. (2007) and McColl & Johnson (2006). This fact really highlights the importance of the provision of culturally competent care by nurses. Cultural competence can be defined as: *“a continuous process of cultural awareness, knowledge, skill, interaction and sensitivity, among caregivers and the services they provide”* (Smith, 1998, p. 9).

This general literature review was written from the nurse's perspective. As nurses are with the patient during 24 hours a day, they are the ones who can influence the quality care the most. Due to the increasing global migration, nurses will get more and more in contact with immigrants during their work. Many nurses expressed they are experiencing challenges when giving care to immigrants (Devillé et al., 2011). Health care providers in general, and among them, nurses, are saying that they *“feel ill equipped to handle the challenges of caring for a culturally and ethnically diverse population”* (Taylor & Alfred, 2006, p. 115).

According to Ahmann (2002), Campinha-Bacote (1997), Campinha-Bacote (2002), Marcinkiw (2003), McGee (2001) and Pruitt (1999), it is important to decrease those challenges by becoming culturally competent. To become culturally competent, nurses should develop a cultural awareness, which is considered to be the first important step (Campinha-Bacote, 2002). Besides decreasing the level of

challenges, increasing cultural competence will improve the relationship between nurses and their patients (Ahmann, 2002; Campinha-Bacote, 1997; Campinha-Bacote, 2002; Marcinkiw, 2003; McGee, 2001). So, in order to improve the quality of care, nurses need to improve their cultural competence, which can be achieved by developing cultural awareness. The latter will be achieved by mapping the factors influencing the quality of care, which is the actual purpose of this general literature review;

The purpose of this study is to illuminate the factors influencing the quality of care of Western nurses to non-Western immigrant patients and their relatives.

1. Methods

This research was conducted according to the principles of a general literature review. Content analysis of pre-reviewed articles has been done in order to meet the purpose of this research. *“Content analysis is a kind of qualitative desk research in which the documents are studied closely for the meaning of and the relationship between the words that have been used”* (Verhoeven, 2011, p. 147). In this chapter a description of the used methods will be presented.

1.1 Article search

When searching for articles, different combinations of key words were used to expand the amount of possible usable articles. Synonyms of those key words were entered in the databases. The same combinations of key words were entered in both Medline and Cinahl, to increase possibility of usable articles. The articles included in this study were found with the following key words: nurses, cultural competency, cultural competence, immigrants, emigrants and immigrants, emigration and immigration, attitude, attitude of health personnel and nurse-patient relations.

After reading through the articles that were found, the reference lists were checked, in order to find more articles which would probably contain information answering the purpose of this research. The articles found in the reference lists of other articles were described as ‘manual search’. In appendix one, the searching strategy table can be found.

The article search was done according to the constant comparative method (Verhoeven, 2011). This means that different rounds of article searches were done, to collect data describing different perspectives on the subject of this study.

1.2 Exclusion and inclusion criteria

The article search was started with developing key words to find articles containing information answering the purpose of this research, as described above. Subsequently, a list of inclusion and exclusion criteria was made. The articles that were included only contained information about first generation immigrants. The articles that were excluded were about second and third generation immigrants. Second, only articles describing nurses originated from the host countries were included. Articles containing information about foreign nurses taking care of immigrants were excluded. Last of all, only studies describing direct factors influencing nursing care were used for this research. Articles only describing in-direct factors were considered as not usable. There was made a choice not to focus on articles about nurses or immigrants from a specific region in the world. This decision was made due to a small amount of articles when searching for a specific region. The nurses described in the articles of this study were inhabitants of Spain, Italy, Sweden, The United States, Germany, Finland

and The Netherlands. All those countries can be seen as Western countries (Huntington, 1996). Those nurses were taking care of immigrants coming from; Morocco, Turkey, Mexico, Somalia, Albania, Romania, China, Ukraine, Afghanistan, Iraq, Iran and people of an African-American and Hispanic origin. Not all the articles mentioned the origin of the immigrants the nurses in the studies were taking care of. All those countries can be considered as non-Western (Huntington, 1996).

Besides the inclusion and exclusion criteria mentioned above, the articles had to meet the following requirements; written in the English language, research article, containing an abstract, published between 2005 and 2015. A list of the included articles in this study can be found in appendix three.

1.3 Data analysis

Qualitative analysis is, among others, meant to provide an overview on a specific subject, from which theories can be developed. When analyzing data collected from a qualitative research, it is about the exploration of the meaning that people attach to certain situations and behaviour (Verhoeven, 2011). The selected articles were all read several times, to get a clear overview on the content. The information was critically read, keeping in mind the purpose of the study and the inclusion and exclusion criteria. A data analysis was done by selecting the information based on the purpose, highlighting meaning units and creating sub-categories and categories (Graneheim & Lundman, 2003). The data was ordered according to the four categories which are leading the result chapter and the discussion chapter. Those categories are as following: the level of the nurse’s cultural competence (divided in knowledge, skills and attitude), nurse’s challenges regarding communication, cultural differences influencing the quality of nursing care and external factors influencing the quality of nursing care. The table containing the data analysis is described in appendix two. One shortened example of the data analysis of one category can be found in table 1: ‘Shortened analysis category 4’.

Meaning unit	Sub-category	Category
The availability of adequate, translated health education materials	Lack of support from the organisation is a frequently discussed topic among nurses.	External factors influencing the quality of nursing care towards immigrants
Lack of recognition of the need by management of the organization	Nurses state that adequate training on giving transcultural care can help them to improve their quality of care.	
General lack of support for culturally competent care from the organization		
Lack of adequate training on culture		
Lack of available written guidelines		

Lack of support or help

The availability of adequate health education documents will help nurses to give better care.

Table 1: 'Shortened data analysis category 4'

1.4 Ethical considerations

The articles included in this research were carefully selected and approved by an ethical committee. Plagiarism was not intentionally conducted and the findings meant to be used in an objective way. The following quotes have been taken into consideration: *"Thus, our presumption is that a text always involves multiple meanings and there is always some degree of interpretation when approaching a text"* (Graneheim & Lundman, 2003, p.106). And: *"There is no single correct meaning or universal application of research findings, but only the most probable meaning from a particular perspective"* (Graneheim & Lundman, 2003, p.110).

2. Results

2.1 The level of the nurse's cultural competence

According to Suurmond et al. (2010), the nurse's cultural competence can be divided into three groups, namely knowledge, attitude and skills. In this chapter, the nurse's needed cultural competence will be described according to this model. Second, negative factors and challenges influencing the level of the nurse's cultural competence will also be described.

2.1.1 The nurse's knowledge

According to many nurses it is important to have knowledge about the background of the immigrants they are taking care of (Degni et al., 2012; Suurmond et al., 2010). Knowledge about the background can include knowledge about the patient's culture, history, religion and political and humanitarian situation in countries of origin and juridical procedures (Degni et al., 2012; Suurmond et al., 2010). Nurses having knowledge about common diseases in the immigrants' countries of origin is a part of cultural competence as well (Suurmond et al., 2010). Nurses knowing the consequences of refugee hood on their patient's life was also considered as important (Degni et al., 2012; Suurmond et al., 2010).

Many nurses expressed a lack of cultural knowledge, understanding, skills or awareness when providing care to immigrants (Berlin et al., 2006; Foley, 2005; Hultsjö & Hjelm, 2005; Jones, 2008; Taylor and Alfred 2010), among others due to a lack of training on intercultural communication or due to a lack of exposure to immigrants (Plaza del Pino et al., 2013; Taylor & Alfred, 2010). Nurses also stated that working intensively with foreign patients (more than 50% of the total amount of patients) or having experience in health services for a longer period of time (more than 20 years), can increase difficulties in providing care (Berlin et al., 2006).

According to Jones (2008) and Festini et al. (2009) it is important to have knowledge of a foreign language, in order to improve nurse-patient relationship and thus the quality of nursing care.

