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# Work-related barriers and resources of migrant and autochthonous homecare nurses in Germany: A qualitative comparative study

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ABSTRACT

*Background:* There is substantial research about the occupational health of nurses worldwide. However, empirical evidence about the psychosocial health of migrant and minority nurses in outpatient settings in Germany in comparison to that of autochthonous nurses is lacking.
*Objectives:* This study aims to identify work-related stressors, resources and the corresponding coping strategies of migrant and minority nurses in comparison to autochthonous nurses.
*Design:* 24 migrant and 24 autochthonous nurses employed in the German homecare sector were interviewed in qualitative explorative manner while a distinction was made between non-commercial and private-commercial services.
*Settings:* The interviews took place in the nursing services' premises or in the nurses' private homes.
*Participants:* Services were randomly chosen among all homecare providers in the second largest German federal city-state Hamburg. Nurses were invited for an interview, once their management agreed to participate in the study. Registered nurses and nursing assistants as well as those with a foreign certificate but validated or in process were eligible to participate.
*Methods:* Relevant literature findings formed the base for the semi-structured interview guide. Key areas in the interview guide were barriers, resources and coping strategies in the collaboration with colleagues, superiors and clients as well as in the collaboration within a linguistically and culturally diverse team and clients. The conventional approach to qualitative content analysis by Hsieh and Shannon guided the analysis.
*Results:* Regardless of their origin or culture, nurses perceive time pressure, lifting patients, lack of appreciation or the client's personal fate as burdening. In the intercultural context, the divergent understanding of behavioral patterns as well as of nursing care and a non-functioning communication impede the collaboration within a diverse nursing workforce. Migrant and minority nurses suffer prejudices, verbal and sexual harassment proceeding from their clients. However they keep it to themselves and don't broach it to their supervisors or colleagues. The interaction with humans, the verbal exchange with colleagues and supervisors at eye level as well as the sensemaking of being a nurse helps nurses to cope with occupational stressors.
*Conclusions:* Differences in language is a main stressor which impedes a functioning team collaboration as well as a positive nurse-client relationship. Migrant and autochthonous nurses share similar coping strategies to master occupational burdens. A good collaboration within the team and having an appreciative supervisor are resources that support migrant and minority nurses as well as autochthonous nurses to face the stressors and to cope with those. Migrant nurses of different origin perceive their status as migrants as a sense of community by sharing commonalities.
*Contribution of the paper:* What is already known about the topic?

- The growing demand for care due to the demographic change leads to an increasing trend to hire healthcare personnel such as nurses from abroad.
- The nurses' workplace is characterized by physically and psychologically demanding tasks leading to musculoskeletal pain and job dissatisfaction.

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- Migrant healthcare workers experience additional stressors like discrimination practices as well acculturative stress.

What this paper adds:

- Migrant and Autochthonous nurses share similar coping strategies to master occupational burdens
- Differences in language is a main stressor, which impedes a functioning team collaboration as well as a working nurse-client relationship. More autochthonous than migrant and minority nurses report these differences as stressful.
- Migrant nurses of different origin perceive their status as migrants as a sense of community by sharing the same destiny – this appears as an important resource for migrant and minority nurses.

## 1. Introduction

The concomitant increase of the elderly population and the decline in the birthrate are challenges to the global demography (GBD 2016 Disease and Injury Incidence and Prevalence Collaborators, 2017; Lutz, Sanderson, & Scherbov, 2008; Mathers, Stevens, Boerma, White, & Tobias, 2015). The global life expectancy at birth rose by 6.2 years from 65.3 in 1990 to 71.5 years in 2013 (Murray et al., 2015), while the population in Europe aged by 12.5 years since 1960 and now amounts to 82 years in average (OECD, 2017b).

The healthcare workforce is not only aging but also declining and so healthcare services are additionally confronted with a declining workforce supply (OECD, 2017a; Simoens, Villeneuve, & Hurst, 2005). Several strategies like large-scale nursing training campaigns (Janiszewski Goodin, 2003), monetary incentives to increase retention rates (Buykx, Humphreys, Wakerman, & Pashen, 2010), the academisation of the nursing profession (Fealy & McNamara, 2007; Heitlinger, 1999) or even the implementation of socially assistive robots (Bemelmans, Gelderblom, Jonker, & de Witte, 2012) are discussed and already partly applied to face the challenge of a long-standing rise in demand for care.

Beside these strategies, healthcare workers from abroad are increasingly hired (Li, Nie, & Li, 2014). The number of migrant nurses and doctors has grown by 60% within the Organization for Economic Co-operation and Development (OECD) since 2004 (ILO, 2015). New Zealand, Switzerland, Australia and Luxembourg register the highest proportion of foreign-born nurses within the OECD with more than 30%. In the United States and in Germany 14% of nurses are not native. Among the OECD European countries, Germany and the United Kingdom account for the largest number of emigrating nurses. (ILO, 2015; OECD, 2016). With reference to foreign-born nurses within the OECD, the Philippines and India accounted for the highest shares (ILO, 2015; OECD, 2016).

Working as nurse comes along with various occupational strains in general. Next to physical strains like acquiring hand dermatitis by using gloves, experiencing musculoskeletal pain by lifting and moving patients or sleep disorder due to shift work, there are several specific psychosocial strains like impaired mental health by facing low social support or effort-reward imbalance (Bernal et al., 2015; Ribeiro, Martins, Marziale, & Robazzi, 2012). Homecare nurses are additionally challenged by musculoskeletal stressors like moving and handling household objects to gain access to the patient in his homely environment (Szeto, Wong, Law, & Lee, 2013). They also experience verbal and sexual abuse and violence, problems with workload planning due to time pressure and so feel rushed (Hignett, Edmunds Otter, & Keen, 2016; Hittle, Agbonifo, Suarez, Davis, & Ballard, 2016) with negative effects on their psychosocial health.

