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Paediatric Intensive Care Nurses' Intercultural Communication Competences

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Paediatric Intensive Care Nurses' Intercultural Communication Competences

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The purpose of this study was to investigate nurses' experiences and competences on intercultural communication in a paediatric intensive care unit. The research was done in cooperation with Helsinki University Hospital's Paediatric Intensive Care unit K9 in Children's Clinic. The research describes intercultural communication from nurses' perspective and indicates their ability to provide culturally competent care based on Campinha-Bacote's (2002) model.

A framework was built to provide a comprehensive approach to the topic, including aspects of family-centered care, cultural competences and intercultural communication. Models of cultural competences and intercultural communication components were provided to build an overall view of the methods applicable to culturally competent care.

The research was a qualitative study and was performed during autumn 2016. The research method used was focus group interview, with five (5) nurses from the unit. A theme interview was conducted to gain in-depth experiences and thoughts from the participants. Data was analysed by using content analysis.

The results indicated that nurses in the paediatric intensive care unit regularly encounter challenges in intercultural communication. Even though intercultural communication was on occasion found challenging, nurses had a positive outlook towards encountering intercultural families. According to the analysis, four (4) themes rose from the focus group interview. The character of paediatric intensive care, linguistic challenges, cultural differences between health care staff and families as well as the effects of nurses' personal abilities' and capabilities' on intercultural communication were raised in the focus group interview.

The results indicate that one-sided communication and nurses' personal abilities and capabilities had a significant effect on intercultural interactions. Nurses had a desire to work in a culturally sensitive manner to decrease marginalization of the families and to improve their feeling of equal and quality care. If it is not possible to communicate in words or signs, presence in the situation, eye contact and kind gestures were seen as an important part of non-verbal communication. Campinha-Bacote's model (2002) applied into nurses' competences indicated high desire and knowledge base on culturally competent care.

Recommendations to improve outcomes of intercultural communication include improving education and awareness towards intercultural communication among the nurses in the paediatric intensive care unit. Communication should also be focused to be more interactive with intercultural families and emphasis on family-centered care should be in daily work. Focus should also be put on offering more support services for intercultural families. More research is also needed on intercultural families' experiences of the support and communication they have received.

Keywords: intercultural communication, culturally competent care, paediatric intensive care.

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1 Introduction

Cultural diversity has increased rapidly around Europe in the past few decades and the number of immigrants in Finland has doubled in the 21st century. The number of immigrants in Finland is estimated to rise by the year 2020 to 330 000 and by the year 2030 the number will be approximately 500 000. (Kotouttaminen 2016.) 32 476 asylum seekers were adapted to Finland between the years 2012-2015 and the biggest number of refugees came between these years from Iraq, Afghanistan and Somalia (Migri 2016). Due to patients' different ethnic and cultural backgrounds health perceptions can vary greatly. This variation in health concepts, knowledge levels and cultural habits affect greatly the level of communication and depth of the knowledge given by the professionals. In these situations, family-centered and culturally competent care is needed. Effective health care in today's intercultural environment demands understanding on how cultural differences affect communication and consequently influence health care.

Finnish legislation states that patients have a right to receive good quality health care. Patients' human dignity, beliefs and privacy must be respected. Patients' individual needs and culture should be noticed and respected as much as possible during the treatment given. Discrimination is forbidden in the legislation, due to such matters as ethnic background, nationality, language, health situation, disability, political views, religion, personal beliefs and sexual orientation. (Laki potilaan asemasta ja oikeuksista 1992/785 3§; Yhdenvertaisuuslaki 2014/1325 8§.) World Health Organization's guidelines of Quality of Care (2016, 9-10) state that effectiveness, efficiency, accessibility, acceptable/patient-centered care, equitable and safe care are the dimensions of quality care that national and international health care systems should strive for.

The National Advisory Board on Social Welfare and Health Care Ethics (ETENE) state in their guideline Multiculturalism in Finnish Health Care (2004, 7-11) that as cultural diversity grows in Finland, new inventive and open-minded services and policies must be made to ensure quality care for intercultural patients and families. ETENE guidelines highlight the importance of valuing cultural differences in health care and aim to provide means to embrace diversity. The right to quality care, respect for human dignity, self-determination, justice, good educational skills, healthy work environment, cooperation and mutual respect are the basic elements that Finnish health care should be able to provide for intercultural patients and their families as well as health care personnel. ETENE guidelines also define knowledge, awareness, sensitivity, interaction and respecting patients and their values and beliefs to be health care personnel's most important work tools in intercultural communication.

In recent years in nursing sciences and research one of the areas of focus has been nursing, culture and their correlations. The effects of globalisation and increasing multiculturalism are

significant in the individual, community and nursing culture levels. (Eriksson & al. 2011, 70.) Improving cultural competences is increasingly important in our multicultural and globalized health care scene. Good interaction and communication in health care are known to improve health outcomes and families' satisfaction in the care given. (Guerrero, Chen, Inkelas, Rodriguez & Ortega 2010, 389.) Migrant Health and Wellbeing Survey (2014) concluded that Finnish health care's focus should be put on decreasing health disparities, improving communication, health promotion and understanding differences between migrant groups and individuals.

In this research, a framework was built as a theoretical background and a focus group interview was conducted to discover nurses' perceptions and experiences on the topic. A qualitative method was used to discover the most vibrant and broad views about intercultural communication from nurses' view (Kankkunen & Vehviläinen-Julkunen 2013, 74; Perry & Southwell 2011, 462). Data was analysed by using an inductive approach, which allowed results to rise from the interviews and new deductions to form from individual observations and answers (Eriksson et al. 2011, 38). Content analysis was used as a systematic research method to categorise the results in themes, categories and sub-categories (Grove, Burns & Gray. 2013, 264; Elo & Kyngäs 2007, 108).

The goal of the research is to develop nurses' intercultural communication competences and to improve care and services for intercultural families and patients. The aim of the study is to identify nurses' intercultural experiences and perceptions towards intercultural communication.

2 Framework for the research

A literature review was conducted to build the framework for the research and to identify the research problem (Kankkunen & Julkunen-Vehviläinen 2013, 92). Tuomi and Sarajärvi (2002, 18) describe the framework to be a basis of qualitative research, where concepts and their relationships build a meaning for the study. The framework can be divided into two parts; the previous knowledge and research conducted on the subject and the methodology used in the research. Grove et al. (2013, 265-266) claim that in qualitative research theoretical frameworks should not always be identified in advance as it can influence the researcher's thinking and result in the findings. In this research the framework was done beforehand to support the researcher's knowledge and understanding on the topic. Initially from international literature pre-understanding was formed and approach to the topic chosen. Pre-understanding of the phenomenon enabled concepts, definitions, argumentation and synthesis to be conducted and critical thinking to develop. The framework was used to identify gaps in the previous literature and to allocate the approach for this study. (Grove et al. 2013, 110-112.)

Systematic searches were made in Meilahti Campus Library Terkko and Laurea's electric library Finna. Articles were searched for CINAHL, PubMed, EBSCO, SAGE and Elsevier. Searches were conducted to find the relevant literature on the topic. Search terms such as mentioned below in Table 1 were used to find the material. Studies selected to the framework had to include aspects of family-centered care, intercultural communication, culturally competent care, intercultural communication competences and/or neonatal/ paediatric intensive care units (NICU/PICU/ICU). The searches were done in English. When evaluating the validity and quality of the studies, abstract was read first and if applicable, the whole research was retrieved. (Kankkunen & Vehviläinen-Julkunen 2013, 94.) The studies selected to the framework are presented in Appendix 2.

Cross-cultural Intercultural Multicultural Transcultural	Paediatric Pediatric Children Infants Nursing Nursing culture	Communication Interaction Language Miscommunication	Intensive care Acute care Critical care Emergency care	Family-centered care Culturally competent care Culture
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Table 1: Search terms and main concepts

Concepts offer a way of looking at the research and are essential in defining the research problem (Silverman 2005, 98; Kankkunen & Vehviläinen-Julkunen 2013, 92). Family-centered care, cultural competences and intercultural communication construct the core of the framework. The concepts provide a valid approach to the topic and support and strengthen the framework combining a multifaceted approach. Previous studies show a wide range of definitions in these concepts, mainly due to their multidisciplinary character. In this research the process began by choosing the concepts and defining them, which abled the process of pre-understanding to develop. The three main concepts; family-centered care (FCC), culturally competent care (CCC) and intercultural communication competences (ICC) are shortly presented in the next chapters.

Family-centered care (FCC) aims for open and equal communication between parents and health care personnel. It is the standard of practise and results in high quality services, in which families and professionals respect each other's skills, actions and motivation, communicate in an open atmosphere and decisions are made together when needed. In the end, family-centered care can result in higher patient and family satisfaction, better communication and use of health care services. (Foster, Whitehead & Maybee 2016, 7-8; Arango 2011, 97-98.)

Cultural competency can be used to describe a variety of actions that aim to improve accessibility and effectiveness of health care services to people from racial or ethnic minorities (Tru-

ong, Paradies & Priest 2014, 1). Campinha-Bacote (2002, 181) presents five (5) steps on developing cultural competences. Firstly, cultural competences are a process, rather than an event. They consist of cultural awareness, knowledge, skills, encounters and desire. Ethnic groups have high variations within them, usually even more than across ethnic groups. Culturally competent health care services require a high level of competence from the staff. Culturally competent care is crucial for effective and sensitive services for ethnically diverse clients. (Campinha-Bacote 2002, 181.)

Chen and Starosta (1998, 241) define intercultural communication competences (ICC) to include one's ability to communicate in appropriate and effective way in different intercultural interaction situations. Intercultural communication according to Patternotte et al. (2015, 420) is comparable to patient-centered communication. Intercultural communication can cause challenges as people from different backgrounds have different expectations and behaviour patterns in communication. However, by understanding cultures effect on communication, this can be improved and communication can become successful. (Lustig & Koester 2003, 103.)

2.1 Family-centered paediatric intensive care

The concept of family-centered care has been developing from the 1960's, when Enid Balint declared that every patient encounter should be seen as a unique and individual appointment. Balint (1969, 262-272) believed that communication is a crucial part of successful treatment and doctor-patient relationship. The development of patient-centered care continued in 1987 when the Picker-Commonwealth program was released to improve patient-centered care. It was the first program to promote health care that was based on the patient's needs. Six dimensions were developed to support the patient-centered care:

- 1) education and shared knowledge
- 2) involvement of family and friends
- 3) collaboration and team management
- 4) sensitivity to nonmedical and spiritual dimensions of care
- 5) respect for patients needs and preferences
- 6) free flow and accessibility of information (Shaller 2007, 5.)

Family-centered care (FCC) has been developed further from the patient-centered care to support especially families and children during their hospital stay. Family-centered care consists of parents being in the centre of the child's world, and their unlimited presence, negotiation and involvement as equals in the care will produce the best outcome for the child, family and health care institution. (Foster et al. 2016, 7-8; Arango 2011, 97-98.)