2.1.2 The nurse's attitude

The nurse's attitude towards immigrant patients, and her awareness of cultural differences related to it, influences the quality of care (Suurmond et al., 2010). Positive attitudes towards patients were found to be: being open (minded), willing to learn from patients, having empathy, being sincere and having compassion. In addition, using a holistic approach, taking time, being patient and being sensitive to cultural differences were also mentioned (Dogan et al., 2009; Matteliano & Street, 2011; Taylor & Alfred, 2010;). Nurses being aware of how culture can influence an individual person's nature was also considered as important when caring for immigrants (Suurmond et al., 2010).

Sometimes nurses saw working with immigrants as a calling; they had a desire to deliver care to minority groups. This passion to deliver culturally competent care is positively affecting the quality of nursing care to those patient groups (Matteliano & Street, 2011; Taylor & Alfred, 2010).

Nurses also expressed negative feelings towards foreign patients because of patients' habits. They reported to feel embarrassed or uncomfortable during care, among others because of patients' religious and worship habits, eating habits and view on personal hygiene. In addition, nurses experienced disapproval for the different behaviour of patients, such as personal hygiene, eating habits and a lack of respect towards nurses (Festini et al., 2009).

Some nurses felt irritated because of patients not learning to speak the language of the host country, even though they have lived in the host country for years. One of those nurses reported that this language barrier resulted in a lot of frustration and even a lack of tolerance to patients who don't speak host country's language (Berlin et al., 2006; Taylor & Alfred, 2010).

Prejudicing, stereotyping and racism were subjects described by both nurses and immigrant patients (Foley, 2005; Pergert et al., 2007; Plaza del Pino et al., 2013). A nurse said that prejudicing patients seemed to be like an expression of relief, but he thought that is was most of all just a habit (Plaza del Pino et al., 2013). On the other hand, being aware of your 'habit' to prejudice and to have biases about patients was one of the cultural competences which can improve the quality of nursing care (Suurmond et al., 2010; Taylor & Alfred, 2010).

2.1.3 The nurse's skills

According to Suurmond et al. (2010), the third group of cultural competencies contained the nurse's skills. An example was that nurses need to be able to collaborate with patients and their families, in order to develop a partnership between the patient and the nurse (Matteliano & Street, 2011; Suurmond et al., 2010; Taylor & Alfred, 2010). Skills related to a trustful collaboration with the patient and his family contained; communication skills such as; careful listening, being able to explain what patients can expect from health care and negotiation skills (Matteliano & Street, 2011; Suurmond et al., 2010). When this partnership between a nurse and a patient was established, the patient was more willing to talk about personal problems and the nurse could ask more sensitive questions. The ability to ask sensitive questions was also seen as a skill improving cultural competence (Suurmond et al., 2010).

Probing for root causes was also seen as an important skill the nurse needs when caring for immigrant patients. It is important to be able to go behind the information that is given by the patient, in order to find the 'real' problem (Matteliano & Street, 2011).

2.2 Nurses' challenges regarding communication

The major problem experienced by nurses when caring for immigrants was difficulties in communication (Degni et al., 2011; Dogan et al., 2009; Festini et al., 2009; Foley, 2005; Hultsjö & Hjelm, 2005; Taylor & Alfred, 2010). The most common subject regarding difficulties in communication was the language barrier (Berlin, 2006; Dogan et al., 2009; Festini et al., 2009; Foley, 2005; Hultsjö & Hjelm, 2005; Jones, 2008; Pergert et al., 2007; Plaza del Pino et al., 2013). Nurses mentioned several problems they experienced in the communication with immigrants. These problems were; not being able to communicate directly with patients and their relatives, problems with giving information to patients or their relatives and not being sure if the given information is understood (Berlin, 2006; Taylor & Alfred, 2010). Many nurses searched for external help to bridge the problems related to language and communication. They did this by asking other colleagues or patients to translate, by using relatives as translators, by calling interpreter services or by using gestures (Dogan et al., 2009; Festini et al., 2009; Foley, 2005; Plaza del Pino, 2013; Taylor & Alfred, 2010). Especially when using interpreters nurses experienced disadvantages. First of all, nurses had problems in finding adequate interpreter services (Degni et al., 2011; Foley, 2005; Hultsjö & Hjelm, 2005; Taylor & Alfred, 2010). Second, if there was an interpreter available, nurses had to wait for them to arrive at the hospital (Taylor & Alfred, 2010). If an interpreter was used, either by phone or on-site, nurses lacked personal contact with their patients and were not always sure about the quality of translation. The translation itself took nurses a lot of time and they felt dependent on the interpreter, because they were not able to communicate with their immigrant patients without using an interpreter (Berlin, 2006; Jones, 2008; Pergert et al., 2007; Taylor & Alfred, 2010).

2.3 Cultural differences influencing the quality of nursing care

Nurses being responsible for the care to immigrant patients also experienced many challenges regarding cultural differences. Examples of those differences in cultures were; different nutrition and eating habits, a different perception of hygiene and a different perception of health and illness. In addition; different religious practices or habits and different behaviour related to ceremonies (Dogan et al., 2009; Festini et al., 2009; Hultsjö & Hjelm, 2005; Pergert et al., 2007; Taylor & Alfred, 2010).

Nurses also faced challenges due to a difference in the expression of emotions (Festini et al., 2009; Hultsjö & Hjelm, 2005; Taylor & Alfred, 2010). Many nurses expressed that there was a difference in the perception and expression of pain between autochthones and immigrant patients. Some nurses thought that foreign children had a higher pain tolerance and other nurses expressed that they thought that parents had a more tolerant attitude towards their children's pain (Festini et al., 2009). On the other hand, some nurses thought that immigrant patients sometimes overreacted on painful

procedures. When it comes to grief or anger, nurses also experienced difficulties (Festini et al. 2009; Pergert et al., 2007). They expressed that the consequences of immigrants having a different behaviour, may lead to misunderstandings and difficulties in assessing the severity of an illness (Hultsjö & Hjelm, 2005; Pergert et al.).

Because of their religion, some immigrant women are not allowed to be examined by a man. They are not allowed to be naked in the presence of a man, unless it is her husband. Those gender preferences was another common problem among nurses (Degni et al., 2011; Hultsjö & Hjelm, 2005; Taylor & Alfred, 2010).

Nurses working with immigrants faced differences in social roles. The opinions patients may have about nurses is depending on their culture. One third of the nurses said that foreign patients had a lower opinion about nurses than autochthon patients. Nurses also perceived difficulties with Muslim men accepting female nurses. (Festini et al., 2009). Foreign patients can have a hierarchical view on health care staff. According to nurses, some foreign patients trusted and accepted authorities like doctors more than nurses (Hultsjö & Hjelm, 2005). Another consequence of this hierarchal view of patients on health care staff is that they don't stand up for their rights as autochthon patients would do (Pergert et al., 2009). A different opinion about the role of the patient can also influence the quality of nursing care (Taylor & Alfred, 2010). Nurses for example reported patients being passive by lying in bed and not wanting to participate. Second, they had difficulties in motivating patients in cooperation in the treatment (Hultsjö & Hjelm, 2005).

Another challenge nurses faced was truth-telling differences. In some cultures there is a taboo on diseases, especially towards children. Some people namely believe that speaking about the disease can lead to patients suffering more, having more fear or being more anxious. Relatives of patients may decide to not tell the patient he has a certain disease or decide to not to tell the whole story. Nurses can experience ethical dilemmas due to those truth-telling differences (Pergert et al., 2007). Nurses also experienced challenges with patients suffering from stigmatised diseases, such as HIV. Patients feared social exclusion when telling their friends and family they had a certain disease, such as HIV. This stigma made caring for those patients more challenging (Foley, 2005).

Other obstacles mentioned by nurses were differences in social situation, differences in identities and differences in status. When there is a big difference in educational level for example, the transcultural relationship gets negatively influenced (Foley, 2005; Pergert et al., 2007). Nurses expressed great frustration about communicating with patients who have little or no formal education. Other challenges were patients being not familiar with the health care system of the host country and lacking knowledge about their diseases (Foley, 2005; Hultsjö & Hjelm, 2005).