While there is a substantial body of research evidence about the psychosocial health of nurses in general, the present knowledge about the health of migrant and minority nurses is scarce as a recent systematic review shows (Schilgen, Nienhaus, Handtke, Schulz, & Mösko, 2017). Just 14 empirical studies explicitly focused on migrant and minority nurses' health in the international research literature. Those studies were mainly conducted in the United States, who are the dominant employer of migrant and minority nurses, while the body of research in countries like New Zealand, Switzerland, Australia and Luxembourg as other major markets for migrant nurses within the OECD is limited. There is evidence that Canadian nurses feel distress due to demands of loss, novelty, and not feeling at home in the receiving country, whereas Philippine nurses reported higher distress due to language accommodation (Beechinor & Fitzpatrick, 2008). Migrant nurses, especially those of ethnic and racial minorities, encounter discrimination, racism and bullying at work on a daily basis (Hogh, Carneiro, Giver, & Rugulies, 2011). This happens in the form of unequal career advancement options, unequal pay, insufficient orientation, overlooking of their skills by colleagues and supervisors (Likupe & Archibong, 2013; Pittman, Davis, Shaffer, Herrera, & Bennett, 2014). Studies showed that the level of acculturation has an influence on the individual's social behavior – e.g. the lower the level is, the higher is the risk for stress in a relationship or conflicts with family members and work colleagues or friends (Renzaho, 2009). Nonetheless, findings also revealed that an initial depression in the first month after arrival goes into remission over time among migrant nurses (Hener, Weller, & Shor, 1997). Measures of mental and organizational support turned out to facilitate the process of acculturation for migrant nurses (Hayne, Gerhardt, & Davis, 2009).

In light of limited empirical evidence on the working situation of migrant and minority homecare nurses, this qualitative study's purpose is to explore their psychosocial strains and stressors, resources and coping strategies.

## 2. Methods

The research questions underlying the qualitative study were

1. “Which psychosocial stressors do migrant and autochthonous homecare nurses experience at work?”
2. “Which resources and coping strategies do they employ to face psychosocial stressors?”
3. “In what way do migrant and autochthonous homecare nurses differ in their experiences in general and in the intercultural context?”

### 2.1. Study design

Qualitative research allows to collect data in a natural setting that is sensitive to the people under study (Creswell, 2007). The interpretation and explanation of behavior in the context of interacting individuals of different cultural backgrounds is prone to cultural bias (Aneas & Sandín, 2009), so migrant nurses as well as native nurses were interviewed in equal shares. The scientific theoretical basis of this study is formed by the phenomenological research approach, which describes the significance of the lived experiences by the individual. The phenomenological approach focuses on the description of what the participants under study recognize together in experiencing a phenomenon (Creswell, 2007).

The qualitative study was conducted in accordance with the “Consolidated criteria for reporting qualitative research” (COREQ) guidelines (Tong, Sainsbury, & Craig, 2007).

### 2.2. Selection and recruitment of participants

The research was undertaken in the federal state of Hamburg. The homecare system in Hamburg is organized either by non-commercial or private-commercial providers (Statistisches-Bundesamt, 2017b). Assuming that the intent to realize a profit within the private commercial services may have an effect on nurses reporting of stressors (Slotala, 2011), such as time pressure (Hielscher, Nock, Kirchen-Peters, & Blass, 2013) led to a subdivision of participants in two strata. Nursing care providers who additionally focus their services on migrant and minority clients may differ from those services that care for clients regardless of their origin (Campinha-Bacote, 2002). This led to a further stratification of the sample: The above-mentioned two strata were subdivided into those focusing on the care for migrant clients and those who not. Finally, two nursing services per stratum were randomly chosen. The choice for a random stratified sample originated on the one hand from the cross-cultural context of the study (Buil, de Chernatony, & Martínez, 2012; Robinson, 2014). On the other hand, it was the study team's aim to have a heterogeneous sample of nurses from different cultural backgrounds and to compare both without predetermining potential "typical" cultural traits to any of them. Firstly, the service's management was contacted. A brief glimpse was given into the study and to get to know whether migrant as well as natives are employed. Studies about data saturation in qualitative research recommend six to twelve interviews per stratum (Guest, Bunce, & Johnson, 2006). Thus, per service six migrant and six natives nurses were recruited for an interview (Fig. 1).

Eligible to participate were (i) registered nurses and nursing assistants with German certificate or whose certificates are in a validation process, since they received their training and certificate abroad; (ii) who were born in Germany or born abroad and migrated to Germany; (iii) had been practising in homecare for at least one year; (iv) being employed on a full-time or part-time basis for at least one year in homecare or for six month in the case of having had changed the employer within the last year (this was needed to ensure a certain familiarity with the recent employer) and (v) who were at least 18 years old.

Not being able to speak German was not an exclusion criteria, since the intention of the study was to include every nurse in the recruiting process regardless of her or his command of language following the principle 'language is no barrier' (Lee, Sulaiman-Hill, & Thompson, 2014; Squires, 2009). In those cases, a professional interpreter would have assisted the interviews.

**Table 1**
Set of interview questions.

Work in general
- Please describe a typical working day!
- What do you like about your work as a nurse?
- What is stressful about your work as a nurse?
- How do you cope with it?

Collaboration with colleagues
- How do you interact with your colleagues?
- What do you like about working with your colleagues?
- What is stressful about working with your colleagues?
- What helps to deal better with the burdens you have just reported?

Collaboration with direct supervisor
- How do you interact with your supervisor?
- What do you like about working with your supervisor?
- What do you experience as stressful about working with your supervisor?
- How do you cope with the burdens you have just reported?

Contact with clients
- How do you experience being in contact with your clients?
- What do you like when you are in contact with your clients?
- What, from your point of view, is stressful in contact with your clients?
- How do you cope with the burdens you have just reported?

Intercultural context – colleagues and supervisors
- Do you also work with colleagues or supervisors who come from other countries or have a different cultural background than yourself?

If so,

- what do you like?
- what do you experience as stressful?
- how do you cope with the burdens?

Intercultural context – clients
- If you ever think about your clients who come from other countries or have a different cultural background than yourself, how do you experience the contact to these people?
- What do you like?
- What do you experience as stressful?
- How do you cope with the burdens?