The goal of family-centered care is to provide health care with dignity and respect, good information sharing, participation and collaboration with the parents (Institute for Family-Centered care 2016). The Maternal and Child Health Bureau (MCHB) states that family-centered care should be a standard of practice, which results in high quality services and a respectful family-professional partnership. In this family-professional partnership family-centered care values the strengths, cultures, traditions and expertise that everybody brings to this relationship. (MCHB 2016.)

Premature birth, acute illness of a child or a trauma can be the first health care contact that immigrant families have with intensive care units, or with the overall health care system. Previous studies show that diminished family-centeredness in health care has been reported by immigrant parents and their needs are not always met by the health care providers. Intercultural parents have also reported decreased sensitivity to their families' values and customs by the health care providers. These possible inequalities and the feeling of decreased appreciation can lead to the disadvantage of immigrant families and decreased health status. (Guerrero et al. 2010, 389.) Tailored communication to meet the parents' and child's needs is the goal of facilitating family-centred care and positive health outcomes. (Foster et al. 2016, 7-9.) Parents' involvement in the care also increases their feeling of respect in their values and preferences. Clinicians tailoring their communication to parents' needs were also seen to support interaction in family-centered care. (Byczkowski et al. 2016, 330-331.) In an intensive care unit setting, a child's admission can cause overwhelming stress to families. In the past decade, ICU health care staff have concentrated on family-centered care, in which close attention has been given to family members' informational and emotional needs. One of the goals of family-centered care in ICUs has been to reduce stress reactions of the families and to prevent traumatic ICU experiences. (Azoulay et al. 2005, 987.)

The European Association for Children in Hospitals (EACH) concluded in their conference in 2014 the new guidelines for parents' involvement in children's care. "Children and young people in hospital and other health care services shall have the right to have their parents or parent substitutes with them anytime, anywhere, any place, 24-hours a day, regardless of the age of the child or young person. ... This applies whether they are within neonatal or paediatric intensive care units..." (Resolution on Parental presence anytime and anyplace 2014.) The Finnish NOBAB association protects children's and families' rights during hospital stay and is part of the Nordisk Förening för Sjuka Barns Behov and European Association for Children in Hospital organization. The Finnish NOBAB organization gives standards and guidelines for children, families and health care personnel how children's rights should be respected in the hospital environment. The standards are based on EACH's guidelines and United Nations' Children's Rights. The aim of the standards is to include the rights of children and families in na-

tional and international legislations, policies and guidelines. The standards have been accepted in 16 European countries and are applied in Finnish health care. The standards include aspects from families' presence in hospital to communication and participation in the care. (NOBAB 2016.)

2.2 Culturally competent paediatric intensive care

Culture has various definitions and it changes in time and context. Bennet and Slater (2008, 18) describe culture as a complex set of rules which are learned and shared. These rules alter in different cultures, though there might be overlapping. Culture can also have different levels and sub-cultures. Merriam-Webster's Thesaurus (2016) defines culture "as a way of people living at a particular time and place". Chen and Starosta (1998, 26) present their definition of culture and emphasise the important relationship between culture and communication and their correlations in interaction. According to them culture is "a negotiated set of shared symbolic systems that guide individuals' behaviours and incline them to function as a group".

The increase in diversity and multicultural societies is creating a need for culturally competent care. Betancourt, Green, Carrillo and Ananeh-Firempong (2003, 294) define a culturally competent health care system as "one that acknowledges and incorporates -at all levels- the importance of culture, assessment of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs." Strategies that support the health care system to move towards elimination of racial and ethnic health disparities include training on cultural competence, cross-cultural issues and creating policies to reduce linguistic and administrative challenges between patients and health care providers. (Betancourt, Green & Carrillo 2002, 5-6.) Flowers (2004, 48) claims that especially intensive and critical care nurses should be able to provide culturally competent care, as they function in high-acuity, high-stress health care environments. Intensive care nurses must develop cultural competences to effectively meet patients' and families' needs.

Successful Culturally Competent Care (CCC) consists of overcoming linguistic and cultural differences. Studies concerning culturally competent care indicate that ineffective communication results in inadequate or negligent health care and can cause stereotyping. (El-Amouri & O'Neill 2011, 241-251.) Cultural competences in health care consist of the ability to provide care to patients with different values, beliefs and behaviours, and includes tailored care to meet patients' social, cultural and linguistic needs. Culturally competent care is seen to improve the quality of care and eliminate racial/ethnic disparities. (Brach & Fraserirector 2000, 182; Betancourt et al. 2002, 3.) In the health care context, the lack of understanding of sociocultural differences between healthcare providers and patients can lead to a decrease in

communication and trust. (Betancourt et al. 2002, 3-5.) Interventions to improve cultural competences have also been seen to improve patient health outcomes (Truong et al. 2014, 1).

Betancourt et al. (2002, 5) claim that the most common barriers that challenge culturally competent care are the lack of diversity in health care staff and leadership, a health care system not efficient enough to meet the needs of diverse patients and families, and the lack of communication between providers and patients of different racial or ethnic backgrounds. Truong et al. (2014, 2-3) reviewed previous researches made on cultural competences in health care. They claim that health care education is lacking understanding of what is the most effective way to improve cultural competences. They also state that there is debate whether interventions to improve cultural competences can lead to reduction of health disparities. The types of interventions to improve cultural competences were training, workshops and programs, peer education and exchange programs. Brach and Fraserirector (2000, 181-190) review on previous literature raised nine concepts that can be used to reduce racial and ethnic disparities in a health care setting. According to their findings, focus should be put on

- 1) interpreter services
- 2) recruitment and retention
- 3) training
- 4) coordinating with traditional healers
- 5) use of community health workers
- 6) culturally competent health promotion
- 7) including family and/or community members
- 8) immersion into another culture
- 9) administrative and organizational accommodations

By addressing the focus in these findings by Brach and Fraserirector (2000, 200) disparities in health care can be reduced. In addition, appropriate processing and implementation will improve cultural competences in health care and affect the health care system positively.

Sainola-Rodriquez (2009, 50) offers an different view on cultural competences as she states that excessive cultural awareness and cultural competences can also affect health care negatively. According to her, cultural competences can be criticized for a narrow perspective and too sensitive and discreet an approach. Williamson and Harrison (2010, 761) reviewed previous literature conducted on culturally appropriate care. The authors claim that learning about specific cultures should be avoided, in fear of stereotyping and failure to identify the needs of individual patients. The authors present that a more structural framework, focusing on social position rather than individual behaviours or beliefs will cause more positive benefits in health care.

2.3 Cultural competence care models

Cultural competence care models are increasingly necessary and used in the multicultural and globalized world. The aim of these models is to define, implement and assess them to improve culturally competent care and personal skills (Perry & Southwell 2011, 453). Previous studies provide several different cultural competence models and frameworks that can be applied to the health care system and education. Over time cultural competence models have expanded from an interpersonal level to include also organizational and systemic aspects (Truong et al. 2014, 1; Saha, Beach & Cooper 2008, 1275). Two models of cultural competences and Hofstede's (2010) approach to cultural dimensions are presented in Table 2 to provide a comprehensive approach to cultural competence care models from different levels and aspects.

Model/ Approach	Content	Author(s)
Cultural competences combine three interdependent components	Organizational level Systemic level Clinical level	Betancourt et al. 2002
Cultural competences need desire to develop	Cultural awareness Cultural knowledge Cultural skills Cultural encounters	Campinha-Bacote 1999, 2002
Six components that build up national cultural dimensions	Power distance Individualism vs. collectivism Uncertainty avoidance Feminity vs. masculinity Long-term orientation Indulgence	Hofstede 2010

Table 2: Cultural competence models

Betancourt et al. (2002, 17-20) provided a cultural competence care model that links recommendations and practical approaches to cultural competences to eliminate racial and ethnic disparities in health care. Their culturally competent care model combined three interdependent components: organizational, systemic and clinical cultural competence levels. Organizational cultural competences consist of programs that are designed to advance minorities' health care, strengthen minority leadership and workforce and include community representatives in a health care organization's planning and quality improvement meetings. Systemic cultural competence highlights the importance of on-site interpreters, the level of health literacy, language proficiency and reflection of the cultural norms of the patients. Government and private organizations should also collect data on race, ethnicity and language preferences to improve the monitoring of health disparities and quality reporting. Clinical

cal cultural competences include providing health care staff with cross-cultural training, quality improvement efforts including culturally and linguistically appropriate patient surveys and programs aiming to help patients to navigate in the health care system.

Campinha-Bacote's (1999, 205-206; 2002, 183) model Cultural Competence in the Delivery of Health Care Services is a more individual five (5) component model for developing cultural competences on a personal level. The model consists of aspects of cultural desire, awareness, knowledge, skills and encounters. The model on Cultural Competences define cultural competence as "a process in which the nurse continuously strives to achieve the ability and availability to effectively work within the cultural context of a client individual, family or community." The development of the model has been an ongoing process of Campinha-Bacote since the first development of the model (Campinha-Bacote 2002, 181).

Cultural desire refers to the motivation of becoming culturally aware and seeking cultural encounters. Desire reflects of being accepting, respecting cultural differences and being willing to learn from others. Cultural awareness involves self-examination on one's own cultural and professional background. Cultural knowledge involves interest in searching for cultural information on different cultural and ethnic groups. Cultural skills include the capability to apply the knowledge of relevant information to a patient's needs. Cultural encounter is defined as the process that encourages nurses to interact with intercultural patients from diverse backgrounds. These five components build the basis of individual cultural competences.

Campinha-Bacote (2002, 181-182) also highlights that desire is the key factor in getting the cultural competence beginning. When nurses have a desire to learn and improve their knowledge, the process of cultural competence begins. By obtaining awareness, knowledge, skills and having encounters with multicultural contacts the cultural competences will develop.

Hofstede's cultural dimensions were developed in the 1970's and it has been refined since. The theory originally included four components of cultural values, fifth and sixth dimension were included in the model in 1991 and 2010. Hofstede's theory has been used in several multifaceted intercultural studies in different fields of science. Hofstede's cultural dimensions enable and encourage health care staff to make insightful observations on cultural behaviours without having in-depth knowledge on that specific culture. Hofstede's model consists from six (6) parts that affect cultural differences. These six components all effect on how communication is perceived and how culture affects the ways of communication. Power distance describes the nature of people/culture, whether its egalitarian or embraces hierarchy. Individualism versus collectivism affect how people/culture understand and react to personal and group's/clan's needs. Uncertainty avoidance describes how people/cultures react in changing situations and how well they deal with these changes. Femininity versus masculinity describe

whether people/culture prioritize nurturing aspects or power. Long-term orientation describes whether people/ culture is more reluctant to make short (values past) or long-term (values future) goals. Indulgence describes how people/ culture feel about pleasures in life versus strict social norms.

