Intensive & Critical Care Nursing 55 (2019) 102752

Contents lists available at ScienceDirect

Intensive & Critical Care Nursing

journal homepage: www.elsevier.com/iccn

Research article

Facing the unfamiliar: Nurses' transcultural care in intensive care – A focus group study

Stephanie Listerfelt [a,b], Isabell Fridh [b], Berit Lindahl [a,*]

[a] Södra Älvsborgs Hospital, The General Intensive Care Unit, Sweden
[b] Faculty of Caring Sciences, Work Life & Social Welfare, University of Borås, SE-501 90 Borås, Sweden

ARTICLE INFO

Article history:
Received 19 October 2018
Revised 25 July 2019
Accepted 1 August 2019

Keywords:
Cultural competence
Culturally diverse
Focus groups interview
Intensive care unit
Intercultural care
Nursing staff
Transcultural care
Relatives

ABSTRACT

Introduction: Western Europe today is a culturally diverse society and expected to become more so in the future. When patients from unfamiliar cultures become critically ill and require intensive care, this places considerable demands on the cultural and linguistic competencies of the intensive care staff. Existing research regarding the transcultural aspects of intensive care is scarce and, in Sweden, non-existent.
Objective: To explore the experiences of critical care nurses and enrolled nurses in caring for culturally diverse patients in intensive care units.
Method: Four focus group interviews were conducted with a total of 15 interviewees. The collected data were subjected to qualitative content analysis.
Findings: The findings mostly concerned the nursing staff's experiences of caring for relatives. Caring for the relatives of culturally diverse patients was described as challenging due to linguistic and cultural barriers.
Conclusions: To overcome linguistic and cultural barriers, intensive care units should be reorganised and restructured to create a more welcoming environment for relatives. Alternative communication methods should be developed and traditional ways of using support from interpreters support must be re-evaluated. Education to ensure cultural competence and the promotion of an intercultural approach is key and the development of research programmes is recommended.

Implications for Clinical Practice

- Intensive care units should be reorganised and restructured towards a more family-centred welcoming environment. This would also facilitate nursing staff caring for culturally diverse relatives. This may include changing work routines, providing single patient rooms and also create facilities where large family groups may be assembled.
- Appropriate resources should be provided to facilitate communication. Amendments to how professional interpreters are used should be considered and where interpreters are unavailable, hospitals must develop safe, smart and easy-to-use language tools that enable caregiver-patient/relative communication.
- Nursing staff should be encouraged to enhance their cultural competence and to adopt an intercultural approach.

Introduction

In recent decades Sweden, with its population of 10 million, has seen an influx of immigration from all over the world. As a result of human suffering arising from wars and conflicts, refugee numbers have increased rapidly in recent years. Sweden has welcomed a significant proportion of these refugees, primarily from Syria (Statistics Sweden, 2017). Today, over 1.8 million of Sweden's inhabitants (i.e., 18.5% of the total population) were born outside of Sweden (Statistics Sweden, 2018). Similar situations are evident throughout Western Europe (Coleman and Angosta, 2017, Markey et al., 2018). In culturally diverse societies, nursing staff must be in a position to provide culturally congruent care (Leininger & McFarland, 2002; Benbenishty et al., 2017). According to Helman (2007), culture has

* Corresponding author at: Allégatan 1, 501 90 Borås, Sweden.
E-mail addresses: stephanie.listerfeldt@vgregion.se (S. Listerfelt), isabell.fridh@hb.se (I. Fridh), berit.lindahl@hb.se (B. Lindahl).

https://doi.org/10.1016/j.iccn.2019.08.002
0964-3397/

a significant impact on people since it defines us as human beings in terms of our identity and how we behave with regard to other people. Leininger and McFarland (2002) observed that culture defines people's perceptions of health, wellbeing, sickness and death. If the intention is to provide meaningful and equal care to patients, culture cannot be ignored. Therefore, awareness of cultural aspects requires knowledge of and sensitivity to different cultures and cultural competence on the parts of health care personnel.

Research regarding care for culturally diverse patients in an intensive care context has hitherto been scarce. Those studies that have been carried out have demonstrated that caring for culturally diverse patients and their relatives in an intensive care unit (ICU) can be challenging. Høye and Severinsson (2008) observed that Norwegian nurses perceived caring for culturally diverse patients as a stressor due to linguistic, cultural and ethnic differences. These differences *have been acknowledged as a potential source of conflict between nursing staff and patients*' family members (Høye and Severinsson, 2010; Van Keer et al., 2015). Nurses' attitudes and subjective norms and values are proven factors that influence their intentions in providing culturally congruent care. Marrone (2008) claimed that nurses who have received formal training in transcultural care have more open attitudes towards culturally diverse patients and are more driven to provide culturally congruent care. To overcome the challenges associated with cultural diversity and nursing, these studies have emphasised above all the need to provide education to ICU nursing staff to improve cultural competence.