The study team agreed on a top-down recruitment approach to arrange each of the 48 interviews. In case of a positive feedback of the management board, each service's nursing manager was contacted and invited for participation in this study.

Out of 404 eligible nursing providers in Hamburg, 62 were stepwise randomly contacted. Of those, fifteen agreed to participate and assured to ask their nurses whether those want to be interviewed. The services' nursing managers received information material mainly via email. In order to increase credibility, the study was presented during the

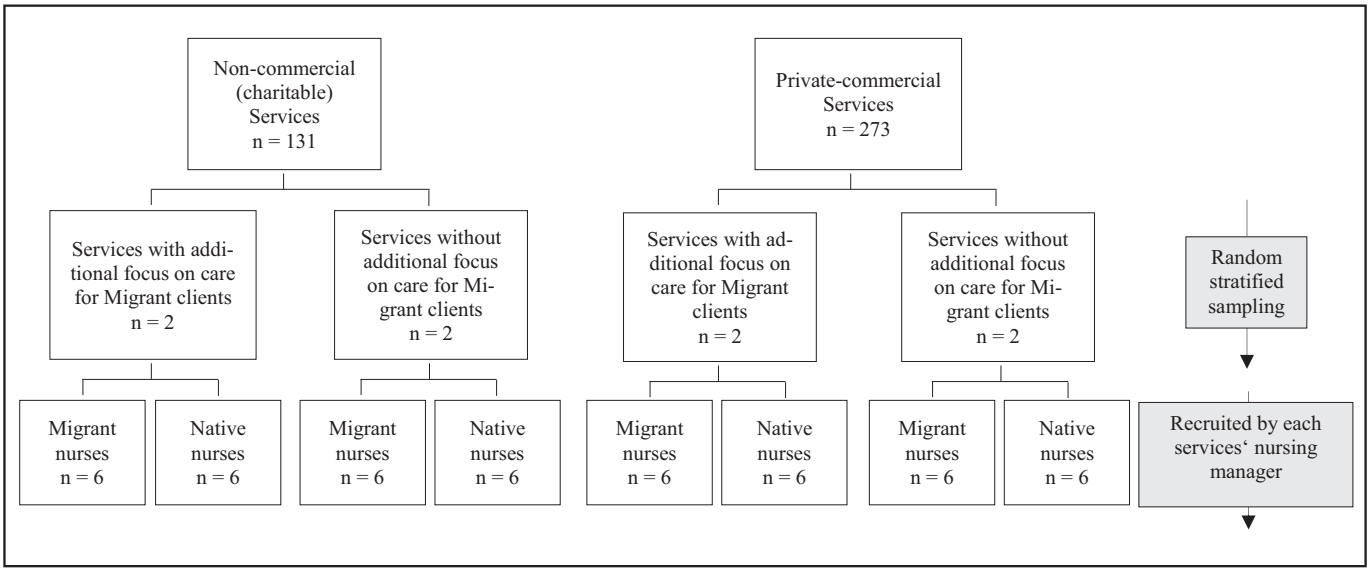


**Fig. 1.** Recruiting process.

employers' meeting in the premises of the services. A positive feedback was finally given by ten providers who provided 60 possible interviews with their nurses. The final study sample was formed by 48 nurses from eight providers.

### 2.3. Data collection

A semi-structured interview guide (Table 1) was developed based on relevant literature findings about work-related strains and stressors. The team of authors first discussed the draft of the guide and adapted it correspondingly. The modified version was then sent to five experts in the field of migration and health and respectively adapted. Finally, the interview guide was pilot tested among four nurses, slightly modified and considered appropriate for application.

Key areas in the interview guide were strains/stressors, resources and coping strategies in the collaboration/contact with colleagues, superiors and clients. In this context, the collaboration within a linguistically and culturally diverse team and with clients was also examined. Each nurse was asked whether she or he works with colleagues or has direct supervisors or cares for clients who each come from other countries or have a different cultural background than themselves.

All but one participant agreed that the interview would be digitally recorded, so one interview was recorded by paper and pencil. The interviewer's thoughts and reflections on all interviews were registered as field notes during as well as after each interview.

The main author conducted all interviews between February and July 2017; those lasted between 35 and 60 min and were taken after or before the nurses' work shift. The interviews took place in the offices of the nursing services or in the nurses' private homes while total privacy was assured.

### 2.4. Data analysis

For the purpose of this study, data were analysed by the conventional approach to qualitative content analysis described by Hsieh and Shannon (Hsieh & Shannon, 2005). The audiotapes were transcribed verbatim. The main author developed an initial coding framework.

In the context of quality assurance, two further members of the research group independently derived categories and its corresponding definitions and prototypical text passages from four randomly chosen transcripts. Their findings were then mapped with the initial coding framework. Differences as well as congruencies were discussed. The final category system was presented and reflected in a workshop within the research group. Afterwards, the suggestions were applied to the entire data set. Therefore, the category system was revised within the process of analysis. MAXQDA version 10 was utilised to manage the coding process (VERBI-Software, 2017).

### 2.5. Ethical considerations

Ethical approval was obtained from the ethics commission of the Hamburg medical council (application “Antrag PV5440”) prior to data collection phase. At the beginning of each interview, written consent was obtained and each participant was reminded that a withdrawal at any time of the interview is possible without any negative consequences for her or him. Each participant received an allowance in terms of a 15 Euro cash pay-out subsequent to the interview.

## 3. Results

The study findings are presented as follows: first, the sample characteristics are described. Then the category system that emerged from the qualitative content analysis is illustrated. The categories are highlighted including verbatim quotes from the interviews. Each quote has a corresponding identifier number for respondents, with captions of “I” for interview and “M” for migrant nurse or “A” for autochthonous nurse.