2.4 External factors influencing the quality of nursing care

Nurses are experiencing a lack of administrative support, a lack of recognition of the need by management and a general lack of support for culturally competent care from their organisation (Berlin, 2006; Taylor & Alfred, 2010). First of all, nurses are missing training on culture and care (Plaza del Pino et al., 2013; Taylor & Alfred, 2010). They said that training would help them to improve their care to foreign patients. Training subjects that emerged were training on cultural competence and teaching about different values, views and habits of foreign patients (Berlin, 2006; Dogan et al., 2009; Plaza del Pino et al., 2013). Second, the absence of usable written material, such as policies, routines and guidelines affected the nursing care in a negative way (Berlin, 2006; Pergert et al., 2007; Taylor & Alfred; 2010).

Husbands sometimes wanted to have control over the provided care to his wife or children. They could influence the care by not allowing his wife making decisions. Some men wanted the nurses speaking to them, instead of speaking to his wife, who was actually the patient or the primary care giver of the patient (child) (Hultsjö & Hjelm, 2005; Pergert, 2007). Not all female patients were allowed to make decisions on their own, but had to ask for permission to their husbands first. This was mainly seen in the Somali culture (Degni et al., 2011).

3. Discussion

3.1 Discussion on results

The purpose of this study was to illuminate the factors influencing the quality of care of Western nurses to non-Western immigrant patients and their relatives.

Many factors influence the quality of nursing care to non-Western immigrants. First of all, there is cultural competence nurses can possess. Those competences are divided in knowledge, attitude and skills. Possessing those cultural competences increases the quality of care. There are also challenges nurses face, which can decrease the quality of care to immigrants and their relatives. Examples of those challenges are; communication difficulties, difficulties related to differences in culture and external factors influencing the quality of care.

3.1.1 The level of the nurses' cultural competence

It is important for nurses to be cultural competent in order to improve the quality of care to non-Western immigrants. Cultural competence is divided in knowledge, attitude and skills. First, the nurses' cultural competence will be discussed in general, subsequently the knowledge, attitude and skills will be discussed separately.

Many nurses do not feel cultural competent when providing care to immigrant patients: they lacked knowledge, understanding, skills and awareness. This is confirmed by studies of Adams et al. (2004), Taylor (2005) and Walker & Barnett (2007). Not being satisfied about your provided care, can negatively influence working conditions, the quality of care and even the nurse's health condition (Tholdy Doncevic, 1999). This is a striking fact, which needs attention, because the consequences of dissatisfaction about one's care, appear to be serious and can decrease the level of quality of care even further, which seems to become a negative spiral. Those facts highlights the importance for nurses to improve their level of cultural competence.

Some nurses experience an increased level of difficulties together with the increase of the intensity of caring for foreign patients; they face more difficulties when being exposed more often or during a longer period of time. Those findings are very contradictory to the findings of Michaelsen et al. (2013), which showed that a lack of exposure leads to more difficulties. Berlin (2006) describes that increase of difficulties together with increase of exposure to foreign patients can have something to do with the level of awareness of the nurses providing care. Nurses with a higher level of exposure, might have developed a higher level of cultural awareness than nurses who have not been exposed to immigrant patients that often or during such a long time. An increased level of cultural awareness

could lead to a higher level of awareness of difficulties. This could be an explanation why nurses who are less exposed to foreign patients are experiencing less problems and difficulties (Berlin, 2006).

It is important to keep in mind that cultural competence *“is often framed as a cyclical process rather than a goal you can tick off as achieved”* (Burt, 2013, para. 1) It should not be seen as a package of characteristics you can apply on every foreign patient. Just like every patient is different and needs a different approach, immigrant patients are different and so are their approaches. Another remark is that those competences are not just applicable when providing care to foreign patients. Being able to collaborate with patients or having knowledge about a patient’s religion is important when giving care to all patients, whether they are immigrants or not.

3.1.1.1 The nurse’s knowledge

Knowledge about the background of the patient is considered as an important aspect in order to provide quality care. This contains knowledge about the culture, the current situation and common diseases in the immigrant’s home country and knowing the consequences of refugee hood on their patients’ lives. Knowledge being a part of the cultural competence was confirmed by other studies such as Campinha-Bacote (2003), Giger & Davidhizar (2004) Leininger (2001) and Smith (1998). Many nurses lack knowledge when giving care to immigrants. This was confirmed by studies of Garrett et al. (1998), Jones et al. (2002), Lipton et al. (1998) and Murphy & Clark (1993). It is important to start teaching on transcultural care during nursing education (Murphy and Clark, 1993). Because nurses will meet more and more immigrants during their career, it is important to prepare nursing students for cultural diversities. To increase the level of cultural competence of nurses, training on cultural competence and gaining experience in practice was seen as helpful, according this study. Michaelsen et al. (2004) concludes that nurses mainly gained their knowledge from the media (newspapers, radio, TV, books and journals) and from contacts with patients. Half of those nurses stated that they gained knowledge through schooling. Unfortunately this study does not describe to what extent these nurses are satisfied about their quality of health care. This makes it difficult to describe what methods will achieve the best learning outcomes for nurses.

3.1.1.2 The nurse’s attitude

The nurse’s attitude towards immigrant patients influence quality of care. Positive and negative attitudes were found. Positive attitudes included; positive personal characteristics (patience, sincerity, empathy etc.), being aware of how culture can influence an individual person’s nature and a passion to deliver culturally competent care. Negative attitudes were found to be; embarrassment, irritation, stereotyping and racism.

The attitude of nurses towards their patients can make a big difference in the quality of provided care. Positive attitudes, such as respect, interest, patience and empathy are even considered to be more important than knowledge about cultural differences (Walker & Barnett, 2007). Hood (2014) describes four principles which positively influence nurse's collaboration with patients. These were found to be: presence, empathy, respect and genuineness. In addition, she says that nurses being empathetic become more tolerant towards different behaviours, attitudes, and values. Those facts emphasize the importance of possessing those characteristics as nurses caring for immigrant patients, but also for patients in general. To develop empathy, nurses need *"awareness and acceptance of self as a feeling person open to one's experiences"* (Hood, 2014, p. 87). In addition, they need the *"ability to listen to each message of the client, to identify the client's feelings associated with it, and to respond to those feelings"* (Hood, 2014, p. 87).

Negative attitudes on the other hand, greatly affect quality of care as well. Studies have found that ethnic minority patients receive poor care, because of their caregivers' negative attitudes about the patients' character or abilities (Karlsen, 2008). Those attitudes negatively influence interventions, the patient-care provider relationship and is a barrier to cultural competence (van Ryn & Burke, 2000). It was even reported to be a barrier for patients to seek care when nurses are giving inappropriate care and stereotyping immigrant patients (Barrett et al., 1998; Bhui et al., 2003; Diaz, 2002; Flores & Vega, 1998; Gray et al., 1995; Hatfield et al., 1996; ten Have & van Bijl, 1999; Jirojwong & Manderson, 2002; Morgan, 1996; Woollet et al., 1995). In addition, discrimination is found to have negative consequences on patients' health and is also reported as a barrier. Several consequences of discrimination are found, such as differences in opportunities and living conditions, differences in treatment (leading to differences in access to health-promoting resources) and stress (both acute and chronic) which produces physiological changes and problems for mental well-being (Frykman, 2006). The latter was confirmed by a study of Scheppers et al. (2005), who described that the discriminated population was more likely to use mental health services.

Nurses sometimes feel provoked, because of immigrant patients not speaking the local language well. This is confirmed by a study of Kulwicki et al. (2000), who describes persistent intolerance of nurses towards those patients.