Western Europe is an increasingly culturally diverse continent and therefore it is reasonable to expect the numbers of multicultural patients requiring nursing within ICUs to rise. The Swedish Registry for Intensive Care (SIR) maintains a quality register to which all Swedish ICUs report their activities. Annual statistics concerning treatments, patients' age and gender distribution are presented on their website. However, patients' ethnicities are not included in these statistics. Intensive care is known to present both medical and ethical complexities, and caring for patients and their relatives is often challenging. It may be assumed therefore, that caring for culturally diverse patients will present even greater challenges, particularly when cultural or religious protocol comes into play. Transcultural research has shown that cultural competence is a crucial aspect of care for patients and their relatives and necessary for the provision of culturally congruent care (Campinha-Bacote, 2002, Maier-Lorentz, 2008). In intensive care contexts, poor cultural competence can lead to negative social and clinical outcomes for both patients and family members (Benbenishty et al., 2017). Linguistic and cultural barriers may also impinge on nursing care, jeopardize patient safety and affect the working environment (van Rosse et al., 2016). There has been little international research concerning transcultural nursing in ICUs and no Swedish studies were found in international scientific databases. How do ICU staff members perceive their cultural competence when caring for patients from diverse countries and cultures? Do language barriers increase the risk of conflict, uncertainty, and stereotyping? Therefore, the aim of this study was to explore critical care nurses' (CCN) and enrolled nurses' (EN) experiences of caring for culturally diverse ICU patients.

Methods

Design and approach

A qualitative design with an inductive approach was chosen (Polit & Beck, 2017). Data were collected through focus group interviews in accordance with the method proposed by Krueger and Casey (2009).

Ethical approval

In Sweden, interviews with staff about their work are not covered by the law on ethical review research involving humans. However, the unit leaders of both ICUs approved the study and all steps in the study were conducted in accordance with the World Medical Association's Declaration of Helsinki (2013). Participants were given oral and written information about the study and advised of their right to withdraw their participation at any time. They were also assured of their anonymity and confidentiality. With regard to the focus group interviews, the interviewees were also encouraged to maintain and respect anonymity and confidentiality with one another. All interviewees gave their written consent.

Participants

Participants were recruited from two general ICUs situated in two different hospitals in Sweden. When the unit leaders had given their written approval, they were asked to distribute written information about the study to their staff members. With their help both CCNs and ENs were approached. In Sweden, nursing staff generally consists of CCNs and ENs working together during each shift. The CCN is responsible for the patients' care, with a degree of medical responsibility but primarily undertaking nursing activities. ENs do not have legislative nursing responsibilities but have considerable caring expertise and assist the CCNs with nursing activities. The inclusion criteria for the study were as follows: participants were required to be registered nurses specialised in intensive care (CCN) and/or enrolled nurses (EN), all with experience of caring for culturally diverse patients in an ICU. A total of 15 nurses, satisfied the criteria for participation: eight CCNs and seven ENs. The participants consisted of twelve women and three men with ages ranging from 28 to 61 years. The length of experience of working within an ICU varied between one and 31 years. Thus, the sampling approach involved participants (two groups of CCNs and two groups of ENs). The participants represented a wide range of variation (Polit & Beck, 2017). Three out of the four focus groups consisted of four participants while one group had just three participants. The latter was due to high workload and difficulties to release staff at the date and time set for the interview session.

Data collection

Data were generated through four focus group interviews conducted at two different ICUs. The focus group interview is an effective means of collecting large amounts of data during a short period of time. With the group dynamic also comes the benefit of participants responding to one another's comments, which may lead to a deeper understanding of the phenomenon at hand (Polit & Beck, 2017). It is also a particularly appropriate method when the phenomenon in question is stigmatised or taboo, since participants may be more encouraged to share their experiences and thoughts if they hear others contribute (Brinkmann and Kvale, 2014). Since the phenomenon in this study targeted a minority group of patients, the focus group interview technique was deemed suitable.

In total, four focus group interviews took place at two different hospitals. The participants were divided into groups according to profession: two groups of CCNs and two groups of ENs. The interviews took place physically near the ICUs and lasted over 35–45 minutes. All interviews were audiotaped and later transcribed. Two researchers were present at all interviews. One, who adopted the role of moderator, also guided the interviews and was responsible for asking follow-up questions. The other researcher was present as an observer, and was responsible for audiotaping and

making notes regarding what was said and what took place in the room during the interviews. An unstructured interview guide was used (Box 1) as recommended by Krueger and Casey (2009) and each interview opened with the question: *What are your experiences of caring for culturally diverse patients in the ICU?* Subsequent questions were aimed at clarifying what had been said, for example: *How do you mean? Can you explain further?* Participants were encouraged to speak honestly and openly. After each interview session, a summary of what had been said was presented to offer the participants an opportunity to clarify, correct or add opinions or experiences.

Box 1 . Interview guide – focus group interviews (Krueger and Casey, 2009).

Questions:

1. Introduction question
   a. What are the biggest challenges of caring for critical ill patients in general?

2. Key questions
   a. What are your experiences of caring for culturally diverse patients in ICU's?
   b. Follow up questions or statements
      - Can you give examples?
      - How do you mean?
      - Can you explain further?
      - How did you think?
      - How did you feel?
      - What does that mean to you as a caregiver?
      - I don't understand

Data analysis

The collected data were subjected to the qualitative content analysis process described by Graneheim and Lundman (2004). After the transcribed data had been read several times, two researchers identified meaning units that correlated with the study's aims. These were then condensed and coded and those that were similar were grouped together and abstracted as categories and sub-categories. All authors were involved in the final analysis and in the development of the categories and subcategories.