**Table 2**
Characteristics of the study sample.

| | Migrant nurse (n = 24) | Autochthonous nurse (*n* = 24) |
|---|---|---|
| Gender | | |
| Female | 21 (87.5%) | 20 (83.3%) |
| Male | 3 (12.5%) | 4 (16.7%) |
| Age (yrs) | | |
| Mean (SD) | 42.92 (11.98) | 45.17 (9.78) |
| Range | 23–68 | 30–62 |
| Country of birth | | |
| Afghanistan, Ghana | 4 (each 2) (16.6% (8.3%)) | |
| Africa, Bosnia, Brazil, Colombia, Croatia, Ecuador, Finland, Indonesia, Latvia, Russia, Uganda, Yugoslavia | 12 (each 1) (50% (4.2%)) | |
| Iran | 3 (12.5%) | |
| Turkey | 5 (20.8%) | |
| Germany | | 24 (100%) |
| Occupational background | | |
| Registered General Nurse | 4 (16.7%) | 12 (50%) |
| Nursing assistant | 3 (12.5%) | 2 (8.3%) |
| Geriatric nurse | 8 (33.3%) | 8 (33.3%) |
| Geriatric nursing auxiliary | 9 (37.5%) | 2 (8.3%) |
| Highest level of education | | |
| Certificate of secondary education | 6 (25%) | 3 (12.5%) |
| General certificate of education ordinary level | 10 (41.7%) | 11 (45.8%) |
| Vocational diploma | 0 | 3 (12.5%) |
| General certificate of education advanced level | 4 (16.7%) | 5 (20.8%) |
| University degree | 4 (16.7%) | 2 (8.3%) |
| Length of time working as nurse in general (yrs) | | |
| Mean (SD) | 12.04 (11.11) | 19.65 (9.27) |
| Range | 1–45 | 5–35 |
| Length of time working at current employer (yrs) | | |
| Mean (SD) | 6.34 (7.20) | 8.71 (8.66) |
| Range | 0.5–26 | 0.5–30 |

### 3.1. Sample characteristics

The sample consisted of 48 nurses. According to the initial criteria, half of them were born abroad. Migrant nurses are those study participants who were born abroad - in other words – not in Germany. Autochthonous nurses are those participants in the study, who were born in Germany and whose parents were both born in Germany. The typical gender distribution in favor for female nurses (Eurostat, 2017) proves true in this study as in both cohorts (migrants nurses & autochthonous nurses) less than 20% of the nurses are male (Table 2). Native nurses in this sample are older on average.

The migrant nurses' sample represents 16 countries on four continents and more likely employed as geriatric nurse or geriatric nursing auxiliary than their native counterparts are. The participants in this study are: 1. Registered general nurses (Gesundheits- und KrankenpflegerIn) who mainly work in hospitals, at specialist medical practices but also in the homecare sector. They assist in medical examinations and treatment and document patient data. Registered general nurses have to complete a three-year vocational training. 2. Geriatric nurses (AltenpflegerIn) mainly work in geriatric and geropsychiatric settings and provide nursing care for the elderly. They also have to successfully pass a three-year vocational training. 3. Nursing Assistants (Gesundheits- und Pflegeassistent/in) completed a two-year vocational training and assist registered general nurses and geriatric

nurses in terms body care (washing the patients'/clients' body) or food intake. 4. Geriatric Nursing Auxiliaries (AltenpflegehelferIn) underwent a one-year training and support nurses in their daily care of the elderly. As the training last from one to three years, there are salary differentials between the different levels of profession (Bundesagentur-für-Arbeit, 2019). Native nurses in this study have worked on average more than seven years longer in the nursing sector than their migrant colleagues and two years longer with their current employer.

### 3.2. Category system

The three leading subjects of the study were “barriers”, “resources” and “coping strategies”. These three subjects were then embedded in four contexts, namely “work in general”, “colleagues”, “direct supervisor” and “clients”. Within the contexts colleagues and clients, a further subdivision into “intercultural” and “general” allowed the distinct description of cultural influences on the work of the nurses under study. Thus, one subject and its specific context formed a cluster (Hsieh & Shannon, 2005). The following grid illustrates the entire category system for the migrant and the autochthonous stratum respectively that was finally derived from the interviews (Table 3).

#### 3.2.1. Work in general

Working as a nurse in the host country is connected with the expectation of better working and living conditions. However, migrant nurses explain that they feel a sense of competitiveness among their colleagues in a way that ‘other’ migrant nurses are competing for the same job.

Caring for clients at their home is associated with physical strains. Migrant nurses reported that they struggle to handle those clients whose furnishing at home does not comply with the requirements of professional care: “*And you also have some heavy bedridden patients and customers. You have such coercive positions. It's all physically stressful.*” (I33-M). Among migrant nurses, the topic ‘Handling of heavy clients’ turned out to be very prominent. 15 out of 24 nurses voiced out that they feel burdened from transferring a heavy client from e.g. the wheelchair to the toilet.

Nurses often work under very physical and psychological stressful conditions. An autochthonous nurse explained that she feels stressed by being unable to distance herself from work. She stated her thoughts about her demanding job are ever-present and so she could not unwind.

Time pressure was perceived as a leading structural stressor with negative effects on nurse's physical and mental health as it was expressed in both strata. “*What's very stressful for me is that I'm under time pressure. It's terrible that it has to be so accurate to the minute. And that's psychological stress for me, too.*”(I33-M).

Approached on the subject ‘resources’ nurses told that they receive vouchers for fitness studios, massages or even special gymnastic exercises taking place in their nursing station. Other nurses added utilizing technical aids if present at client's household.

Being in contact with own friends and pursuing one's hobby supported nurses to cope with daily stressors. “*If something is bothering me at work now, I'm not going straight to my supervisor. First of all, I talk to my mother or my family about it.*” (I3-M).