Dimensions of national culture and its effects on cross-national differences in medical communication was researched by Meeuwesen, Van Der Brink-Muinen and Hofstede (2009, 58-62). The researchers' used Hofstede's cultural dimensions; power distance, uncertainty avoidance, individualism/collectivism, masculinity/femininity and national wealth as indicators. They concluded that the larger the nation's power distance the less unexpected information exchange there is and the shorter the appointments are. In high power distance countries, the roles of health care personnel and patients are clearly described and fixed. The high levels of uncertainty avoidance affected the levels of attention given to rapport giving; for example, less eye contact was given. In masculine countries less instrumental communication was given in the medical interaction and in wealthy countries more attention was given in to psychosocial communication. The study showed that Hofstede's cultural dimensions can be used to identify and understand individual countries habits of communication and applied to improve medical communication.

2.4 Intercultural communication in paediatric intensive care

Communication is part of people's everyday life and it has different levels in daily encounters. Communication has different kinds of forms and it alters in different situations, it is also affected by the roles of the people involved. (Bennet & Slater 2008, 6.) Merriam-Webster's Thesaurus (2016) defines communication to be interchange of thoughts, opinions or information by speech, signs or writing. In addition to verbal communication there is also non-verbal, paralanguage factors and kinesics, which affect how we understand and perceive interaction. Paralanguage factors such as pitch, tone, rhythm, intonation and speed can have a major impact on intercultural interactions and how people understand and receive the message given. Kinesics such as facial impressions, gestures, postures and looks also affect how the message is taken from the other person. (Spencer-Oatey & Franklin 2009, 91-93.)

Intercultural communication is defined to happen between individuals as cross-cultural communication is something that involves general tendencies (Guidelines on intercultural education 2005, 17). Variations in the terminology are wide, as for example cross-cultural, intercultural and multicultural are sometimes used as synonyms. Term intercultural is used in this research as nurses' perceptions of multiple intercultural contacts were studied rather than one single ethnic group. Lustig and Koester (2003, 294) claim that in intercultural communication

which includes two or more cultures, peoples' expectations and interpretations vary and communication can become unpredictable and problematic due to different interaction and behaviour patterns. Intercultural communication is bound between culture and communication, as culture builds the framework in which the communication and behaviour is interpreted. (Lustig & Koester 2003, 292-294.)

Schouten and Meeuwesen (2006, 22-26) reviewed previous literature on cultural differences in medical communication. They claimed that culture and ethnicity can affect the doctor-patient relationship negatively due to various reasons. Literature review showed that there were five (5) major key factors in intercultural communication that might affect medical communication:

- 1) cultural differences on how health and illness are perceived
- 2) differences in cultural values
- 3) cultural differences on patients' preferences for doctor-patient relationship
- 4) racism/ perceptual biases
- 5) linguistic challenges

Schouten and Meeuwesen concluded that culturally sensitive approach should be used when treating people from diverse backgrounds. In a similar study by Frivold, Dale and Slettebo (2015, 233-234) family members' experiences in ICU were researched. They concluded that two main themes rose in the experiences; being in a receiving and being in a participating role. When the family members were in a position of participating role, they were more satisfied with the care given and felt that they received a lot of informational and emotional support. The families, who felt as being in a receiver's role, did not experience such care and support from the health care staff. These families expressed feelings of frustration, confusion and loss of confidence.

Cioffi (2002, 304) researched intercultural communication from nurses' perspective in acute care setting and concluded that different tools were used to help in communication with culturally diverse patients. Interpreters, bilingual health workers and different tools were used to communicate with. A lot of emphases was put in the personal abilities of the nurses in their communication. Nurses showed significant amounts of empathy, respect and willingness to make an effort in intercultural communication and an ethnocentric orientation was common for the nurses.

2.5 Intercultural communication competences in paediatric intensive care

Intercultural communication competences (ICC) are becoming more relevant in the increasing multicultural encounters that health care professionals have with patients and their families. As intercultural communication competences have a multidimensional background in different theoretical study fields, the definitions are also variable. Arasaratnam and Doerfel (2005, 137-138) define ICC to include listening skills, prior cross-cultural experiences, having a global outlook as opposed to an ethnocentric one and global communication skills. The researchers also discuss the challenge of defining competences as they are always subjective views on the area of interest. Chen and Starosta (1998, 241) define ICC as one's ability to communicate in appropriate and effective way in different intercultural interaction situations.

Spencer-Oatey and Franklin (2009, 201) defined components of intercultural communication. The authors state that intercultural communication competences consist of three components: knowledge, skills and attitudes. In Table 3, these components have different levels of behavioural strategies and types. These types can be affective, cognitive or behavioural. (Spencer-Oatey & Franklin 2009, 202; Cioffi 2003, 300.) Cognitive strategies involve cultural knowledge, ability to recognize cultural issues and understanding different meanings in cultural contexts. Behavioural strategies involve flexibility in verbal and non-verbal communication, ability to speak clearly and encourage others to express themselves and ability to indicate empathy and sincere interest. Affective strategies include respect, awareness in own and other cultures and enjoyment of learning through cultural encounters. (Cioffi 2003, 300.)

COMPONENT	EXAMPLE	TYPE	TIME SPREAD
Knowledge	Knowledge about values, norms, behaviours	Cognitive	Short term
Skills	Active listening, linguistic accommodation, managing relationships, showing emotional interest	Behavioural	Short to medium term
Attitude	See others from different perspectives	Affective, Cognitive	Medium to long term

Table 3: Components of intercultural communication competences (Spencer-Oatey & Franklin 2009)

According to Spencer-Oatey's and Franklin's definitions, knowledge will increase by understanding aspects of intercultural communication and interaction and it can be acquired in short term. Knowledge includes understanding about different cultures, values, norms and behaviours. Knowledge also affects skills and attitudes as it supports and modifies the ways of

thinking. This component is highly cognitive. Knowledge is relatively easy to obtain, in contrast to skills and attitudes, in developing own personal intercultural communication competences. (Spencer-Oatey & Franklin 2009, 201-210.) Previous researches made in the field of intercultural communication in the intensive care units indicate that there is a lack of knowledge and education in the nursing skills. (Hoye & Severinsson 2008, 347; Nicholas, Hendson & Reis 2014, 151.) Increasing knowledge of different cultures and religions may diminish nurses' stress towards intercultural interactions and improve skills. (Hoye & Severinsson 2008, 346.)

Skills on the other hand will enable a person to act in the intercultural environment with appropriate manner. These skills can be acquired in short or medium amount of time. Active listening, linguistic skills, managing relationships and showing emotional interest are key elements of this component. This outcome is behavioural, but knowledge and attitudes support and strengthen the way of behaving. Development of personal skills are more demanding than acquiring knowledge, but it is a component that professionals might need even more in their professional life. (Spencer-Oatey & Franklin 2009, 201-213.) Challenges described in the previous researches usually consist of discordant cultural norms, translation difficulties and incompatibilities that resulted in conflicts and misunderstandings between families and health care providers in intensive care units. (Nicholas et al. 2014, 150.) Söderström, Saveman and Benzein (2006, 712) researched interactions between family members' and nurses' in intensive care unit. They concluded that in healthcare communication is an important factor for successful treatment. Family members who had difficulties in understanding the explicit and medical information were more insecure and misunderstood in the intensive care unit and the communication with the staff was not successful.

Attitudes allow us to see people from different perspectives and experience interaction with them. This component usually requires medium to long term to get acquainted with. Sometimes the change of attitudes can be challenging, and require a lot of training and developing of own personal skills. This component is affective as well as cognitive by nature. Adopting attitudes, perspectives and values can be the most challenging part of developing intercultural communication competences. In the end intercultural communication should be seen as an opportunity to interact in new and unfamiliar situations, and that it requires a flexible and open mind. (Spencer-Oatey & Franklin 2009, 202-216.) Nurses found it important to practice nursing in a way that supported positive family experience and tried to establish a meaningful cross-cultural connection and relationship of trust. (Nicholas et al. 2014, 150.)

Previous literature on intercultural communication displays various definitions and models on the topic. In Figure 1 different connections between terminology and possible ways to present the needed components for intercultural communication competences are presented. In this

research intercultural communication competences by Spencer-Oatey and Franklin (2009) conduct the core of the competences, and other definitions can be used to provide a comprehensive approach on this multifaceted view on the topic.

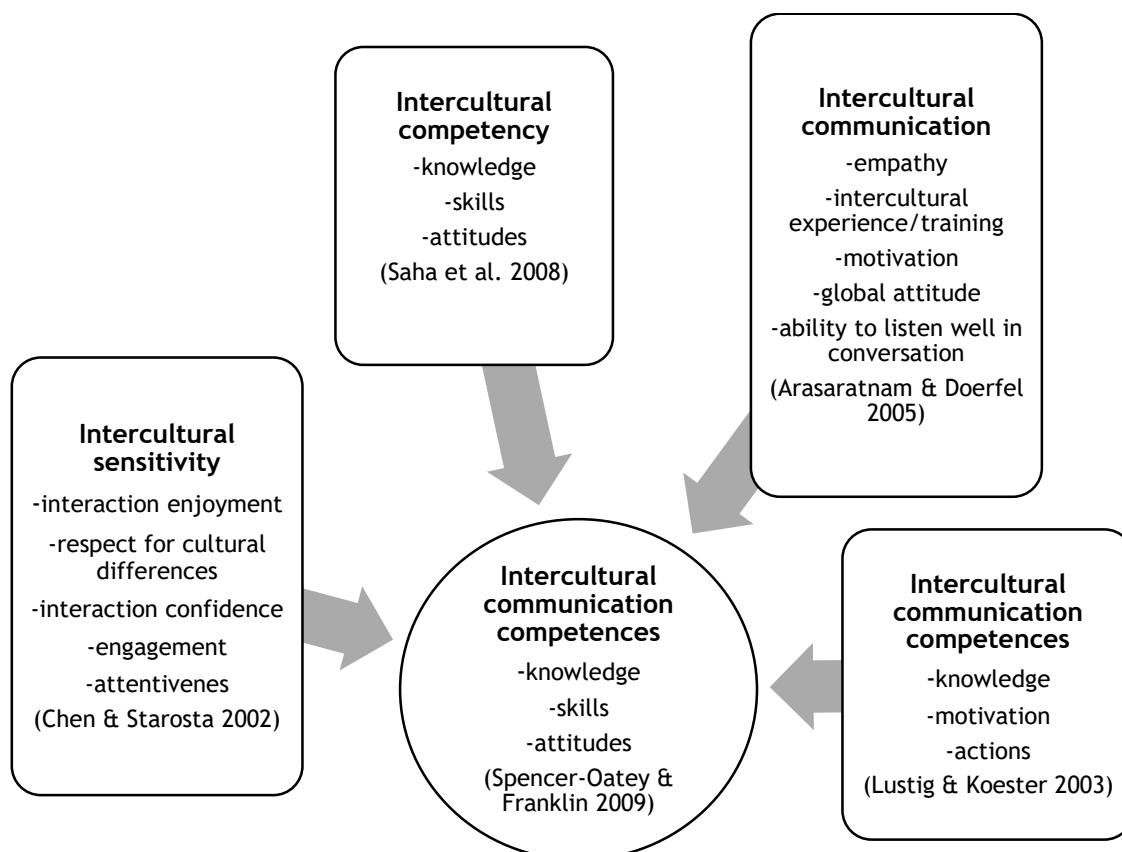


Figure 1: Synthesis of intercultural communication components

As mentioned, Spencer-Oatey and Franklin (2009) present the intercultural communication competences to consist of knowledge, skills and attitudes. However, several studies also identify intercultural sensitivity, intercultural competences and communication skills to be highly important in successful communication. In these concepts there are a lot of overlapping in terminology and definitions. Chen and Starosta (2002) created aspects of intercultural sensitivity that can be used to measure health care personnel's skills on the matter. Saha et al. (2008, 1275-1277) claim that the components of knowledge, skills and attitudes can also be used as health care's cultural competency framework as well as components of intercultural communication. The authors define knowledge as referring to knowledge about different cultures as well as the impact of cultural experiences in patient-personnel contact. Skills include communication skills and implication of knowledge. Attitude consists of self-efficacy, attitudes towards community health issues and interest in learning about patient and family backgrounds. Arasaratnam and Doerfel (2005) on the other hand described what qualities are

needed in personal level to have a successful intercultural interaction. These different definitions and components can be connected to each other in various ways and in different levels of knowledge. Lustig and Koester (2003) present that knowledge, motivation and actions build the basis of ICC competences. This definition is very similar and has a lot of overlapping to Spencer-Oatey's and Franklin's definition. Lustig and Koester (2003, 64-65) put a lot of emphasises on the relationship between culture and communication. They claim that intercultural communication competences also vary from culture to culture, as the effect of culture is always a factor in the process.