Findings

Nursing staff identified that their main experience of caring for culturally diverse patients in the ICU largely involved caring for the patients' relatives. Analysis of the focus group interviews revealed one theme, "*facing the unfamiliar*" a set of linguistic and cultural challenges that may be classified into four categories and ten sub-categories (Table 1).

Relatives taking up space

In all interviews, the CCNs and ENs reported that, in their experience, culturally diverse patients can have large numbers of relatives, which results in many visitors who occupy considerable amounts of space in the ICUs.

Large numbers of relatives are challenging

One challenge described was the logistical problem of there being insufficient physical space in the ICU to accommodate large numbers of relatives. This represented a potential challenge, particularly with regard to patients' immediate bedside vicinities, where space tends to be limited. When providing care for the patients, the nursing staff admitted that it was sometimes difficult to ask relatives to move aside. Nurses also reported that large visitor numbers interrupt their work since it requires opening the locked doors to the ICU's every time someone wishes to enter. In some instances, family members opened the doors for one another when nurses' took too long to respond. Nurses described heightened security concerns and a sense of loss of control at not knowing precisely who is present in the ICU at a given time. Multiple relatives often addressed numerous questions to the staff. Having to respond to the same questions several times was considered to be time-consuming, resulting in reduced time spent caring for patients. One participant expressed this as follows:

> "*The fact that there are so many of them* (the relatives) *can be very strenuous for us. Everyone needs to know everything and you barely have time for the patient, instead you need to tell everything to all the relatives.*"

One focus group reported that this situation improved after the decision had been made to only give information to a designated relative. All focus groups stated that their intentions were always to take care of all relatives in the best ways possible, but that lack of resources (time and personnel) sometimes made this task difficult and inadequately executed.

The relatives wish to be near

One interview group observed that relatives of culturally diverse patients exhibit great need to participate in the care of their loved ones. These relatives wished to be involved in nursing activities and some were present in the ICUs around the clock. The perceptions were that these relatives sometimes failed to appreciate critically ill patients' need for calmness and rest. However, the same group of nurses argued that, if time was taken to thoroughly explain the reasons and purpose for patient rest, there were seldom problems, as related below:

> "*We have resting hours for the patients in the middle of the day and then you need to shove everyone out for the sake of the patient* [. . .]*You have to convince them* (the relatives) *even more in order to make them understand. It usually works. This you also have to do during the night.*"

Table 1
Description of theme, categories and subcategories.

Relatives taking up space	Communication as a challenge	Crisis reactions cause drama	Providing equal and personal adjusted care
Large numbers of relatives are challenging	Language barriers complicates already complicated care	Unfamiliar reactions to crisis cause feelings of insufficiency and insecurity	Cultural compliance within certain boundaries
The relatives wish to be near	Relatives as interpreters – good and bad	Unfamiliar reactions to crisis create a sense of compromised control	Equal care for everyone
	Language barriers increase workload		
	Language barriers demand new solutions about how to connect		

The acceptance of and adherence to visitor rules (e.g., visiting hours, numbers of visitors permitted at the bedside simultaneously) were discussed by some groups. They reported that relatives of culturally diverse patients often had problems with this, despite being briefed several times. Nursing staff admitted that they sometimes decided to "break the rules" themselves by permitting more than two relatives to enter the patient's room (two visitors simultaneously is the norm). This was aimed at diminishing distress and reducing the total visiting time when there were many worried relatives that wished to see the critically ill patient prior to medical intervention or nursing activities. In these situations, the continuous communication of information to the relatives was acknowledged to be important. Some nurses found there to be no problems in dealing with constantly present relatives; rather, they were seen as a recourse for the nursing staff but foremost for the patient. Regarding situations where the decision had been made to withdraw intensive care and allow a patient to die, the nurses reported that they had no problem in allowing the relatives to take over and letting their needs and ways of saying goodbye guide the end-of-life care.

Communication as a challenge

The experience of caring for culturally diverse patients and their relatives was reported to frequently present challenges with regard to communication.

Language barriers complicate already complicated care

Caring for culturally diverse patients when there are language barriers was described as challenging. Explaining the concepts of intensive care was reported to be difficult in any situation, let alone explaining it to someone who does not understand Swedish (or English). Relatives were considered to require significant amounts of information overall, particularly during the patients' most critical periods, and the inability to provide information instantly due to language barriers was described by nurses as frustrating.

> "*The worst part is that they* (the relatives) *might not get the information they really need then and there [. . .] but we still must do what we ought to do. Then the information must come later.*"

Professional interpreters were available almost exclusively for physicians' meetings and not for everyday encounters with relatives, since professional interpreters tend to be in short supply.

Relatives as interpreters: good or bad?