As Jirwe et al. (2010) states; *"Nurses should avoid stereotypes but need sufficient knowledge to know what might be relevant in the cross-cultural care encounter"* (p. 442). So, a negative attitude towards immigrant patients can be influenced by cultural knowledge. When one is aware of different habits and practices of a patient, the nurse might be prepared for it and can adapt his or her care to it.

3.1.1.3 The nurse's skills

Nurses possessing certain skills is considered to be an important aspect influencing the quality of care. Those skills are; the ability to collaborate with patients and their relatives and communication skills such as careful listening, being able to explain what patients can expect from health care, negotiation skills, the ability to ask sensitive questions and the ability to probe for root causes.

The possession of skills by nursing staff is seen as an important part of cultural competence according to Campinha-Bacote & Munoz (2001) and Moule (2013). Skills considered as necessary related to communication, were basic communication skills, but also probing for underlying reasons (Shapiro et al., 2002). This confirms the results of this literature review. Nurses developing partnerships with their patients was also mentioned in other studies, such as Alexander (2004), Martin et al. (2005) and Tyler & Horner (2008).

Hogan (2013) has dedicated a whole book to skills being part of cultural competence. In his book, those skills are divided four categories, namely 1) understanding culture as multilevel and multidimensional, 2) understanding the six barriers (barriers to effective relationships, personal/interpersonal barriers, organizational/institutional barriers and five gender issues), 3) practicing culturally centred communication skills and 4) designing and implementing organizational cultural competence. Campinha-Bacote (2002) describes the skills related to cultural competence as following: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. When comparing the skills found in this study to the skills described by Campinha-Bacote (2002) and Hogan (2013), there can be stated that those skills are overlapping, and confirm the findings in this literature review. On the other hand, when looking at the factors in the latter two paragraphs ('The nurse's knowledge' and 'The nurse's attitude'), many factors mentioned in the latter two studies can be recognized. This shows that many cultural competences are overlapping each other and might not always belong to just one category.

3.1.2 Nurses' challenges regarding communication

Many nurses experience problems when communicating with immigrant patients. The language barrier is a major challenge. This was confirmed by studies of Andrews (2008), Choi Wu et al. (2009), Lee (2000), Murphy & Clark (1993), and O'Toole (2008). This language barrier has a negative effect on the quality of health care and patient safety, but also on the costs of health care (Bischoff & Denhaerynck, 2010; Koff & McGowan, 1999; Ku & Flores 2005; Quan, 2010; Robledo et al., 1999; Timmins, 2002). In the emergency department, patients were found to stay longer, together with an increased resource utilization, due to language difficulties (Hampers et al. 1999). In addition, a negative relationship between language barriers and dissatisfaction of patients was found

(Carrasquillo et al., 1999; David & Rhee, 1998). Those facts emphasize the importance of reducing the language barrier, and should be a very important reason to bridge communication problems between nurses and their patients.

Nurses experience several problems when communicating with immigrant patients, such as not being able to communicate directly, problems with giving information and not being sure if the given information was understood. A study of Hjelm et al. (1998) confirms that health care staff were not sure if the information was well received. The results in this study are partially confirmed by a study of Bernard et al. (2006) which said that that nurses were especially challenged during general communication, comforting or pain assessment and conveying information. Only 5% of the participants experienced assuring quality of care as source of stress. This is interesting, since a decreased quality of care was proven due to the language barrier, as described above. It may be possible that the nurses in the latter study might not have been aware of a decrease in the quality of care, even though it might have been present.

When facing those communication problems, often look for external help to translate, such as; colleagues, (relatives of) patients or interpreter services. According to Rice (2014), health care staff are using professional interpreter services not enough when needed, which could even lead to an increased risk of medication errors, wrong procedures and avoidable readmissions. Also Wilson-Stronks & Galvez (2007) point out that using family members and fellow nurses as interpreters should be avoided. Neither (O'Toole, 2008) encourages the use of colleagues or relatives as interpreters, as they are often not trained and tension within the family can increase. However, O'Toole (2008) does not clearly abandon those alternatives.

Even though the use of interpreter services are seen as important, it is even obliged by federal civil rights policy (U.S. Department of Health and Human Services, 2003), many disadvantages are reported by nurses. Disadvantages of the use of interpreter are, among others; problems in finding adequate interpreters, the wait for interpreters to arrive at the hospital, not being sure about the quality of translation and the duration of the translation. The lack of finding adequate interpreter services was also found by other studies (Andrews & Boyle, 2008; Henenberg & Parady, 1995; Woloshin et al., 1995). Not being sure about the quality of the translation is confirmed by Kaufert & Putsch (1997).

Nurses express that using interpreters take a lot of their time; first they have to wait for them to arrive and second, the talk itself takes too long. According to Pergert et al. (2007): *"Nurses with the most control over their time have been shown to be more likely to use interpreters"* (p. 323). This shows a strong relationship between the nurse's time and the likelihood of using an interpreter.

What also should be considered is that the translation with an interpreter can take a long time, but the long term effects will be worth it, taking in consideration the negative consequences of using not adequate interpreter services.

Even though the use of interpreter services are not without disadvantages, *“they have been determined to be the optimum choice, resulting in fewer errors in translation, higher patient satisfaction, and improved patient outcomes”* (Giordano, 2007, p. 126). In addition, the use of professional interpreters leads to more targeted health care, improves the quality of care, the overall provider-patient satisfaction and concentrates higher health care utilisation into a smaller number of visits (Bischoff & Denhaerynck, 2010; Degni et al., 2004; Garcia et al., 2004).

Hospitals should therefore be recommended to provide better interpreter services. Even though it might take a lot of their expenses, using adequate interpreters could prevent ‘the escalation of long-term costs’ (Bischoff & Denhaerynck, 2010).

3.1.3 Cultural differences influencing the quality of nursing care

When providing care to immigrant patients, nurses face many challenges related to differences in culture. Nurses mention different nutrition and eating habits, different perception of hygiene, different perception of health and illness, different religious practices or habits and different behaviour related to ceremonies. When it comes to the expression of emotions, nurses experience a different perception of expression of pain, grief or anger, which sometimes leads to misunderstandings and difficulties in assessing the severity of an illness. Other challenges are gender preferences, differences in social roles, truth-telling differences and patients suffering from stigmatised diseases. In addition; differences in social situation, patients being not familiar with the health care system of the host country and a lack of knowledge about their diseases.

First of all, there should be emphasized that a difference in culture between the nurse and the patient does not have to be negative. Just as every patient is unique, with his or her own beliefs, practices and habits, so are immigrant patients. The existence of cultural differences between patients and health care providers, even though they share the same cultural background, is described by Scheppers et al. (2005). This uniqueness of every human being is beautifully described by Hesse (1968). *“We are sun and moon, dear friend; we are sea and land. It is not our purpose to become each other; it is to recognize each other, to learn to see the other and honour him for what he is: each the other's opposite and complement”* (p. 248-249). It is important to keep this in mind and not to only focus on the actual differences between nurses and immigrant patients. In addition, even though patients belong to a certain culture, patients are individual human beings and should not be categorized because of their cultural heritage (Giger & Davidhizar, 2002).

Challenges related to differences in culture in general are confirmed by several other studies, such as Koenig & Davies (2003), Scheppers et al. (2005) and Tripp-Reimer et al. (2001). More specific barriers were also found in literature, among others differences in health beliefs (Bäärnhielm & Ekblad, 2000; Eshiett & Parry, 2003; Flores & Vega, 1998; Knipscheer & Kleber, 2001), immigrant patients lacking knowledge about the health care system (ten Have & van Bijl, 1999; Moon et al., 1998; Smith et al., 2000;) and difference in status (Garrett et al., 1998; ten Have & van Bijl, 1999; Jones et al., 2002). Those factors are confirming the factors found in this literature review. According to Tripp-Reimer et al. (2001), many health care providers often see those barriers resulting from their patients' cultures, but in their opinion they should be seen from *"the values and beliefs inherent in biomedical culture, insufficient professional training, and care system barriers"* (p. 14).