**Table 3**
category system for the qualitative content analysis.

| | | | | Migrant nurses | Autochthonous nurses |
|---|---|---|---|---|---|
| 1. | Work in general | barriers | | *Personal:* | *Personal:* |
| | | | | Competitiveness | Non-distancing oneself from others and work |
| | | | | *Structural:* | *Structural:* |
| | | | | Time pressure | Time pressure |
| | | | | Handling heavy clients | Mobilization of clients |
| | | | | Lack of/absence of resources | Lack of/absence of resources |
| | | resources | | | *Professional:* |
| | | | | | Technical aids, Offers from employer (e. g. training courses) |
| | | | | | *Personal/Private:* |
| | | | | | Social contacts |
| | | | | | Freelance activities |
| | | coping strategy | | | Endowment of the profession |
| | | | | | Human interaction |
| 2. | Collaboration with colleagues | barriers | Intercultural | | Divergent understanding of behavioral patterns |
| | | | | | Differences in language |
| | | | | | Divergent understanding of nursing care |
| | | | In general | Talking about each other instead of one with other | Prioritizing one's own well-being |
| | | resources | | | Addressing a problem directly to colleagues |
| | | coping strategy | Intercultural | No ethnicization or culturalization | No ethnicization or culturalization |
| | | | | Sharing commonalities | Mutual support as language/cultural interpreter |
| | | | In general | | Supporting mutually |
| | | | | | Experiencing friendliness/respect |
| | | | | | Working on one's own |
| 3. | Collaboration with direct supervisor | barriers | | | Lack of appreciation |
| | | | | | Unequal treatment |
| | | resources | | | Seeking clarifying discussions |
| | | | | | Appreciation of the individual by superiors |
| | | coping strategy | | Voicing out own opinion | Willingness to talk |
| | | | | Meeting at eye level | Meeting at eye level |
| 4. | Contact with clients | barriers | Intercultural | Claims/expectations of clients | Malfunctioning verbal communication Claims/expectations of clients |
| | | | | Prejudices against migrants | |
| | | | In general | Client's personal fate | Client's personal fate |
| | | | | Harassment (e.g. verbal, sexual) | |
| | | resources | | Exchanging with colleagues | Exchanging with colleagues |
| | | | | Discussing problems directly with clients | |
| | | coping strategy | | | Conversing with clients |
| | | | | | Perceiving gratitude/appreciation |
| | | | | | Keeping one's distance |

The sensemaking of the profession 'nurse', the human interaction, helping elderly dependent people who in turn are shining with gratitude were vented a number of times as coping strategies "*because nursing it's something meaningful, the gratitude that comes back.*" (I32-A).

### 3.2.2. Collaboration with colleagues

A divergent understanding of behavioral patterns challenges the collaboration of migrant nurses and autochthonous nurses. In this intercultural context, an autochthonous registered general nurse expressed about her migrant colleague: "*it is this mentality; she arrives at work 45 minutes late. That is their laxly mentality. Of course, some of them come from another cultural background, where it's all handled a bit more laxly.*" (I17-A). German colleagues are perceived as strict in their way of working as this migrant registered general nurse noted: "*Foreigners are more flexible. I feel that the Germans are a bit strict but on the other hand, they are trying to do the job properly, so correct.*" (I24-M).

A leading stressor that hindered the collaboration of colleagues from different origins were differences in language. Experiencing communication difficulties with their migrant colleagues is burdensome as this negatively affects their way of working: "*filling out forms and explaining to them why, where, what has to be filled out is very difficult, because it goes back to almost baby language. It takes a lot of time.*" (I35-A). Beyond, a migrant nursing assistant expressed: "*The hard time was my language, because I could not speak German so well and my colleagues sometimes did not understand me.*" (I18-M).

Prioritizing one's own well-being affected the collaboration within a team as these nurses were missing common effort from their colleagues to balance unexpected events: "*Yeah, but I find that disrespectful if someone just does what he or she wants. Don't think what others want.*" (I18-M). Another registered general nurse complained: "*If it's always the same people who pick up the slack. Those who always say: 'No, I can't.' Everyone can be in that situation - but not always.*" (I7-A). Another registered general nurse said: "*Sick leave is an issue here; they are always the same four or five calling sick, but secondly there are always - and I count myself among them - the same four or five who, strangely enough, are almost never ill and have to absorb what the sick colleagues cause.*" (I10-A).

Nurses reported that they feel stressed by colleagues who talk about each other instead of one with other. This migrant registered general nurse reported: "*there were colleagues backbiting me. And I don't like that. You should rather say it directly to me, but don't blaspheme over others. I expect them not to hide anything from me. I want us to work together.*" (I40-M).

Even though homecare nursing is regulated by quality standards, the understanding of what is client oriented nursing care of high quality differs among nurses. This autochthonous nursing assistant pointed out that quality in nursing care means more than "*sated and tidy*" and she missed the lacking "*German efficiency*" (I36-A) among her migrant colleagues. This migrant nursing assistant was missing an understanding of holistic care and explained that care also has an emotional element: "*You can't prepare breakfast or lunch and leave the kitchen dirty afterwards, since the client is no longer able to clean the kitchen. There are colleagues who are just, what's it called, sloppy. They leave everything there or not really pay attention to cleanliness. But I've learned that we are not equal and you can't change your colleagues.*" (I18-M).

The direct verbal exchange with colleagues as the leading resource among the nurses under study enables them to cope with and possibly resolve barriers and strains. This migrant geriatric nurse expressed: "*If I have had difficult situations at work, I try to converse with my colleagues here.*" (I33-M). Her migrant colleague explained: "*Afterwards you also sit together and put the situation, the mistakes from both sides on the table and find a solution.*" (I34-M).

Migrant and autochthonous nurses commented positive on a diverse workforce: "*Well, I mean, we all see ourselves as normal, as human beings. And we don't say 'Oh, look, they're from Turkey or they're from Poland'. I think we are steering more and more towards becoming multicultural.*" (I15-A). "*Turkey or Russia, Poland, Hungary. I work with all of them. To me, everyone is the same, the most important thing is [that they are] people.*" (I40-M).

Autochthonous registered general nurses reported that they appreciate the support of their migrant colleagues as language or cultural interpreter: "*I have my apprentice with me and she translates everything wonderfully. Sometimes she also has a different feeling, because she is just a little bit closer to the culture. She can give me information that I might not have right now.*" (I6-A).