Owing to the shortages of professional interpreters, nursing staff must often resort to using relatives as interpreters, which was described as both a benefit and a hazard. The experience of the nursing staff was that, due to a large network of countrymen, there is almost always someone close or a more distant relative or friend who understands and speaks Swedish. With the help of these people, nursing staff can communicate with and involve both patients and relatives. The disadvantages to relying on relatives as interpreters include that the nurses are sometimes unable to estimate the relative's level of proficiency in Swedish. There is always the risk that the relative who translates may not understand medical words or contexts, and misunderstandings may therefore ensue. Another risk described by one of the nurses was that relatives may not translate all the information and may withhold some details:

> "*A relative who acted as an interpreter did not translate everything. This is a big problem and they* (the interpreter) *do not realise the seriousness of it* [. . .] t*hat they do not translate everything* [. . .] *glossing over* [. . .] *And then the real shock comes when a professional interpreter is used.*"

Language barriers increase workload

Nursing staff reported that dealing with language barriers demands manpower and is time consuming. It also involves planning if a professional interpreter is being used, since this service needs to be booked in advance. More manpower may be used if nurses are required to act as interpreters in place of performing their usual tasks; being torn between patient care and relatives' need for attention contributes another burden. This was expressed by one nurse as follows:

> "*You don't want to create misunderstandings and then you need to be extremely explicit. That demands both time and energy and sometimes you don't have that time.*"

Language barriers require new strategies to facilitate communication

Although there are many challenges in dealing with language barriers, the nurses explained that other modes of communication are often found via improvisation and innovation. One participant stated:

> "*What do you do? Body language, picture, drawings. You ask the relatives to write down the most important words, learn from the relatives so you can say pain or so* [. . .]. *It works out fine most of the time.*"

The use of computerised translation programmes or the incorporation of colleagues who are familiar with the language or culture at hand were mentioned as alternatives.

Crisis reactions cause drama

The nurses reported that the emotional distress of culturally diverse patients' relatives can cause drama and stir up emotion among the nursing staff themselves.

Unfamiliar reactions to crisis cause feelings of insufficiency and insecurity.

It was observed that relatives of culturally diverse patients express emotions differently. Feelings of grief and sorrow were more likely to be expressed loudly and dramatically. Behaviour of this nature may cause stress and anxiety among nursing staff due to uncertainty as to how to respond to family members. The lack of resources to care for relatives in need of support was another source of stress. Some nurses had experienced situations where reactions to crisis became both fractious and threatening, which caused an unpleasant work environment. The nurses stated, however, that the expression of sorrow is generally healthy, even when it may be unfamiliar and uncomfortable for the staff. One of the nurses explained:

> "*It's just that they need to let loose their feelings. Maybe it's not so bad as one thinks just because it's loud and there are screams and cries. Maybe they are not really angry at you but the situation. That's also important to remember.*"

Unfamiliar reactions to crisis create a sense of protecting others

Loud expressions of sorrow generate the need to regain control among the CCNs and ENs, in order to protect other patients and relatives present in the ICU. The nurses expressed concern that others present in the ICU might be disturbed and that intensive care should always be administered within a calm environment. One of the participants said:

> "*There is too much to overhear and experience for other patients and their love ones. You cannot take the time and you have often no possibility or place to take these upset relatives to where you can calm them down in private*"

The attempt to regain control over a situation often meant showing relatives to a designated room, but these were not always available or adequate.

Providing equal and personal adjusted care

The CCN's and EN's all agreed that there is no difference in caring for a culturally diverse person/patient. All patients are entitled to receive equal care but the way towards achieving that goal may take various forms.

Cultural compliance within certain boundaries

Nurses described themselves as having both the desire and capacity for cultural sensitivity and flexibility towards cultural or religious wishes. Theses competencies were described as having been developed through frequent caring for culturally diverse patients and working over several years in an ICU. A general knowledge and experience of different cultures or religions and their traditions was described as engendering a certain comfort in caring for the unfamiliar as well as a capacity for providing culturally congruent care. However, some nurses still maintained an uncertainty with regard to caring for culturally diverse patients, in that they were afraid of being culturally inappropriate and portrayed as disrespectful. They expressed the intention to always provide culturally congruent care as far as possible, albeit with some reservations: as long as it does not affect the patient, other patients or their relatives in a negative way.

> "*If they* (the relatives) *do not negatively impact care then they can do what they need to do without us interfering. It's just that you have to protect other patients so they aren't get affected.*"

Equal care for everyone

Medical needs were reported to always determine the level of care provided; in this regard, there is no difference in caring for culturally diverse patients. Although there may be linguistic and cultural barriers, the nurses explained that they always endeavour to provide equal care regardless. One participant said:

> "*There is no real difference compared to other patients, right? It's just that you have to have someone who can translate so that we can communicate.*"

Discussion

Regarding CCNs' and ENs' experiences of caring for culturally diverse patients within ICUs, it was found that caring for the relatives of culturally diverse patients was challenging due to linguistic and cultural barriers.

Caring for culturally diverse patients in ICUs

While the initial aim was to focus on the patients' perspectives, the nurses mainly spoke about their encounters with relatives. Previous studies have shown that tending to relatives' needs constitutes a significant proportion of care where critically ill patients are concerned (Stayt, 2007; Engström, Uusitalo & Engström, 2011). We assert that the patient's perspective will always encompass their relatives, and so caring should be sensitive and holistic. This is particularly true of intensive care nursing (Al-Mutair et al., 2013). When Nyholm and Koskinen (2017) interpreted ICU nurses' written testimonies regarding threats to patients' dignity, they included patients' relatives. If the nurses failed to protect patients' dignity, they considered their lost their own dignity too.