3.1.4 External factors influencing the quality of nursing care

The quality of nursing care is also influenced by external factors. Those factors are; lack of organizational support, lack of training, lack of usable written materials and the attitude of patients' husbands.

A supportive organization is greatly contributing to cultural competence and thus the quality of care. According to Werner (2006) is it difficult for people to continue with their behaviours if those are not 'expected, supported and rewarded'. A cultural competence-supportive organization will encourage nurses to provide culturally competent care. This is also confirmed by Taylor (2005). Anderson et al. (2003) found several interventions to improve cultural competence in a health care system, which are among others: *"programs to recruit and retain staff members who reflect the cultural diversity of the community served, use of interpreter services or bilingual providers for clients with limited English proficiency, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials"* (p. 70). The latter four interventions were confirmed by Delphin-Rittmon (2013). When looking at the factors found in this study, those factors are exactly the opposite from the interventions mentioned by Anderson et al. (2003) and Delphin-Rittmon (2013). There can be concluded that the factors found in this literature review (lack of training and lack of usable written materials) are all related to a whether or not supportive organization, and the extent of it greatly interacts with the quality of care.

Another factor influencing the quality of care is the attitude of patients' husbands. Some husbands are found to be dominantly involved in their wife's or children's care. Those families were mainly people originated from Somalia, which is an Islamic country. In traditional Muslim families it is often the men who take decisions: *"Where a decision must be made, after consultation and consideration, it should be the husband's decision, for better or worse"* (Mawsood, 1995, p. 102). Nurses should be

aware not to tend to stereotyping. As there is different denominations in Christianity and other religions, there is different denominations in the Islam. Not all the husbands will take in the same dominant position.

Several studies have demonstrated the positive impact of training on cultural competence of health care providers. Training has been shown to improve the communication across cultural and linguistic differences (Webb, 2003) and attitudes about the importance of cultural assessments (Crosson et al., 2004). Cultural competence education for nurses has been shown to be effective in increasing knowledge and self-efficacy (Napholz, 1999; Smith, 2001). Taking this in consideration, healthcare organizations should be encouraged to provide more training to nurses on cultural competence.

3.2 Discussion on method

The discussion on the method of this general literature review will be described according to the aspects of trustworthiness for qualitative studies. Those aspects of trustworthiness contain credibility, dependability and transferability (Graneheim & Lundman, 2003). Despite the fact that those aspects will be described in different paragraphs, *“they should be viewed as intertwined and interrelated”*, according to Graneheim & Lundman (2003, p. 109).

3.2.1 Credibility

“Credibility is achieved to the extent that the research methods engender confidence in the truth of the data and researchers’ interpretations” (Polit & Beck, 2012, p. 175), which will be discussed in this paragraph.

The whole process of this general literature review was started with the decision about the focus of the study. The focus was decided to be on ‘factors influencing the quality of care’, ‘Western nurses’ and ‘non-Western immigrant patients’. The choice was made to focus on factors in general, both positive and negative. The choice for those two broad populations was made due to a lack of available articles when searching for articles about nurses from a specific country or continent. The decision to broaden the focus of this research, resulted in a lot of data. This may be visible in the amount of sub-categories belonging to one category, which can be seen in the analysis table in appendix 2. This is confirmed by Graneheim and Lundman (2003): *“Meaning units that are too broad, for example, several paragraphs, will be difficult to manage since they are likely to contain various meanings”* (p. 110). This may have led to an extended answer on the research question, which may have remained quite general. Unfortunately not all the results were discussed, because of an overload of data. If this research would have been carried out while only focusing on communication between Western nurses and non-Western immigrants, for example, the results could have been more in depth. The results might also have been more practical, with more attention to the application for daily nursing practice. On the other hand, a broad population can affect the transferability in a positive way, which will be described later in this chapter.

In order to find articles which met the purpose of the study, key words were chosen. Also synonyms of key word were used, in order to improve the amount of research articles meeting the purpose of this study. Using the same combinations of key words in Medline and Cinahl, increased the possibility to find suitable articles. More usable articles could have been found when searching for ‘factors influencing cultural competence’ and ‘barriers to cultural competence’. When writing the discussion on results, those two terms appeared to result in a lot of usable articles meeting the purpose of this study.

More databases could have been used, but because sufficient articles were found in Medline, Cinahl and through manual search, the article search was discontinued. Twelve articles were used for this general literature review. However, more articles meeting the purpose could have been included, because of time the decision was made for the minimum amount of requested articles. However, using more articles could have increased the strength of the findings in this study.

Ten articles concerned qualitative studies, while two articles were a combination of qualitative and quantitative studies. An advantage of the use of quantitative studies is that it leads to the possibility to see *how many* nurses experienced a certain barrier, because quantitative research is about numbers (Verhoeven, 2011). In qualitative research, it is more about *how* things are perceived by people (Verhoeven, 2011). In the majority of the included qualitative studies no description was found about how many participants were perceiving certain things. This could result in that a certain aspect was mentioned as a result, even though it was only expressed by one nurse.

Ten articles were written from a nurse's perspective, but two articles included data about opinions of both immigrant patients and nurses. The choice for a nurse's perspective in this literature review was made to increase the awareness of nurses about factors influencing their care. When being aware of these, it is more likely for nurses to change their behaviour, if possible. On the other hand, it would have been very useful to have written this study from a patient's perspective, because the opinion of nurses and patients about good care and factors influencing it may differ.

3.2.2 Dependability

According to Lincoln & Guba (1985, p. 299) "*dependability seeks means for taking into account both factors of instability and factors of phenomenal or design induced changes*".

The studies used for this general literature review dated from 2005 until 2013. Since this is relatively a short period, it is less likely that the results of those studies have changed over time. When looking at the results from the included articles dated from 2005 and 2006 and comparing them with the results from the included articles from 2013, it can be stated that there are no major differences found.

3.2.3 Transferability

Transferability is "*the extent to which qualitative findings can be transferred to other settings, as an aspect of a study's trustworthiness*" (Polit & Beck, 2012, p. 180).

Even though the studied population was very broad (nurses from all different kinds of Western countries caring for patients from all different kinds of non-Western countries), many similarities in results were found. Barriers, such as communication problems and differences in culture were

mentioned in every article containing barriers to provide quality of care. This increases the transferability, because those factors seem to be experienced by nurses from many countries.

On the other hand, whether a nurse is providing care to an African immigrant or an Asian immigrant, there will be differences in nationality and culture anyway. Of course, additional en specific knowledge of the patient's culture is required, but the fundamental cultural competences are required in every contact with a foreign patient.

Seven articles included in this study only described the experiences of nursing staff. The other five articles contained a population of nursing staff in combination with patients or other disciplines, such as; midwives, nurses' managers, physiotherapists or medical doctors. Because all these disciplines are part of the healthcare staff, this does not have to influence the usability of this study for nurses. It can be expected that nurses expressed more challenges when providing care to foreign patients, because they are spending most time with the patients, compared to other disciplines.

4. Conclusion

The purpose of this literature review was to illuminate the factors influencing the quality of care of Western nurses to non-Western immigrant patients and their relatives.

- In order to improve the quality of care, nurses need to improve their cultural competence, which can be achieved by developing cultural awareness.
- Many nurses do not feel cultural competent when providing care to immigrant patients, which can negatively influence working conditions, quality of care and the nurse's health condition. This fact highlights the importance for nurses to improve their level of cultural competence.
- Nurses can improve their level of cultural competence by training. On the other hand, in practice, nurses express to learn about cultural competence through the media, exposure to immigrant patients and training. Some nurses experienced more problems when being exposed to immigrant patients for longer period of time of high intensity. Recommended is to compare the effect of training, a high exposure and a low exposure on the level of the nurse's cultural competence.
- Ethnic minority patients receive poor care, because of their caregivers' negative attitudes about the patients' character or abilities. Those negative attitudes have several severe consequences. This should be a very important reason for nurses to improve their level of cultural competence.
- The language barrier between nurses and immigrant patients negatively affects the quality of healthcare, patient safety and increases the costs of health care. To overcome this barrier, organizations should provide a better access to interpreter services and nurses should use interpreter services more often.
- Nurses are lacking organizational support when providing care to immigrant patients. Organizations should provide more usable written materials and should find the best strategy for nurses to improve their cultural competence (see fifth bullet point).