3 Goal and aim of the research

The goal of the research is to develop nurses' intercultural communication competences and to improve care and services for intercultural families and patients. The aim of the study is to identify nurses' intercultural experiences and perceptions towards intercultural communication.

Research questions are:

1. How do nurses experience intercultural communication with parents in PICU?
2. What strengths and challenges do nurses come across in intercultural communication with parents from diverse backgrounds?
3. How do nurses consider their intercultural communication competences in PICU?

4 Methods

The process of this study began by choosing the topic and models used in this research. Following the instructions of Silverman (2005, 99-102), Kankkunen and Julkunen-Vehviläinen (2013, 178) the next steps included building up the knowledge in concepts, definitions and theories that were applicable to the topic. The building of the framework helped in understanding the connections and structures of the previous studies made in the field and gave pre-understanding on the topic. In the next step, research questions were made and methodology chosen. Focus group interview was chosen to be the method used in the research, as it provided a comprehensive approach to the field of interest and was seen able to produce new information in the field (Tuomi & Sarajärvi 2002, 76; Grove et al. 2013, 274-276; Steward & Shamdasani 2015, 12-13). A small pilot group was interviewed beforehand to structure the themes and test the facilitator's abilities to conduct the interview. Also a key informant was used to discuss any unclear parts in the focus group interview's data analysis.

An inductive approach was used and the data was analysed by using content analysis. Content analysis enabled new knowledge, insights and representation from the analysis to rise. Results were categorized and presented in the report using categorizing and conceptual mapping. (Elo & Kyngäs 2007, 108.) After reaching the findings, the research questions were assessed again in a critical manner. Critical discussion was done to evaluate and discuss the process of the study and suggestions were made for the future research on the topic. (Silverman 2005, 99-102.) Good research conducts and nursing science norms were followed throughout the process (TENK 2012; Kankkunen & Vehviläinen-Julkunen 2013, 28.)

The World Health Organization's Quality of care guidelines (2016) were also used during the process to improve quality of the research. In Figure 2, guidelines are presented and applied into this research.

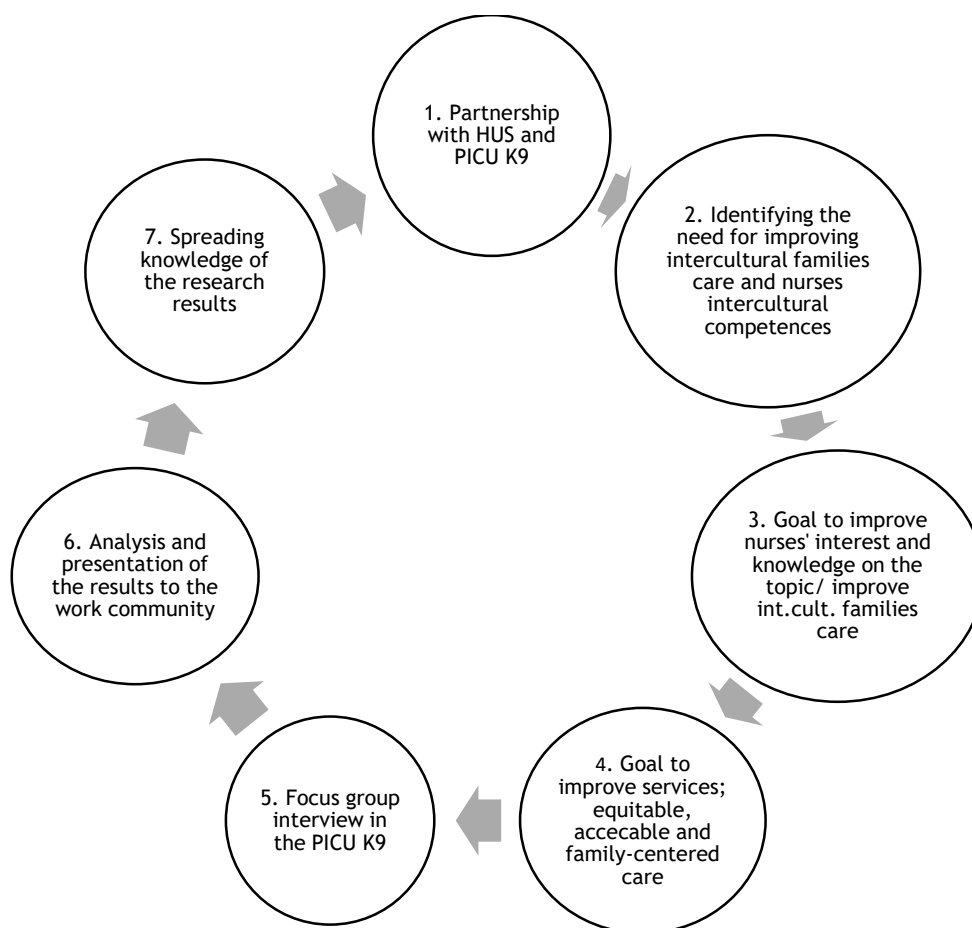


Figure 2: WHO's Quality of Care guidelines applied into the research process

The first step of the process involved stakeholder involvement and in this study the partnership was formed with the HUS organization and PICU K9. Situational analysis identified the

need for improvement in knowledge and health care services from both nurses' and intercultural families' perspective. The third step included identifying the goals and aims of the study. The fourth step discussed the goal from quality of care's perspective. The goals were based on the framework and WHO's dimensions of quality. Focus group interview was chosen as an intervention/method to be used in the study as it gave good insight on the topic from nurses' perspective and made collective discussion possible. The sixth step included analysis of the data from the interview. The finalized study will be presented in the PICU's education day in January 2017, where nurses from the PICU will be participating. The last step was monitoring the process, which in this study means saving the final report to HUS's database, in the PICU's internal internet pages and on the public thesis archive Theseus.

4.1 Paediatric intensive care unit setting

The Hospital district of Helsinki and Uusimaa (HUS) is a joint authority by 24 municipalities. The aim of HUS is to offer patients timely and equal access to specialized medical care. The HUS region consists of 452 988 patients and it employees nearly 22 500 professionals. (HUS 2016.)

Paediatric intensive care is a special field of intensive care/ critical care medical treatment. Paediatrics in the Finnish health care context includes children's medical care between ages 0 to 16. Intensive care treatment is required when a patient has a severe illness or injury and requires monitoring and support in vital functions, such as breathing, circulation of blood, renal and hepatic functions. Intensive care treatment may also be planned electively postoperative from major surgical operations. The ward K9 is a multi-professional work community with approximately 90 registered nurses, specialist doctors, physiotherapist, secretaries and administrative nurses. Intensive care units are staffed with nurses who are skilled to attend complex medical treatments. (HUS 2016.) Nursing staff in the paediatric intensive care unit are educated to provide good quality health care, reduce patients' symptoms, affect positively in the commitment in treatment and base their work on evidence-based knowledge. Ethical guidelines for nurses also highlight continuous education and improving personal skills to insure the best possible care for the patients. Nurses are also obligated to ensure that patients receive understandable and adequate information on their health issues. (Sairaanhoitajaliitto 2016.)

PICU K9 is located in the Children's Clinic in Helsinki. All children from the HUS area, in need of intensive care, are treated in the unit. In addition, the ward K9 is responsible for whole Finland's children's complex heart surgery and organ donations. In 2015 687 children got treatment in the intensive care unit. 334 patients were elective, and required intensive care treatment after surgical procedures and 353 patients were acute emergency patients. The average time spent in intensive care was 4,09 days. 31% of the patients had open-heart surgery,

21% other major surgical operations, 10% acute respiratory deficiency, 9% acute blood circulation deficiency, 7% closed-heart surgery, 4% metabolic disorders & intoxications, 3% pneumonia, 3% transplantation, 3% trauma, 3% neurological/ neurosurgical treatment, 3% inborn abnormalities and 3% respiratory monitoring due to age indication. (HUS 2016.)

The New Children's Hospital is under construction and should open by the year 2018. In the new Children's Hospital most of the functions and spaces are designed to support families and children during their hospital stay. Free visiting hours, easier access to children and family-centered care are developed to support families' involvement in the care. In the PICU the patient rooms are designed to give families more privacy and enable parents to participate better in the treatment of their children. Family-centered care has been one of the focal points in the development and design of the PICU in the new premises. (Uusi lastensairaala hankesuunnitelma 2017.)

4.2 Focus group and theme interview as a data collection method

Focus group and theme interview were used as a data collection method in this research. The interview took place in September 2016. Focus group interviewing was chosen as a research method as it can be used to gain in-depth and expert understanding of the behaviours of the care-givers and clients. By interviewing the nurses, it was possible to discover their feelings, perceptions, thoughts, experiences and opinions. (Bourgeault, Dingwall & De Vries 2010, 33-36; Stewart & Shamdasani 2015, 12.) Even though the use of focus group interview was found appropriate in this study, some criticism has been pointed out in using it in nursing sciences. Webb and Kevern (2001, 798-799) state that researchers' using focus group interview as data collection method should have a high consideration at the research planning stage, familiarizing with the analysing methods and reporting the data beforehand. The authors claim that using focus group interview as a data collection method requires a lot of method discussions and criticism in its process. In this study, consideration was done concerning the methodological choices, and argumentation has been made to justify and validate the chosen methods.

Summary and timetable of the focus group interview process are presented in Table 4. Even though, the process is presented in a linear fashion, the process required several re-evaluations and changes throughout the process. Pilot group interview was carried out in the early September 2016. In the end of September, the focus group interview took place and key informant was used to clarify some of the meanings during October 2016.