Our findings showed that the interviewees expressed uncertainty in situations where there were large groups of visitors at the same time that wanted to be near the patient. ICUs in the Nordic countries apply an open visitation policy. The ICUs are literally locked and visitors need to ring a bell and announce their presence. Moreover, visits are supposed to be planned ahead together with staff. This is something that often surprises relatives who never previously visited an ICU but is a measure to protect patient's integrity and safety (Lindahl & Bergbom 2015). Visitors are also often advised to approach the bedside two at a time. Language barriers can make such regulations even harder to understand. It is well known that the physical ICU environment could obstruct human interactions as ICU bed spaces are narrow and filled with technological devices that hinder the relatives to come near the patient (Andersson et al., 2019). Wong et al. (2015) point to the risk that culturally diverse patients and their families receive less information and emotional support from healthcare professionals. We suggest that the meaning within the concept intersectionality needs to be critically reflected by ICU staff. To take on an intersectional perspective involves awareness of social positions, e.g., that ethnicity, gender and class affect the caring relation (Dahlborg Lyckhage, Brink & Lindahl 2018). Wikberg and Eriksson (2008) claim that patient's and family's cultural background as well as the nurse's cultural background, cultural competence and caring organisation influence nursing care activities. Thus, caring is a complex whole involving both universal and diverse aspects.

Nursing theories and cultural competence

To address the cultural challenges within the healthcare sector, transcultural nursing theories that emphasise the importance of cultural competence have been developed. Jirwe, Gerrish and Emami (2006) argue that, through enhanced knowledge of different cultures and religions and their associated traditions and characteristics, cultural competence can be realised, which may help in overcoming cultural barriers and facilitate an authentic, caring relationship between patient and nurse. Several researchers have suggested that cultural competence among health care personnel is particularly important in the context of providing intensive care for culturally diverse patients and their relatives (Engström and Söderberg, 2007; Høye & Severinsson 2008, 2010a, 2010b). However, a shortcoming of transcultural nursing theory and the cultural competence concept is the risk of categorisation and the generalisation that may result in patients or their relatives being defined according to rigid cultural frameworks. For example, if all patients originating from a certain part of the world were assumed to be homogenous with regard to their beliefs, feelings and thoughts, the patient's individual and lifeworld perspectives may be overlooked. Björk Brämberg (2008) claims that cultural competence of this nature engenders stereotyping and is therefore incompatible with a lifeworld-orientated caring science.

Promoters of lifeworld-orientated caring sciences believe that maintaining a focus on the lifeworld perspective (Todres, Galvin & Dahlberg, 2014) while caring for each individual patient will ensure that due consideration is given to cultural and religious issues and will also reduce the risk of patients being categorised. Wikberg and Eriksson (2008), however, favour a combination of transcultural nursing theories and caritative nursing theories, which they term 'intercultural care'. They claim that by adding cultural competence to a lifeworld nursing perspective, a better standard of care, wherein each individual patient has a better chance of obtaining health and wellbeing, is possible. They further claim that the adoption of an intercultural approach exclusively by nursing staff is not enough: an intercultural approach must permeate the entire healthcare organisation, including leaders and heads of departments. In a study regarding cultural conflict in ICUs, Van

Keer et al. (2015) report that the provision of cultural competence training to nursing staff alone is insufficient to overcome cultural conflict or challenges. They argue that there are structural and organisational characteristics inherent in ICUs that exacerbate or even trigger conflicts. Therefore, to prevent cultural conflict, the ICUs' everyday work environment surrounding each patient must be more accommodating towards relatives so that they may feel more informed and involved than is currently the case.

Family-centred culturally sensitive care

Our findings indicated that the nurses lacked the resources to offer privacy to the patients and their relatives. This was particularly evident in relation to relatives' crisis reactions and distress. The international guidelines for family-centred care (Davidson et al., 2017) strongly recommend that all families should be allowed open and flexible family presence at the ICU patient's bedside, and that the patient should be cared for in a private room. Today, many hospital buildings and ICUs are undergoing construction or refurbishment, and considerable attention is paid to the design of single rooms (Ulrich, 2006; Halpern, 2014). To meet the needs of various families, in our view, the construction and design of single patient rooms, conversation rooms and family waiting rooms should also be included in the architectural design (Andersson et al 2019). This is important for staff, patients, and their visitors, in general, but is particularly pertinent in encounters with people with whom language barriers are an issue. It is also intrinsic to the protection of the privacy and integrity of neighbouring patients and their visitors.