The main results of this study are illustrated in table 2: *'Factors improving the quality of care'*, which can be found below.

Table 2: 'Factors influencing the quality of care'

Factors influencing the quality of nursing care to immigrant patients and their families.

Challenges related to cultural differences:

- Nutritional habits
- Perception of hygiene
- Perception of health and illness
- Religious practices
- Expression of emotions
- Social roles
- Truth-telling
- Stigmatised diseases
- Social situation, identities and status
- Not being familiar with the health care system
- Patient lacking knowledge diseases

Challenges related to external factors:

- Lack of organizational support
- Lack of training
- Lack of written material
- Husbands' influencing care

Communication challenges:

- Language barrier
- No direct communication
- Not knowing if the information is fully understood
- Problems related to interpreter services

Level of cultural competence:

- *Knowledge*: background of immigrants (culture, history, religion, political and humanitarian situation), common diseases in country of origin, consequences of refugee hood life, juridical procedures, a foreign language.
- *Attitude*:
 - o Positive: openness, willing to learn from patients, empathy, sincerity, patience, compassion, using a holistic approach, taking time, sensitivity to cultural differences, passionate to deliver cultural competent care and awareness of how culture can influence an individual person's nature.
 - o Negative: feelings of embarrassment, disapproval and irritation, prejudicing and stereotyping.
- *Skills*: ability to collaborate with patients and their relatives, communication skills, being able to explain what patients can expect from health care, negotiation skills, the ability to ask sensitive questions and the ability to probe for root causes.

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Appendices

Appendix 1 – Overview of searching history

Database	Limitations	Key words	Matches	Selected 1	Selected 2	Selected 3	Selected 4
Medline (01.03.15)	English language Abstract Publication year: 2005-current	cultural competency AND nurses	62	9	6	5	3
Medline (11.03.2015)	English language Abstract Publication year: 2005-current	nurses AND emigrants and immigrants AND Attitude	6	3	1	1	1
Manual search (12.03.2015)	Reference list in articles						3
Cinahl (21.03.2015)	Publication year: 2005-current Abstract Research article	nurses AND immigrants AND attitude	24	4	4	4	3
Cinahl (16.04.2015)	Publication year: 2005-current Research article	nurse-patient relations AND	12	2	2	1	1

		cultural competence						
		AND						
		Immigrants						
Medline	English language	attitude of health	121	6	3	1	1	
(07.05.2015)	Abstract	personnel						
	Publication year: 2005-current	AND						
	Humans	emigration and immigration						

Selected 1: read the title

Selected 2: read the abstract

Selected 3: read the entire article

Selected 4: selected for further review

Appendix 2 – Analysis table

Meaning unit	Sub-categories	Categories
<p><i>Article 1</i></p> <p>Cultural competences needed for working with asylum seekers:</p> <ul style="list-style-type: none"> - Knowledge <p>Knowledge of the political and humanitarian situation in countries of origin</p> <p>Knowledge of epidemiology and the manifestation of diseases in asylum seekers' countries of origin</p> <ul style="list-style-type: none"> - Attitudes <p>Awareness of the juridical context of the host country in which asylum seekers live</p> <p>Awareness of how culture shapes individual behaviour and thinking</p> <p>Awareness of one's own prejudices and tendency to stereotype</p> <ul style="list-style-type: none"> - Skills <p>Ability to develop a trustful relationship with an asylum seeker</p>	<p>The nurses' knowledge is a part of the cultural competence.</p> <p>Nurses are lacking of cultural knowledge and understanding due to a lack of training, a lack of exposure and because of working intensively with immigrant patients.</p> <p>The nurse's attitude is a part of the cultural competence.</p> <p>Some nurses are having negative feelings about immigrants, which influences the quality of care.</p> <p>Some nurses see working with immigrant patients as a calling.</p> <p>The nurse's skills are a part of the cultural competence.</p> <p>-----</p>	<p>The level of the nurses cultural competencies are greatly influencing the quality of nursing care to immigrants</p>

Ability to ask delicate questions about traumatic events, personal problems	Poor communication because of the language barrier and the consequences of this is a	----- -
Ability to explain what can be expected from health care (in order to develop a trustful relationship)	common problem experienced by nurses giving care to immigrants.	
<i>Article 2</i>	Nurses searched for external help within communication by asking other colleagues, patients, relatives or interpreters.	
Nurses mainly used gestures or called a volunteer cultural mediator when facing communication difficulties		Nurses are experiencing challenges regarding communication with immigrants
<u>Positive factors:</u>	Many difficulties are being experienced by nurses when using interpreters for the communication with immigrants and/or their relatives	
Knowing at least one foreign language		
<u>Negative factors:</u>	-----	
Communication problems; language barrier	Many nurses working with immigrants face	-----
Different nutrition and eating habits	differences in habits related to ceremonies,	
Different perception of personal hygiene	nutrition, hygiene and religion between her and	-
Different attitude regarding painful procedures:	her patients and/or relatives.	
- foreign children have a higher pain tolerance	Differences in emotional expressions between	
- parents have a more tolerant attitude towards their child's pain)	the nurse and the patient and/or relatives can lead to misunderstandings and difficulties in	
Problems because of religious practices or habits	assessing the severity of an illness.	

<p>Difficulties when supporting foreign parents during their grief Different opinion about the role of the nurse :</p> <ul style="list-style-type: none"> - Foreign patients have a lower opinion about nurses than native patients - Difficulties with Muslim men accepting female nurses) 	<p>Gender preferences of patients can complicate the care.</p> <p>Nurses working with immigrants may face differences in social roles.</p>	
<p>Feeling embarrassed or uncomfortable during care due to several reasons because of patients':</p> <ul style="list-style-type: none"> - Religious and worship habits - Eating habits - View on personal hygiene 	<p>Nurses working with immigrants can experience dilemma's regarding truth-telling differences and patients suffering from stigmatised diseases.</p> <p>Nurses are experiencing challenges when caring for patients with a lower educational level.</p>	<p>Cultural differences are influencing the quality of nursing care to immigrants</p>
<p>Feeling disapproval for the behaviours or habits of parents of foreign children because of differences in:</p> <ul style="list-style-type: none"> - Personal hygiene <p>Eating habits a lack of respect towards nurses</p>	<p>Immigrants' limited knowledge about their diseases or about the health care system is a challenge for nurses.</p> <p>-----</p>	
<p><i>Article 3</i></p> <p>Nurses sometimes used colleagues, patients or interpreters to improve the communication with their patients.</p>	<p>Lack of support from the organisation is a frequently discussed topic among nurses.</p> <p>-----</p>	<p>-----</p> <p>-</p>

<u>Positive factors:</u>	Adequate training on giving transcultural care can help them to improve their quality of care.	
Passion for culturally competent care		
Being open minded		
Being sensitive to cultural differences	The availability of adequate health education documents, will help nurses to give better care	
Being aware of personal biases		
Working effectively with family members		External factors influencing the quality of nursing care towards immigrants
The availability of adequate, translated health education materials	Husbands sometimes wanted to have control over the given care to his wife or children.	
<u>Negative factors/challenges:</u>	-----	
Communication difficulties:		
- Not being able to communicate with patients	..	-----
- Lack of adequate interpreter services		-
- The wait for interpreters to arrive		
- Concerns about the accuracy of the interpretation		
Lack of knowledge of cultural differences		
Lack of exposure to patients from different cultures		
Lack of tolerance of patients who do not speak English		
Differences in the perception of health and illness		