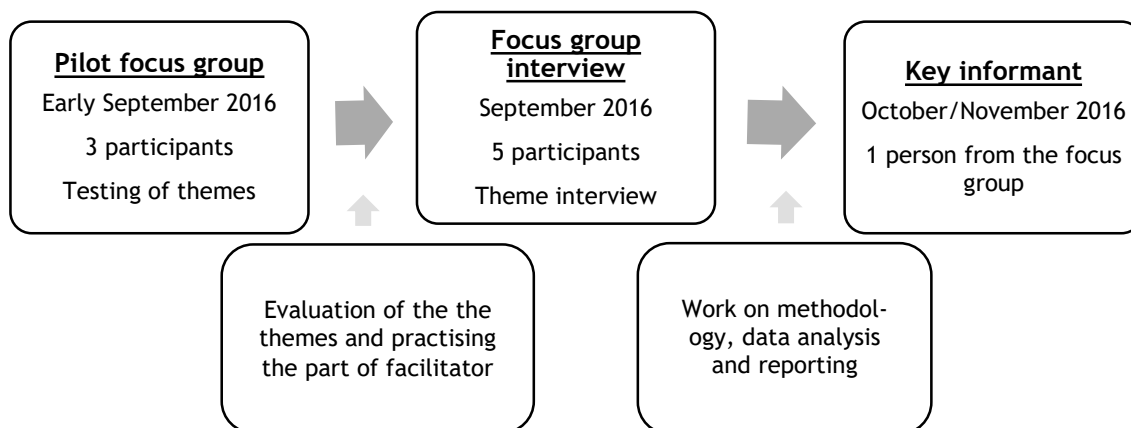


Table 4: Summary of the interview process

The pilot focus group interview was made with three (3) nurses before the actual interview. The pilot group did not involve nurses from the PICU, but from other intensive care units in the HUS organization. None of the participants in the pilot focus group had any connections to the PICU. The aim of the pilot group was to help the researcher to practice the role of the facilitator and to validate the themes asked in the interview. (Kankkunen & Vehviläinen-Julkunen 2013, 205; Grove et al. 2013, 272.) Few changes were made to the structure of the interview after the pilot group; themes and key words were re-evaluated to help the facilitator to reach the themes wanted. Also questions concerning the themes were made to get the discussion started in the focus group interview. More accuracy was targeted in the themes and more time was reserved for the interview. The pilot group also taught the researcher how to provide a more natural and relaxed atmosphere in the interview, to gain as vibrant and open discussion as possible. (Grove et al. 2013, 272.) Pilot group interview also prepared for the focus group interview, by giving a experience and knowledge on how to act as a facilitator.

The number of participants in the focus group was thought carefully before the interview and six (6) nurses were asked to participate. Grove et al. (2013, 275) suggest the number of participants in a focus group to be between 4 and 12, to enable rich discussion and interaction. One of the participants was not able to attend, so five (5) nurses joined the focus group interview. Before the interview the nurses' got a participation letter, which cleared the purpose of the study and was asked to be returned with an informed consent (Appendix 1).

The participating nurses were selected using different aspects as such: service years, special knowledge on the topic and interest. The minimum amount of service years was limited to

two years and previous work abroad was seen as having personal knowledge on the topic. The nurses who were chosen to the focus group were all women and aged between 25 and 43. One of the nurses had previous experience working abroad and two of the nurses were members of the paediatric intensive care unit's family cluster. The recruitment of the participating nurses was carefully thought as it had a great effect on the outcome of the study. The instructions of Grove, Burns and Gray (2013, 275, 371) were used in the selection of the participants, as the authors emphasise the meaning of appropriate participants, as it can be crucial for the success of the interview. In qualitative research the focus was put on the quality and in-depth information and not in the number of participants.

Paediatric intensive care nurses involved in the study were able to attend the focus group interview at their work time. The interview place was a quiet conference room in the PICU premises that abled private and confidential discussions (Grove et al. 2013, 272). The time reserved for the interview was two (2) hours. The interview time was scheduled in work time which abled the nurses to participate and the least possible costs came to the employer.

The focus group interview was conducted as a theme interview. A list of themes is presented in Table 5. Themes were made beforehand using the experience and knowledge gained from the pilot group interview, framework and research questions done beforehand. Pre-understanding of the framework enabled the focus to be in the themes, even though, the course of the interview was not structured. Theme interview was chosen as an interview method as it enabled free discussion, gave power and meaning to the participants and to their opinions and experiences. (Stewart & Shamsadani 2015, 12.)

The themes were carefully planned to structure the interview and to help the facilitator to cover the main topics and to meet the research questions. The themes and questions were structured to go from a wider approach into more detailed themes. The interview was allowed to follow its natural course, as long as the topics were addressed at some point. Key words were formed to help the facilitator to bring up topics, if the participants did not raise the issues on their own. (Stewart & Shamdasani 2015, 81-84.)

None of the themes or open-ended questions were shown beforehand to the participants. If the themes were covered and the discussion involved the elements wanted, no questions were made. Research themes and questions were made in Finnish, but translated for the Table 5.

Main themes	Key words in the interview to help to meet the themes wanted
Nurses' experiences and perceptions on intercultural encounters in PICU	Experiences Perceptions Personal opinions
Intercultural communication in PICU	Personal/ unit's strengths Personal/ unit's challenges/ weaknesses Work community Education Tools/Means
Personal competences	Knowledge Willingness Awareness Education Personal abilities

Table 5: Interview themes and key words

The interview was audiotaped and the recording was approved by the participants in the interview. At the beginning of the discussion, participants were asked to tell their names on the recorder, to ease the process of recognizing the voices on the tape. (Stewart & Shamdasani 2015, 29-30.) In the focus group interview the goal was to have an open discussion on the themes and topics mentioned. The participants were clarified that they were able to bring up their personal and professional views on the subject and discuss the issue freely. (Grove et al. 2013, 272.) But as the pilot group had proved, the participants had challenges, especially in the beginning, with free expression. The facilitator was prepared to ask questions to get the discussion started (Table 6; Interview questions made in the focus group interview). As the focus group interview went further, the participants relaxed and started to communicate more and discuss with each other and comment on each other's statements. Table 6 includes the start and finishing questions, key questions and follow-up questions made by the facilitator on the discussion of the participants.

Interview questions made in the focus group interview
<ul style="list-style-type: none"> -Tell me something about intercultural communication in PICU -What kind of experiences do you have from intercultural encounters in PICU -You discuss the acute environment in the PICU quite strongly affecting the communication. Tell me more about that -You mentioned time management, what do you mean with that -What kind of intercultural communication strengths/challenges have you faced in PICU -What is a successful encounter in PICU -How do you support the feeling of safety in the PICU -You said that sometimes you feel inadequate if parents don't understand. Tell me more about that

<ul style="list-style-type: none"> -What kind of tools/means do you have to cope with these situations -What would be needed to improve your personal knowledge on the subject -Is there something else that you would like to address or say about the topic
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Table 6: Questions made in the focus group interview

Participants answered to the questions mainly with long phrases and stories about their personal experiences and thoughts. They were elaborate with their discussions and commented on each other's experiences bringing up their own views. They were agreeing and sharing similar views on the topic. Only few follow-up questions were made in the interview, as participants elaborated widely on their experiences. (Grove et al. 2013, 272). Participating nurses in the interview were all well-informed, communicative and good in articulation. (Grove et al. 2013, 371-372; Stewart & Shamdasani 2015, 40.) After 1 ½ hours no new information was any longer provided by the participants and saturation of the data occurred. In the saturation, richness of the data required fewer participants than in quantitative research as it is not connected to the number of participants. In saturation of the data it was essential that the researcher was aware of what was wanted from the interview. A good understanding of the framework and the pilot group helped in understanding the different aspects of the topic and the themes what were wanted to be discussed. Saturation was used to measure the similarities in answers, but not disparities. In qualitative research saturation as a tool was used as a descriptive manner rather than trying to gain proof or quantities in answers. (Tuomi & Sarajärvi 2002, 89-90.)

4.3 Content analysis

Theme interview can be analysed by using thematic and/or content analysis. It required thorough acquaintance with the topic and knowing the context of the interview. In the analysis recordings played a visible role, but the interview situation contained much more information than audio sound. Feelings, emphases and nonverbal communication were as important parts of communication as words. (Grove et al. 2013, 281.) In this focus group interview, laughter and sighs were written in the transcript. However, since there was only one researcher present as a facilitator in the interview situation, no facial-impressions or body-language were able to be registered in the interview.

Content analysis can be defined as a method for identifying, analysing and reporting patterns within the data (Elo & Kyngäs 2007, 107-109; Graneheim & Lundman 2003, 108). Content analysis was chosen as a research method, as it allowed flexibility and detailed descriptions of the material. Applying the instructions of Elo and Kyngäs (2007) and Graneheim and Lundman (2003) three (3) steps were followed in the process:

- 1) Preparation phase
 - selecting the unit of analysis (meaning units)
 - familiarizing with the data
- 2) Organising phase
 - open coding
 - coding sheets
 - grouping
 - categorization
 - abstraction
- 3) Reporting the analysing process and the results
 - conceptual map/ categories

The analysis started from detailed data, phrases and single wordings, and was expanded into wider approaches, categories and themes (Graneheim & Lundman 2003, 108; Elo & Kyngäs 2007, 109). The transcript was categorized several times in the analysis process, as it was not always clear how the categorization should be made (Graneheim & Lundman 2003, 107).

By choosing an inductive approach, the analysis was able to be text driven and the voices of the informants lead the process. (Grove et al. 2013, 58; Kankkunen & Vehviläinen-Julkunen 2013, 54.) The process of familiarizing with the data started as the transcript was being written. The data collected from the focus group interview was first transcribed into paper in Finnish and it was done in a week after the interview. The parts used as quotations in the text were translated into English as accurately and to the best abilities of the researcher. The transcript included 17 pages, font used was Calibri and line spacing was one (1). Data was read over several times to understand the information it included.

After getting acquainted with the text, meaning units were conducted from the data. Examples of these meaning units, categorizations and themes are presented in Table 7. Meaning units included phrases and words from nurses' discussions. Meaning units were marked on the sides of the data and they were coded. Coding meant that the meaning units were written out in own words and the meanings of the words were categorized. In the next step, categories were formed from the coding. (Stewart & Shamsadani 2015, 125-129; Graneheim & Lundman 2003, 108-109.) Nine (9) main categories and twenty-nine (29) sub-categories were conducted from the coding. Last step was to create themes, and the results ended up with four (4) entities. Categories and themes were analysed critically and changes in categorization were made during the process. While producing the analysis, the transcript was followed very carefully and important quotations were taken and translated into the text. (Elo & Kyngäs 2007, 110; Graneheim & Lundman 2003, 107-109.)