The participants also reflected on communication difficulties that arose due to a lack of mutual understanding of traditions, behaviours, beliefs and values in relation to culturally diverse patients and their families. They stressed the importance of providing equal care to all. This aligns with Coleman and Angosta's (2017) findings from their interviews with 40 nurses working in acute care. The nurses strove to foster a caring relationship in which they showed respect and understanding. When distributing the Critical Culture Competence Scale (Almutairi et al., 2017) to 170 hospital nurses, Almutairi's team found that cultural competence was correlated with age, experience and country of birth. Younger nurses who had been born in Anglo-Saxon countries had the highest levels of cultural perception. In the actual study, no data was collected with this set of questions or approach. In a grounded theory study (Markey et al., 2018) that focused on nurses and nursing students' experiences of caring for people with diverse cultural, ethnic and linguistic backgrounds, uncertainty was found to be a core concept. This became evident through ambiguity regarding how to behave, a lack of knowledge and unawareness of ethnocentric beliefs. The organisational culture also affected the nurses' uncertainty. To strengthen ICU nurses' self-confidence both individually and on an organisational level, the position statement developed in 2016 by the World federation of Critical Care Nurses (WfCCN, 2016) may be recommended.

Future challenges

Although the nurses in this study claimed that they provided equal care to all patients, it is apparent that there are challenges present in interactions between the nursing staff and patients' family members. Some of the perceived difficulties reported by staff might possibly be resolved through education. In times of growing xenophobia and ethnocentrism, the MICE-project (Multicultural Care in European Intensive Care Units) is a commendable initiative aimed at enhancing cultural competence in European ICUs (http//mice-icu.eu). This ERASMUS-plus project, founded by the European Union, has made considerable achievements in the initiator countries, resulting in an E-learning course that is available in English (https//lms.mice-icu.eu). In cooperation with the European federation of Critical Care nursing association (EfCCna) this course will be translated into several European languages. It is expected that this course will contribute to enhanced cultural competence among nursing staff in Swedish ICUs as well as in the rest of Europe. Finally, examples of positive experiences shared by international colleagues can open up nurses' eyes and minds, and make the unknown a little more familiar (Benbenishty & Biswass 2015).

Limitations

Krueger and Casey (2009) argue that a well-prepared interview guide is essential for a successful interview session. After two interview sessions, the introductory question, the purpose of which was to warm up the interviewees, was removed (Box 1). This question proved to be too complex and difficult to answer and therefore did not fulfil its purpose. The recommended number of participants in a focus group varies but Côté-Arsenault and Morrison-Beedy (1999) and Krueger and Casey (2009) suggest groups of four to six participants, so that all participants have an opportunity to speak. However, groups that are too small may cause discomfort for the participants as they may feel pressured to speak. In our study, one group consisted of only three participants, due to this particular ICU's heavy workload and staff shortages. Performing research in an ICU means to adapt the time set for data collection to a fast-paced environment. Here the researcher needs to be flexible. Wilkinson (2008) suggests the researcher to over-recruit participators to ensure attendance when using focus group interviews. However, she also describes the risk that the focus group session then may risk having too many participators and problems with too quiet or too talkative participants. In the actual study the group with three nurses all were prepared for the interview session and therefore it was decided to respect their time and planning, i.e. to carry out the interview as planned. In terms of speaking space, however, the space was considered to be fairly divided among the participants and the interview sessions did not lose focus or become dominated by any single individual, a risk identified by Brinkmann and Kvale (2014). The reason for including two different health care professions, CCNs and ENs, was that both professions work together at patients' bedsides. Since the aim of the study concerns a phenomenon that involves both CCNs and ENs we deemed it fair and appropriate to include both. Côté-Arsenault and Morrison-Beedy (2005) assert that there should not be any hierarchical differences among the interviewees in a group or any individuals who are dependent on one another, since this can impair interviewees' willingness to talk. Since there are hierarchical differences in terms of education level, work tasks and responsibilities between CCNs and ENs, a division between the two professions was judged to be necessary to avoid compromising the study's credibility.

Our study examined the phenomenon from two general ICU settings. However, we argue that the findings can be transferred to other Swedish ICUs with similar constitutions/characters. Creswell and Poth (2018) stress that, in order to claim a study as an example of sound analytical work, the researchers must position themselves within the report (i.e. disclose their own histories, culture and experience). The researchers in our study are white Swedish women. We are all CCNs, one clinically active in an ICU and has experience of working in the organisation Doctors Without Borders (i.e. in countries with poor resources). The others are well-experienced researchers in intensive care and in interpretive qualitative methods and are active contributors to the university's international profile. We argue that this enhanced the reliability

of our findings. Furthermore, the study has been critically reflected on during research seminars.

Conclusions

CCNs and ENs reports of their experiences of caring for culturally diverse patients in ICUs centred largely on their encounters with relatives. Caring for the relatives of culturally diverse patients entails linguistic and cultural challenges. If ICU nursing staff are to provide equal care to all patients and their relatives, strategies for doing so must be developed. This study contributes to a wider understanding of nursing staff's experiences of caring for culturally diverse patients in ICUs. The subject has not been well researched from an international perspective and not at all from a Swedish context, and thereby this study introduces a new field of research in Sweden. Cultural care is also a subject that should be incorporated into nursing education curricula.

Implications for further research

Our recommendation is that further research should be conducted from cross-cultural and family perspectives. For example, the outcome of educational efforts in multi-cultural/sensitive care addressed to staff members should be evaluated by those in receipt of care.