Differences in the perception of pain

Expectation of the role of the patient

Gender preferences

Different practices related to dying

Lack of administrative support from the organization

Lack of recognition of the need by management of the organization

General lack of support for culturally competent care from the organization

Lack of adequate training on culture

Article 4

Positive factors:

Nurses understanding the history, culture, religion and changes in patients' lives in the hosting country

Negative factors/challenges:

Communication problems between patients and health care providers

Different perception about male staff (female patients not wanting to be treated by male staff)

Husbands of female patients wanting to make the decisions for her

General lack of professional medical interpreters

Article 5

Positive factors:

Having altruistic motivations

Probing for root causes

Using a holistic approach to patient care

Establishing partnerships with patients

Willingness to share personal information about themselves

Willingness to learn important patient cultural practices

Having patience

Taking time

Having empathy

Listening carefully

Article 6

Positive factors:

Formal training in cultural competence

Negative factors/challenges:

Lack of available written guidelines

Lack of support or help

A feeling of one's own inadequate cultural knowledge

Language difficulties:

- Not having direct communication with children and parents
- Not knowing if healthcare advice is fully understood by the parents

To convey knowledge to parents concerning children's health and development

Challenges related to interpreters:

- To be independent of the interpreter,
- A feeling of insecurity about the interpreters' translations
- The interpreters talk takes a lot of time from other tasks

A feeling of being provoked that parents did not learn to speak Swedish despite many years of stay in the country

Having professional experience within the PCHC services for more than 20 years
Being responsible for more than 50% of children of foreign origin

Article 7

Positive factors:

Speaking Spanish to the patient

Negative factors/challenges:

Language barrier

- Concern about the accuracy of translation from sources other than the hospital translators
- Concern about the accuracy in translation over the phone

Limited cultural knowledge

Article 8

Negative factors/challenges:

Difficulties related to different cultural behaviours:

- Difficulties in assessing the seriousness of illness because of the different behaviour
- Limited knowledge about behaviours related to different cultures
- Problems in treatment related to patients being passive
- Difficulties in motivating cooperation in the treatment
- Appear more emotional and loud
- Different behaviours related to cultural ceremonies

Difficulties related to gender roles :

- Women are not allowed to act because of the husband
- Same gender on caregiver and patient

Complicating organizational factors :

- Trouble in finding interpreters as the main problem
- Migrants having limited knowledge about the Swedish health care system

Communication barriers (language)

Hierarchical view of health care staff

Article 9

Negative factors/challenges:

Linguistic obstacles

Interpreter dependency

Loss of information control

Cultural and religious obstacles:

- Different views and practices of gender roles,
- Different views on family roles
- Different views on health care staff roles
- Odours/cooking smells
- Differences in emotional expressions (expression of grief or anger) which can lead to misunderstandings
- Truth-telling differences

Social obstacles:

- Differences in social situation
- Differences in identities
- Differences in status
- Racism and prejudice

Organizational obstacles:

Unadjusted policies and routines

Article 10

Some nurses used spouses, children, relatives or friends to translate

Positive factors:

Education programme about different values and habits of foreign patients

Having empathy

Having compassion

Being sincere

Openness to different cultural values

Being sensitive to foreign patients

Negative factors/challenges:

Poor communication because of language barriers

Patients having the feeling that their complaints or the health care staff's suggestions were lost in translation

Difference of habits based on culture (eating, hygiene)

Religious differences

Article 11

Other patients were sometimes used as translators between the nurse and the patient

Positive factors:

Training on how immigrants experience health and illness

Negative factors/challenges:

Lack of training in intercultural care resulting in a lack of skills in intercultural care

Language barrier

Prejudicing and stereotyping by nurses

Article 12

Negative factors/challenges:

Language barriers

Nurses often had to rely on children, friends or relatives to translate for them

Difficulty finding translators for medical appointments

Difficulties with communicating effectively with patients who have little or no formal education and limited fluency in English or French

Patients being unfamiliar with biomedicine and the organization of the health care system

Lack of understanding in American medicine

Health care providers having little understanding of the sociocultural context of HIV/AIDS in Africa, and how lack of ARV treatment and high mortality rates in their home countries shapes Africans' attitudes to testing and treatment in the US.

Non-disclosure of patients with HIV

Health care providers having insufficient resources

Health care providers lacking compassion for the African population (racism and discrimination)

Immigrant patients lacking information about HIV

Appendix 3 – Overview of included articles

Article	Author, year Country Journal	Purpose of the study	Design/ intervention/ instruments	Sample	Main results
1	Suurmond et al. (2010) The Netherlands <i>Nurse Education Today</i>	To describe the cultural competences that are needed when working with asylum seekers.	Qualitative study Questionnaires (89) Semi-structured group interviews (seven group interviews with 36 participants)	Nurse practitioners working in asylum seeker centres	Cultural competencies needed for working with asylum seekers: - Knowledge Knowledge of the political and humanitarian situation in countries of origin Knowledge of epidemiology and the manifestation of diseases in asylum seekers' countries of origin Knowledge of effect of refugee hood on health - Attitudes Awareness of the juridical context of the host country in which asylum seekers live Awareness of how culture shapes individual behaviour and thinking Awareness of one's own prejudices and tendency to stereotype - Skills Ability to develop a trustful relationship with an asylum seeker Ability to ask delicate questions about traumatic events, personal problems

					Ability to explain what can be expected from health care (in order to develop a trustful relationship)
2	Festini et al. (2009) Italy <i>Journal of Nursing Scholarship</i>	To estimate the frequency of problems perceived by nurses in delivering care to immigrant children and their families and to explore the perceptions of nurses regarding nursing care of immigrant children and their families.	Qualitative and quantitative study Questionnaires (129) Two focus groups	Nurses working in a third-level regional Paediatric hospital in Italy	Nurses mainly used gestures or called a volunteer cultural mediator when facing communication difficulties <u>Positive factors:</u> Knowing at least one foreign language <u>Negative factors:</u> Communication problems; language barrier Different nutrition and eating habits Different perception of personal hygiene Different attitude regarding painful procedures: <ul style="list-style-type: none"> - foreign children have a higher pain tolerance - parents have a more tolerant attitude towards their child's pain) Problems because of religious practices or habits Difficulties when supporting foreign parents during their grief Different opinion about the role of the nurse : <ul style="list-style-type: none"> - Foreign patients have a lower opinion about nurses than native patients - Difficulties with Muslim men accepting female nurses) Feeling embarrassed or uncomfortable during care due to several reasons because of patients':

					<ul style="list-style-type: none"> - Religious and worship habits - Eating habits - View on personal hygiene <p>Feeling disapproval for the behaviours or habits of parents of foreign children because of differences in:</p> <ul style="list-style-type: none"> - Personal hygiene - Eating habits a lack of respect towards nurses
3	<p>Taylor & Alfred (2010)</p> <p>United States of America</p> <p><i>Western Journal of Nursing Research</i></p>	<p>To determine nurses' views on the organizational supports needed for the delivery of culturally competent care.</p>	<p>Qualitative study</p> <p>Interviews (23), document analysis and report of critical incidents</p>	<p>Nurses in an inpatient department, outpatient department and community-based health centres and managers supervising such nurses in the USA</p>	<p>Nurses sometimes used colleagues, patients or interpreters to improve the communication with their patients.</p> <p><u>Positive factors</u></p> <p>Passion for culturally competent care</p> <p>Being open minded</p> <p>Being sensitive to cultural differences</p> <p>Being aware of personal biases</p> <p>Working effectively with family members</p> <p>The availability of adequate, translated health education materials</p> <p><u>Negative factors:</u></p> <p>Communication difficulties:</p> <ul style="list-style-type: none"> - Not being able to communicate with patients - Lack of adequate interpreter services - The wait for interpreters to arrive