Four-fifths of all nurses in both strata explicitly appreciated the mutual support among their colleagues. They support each other by either picking up the slack for someone who calls in sick or switching shifts due to private reasons. Mutual respect and friendliness were also frequently mentioned factors having positive influence on nurses' collaboration: "*I especially like the way we deal with each other. I find the respect for each other very very important, because there are a lot of different people who work together and of course a lot of characters.*" (I8-A).

Migrant nurses felt in various situations at work more comfortable with other migrant nurses, since they are sharing commonalities: "*Somehow I feel better with these people, they're so close to me. For example, people from Poland - we have a lot of similarities with them.*" (I24-M, migrant registered general nurse). "*I experience the cooperation with foreigners better. I feel better because we are sharing the same destiny. With Germans, well, I don't feel bad, of course. But somehow, we are foreigners together.*" (I30-M, migrant nursing assistant).

Working on one's own and not pursuing further the solution of a problem with a colleague helped this autochthonous geriatric nurse: "*actually one cannot change the world and cannot change people and then I say I prefer to do it alone instead of facing these conflicts. Firstly, I am more time-saving and secondly, the many years of work experience show me that the individual person does not want to change, or the structures cannot be changed.*" (I10-A).

### 3.2.3. Collaboration with direct supervisor

Nurses felt burdened by supervisors who demand complete commitment from their employees, but do not value their effort: "*Sometimes, I would wish she had that look that she has on herself on us, too. The praise here is very, very sparse.*" (I12-A).

Migrant nurses reported to be treated unequal in terms of wishing for off days or holidays as this migrant nursing assistant explained: "*I find that burdensome sometimes. I have no children. I always have to go on holiday earlier, although I would also like to go in midsummer.*" (I31-M). She wondered, whether the higher qualification of her colleagues, namely registered general nurses is prejudicial to her.

In case of misunderstandings or problems with her supervisors, this migrant registered general nurse explained: "*I try to find a conversation with the supervisors asking whether I made a mistake, or how could it get better? So it's important to me that I can get rid of that.*" (I33-M). Appreciative supervisors are perceived as those who support and motivate nurses to show commitment in challenging times of high demand or important structural changes. "*Well, I think it's good that they give me all the opportunities to further my education.*" (I41-M). "*She has an ear for everything. So it's nice when I come to the office at noon after a longer tour and someone is sitting there listening to you and smiling or sometimes takes you in his arms.*" (I6-A).

Voicing out your own opinion is a coping strategy among migrant nurses to enable a functioning collaboration with their supervisor. This migrant registered general nurse explains: "*Of course it is necessary to maintain distance; but here [Germany] it is not the same as in [home country], where as a subordinate you are not allowed to say anything. Here you are asked for your opinion.*" (I47-M). This migrant registered general nurse confirmed: "*we always meet at eye level here. It is not that we always get orders from above, but that we work together.*" (I33-M). Autochthonous nurses appreciated having a supervisor who is ready and willing for talks but who also volunteers addressing issues: "*you get answers to your questions and he [the supervisor] is always solution-focused, will never tell you 'do it alone or google it'.*" (I14-A). This registered general nurse was

glad: "*He [the supervisor] is really great. A great, a fair boss. Even if it's something unpleasant. He is here and goes off to the side with the people and does it all discreetly.*" (I17-A).

### 3.2.4. Contact with clients

Participants from the German cohort reported that they feel burdened by a malfunctioning verbal communication with those clients, with whom they cannot communicate in their first language: "*it's really stressful that in this case, you can't make yourself understood because you don't share the same language.*" (I15-A). "*I find that incriminating when you don't know what they want.*" (I44-A). Another registered general nurse confirmed that forming a relationship to a client is difficult: "*you just don't have that kind of bond, because you can't really converse with them properly about something.*" (I6-A).

The intercultural exchange with clients was affected by the clients' expectations or claims of how to be cared for in the health care system and that hinder the nurse's work: "*When I go to a client who's praying, he expects me to wait. Sit, stay calm, even though I'm under time pressure because my other clients are waiting. And this is mentally a burden for body and soul. We work with completely different models, with completely different behaviors.*" (I45-M). Another registered general nurse felt that her ideas and those of her migrant clients about how nursing in Germany works, strongly differ: "*They think that, just because they pay five Euro prescription fee which is indeed very, very much for them, they have a right to tell us when to come and how long to stay there.*" (I27-A).

A migrant geriatric nurse reported that she experienced clients who feel uncomfortable to be taken care by a foreign nurse: "*there are also people who have problems with foreigners and show that.*" (I11-M). This migrant female registered general nurse reported an articulate form of racial discrimination: "*When I was with a client, she was always so scared of me. And I asked her why. She replied 'because you're black'.*" (I28-M). This male migrant geriatric nurse experienced ethnical discrimination: "*Some clients don't like foreigners. And that's something you have to respect when they don't want you to come in, while other colleagues are allowed to come in. You know what I mean?*" (I21-M). A Muslim registered general nurse reported that her German client did not allow her enter the flat as long as she was still wearing her scarf (I49-M).

The very close relationship with clients can be very stressful by experiencing her or his living circumstances in detail. This nurse particularized: "*He has no pants, no clean laundry, no bed linen. Sometimes I feel like I have to take my salary to him. It burdens you because you see this every day.*" (I11-M). Another registered general nurse stated: "*They are seriously ill people. If you take this closer to yourself, it's very stressful.*" (I48-A).

Three out of 21 female nurses in the migrant cohort experienced forms of sexual harassment from male clients. A migrant nursing assistant remembered: "*I don't like that. When a man tries to touch me. And too many men do, but not all.*" (I18-M). A migrant registered general nurse reported: "*Men, older men. They think, a woman is meant to be touched and not only for care. And that's disgusting. And to some people I don't like to go and I try to ignore what they want. Some people think, foreigners are like this.*" (I24-M). A further migrant nursing assistant explained that she has never talked to someone about her experiences of having been a victim of sexual harassment.