Meaning unit	Code: What is it about?	Main category	Sub-category	Theme
“Yes, I think we quite easily think that we are not that important, that we shouldn’t call them [interpreters] just for us.”	Nurses feel that their dailywork is not important enough to call the interpreter just for their use.	Daily communication	Importance of daily communication	Linguistic challenges in PICU
“It’s in your gestures, I think [empathy] is something that you can show in the way you touch and it’s in a soft essence.”	Nurses thought that warm caring for the children increased trust and feeling of safety in the parents.	Nurses’ personal abilities’ in communication	Trust and presence	Nurses’ personal abilities on intercultural communication in PICU
“It must be really scary to walk into an intensive care room. The sight isn’t normal, and it shouldn’t be.”	PICU as an environment can be fast changing and parents’ can be scared or confused.	Acute environment of PICU	Fear	PICU’s character’s effects on communication

Table 7: Example from the content analysis

A nurse from the focus group interview was used as a key informant for the analysis of the data. The key informant was asked to read through the chosen parts of the study, to validate and clear the meanings of the words used. In a few parts there were discussions on the researcher’s and key informant’s part on how the text was understood and categorized. Discussions concerned mainly the categorization of main and sub-categories’ key informant clarified unclear statements from the theme interview and categorical changes were made after the clarifications. The transcript was reverted back to several times, and the process of analysis was continuous movement. The key informant was also used to verify and discuss the categorization in the analysis. Language caused some challenges during the process, as for example, how to translate words and meanings so that nothing got lost in the translations.

5 Results

Nurses who participated in the focus group interview were all nursing professionals, with variation in their backgrounds and previous knowledge on the topic. Their initial approach to the topic was very positive and they all expressed feelings of interest and respect towards intercultural communication. Discussion in the interview was lively and the participants brought up their personal insights on the topic. All the nurses had experience on using face-to-face interpreters, different linguistic tools and using non-verbal communication methods. The participating nurses all had encountered and experienced intercultural communication and had lively views of the challenges and strengths of the communication.

The results are presented in four (4) themes that rose from the analysis; PICU's character's effects on communication, Linguistic challenges in PICU, Cultural differences between health care staff and families and Nurses' personal abilities and capabilities on intercultural communication in PICU. The synthesis of the themes and main categories are seen in Figure 3.

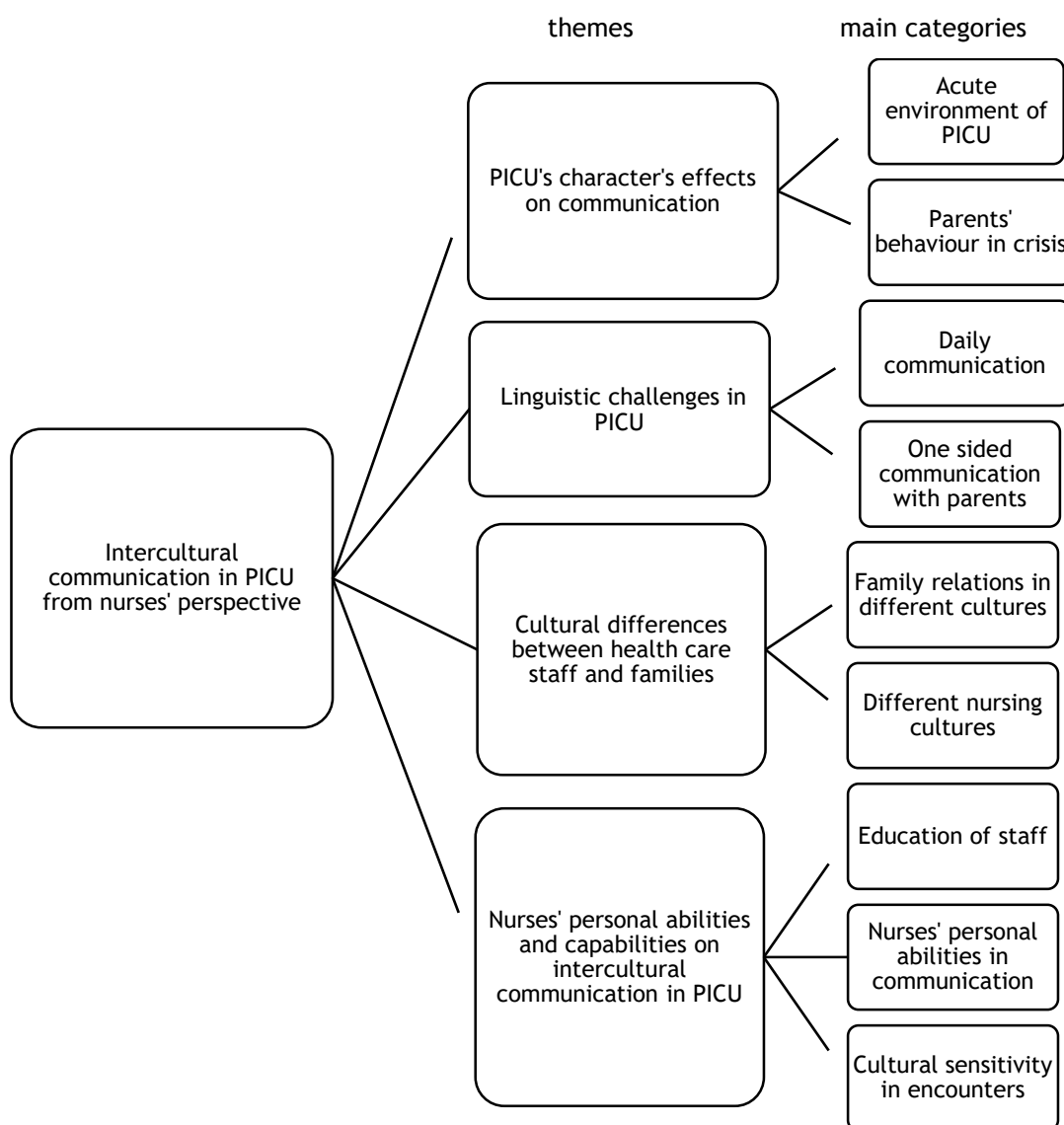


Figure 3: Synthesis of the results in theme and main category levels

The four (4) main categories shown in Figure 3, present the results of PICU's intercultural communication from different perspectives. Main categories build an abstract view on the topic. Sub-categories are presented in the next chapters to give more detailed views about the main categories. Parts of participating nurses' quotations have been added in the result section to improve transparency and clarify the context of the discussions.

5.1 Paediatric intensive care's character's effects on communication

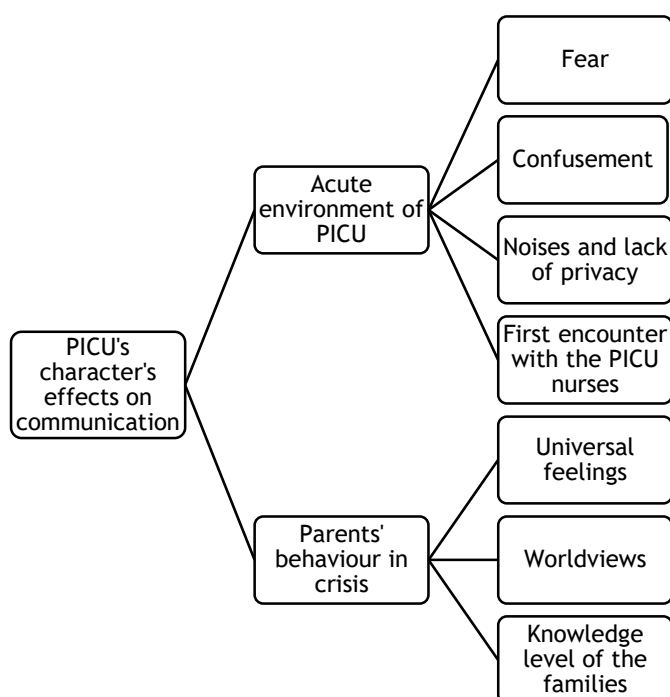


Figure 4: Synthesis of the main- and sub-categories in PICU's characters effects on communication

In the focus group interview acute environment and the challenges it causes to intercultural communication were raised strongly in the discussion by the nurses. Participants pointed out the challenge of rapidly changing situations in the child's health as being one of the major challenges in communication. Paediatric Intensive Care Unit as an environment was described by the nurses as scary, restless and confusing for the parents. This assumption was made by their professional experiences working in the unit for several years. They described the unit to be loud and full of constant noises, which can affect concentration and cause challenges in communication. Children are treated in rooms with several patients in them and privacy can be hard to attain. Nurses also indicated that PICU was a unique environment in comparison to other wards, as children who are treated in the intensive care unit are in critical state and uncertainty of the future is always present.

It must be really scary to walk into an intensive care room. The sight isn't normal, and it shouldn't be. So even that they [parents] are able to come in, is quite an achievement for many.

An unsuccessful encounter in the first visit to PICU by the parents was seen to hinder the future communication and its success. Nurses' saw that in PICU it was extremely important how

parents were met in the environment for the first time. At the first acquaintance with parents, trust and overall atmosphere started to build. Nurses indicated that meeting with the parents for the first time can be also challenging for them. Not being aware of the families' background and their level of knowledge was found challenging. Also the behaviour of other nurses' and employees' were seen as an important element in building opinions and trust towards the unit.

The first nurse who sees the family, is in such an important position. Everything kind of comes together in that first encounter. It's the first impression that we give, and that's when everything begins.

Parents' universal feelings were also raised up in the interview, when nurses' discussed PICU as an environment and PICU's own special characters. No matter of cultural background, parents were seen to have universal feelings and behavioural patterns in moment of crisis. Nurses' saw that always when a child was admitted to an intensive care unit, it was some level of a crisis for a family.

Nurses described how parents' emotions and feelings were very humane and universal no matter of cultural background. These emotions and ways of acting were seen to empathise in a moment of crisis. They described working in these situations to require a sensitive approach and the ability to encounter families as equals. Nurses' felt that they had no difficulty understanding the feelings and minds of parents. No matter of cultural background, parents were seen to have universal feelings, concerns and questions about their child's condition. Nurses' saw that their presence and kind care for the child were equally important to parents despite of background or lack of mutual language.

... feelings are quite universal. Once you have worked for a while in PICU, your kind of start knowing what the parents are typically thinking, watching and asking. It's exactly the same questions with intercultural parents. And often they ask questions that are highly irrelevant for the care, but they are important for the parents.

We have really sick children here, but then we have no mutual language. ...And we should be able to meet them in that situation with a different language or no language at all, but luckily the feelings are universal. And you can show with little things that you care.

Nurses' also pointed out in the discussion, that even though feelings might be universal, the ways of behaviour and actions were culturally bound. Worldviews were seen to differ greatly in different cultures, and behaviours and values were seen to be culturally bound. For instance attitudes towards child's illness or mortality were seen to vary with families' ethnic backgrounds. Nurses indicated that sometimes it was difficult to understand or predict how parents or families with diverse backgrounds will react to certain things.

Child's death might be seen in completely different way in different cultures, it's not always seen as bad as we are used to.

We can't even think how much these people might have seen death, many of them come from war areas. And if you come from a developing country, child mortality might be a lot higher than we are used to.

Parents and families' knowledge and education levels were also discussed by the nurses. They indicated that not knowing the education level of intercultural families sometimes challenged the communication. In some occasions they had encountered families with no literacy skills and no previous knowledge on human anatomy or children's acute illnesses. The nurses thought that the information given should be based on the families' knowledge level. Nurses also hoped to have some basic information or leaflets about health and common illnesses in different languages that could be given to parents in their own language.