					<ul style="list-style-type: none"> - Concerns about the accuracy of the interpretation Lack of knowledge of cultural differences Lack of exposure to patients from different cultures Lack of tolerance of patients who do not speak English Differences in the perception of health and illness Differences in the perception of pain Expectation of the role of the patient Gender preferences Different practices related to dying Lack of administrative support from the organization Lack of recognition of the need by management of the organization General lack of support for culturally competent care from the organization Lack of adequate training on culture
4	Degni et al. (2012) Finland	To explore the Finnish health care providers' communication and cultural sensitivities in providing	Qualitative study 4 individual interviews and 3 focus group interviews (25 participants)	Gynaecologists/ obstetricians and nurses/midwives in family planning and maternal clinics in Finland	<u>Positive factors</u> Nurses understanding the history, culture, religion and changes in patients' lives in the hosting country <u>Negative factors</u> Communication problems between patients and health care providers

	<i>Journal of Immigrant and Minority Health</i>	reproductive health care to Somali women living in Finland.			Different perception about male staff (female patients not wanting to be treated by male staff) Husbands of female patients wanting to make the decisions for her General lack of professional medical interpreters
5	Matteliano & Street, 2011 <i>Journal of the American Academy of Nurse Practitioners</i>	To document unique ways Nurse Practitioners contribute to the delivery of culturally competent healthcare to diverse and underserved patient populations in urban primary care practices.	Qualitative study Interviews (50) and repeated observations	Nurse practitioners in urban primary health clinics in the USA	<u>Positive factors</u> Having altruistic motivations Probing for root causes Using a holistic approach to patient care Establishing partnerships with patients Willingness to share personal information about themselves Willingness to learn important patient cultural practices Having patience Taking time Having empathy Listening carefully
6	Berlin (2006) Sweden	To investigate PCH nurses' opinions regarding their working conditions	Qualitative and quantitative study	Primary Child Health Nurses working in PCHC centres in Stockholm	<u>Positive factors</u> Formal training in cultural competence <u>Negative factors</u> Lack of available written guidelines

	<i>Scandinavian Journal of Caring Sciences</i>	and cultural competence when interacting with children and parents of foreign origin.	Questionnaires (270)		<p>Lack of support or help</p> <p>A feeling of one's own inadequate cultural knowledge</p> <p>Language difficulties:</p> <ul style="list-style-type: none"> - Not having direct communication with children and parents - Not knowing if healthcare advice is fully understood by the parents <p>To convey knowledge to parents concerning children's health and development</p> <p>Challenges related to interpreters:</p> <ul style="list-style-type: none"> - To be independent of the interpreter, - A feeling of insecurity about the interpreters' translations - The interpreters talk takes a lot of time from other tasks <p>A feeling of being provoked that parents did not learn to speak Swedish despite many years of stay in the country</p> <p>Having professional experience within the PCHC services for more than 20 years</p> <p>Being responsible for more than 50% of children of foreign origin</p>
7	Jones (2008) United States of America	To understand emergency nurses' experiences when	Qualitative study Interviews (5)	Caucasian, non-Hispanic nurses working in an Emergency	<p><u>Positive factors</u></p> <p>Speaking Spanish to the patient</p> <p><u>Negative factors</u></p> <p>Language barrier</p>

		caring for Mexican American patients.		Department in a hospital in the USA	<ul style="list-style-type: none"> - Concern about the accuracy of translation from sources other than the hospital translators - Concern about the accuracy in translation over the phone <p>Limited cultural knowledge</p>
8	Hultsjö & Hjelm (2005) Sweden <i>International Nursing Review</i>	To identify whether staff in somatic and psychiatric emergency care experience problems in the care of migrants, and if so to compare these.	Qualitative study Focus group interviews (35, 3-6 participants each group)	Nurses and assistant nurses at an emergency ward, an ambulance service and a psychiatric intensive care unit	<p><u>Negative factors</u></p> <p>Difficulties related to different cultural behaviours:</p> <ul style="list-style-type: none"> - Difficulties in assessing the seriousness of illness because of the different behaviour - Limited knowledge about behaviours related to different cultures - Problems in treatment related to patients being passive - Difficulties in motivating cooperation in the treatment - Appear more emotional and loud - Different behaviours related to cultural ceremonies <p>Difficulties related to gender roles :</p> <ul style="list-style-type: none"> - Women are not allowed to act because of the husband - Same gender on caregiver and patient <p>Complicating organizational factors :</p> <ul style="list-style-type: none"> - Trouble in finding interpreters as the main problem - Migrants having limited knowledge about the Swedish health care system <p>Communication barriers (language)</p>

					Hierarchical view of health care staff
9	Pergert et al. (2007) Sweden <i>Journal of Pediatric Oncology Nursing</i>	To explore the caring situation of families with an immigrant background within the context of pediatric oncology care.	Qualitative study Focus group interviews (35, 4-10 participants each group) Complementary individual interviews (5)	Nursing staff (registered nurses, child minders, nurse aides) and medical doctors	<p><u>Negative factors</u></p> <p>Linguistic obstacles</p> <p>Interpreter dependency</p> <p>Loss of information control</p> <p>Cultural and religious obstacles:</p> <ul style="list-style-type: none"> - Different views and practices of gender roles, - Different views on family roles - Different views on health care staff roles - Odours/cooking smells - Differences in emotional expressions (expression of grief or anger) which can lead to misunderstandings - Truth-telling differences <p>Social obstacles:</p> <ul style="list-style-type: none"> - Differences in social situation - Differences in identities - Differences in status - Racism and prejudice <p>Organizational obstacles:</p> <ul style="list-style-type: none"> - Unadjusted policies and routines
10	Dogan et al. (2009)	To describe the problems in	Qualitative study	Turkish patients, German nurses and	Some nurses used spouses, children, relatives or friends to translate

		transcultural care	Questionnaires	German	<u>Positive factors</u>
Germany		faced by Turkish immigrants and	(150)	physiotherapists	Education programme about different values and habits of foreign patients
<i>Nursing Ethics</i>		German health care personnel.			Having empathy
					Having compassion
					Being sincere
					Openness to different cultural values
					Being sensitive to foreign patients
					<u>Negative factors</u>
					Poor communication because of language barriers
					Patients having the feeling that their complaints or the health care staff's suggestions were lost in translation
					Difference of habits based on culture (eating, hygiene)
					Religious differences
11	Plaza del Pino et al. (2013)	To ascertain how nurses perceive their intercultural communication with Moroccan patients and what barriers are evident which may be	Qualitative study Semi-structured interviews (32)	Nurses working in three public hospitals in southern Spain	Other patients were sometimes used as translators between the nurse and the patient
	Spain				<u>Positive factors</u>
					Training on how immigrants experience health and illness
	<i>BMC Nursing</i>				<u>Negative factors</u>
					Lack of training in intercultural care resulting in a lack of skills in intercultural care
					Language barrier

		preventing effective communication and care.			Prejudicing and stereotyping by nurses
12	Foley (2005) USA <i>AIDS Care</i> 'HIV/AIDS and African immigrant women in Philadelphia: Structural and cultural barriers to care'	To explore the perspectives of HIV service providers and to examine the cultural and structural barriers African women face in the area of HIV prevention, testing and treatment.	Qualitative study Interviews and focus groups (8, 78 participants)	West and East African women and men living in Philadelphia. Medical practitioners, social workers and (peer) counsellors, (nurse) case managers working at area hospitals, clinics and health centres in Philadelphia.	<u>Negative factors</u> Language barriers Nurses often relied on children, friends or relatives to translate Difficulty finding translators for medical appointments Difficulties with communicating effectively with patients who have little or no formal education and limited fluency in English or French Patients being unfamiliar with biomedicine and the organization of the health care system Lack of understanding in American medicine Health care providers having little understanding of the sociocultural context of HIV/AIDS in Africa, and how lack of ARV treatment and high mortality rates in their home countries shapes Africans' attitudes to testing and treatment in the US. Non-disclosure of patients with HIV Health care providers having insufficient resources Health care providers lacking compassion for the African population (racism and discrimination)