Nurses report that they converse with their colleagues about problems or issues that burden them. This exchange of views helps them to reflect the situation and to find a way to solve it or to accept the situation as it is: "*I discuss this with my colleagues, or I can also talk about it with my supervisor. Then I reflect about it again.*" (I47-M). Another participant perceived the verbal exchange with her colleague as a resource to cope with client-related burdening situations: "*I will talk to my colleagues about it. Well, I'm actually a person who addresses it directly.*" (I43-A). In contrast, this migrant registered general nurse discusses issues directly with the client: "*But I try to solve the problem myself instead of coming to the office and complaining or taking the problem home with me. I'll take my time and talk to the client and ask 'What's wrong with you? What can I do?'. I don't leave my client's home being nasty and slamming the door.*" (I28-M).

The personal exchange with clients and colleagues helps nurses to cope with burdening client-related situations: "*And I still like the conversations with the people, talking about what kind of life they had or what kind of person they are.*" (I12-A).

Feeling appreciated or receiving signs of gratitude motivate nurses to persevere in challenging times: "*There are nice moments or people who are just happy when you arrive. If you haven't been there for a while and they welcome you, saying 'Aaah, it's nice to have you back'. That balances the stress, else I probably wouldn't have persevered for 25 years in nursing.*" (I17-A). These nurses experienced forms of gratitude from their clients: "*Well, there are very special clients where I really like to go because they are very warmhearted, very cordial. That's what I think is the price of care that you get something back.*" (I14-A).

Keeping one's distance from clients, with whom the relationship is affected, helped nurses to master those challenging situations. A kind of professional distance was reported by this nurse: "*And if I don't like someone, I'll keep a distance. Just ignore it. That's what I learned. But I'm still going there and do my job. And afterwards I leave the place.*" (I18-M). This migrant registered general nurse coped by keeping a local distance: "*I then go to my supervisors and ask if I might be allowed to work somewhere else for a few days. So that I will be relieved a little bit psychologically.*" (I47-M).

Taken together nurses share similar barriers at work regardless of their ethnic or cultural background. However, more Migrant nurses indicated that they feel physically burdened by handling heavy patients. Time pressure is a further prominent stressor that is causing mental and physical stress among nurses. Communication problems due to language barriers turned out to be a leading stressor for the autochthonous nurses in collaboration with their migrant colleagues. The teamwork within a diverse workforce is also affected by different work-related mentalities. On the one hand, migrant nurses perceive their autochthonous colleagues as sometimes strict, while their autochthonous colleagues on the other hand report that they feel burdened by migrant nurses with a laxly mentality. Migrant and German nurses feel stressed by colleagues who exclusively focus on their own well-being instead of the whole team. A supervisor who treats her or his employees unfairly or does not appreciate their effort causes burden in nurses. This study also showed that communication barriers impede a functioning relationship with clients leading to a stressful feeling of not being able to reach the client. The very close relationship with clients on the other hand makes nurses also feeling burdened by their client's personal fate.

Foreign nurses reported forms of discrimination proceeding from clients. The close nurse client relationship in the homecare setting involves the danger of being sexually harassed as this was reported in the migrant cohort.

For autochthonous as well as migrant nurses the endowment of the profession as a nurse, the mutual support among colleagues, the direct verbal exchange with the supervisor at eye level and the perception of gratitude/appreciation are coping strategies that helps them to successfully master barriers occurring at their workplace.

## 4. Discussion

This study provides a comparative insight into work-related stressors, resources and coping strategies of migrant and autochthonous nurses. By interviewing migrant and minority nurses as well as autochthonous nurses, a detailed insight into factors that influence the togetherness of human beings of different origins and culture was possible.

Typical work-related stressors of nurses like lifting heavy patients, time pressure or prioritizing one's own well-being are perceived burdening regardless of the nurses' origin or cultural background. Different patterns exist in the way how nurses perceive stressors which seems to

be related to their cultural background and/or their origin. This study confirms that human beings who are interacting with others of diverse background tend to mutually attribute 'typical' traits (Czopp, Kay, & Cheryan, 2015; Drewniak, Krones, & Wild, 2017; Elbarazi et al., 2017; FitzGerald & Hurst, 2017; Hammond, Marshall-Lucette, Davies, Ross, & Harris, 2017; Hollup, 2014; Ito & Tomelleri, 2017; Ndobo, Faure, Boisselier, & Giannaki, 2017; Spencer, Logel, & Davies, 2016). Migrant and native nurses in this study agreed on time pressure as a leading stressor. Their corresponding explanations diametrically oppose. Migrant nurses attribute the obligation to arrive on time at one's client's household to the 'German punctuality' and the explicit obligation to follow rules and guidelines e.g. in terms of completing forms to the 'German strict way of working'. Both is perceived as burdensome, since complying with these obligations takes time, next causes time pressure that is in turn causing stress. Migrant nurses in this study report adequate nursing care requires being flexible in talking and communicating with clients rather than complying with obligations like doing paperwork. On the contrary, German nurses feel burdened by the migrants 'laxly mentality' in the context of time management causing time pressure. FitzGerald and Hurst (2017) distinguish between implicit prejudices and implicit stereotypes, since the latter ones can cause damages even when they are not negative per se (FitzGerald & Hurst, 2017). The 'German punctuality' and the 'German strict way of working' are examples for implicit prejudices that can also be a positive stereotype (Czopp et al., 2015), since migrant nurses consider that as an important trademark for qualitative care in the host country.

Differences in language are perceived as a barrier affecting nurses' mutual collaboration as O'Daniel and Rosenstein explain (O'Daniel & Rosenstein, 2008). They add that a cultural and ethnic diverse workforce challenges intraprofessional communication and collaboration, since ways of communication and behavior differ across culture and ethnicity (O'Daniel & Rosenstein, 2008). A strategy to cope with these barriers is working alone, since the person who is perceived to cause the barrier or the setting might be unfluctuating. An enormous amount of time to the detriment of one's clients being necessary justifies the decision to not further clarify unclear situations or issues. It remains in doubt, whether eschewing burdening barriers benefits the health of a nurse. Especially, when the nurse justifies this decision with the obligation for the well-being of the client. Changing the perspective towards clients, language barriers can also put the client's safety at risk as van Rosse, de Bruijne, Suurmond, Essink-Bot, and Wagner (2016) explained and named medication errors, erroneous pain or fluid balance management as possible risks. Flores (2005) reviewed the impact of interpreter services on the quality of healthcare. She highlights that hospital patients with a low English proficiency report better health outcomes and "greater levels of comfort" when treated by bilingual practitioners or in the presence of professional interpreters than by ad hoc interpreters (Flores, 2005).