You don't always know what is the education level and knowledge of the parents. You aren't always even sure, if they know what blood circulation is and how it works.

5.2 Linguistic challenges in paediatric intensive care

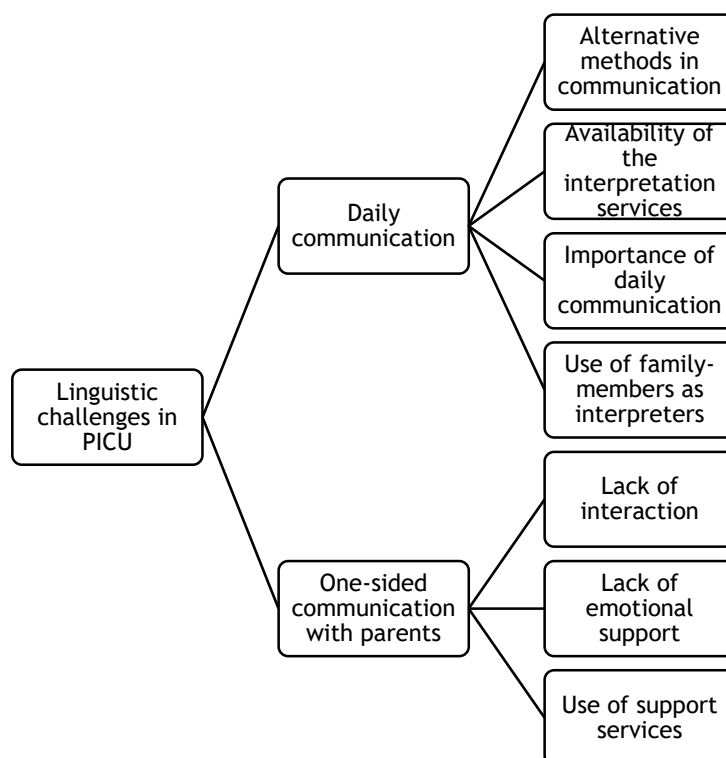


Figure 5: Synthesis of the main- and sub-categories in linguistic challenges in PICU

As seen in most of the previous studies made in the field of intercultural communication, linguistic challenges were also seen as part of the biggest challenges in communication in PICU. Lack of mutual language caused stress to nurses' and challenged them to create optional ways in communication. When interpreters were not present, nurses used family members as interpreters, signs, drawings, language tools and body language. Participants' saw that nurses had a lot of responsibility on themselves, how to communicate and how much effort to put into interaction. Creativity and ability to figure out new ways of communication were seen to lie a lot on personal abilities.

It takes a lot of creativity and will from a nurse. You need to put your personal-ity in the stake. I think you should be able to communicate basic things even without an interpreter, but it takes willingness from the nurse. We must put effort in the communication, make up some hand signals or something.

From patient safety perspective, one of the biggest issues is hand-hygiene. I saw one of our nurses greet a family for the first time and she took them to the family room and washed hands with them and showed them how the disinfectant pump works. The next day she only showed the sign to them, and the family knew what to do.

Difficulties also occurred with the interpreters' availability and presence, especially in certain times of the day; evenings, night shifts and acute situations. Elective appointments with the interpreters were seen as a well-functioning service, even though nurses did not use it as much as they could have. Nurses' seem to weight between needs and costs in getting the interpreter present. Nurses also preferred face-to-face interpretations more than telephone interpretations, and saw this being much more useful to the families. Interpreters were mainly called only if doctors' had information for the parents. Nurses' seem to think that they do not have the right to call for an interpreter concerning daily matters.

And sometimes it feels like we should have an interpreter here every single day, that it is not enough to have them every once in a while and then maybe a week after. You should be able to tell the parents every single day how their child is doing.

Yes, I think we quite easily think that we are not that important, that we shouldn't call them [interpreters] just for us.

On the other hand, they realized that when something big was happening and parents met with the surgeon or anaesthesiologist, parents might be overwhelmed and not willing to discuss their own fears and doubts. Nurses' found it important that the interpreter would be available daily, so that interaction and communication would be easier. Also they wished that interpretation services would be available throughout the day. Nurses' also thought about money and saw that using interpretation services for only their needs was too much of a cost.

It's funny, how we think so much about money. Even though it might be so important for the parents and their feeling of trust.

Nurses' also felt that in some occasions parents might get too much information at once, and so they would benefit more from having the interpreter present in several different times. Also the nurses' thought that they could improve their own coordination and cooperation with social worker and support services when the interpreter was present. They also hoped that having the interpreter more present would make their job easier and communication with the parents more successful.

Nurses' also discussed the use of interpreters and challenges that had occurred. Medical terminology was seen to cause troubles also for the interpreters.

It must be the unit's character, that we have so much of these fast changing situations, and we have such a high presence of medical science in here, that I often think that does the interpreter even know what the words mean.

Sometimes even family-members and relatives were used as interpreters even though it is not recommended. Nurses acknowledged this as a bad habit and un-ethical way of working, but it

was still in some occasions the most practical way to proceed. Using family-members as interpreters raised also ethical issues, such as can the nurses be sure what the person is translating and does the person understand the words and phrases used. In the other hand nurses found it very important that parents and families knew what was the health situation of the child at the moment.

We should pay attention to the fact, that we wouldn't use relatives as interpreters in these situations, but I know it's difficult in real life.

Nurses' also brought up one-sided communication with intercultural parents. They felt that communication and interaction with intercultural parents was often one-sided, so that even if they kept talking to parents, they did not receive a response or interaction back. Nurses' felt that the parents were usually gaining as much knowledge as they can from the health care staff, but didn't show their feelings or doubts. This caused a feeling of insecurity to the nurses on how the family was really doing and did they really understand the information given.

Now that I start to think about it, I can't remember many cases, actually not even one discussion with parents in any foreign language, where I would have been discussing about parent's feelings and thoughts.

It can actually make you feel quite frustrated and awkward, if you don't get any response from the parents.

Interaction, it should go both ways, not only so that the nurse keeps talking, that it wouldn't be one-sided.

Nurses' also realized that the conversations with intercultural parents tend to be very fact orientated, especially if the interpreter was present. Participants acknowledged that culture might have an effect on this phenomenon, but maybe feelings were not so often asked from intercultural parents either. Cultural differences were also seen to effect in how often support services were offered for the parents. Intercultural parents were not directed to meet psychiatric nurse or priest as often as native Finnish parents.

It came quite clear at some point, that it wasn't part of their culture to meet a psychiatric nurse and discuss [about their feelings].

Every now and then there might also be lack of understanding about the services provided.

...then I realized that the mother didn't even understand what [services] I was trying to offer.

Nurses also felt that intercultural parents were not often correcting mistakes or misbeliefs of family or relative connections. Nurses' pointed out that getting intercultural families to discuss and interact was found challenging.

Participants' pointed out that they had different linguistic tools in the PICU, that they could use to help in the interaction. They discussed about using dictionaries, phrase-translators and picture cards. They came to the conclusion, that even though they had these tools to help, they did not often use them. One of the reasons for not using the tools, was that they just hadn't remembered to use them. Bringing these tools to active use, was one of the things that was seen important to help nurses' in their daily encounters. Also discussing intercultural issues in the unit's education days was mentioned as an important educational tool.

5.3 Cultural differences between health care staff and families

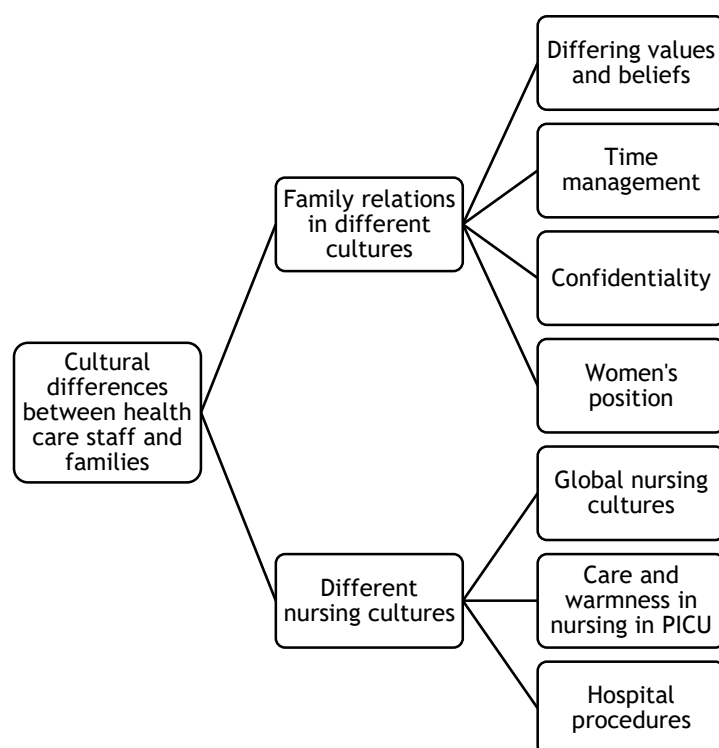


Figure 6: Synthesis of the main- and sub-categories in cultural differences between health care staff and families

Cultural differences were described in the PICU as challenging by the nurses. Nurses' felt that they do not often get as good interaction with the intercultural families as they would like to have. Things that affected this were mainly due to linguistic challenges, one-sided communication and not enough knowledge about cultures. Nurses' felt that in many cases they did not have enough knowledge about the cultures of their patients and their families or did not now how to respond to their needs.

We had this young asylum seeker girl as a patient. She was so anxious and restless and we didn't have a mutual language. But when she managed to do a scarf to her head from a diaper, she calmed down instantly. We just didn't understand what she wanted and needed.

Keeping up with the visiting hours and being present at meetings on a precise time was also seen as a cultural difference. Nurses' admitted that they quite often had perceptions about intercultural families' time management and keeping up with the appointed visiting hours. Feelings of frustration were reported by the nurses on occasions when they felt that even though they kept repeating details about visiting hours or giving instructions about the unit, they felt that families did not intake information, remember or pay attention to many of the things said.

Just yesterday we had parents coming in at noon. They didn't understand our visiting hours, even though they were told many times.

And we always assume that these parents can read or know the time. We might have these really strong perceptions about things, and then they don't always come true.

Nurses' brought up an occasion, where an instructor had come from an asylum seeker center with the father to visit his child. Nurses' found this to be very beneficial, as the father had support with him, and the instructor was able to help and advise the father during the visit as he was accustomed with Finnish hospital procedures. Nurses' thought that it would be very beneficial to do more cooperation with the asylum seekers' centers and get more information and cooperation between the two instances.

Family relations were also seen to have different meanings in different cultures. Some cultures had wider links; where relatives were close part of the core family and participated in the treatment of the child. Nurses brought up that in some cultures family-members and friends were all introduced as brothers, sisters or cousins and this caused uncertainty in nurses about confidentiality issues concerning child's health situation. In other cultures, parents had difficulties leaving their child in a hospital without a parent, as this was not their custom.