Acknowledgements

We would like to offer a special thanks to Christina Sundstedt for her comprehensive contribution to this study. Without her there would not be a study.

Declaration of Competing Interest

There is no conflict of interest.

Author contribution

S.L designed the study, collected the data, worked with analyses and drafted the paper; I.F worked with analyses, wrote some shorter section and commented on the paper; BL designed the study together with SL, worked with analyses and wrote some parts and commented on the paper. All authors have had a creative collaboration in working with drafting the manuscript.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.iccn.2019.08.002.

References

Al-Mutair, A.S., Plummer, V., O'Brien, A., Clerehan, R., 2013. Family needs and involvement in the intensive care unit: a literature review. J. Clin. Nurs. 22 (13/14), 1805–1817. https://doi.org/10.1111/jocn.12065.

Almutairi, A.F., Adlan, A.A., Nasim, M., 2017. Perceptions of the critical cultural competence of registered nurses in Canada. BMC Nursing 16, 1–9. https://doi.org/10.1186/s12912-017-0242-2.

Andersson, M., Fridh, I., Lindahl, B., 2019. Is it possible to feel at home in a patient room in an intensive care unit?: reflections on environmental aspects in technology dense environments. Nursing Inquiry. https://doi.org/10.1111/nin.12301.

Benbenishty, J., Gutysz – Wojnicka, A., Harth, I., Barkestad, E., Satosek, D., Jacobsson, K., Blackwood, B., 2017. The migrant crisis and the importance of developing cultural competence in the intensive care unit. Nurs. Critical Care 22 (5), 262–263. https://doi.org/10.1111/nicc.12313.

Benbenishty, J., Biswas, S., 2015. Cultural competence in critical care: case studies in the ICU. J. Modern Educ. Rev. 5 (7), 723–728. 10.15341/jmer(2155-7993)/07.05.2015/011 © Academic Star Publishing Company. http://www.academicstar.us.

Björk Brämberg, E., 2008. To be an immigrant and a patient in Sweden. (An individualised perspective). Acta Wexionensia. No 136/2008. ISSN: 1404-4307, ISBN: 978-91-7636-594-6. (Written in Swedish with a summary in English.).

Brinkmann, S., Kvale, S., 2014. InterViews: Learning the Craft of Qualitative Research Interviewing. Sage, Los Angeles.

Campinha-Bacote, J., 2002. The process of cultural competence in the delivery of healthcare services: a model of care. J. Transcult. Nurs. 13 (3), 181–184.

Coleman, J.S., Angosta, A.D., 2017. The lived experiences of acute-care bedside registered nurses caring for patients and their families with limited English proficiency: a silent shift. J. Clin. Nurs. 26 (5–6), 678–689. https://doi.org/10.1111/jocn.13567.

Côté-Arsenault, D., Morrison-Beedy, D., 1999. Practical advice for planning and conducting focus groups. Nurs. Res. 48 (5), 280–283.

Côté-Arsenault, D., Morrison-Beedy, D., 2005. Maintaining your focus in focus groups; avoiding common mistakes. Res. Nurs. Health 28, 172–179. https://doi.org/10.1002/nur.20063.

Creswell, W.J., Poth, N.C., 2018. Qualitative Inquiry & Research Design: Choosing among Five Approaches. SAGE, Los Angeles.

Lyckhage, E.D., Brink, E., Lindahl, B., 2018. A theoretical framework for emancipatory nursing with a focus on environment and persons' own and shared lifeworld. Adv. Nurs. Sci. 41 (4), 340–350. https://doi.org/10.1097/ANS.0000000000000227.

Davidson, J.E., Aslakson, R.A., Long, A.C., Puntillo, K.A., Kross, E.K., Hart, J., Kon, A.A., 2017. Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. Crit. Care Med. 45 (1), 103–128. https://doi.org/10.1097/CCM.0000000000002169.

Engström, B., Uusitalo, A., Engström, Å., 2011. Relatives' involvement in nursing care: a qualitative study describing critical care nurses' experiences. Intensive Critical Care 27, 1–9. https://doi.org/10.1016/j.iccn.2010.11.004.

Engström, Å., Söderberg, S., 2007. Close relatives in intensive care from the perspective of critical care nurses. J. Clin. Nurs. 16, 1651–1659. https://doi.org/10.1111/j.1365-2702.2005.01520.x.

Graneheim, U.H., Lundman, B., 2004. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ. Today 24, 105–112. https://doi.org/10.1016/j.nedt.2003.10.001.

Halpern, N.A., 2014. Innovative designs for the smart ICU: Part 2: the ICU. Chest 145 (3), 646–658. https://doi.org/10.1378/chest.13-0004.

Helman, C.G., 2007. Culture, health and illness. Oxford University Press, New York.

Høye, S., Severinsson, E., 2008. Intensive care nurses' encounters with multicultural families in Norway: an exploratory study. Intensive Crit. Care Nurs. 28, 338–348. https://doi.org/10.1016/j.iccn.2008.03.007.

Høye, S., Severinsson, E., 2010a. Professional and cultural conflicts for intensive care nurses. J. Adv. Nurs. 66 (4), 858–867. https://doi.org/10.1111/j.1365-2648.2009.05247.x.