Similarly, Macdonald et al. (2013) argued that language barriers in a team can lead to misunderstandings and misperceptions of each other's views of health and healing to the disfavor of the patients and clients (Macdonald et al., 2013). Communication skills are a leading competence that nurses must be equipped with to establish an adequate nurse-client relationship and an adequate working relationship with the nursing colleagues and supervisors (Halcomb, Stephens, Bryce, Foley, & Ashley, 2016).

There is convincing evidence that effective communication leads to improved information flow, more effective interventions to the favor of employees and clients, improved safety and enhanced employee morale (Brunton & Cook, 2018; O'Daniel & Rosenstein, 2008). This study confirms that the mutual exchange among colleagues and direct supervisors not only serves as a key resource to address the issue of differences in language but also allow a positive working atmosphere in the context of coping.

Feeling appreciated by supervisors supports nurses to cope with stress and serves as a motivational factor. Toode, Routasalo, and Suominen (2011) confirmed the importance of enabling nurses to advance their knowledge and allowing them to exchange with colleagues and supervisors (Toode et al., 2011). Making an organization highly performing and its workforce effective, Hunt (2007) explains that managers and supervisors should value individuals regardless their ethnic, racial or cultural background. Once again, this promotes the need to consider diversity as enriching rather than hindering.

Within the healthcare sector, nursing care is dominated by women who in general are at higher risk to experience sexual harassment than men (Eurofound, 2017). This situation is exacerbated by the circumstance that homecare nursing takes mainly place in the clients' household. Thus, homecare nurses, mainly female are working in a context, where they are at their client's mercy as this could be also shown in this study (Adrienne Cruz & Klinger, 2011).

Within this study, the nurses' reports of barriers and resources did not substantially differ within services operated by either non-commercial or private-commercial providers. The assumption, the intent to realize a profit within the private commercial services may have an effect on nurses reporting of stressors (Slotala, 2011), such as time pressure (Hielscher et al., 2013) was not confirmed.

### 4.1. Strengths and limitations

Participant selection in qualitative studies is prone to selection bias. Even though, this study employed a stratified random sampling to select nursing services, the services' nursing managers ultimately provided the study team with the contact data of the nurses willing to participate. Notwithstanding the nursing director had already assured the nurse's voluntary participation on call with the main author, each nurse was asked by the main author at first contact again whether she or he volunteers in participating.

In the light of strains and stressors, some participants may not have mentioned some experiences, knowing that the study results would be discussed and published although pseudonymization and confidentiality were assured several times following the ethical rules of the ethics commission of the Hamburg medical council.

Once the interviews were carried out and transcribed, the transcripts were not returned to the participants for comment and/or correction. At the time of writing this manuscript, the participants have not provided any feedback on the findings.

This study has also its distinct strengths, since the cohort is representative to nurses' gender, age and qualification distribution in Hamburg (Rothgang, Sünderkamp, & Weiß, 2015; Schleswig-Holstein, 2017; Statistisches-Bundesamt, 2017a, 2017b). The process of discussing the data and forming categories with researchers of different educational background in several rounds is a major benefit to provide alternative interpretations of the data (Barbour, 2001).

The main author's background as a studied nurse as well as the diverse expertise of the researchers involved in this study (Health Services Researcher, Psychologists, Epidemiologist) supports the claim for 'thinking conceptually and reflexively' (Polit & Beck, 2010). The transferability of the study results is additionally to the sample's representativity supported by the *thick* description of the study data. Thus, proximal similarity is clearly given (Polit & Beck, 2010).

## 5. Conclusion

This qualitative study as the first survey of its sort in the German homecare setting confirms international findings about occupational stressors of homecare nurses in general and goes beyond in identifying stressors, resources and coping strategies by comparing migrant and autochthonous nurses (Hittle et al., 2016; Macdonald et al., 2013; Schilgen et al., 2017; Young et al., 2017). Migrant and Autochthonous nurses share similar coping strategies to master occupational burdens. Physical stressors like lifting heavy clients turned out to be a common stressor across both groups. However it was reported by more migrant

and minority nurses. A good collaboration in the team and a having an appreciative supervisor are resources that support migrant and minority nurses as well as autochthonous nurses to face the stressors and to cope with those.

Differences in language is a main stressor which impedes a functioning team collaboration as well as a working nurse-client relationship. This stressor is quoted by more autochthonous than migrant nurses.

Sexual and verbal harassment towards nurses is still a threat that happens to migrant and minority nurses as this study showed.

Migrant nurses of different origin perceive their status as migrants as a sense of community by sharing the same destiny – this appears as an important resource for migrant and minority nurses.

An increasingly diverse nursing workforce benefits an increasingly diverse aging society. The political will to strengthen homecare nursing in Europe will by default lead to an increasing demand for those services. The diversity in the nursing workforce should not only be seen as an enforced political and societal automatism that nursing is relying on to face the workforce gap. Migrant and minority nurses enrich the provision of care and contribute to its professionalization, since they are experts in understanding the challenges of cultural and ethnic diversity. Thus, policymakers, organizations and those responsible at meso- and micro levels are called upon to advocate for the inherent expertise of migrant and minority nurses as ambassadors of culturally diverse nursing care. This appreciation of their competence is surely beneficial for their health. This study allows an insight into a diverse nursing workforce and their challenges and capabilities in the context of collaboration and client-centered care. Based on the findings, strategies to make a diverse team successful and healthy can be derived.

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