Høye, S., Severinsson, E., 2010b. Multicultural family members' experiences with nurses an intensive care context: a hermeneutic study. Intensive Crit. Care Nurs. 26, 24–32. https://doi.org/10.1016/j.iccn.2009.10.003.

Jirwe, M., Gerrish, K., Emami, A., 2006. The theoretical framework of cultural competence. J. Multicultural Nurs. Health 12 (3), 6–16.

Markey, K., Tilki, M., Taylor, G., 2018. Understanding nurses' concerns when caring for patients from diverse cultural and ethnic backgrounds. J. Clin. Nurs. 27 (1–2), e259–e268. https://doi.org/10.1111/jocn.13926.

Nyholm, L., Koskinen, C.A.L., 2017. Understanding and safeguarding patient dignity in intensive care. Nursing Ethics 24 (4), 408–418. https://doi.org/10.1177/0969733015605669.

Krueger, R.A., Casey, M.A., 2009. Focus Groups, A Practical Guide for Applied Research. SAGE Publications Inc., Thousand Oaks.

Leininger, M., McFarland, M.R., 2002. Transcultural Nursing. Concepts, Theories, Research and Practice. McGraw-Hill Companies Inc., United states of America.

Lindahl, B., Bergbom, I., 2015. Bringing research into a closed and protected place – development and implementation of a complex clinical intervention project in an ICU. Critical Care Nurs. Q. 38 (4), 393–404. https://doi.org/10.1097/CNQ.0000000000000087.

Maier-Lorentz, M., 2008. Transcultural nursing; its importance in nursing practice. J. Cultural Divers. 15 (1), 37–43.

Marrone, S.R., 2008. Factors that influence critical care nurses' intention of providing culturally congruent care to Arab Muslims. J. Transcult. Nurs. 19 (1), 8–15. https://doi.org/10.1177/1043659607309143.

Multicultural care in European Intensive Care Units (MICE). http//mice-icu.eu (accessed 18.08.25).

Polit, D.F., Beck, C.T., 2017. Nursing Research: Generating and Assessing Evidence for Nursing Practice. Wolters Kluwer Health/Lippincott Williams & Wilkins, Philadelphia.

Ulrich, R.S., 2006. Essay evidence-based health-care architecture. Lancet 368, 538–539.

Statistics Sweden, 2017. Rekordstor invandring under 2015. (All time high in immigration during 2015). http://www.scb.se/sv_/Hitta-statistik/Artiklar/Rekordstor-invandring-under-2015/ (accessed 17.10.08).

Statistics Sweden, 2018. Utrikesfödda efter län, kommun och födelseland 31 december 2017. (Foreign-born according to county, municipality and country of birth 31 December 2017.) http://www.scb.se/hitta-statistik/statistik-efter-

amne/befolkning/befolkningens-sammansattning/befolkningsstatistik/ (accessed 18.02.28).
Stayt, L.C., 2007. Nurses' experiences of caring for families with relatives in intensive care units. J. Adv. Nurs. 57 (6), 623–630. https://doi.org/10.1111/j.1365-2648.2006.04143.x.
Swedish Register for Intensive Care (SIR). https://www.icuregswe.org/ The multicultural course for ICU nurses, https://lms.mice-icu.eu/ (accessed 18.08.25).
Todres, L., Galvin, K.T., Dahlberg, K., 2014. "Caring for insiderness": phenomenologically informed insights that can guide practice. Int. J. Qual. Stud. Health Well-Being 21 (9), 1–10. https://doi.org/10.3402/qhw.v9.21421.
Van Keer, R.-L., Deschepper, R., Francke, A.L., Huyghens, L., Bilsen, J., 2015. Conflicts between healthcare professionals and families of a multi-ethnic patient population during critical care: an ethnographic study. Crit. Care 19 (441), 2–13. https://doi.org/10.1186/s13054-015-1158-4.
van Rosse, F., de Bruijne, M., Suurmond, J., Essink-Bot, M.-L., Wagner, C., 2016. Language barriers and patient safety risks in hospital care. A mixed methods study. Int. J. Nurs. Stud. 54, 45–53. https://doi.org/10.1016/j.ijnurstu.2015.03.012.
Wikberg, A., Eriksson, K., 2008. Intercultural caring – an abductive model. Scandinavian J. Caring Sci. 22 (3), 485–496. https://doi.org/10.1111/j.1471-6712.2007.00555.x.
WfCCN (World federation of Critical Care Nurses). 2016. Brisbane declaration – culturally sensitive critical care nursing. https://evereth.pl/brisbane-declaration-culturally-sensitive-critical-care-nursing.
Wilkinson, Sue, 2008. Focus group research, in Silverman D. (Ed.). Qualitative research – theory, method and practice. Second edition ed. London: SAGE, pp. 176–199.
Wong, P., Liamputtong, P., Koch, S., Rawson, H., 2015. Families' experiences of their interactions with staff in an Australian intensive care unit (ICU): a qualitative study. Intensive Crit. Care Nurs. 31 (1), 51–63. https://doi.org/10.1016/j.iccn.2014.06.005.
World Medical Association, 2013. Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects. https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/ (accessed 17.10.25).