And then there's the uncles, and cousins and sisters. And I have no clue who's who. But they all seem to be really close.

Women's and mothers' position also raised discussion among the participants, as nurses' felt that quite often fathers and male relatives were the ones visiting a child and discussing with

the health care staff. They also mentioned that mothers' often had poorer language skills than fathers' and were not able to participate in the discussions.

...doctors' discuss with the fathers', quite seldom with the mothers. And in native Finnish families, the both parents always want to be present. Sometimes these things are quite hard to understand, they are so different from our culture and habits.

And we are so accustomed that mothers' come and see their new born babies, but then it's only the father and relative men who come and visit.

Nurses also felt sorrow and frustration in cases where they were not sure whether the parents understood the situation of the child.

I remember this one case; it wasn't life threatening but it left permanent damage to the child as it was born. And we had this relative man who was translating to the mother. I just thought that what did the mother understand about the future with that child.

It feels so bad, when you are caring for a really sick child, and you can't really help or even tell what the situation is [to the parents].

Participants' were also interested in learning more about different nursing cultures and nurses' position globally. Nurses' pointed out that parents might have sometimes difficulties with understanding Finnish health care services and customs if they were accustomed with different nursing culture. They thought that by knowing about different nursing cultures, it would be easier to communicate with parents and to understand the culture they came from.

...we have a lot of patients coming from different cultures, but then we also have families who come from totally different nursing culture.

When one mother was describing how nurses were caring for children in their own home country, I just thought that, wow, we are doing quite well in here. I think we do our work really well. Our nursing is quite progressive and it would be really nice to be able to show this also to the intercultural parents.

Nurses' were very proud of their own work and way of nursing in PICU. Nurses indicated that in PICU's nursing culture it was found very important that parents were encouraged to participate in the care of their child as much as possible. Parents' were also encouraged to touch their child and be present. Nurses' found it very important that parents were supported by them and that they were encouraged to build a relationship with their new born children already in hospital.

This one family had this thought from their own country that they are not allowed to touch their child, they had totally different way of nursing for the children. ... It was emotional how we were able to encourage the mother to touch her child and hold her baby for the first time ever here in Finland. We all cried when they left back to their home country.

Nurses' are gentle towards children, petting them and encouraging parents to participate. This is the way we want to care for the children in here.

Nurses were concerned about stigmatizing especially asylum seeker patients and their families, as they were required to stay in isolation rooms because of hospitalbacterias. Nurses felt that families did not often have any knowledge about Finnish screening procedures, and by giving them individual rooms made the families feel unequal. Even though nurses understood this procedure, they felt that it was also challenging to explain for the families.

It is challenging that we put them in the isolation rooms and nobody is allowed to sniff, because we don't know how many bacteria's they have. ... So we kind of stigmatize them with one more label.

5.4 Nurses' personal abilities and capabilities on intercultural communication in paediatric intensive care

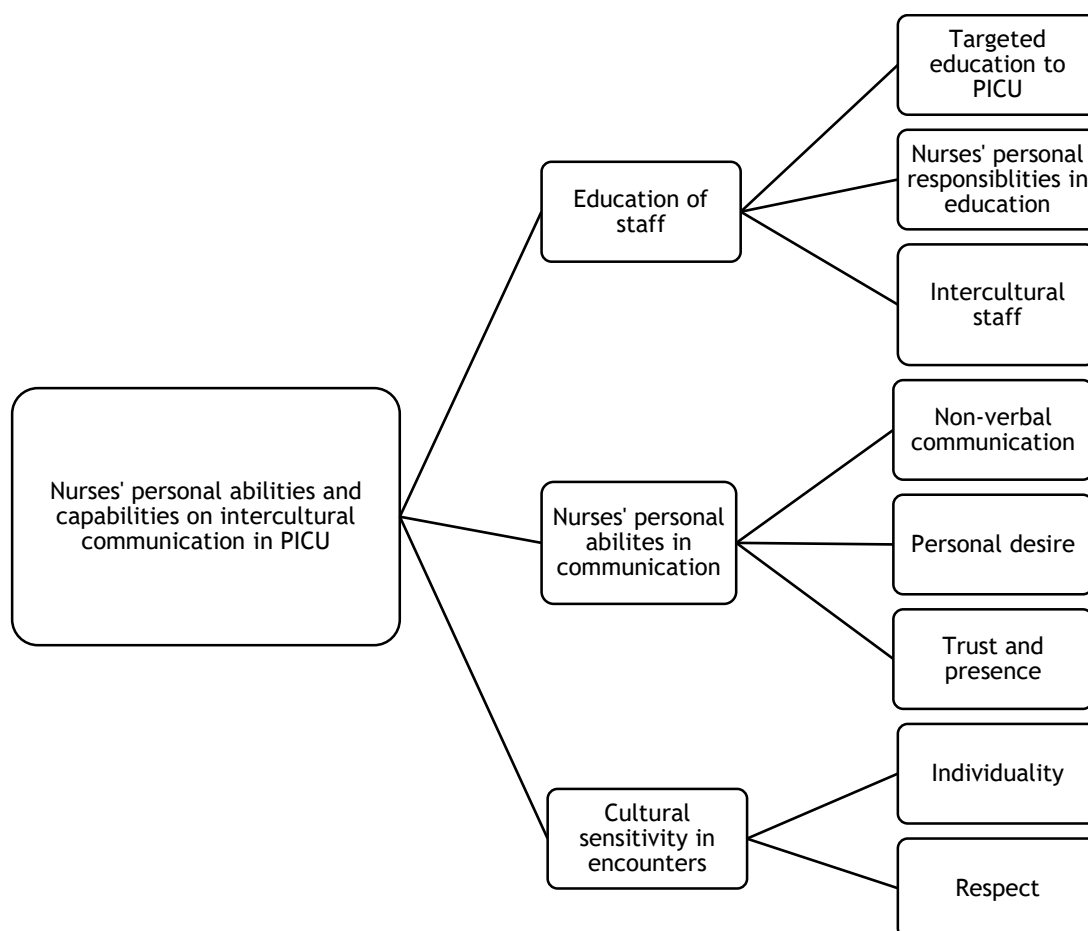


Figure 7: Synthesis of the main- and sub-categories in nurses' personal abilities and capabilities on intercultural communication in PICU

Nurses provided a lot of discussion on their personal and unit's abilities and capabilities towards intercultural communication in PICU. Nurses indicated to have abilities to be respectful, interested and empathic towards intercultural communication. The goal of wanting to provide quality health care services, culturally sensitive nursing and to decrease marginalization was evident. The participants discussed in the interview about culturally sensitive care rather than culturally competent care as it was not a familiar term to them. All the participants had a positive attitude towards communication and were highly interested on further education on the topic.

Participating nurses had a very positive opinions about education on intercultural issues, and were able to identify several educational needs in the field. Nurses' discussed vibrantly the importance of education, and how it was considered to be an important factor for successful communication. Also language skills were seen important and few of the participants were taking part in HUS's language studies to improve their language skills. The possibility of being able to participate in these studies during work hours, were highly appreciated and valued.

The need for education was highly requested, and the nurses brought up different detailed situations and needs that were seen especially important in the PICU environment. Nurses' requested for cultural ambassadors, who would teach about their own cultures. They saw that first-hand information was the best way to learn and hear about cultural habits, beliefs and values. Cultural knowledge was seen to be important to the nurses and they considered it to be a factor for successful interaction. By knowing basic details about cultures and habits were seen to improve nurses' understanding and help them further to support families.

...I would like to have more education on crisis situations and about interaction in these situations, because the feelings are so universal. ... and we would need further education in the PICU, because our situations are so different from others.

Also being better prepared and taking personal responsibility for own knowledge and education was mentioned. Interacting equally and by best personal abilities were seen to be personal responsibilities and pride of every single nurse. Education was not always seen to be only formal lectures or discussions, but also knowledge gained from colleagues was seen to be important. Nurses felt that by discussing with colleagues and bringing up difficult situations and issues helped them in coping with their stress. Collegial behaviour, debriefing and discussions with other colleagues helped the nurses in their own work and gave them new knowledge and support in their work.

We just need more time for discussion [among nurses]. This was so nice, as I just noticed, that actually, I have been doing okay in these situations. Even though I thought that I don't know anything about cultures or immigrant families. But actually, maybe I have done something right.

It starts with education, but then it's our own responsibility, like everything else in this work, to sustain our professional knowledge and find new information in these special occasions.

We need to bring up these deficiencies we have, and what we need, and then we should just discuss. Maybe our knowledge, skills and know-how will increase from there.

Intercultural staff was also seen to benefit the whole work community and help intercultural parents. Not having nurses with intercultural background in PICU at the moment was seen as lack of diversity, as nurses could learn from their colleagues.

It [intercultural nurses] would help so much, they could bring their knowledge in here and the whole work community would benefit from it.

In my previous work place with had this Somali nurse, and every time the parents saw her, their whole appearance changed as they saw that somebody with a scarf over her head was walking towards them. They were so happy that someone could talk to them.

Nurses were willing to use alternative methods in communication, if it helped in encounters with the families and did not see this as an additional task in their daily work. Nurses' also demanded quite a lot from themselves. They found it very important to be able to provide information due to their best abilities. And if not able to communicate in words or signs, presence in the situation and kind gestures were seen as important part of non-verbal communication.

Especially in acute situations nurses' indicated that creativity and their personal abilities in communication were important factors for successful interaction. In some occasions there was not enough time to call for interpreter and nurses' needed to figure out optional ways to communicate with the parents if there was no mutual language. One of the participating nurses had a summary of basic words in Somali to help communication.

One child needed a fistula and I tried to explain, but the family only knew few English and Finnish words, and I tried so hard to explain them. But then I started to draw fistulas, but they didn't really realize where they are going to be. But I tried my best, I draw a baby and fistula and even crafted from rubber glow a piece of bowel to show the parents.

Nurses' also mentioned that caring for children in the intensive care unit can also bring up the basic needs of the family in an emphasised way. Nurses also showed willingness to use their personal abilities to provide the best possible care and services for intercultural families.

I find it so important that we make an effort, just one or two words and a smile, it makes such a difference.

When a child is sick and in the PICU and possibly they are in a new country, then maybe even these basic things come more important for the family. In these cases, just a little bit more effort and support should be provided from us to the families.

Personal abilities and own interest in intercultural issues were seen to be an important skill and strength as PICU is caring for more and more intercultural patients and their families. Even though nurses thought that personal responsibility on knowledge, education and personal skills and abilities were important, they also acknowledged that they do not have the means to all challenges.

We can give means and bring up these important issues, like how to interact in a nursing situation, but we don't have one medicine that would fix everything. I think we should be very self-conscious in these situations.

Trust and presence were brought up by the nurses very strongly in the interview. In their opinion a good intercultural communication and interaction were based on trust and presence.

Being able to create a feeling of trust was seen as a skill, which demanded nurses to interact in an emphatic way. The meaning of trust was seen to be the most important feeling and thing that nurses' wanted to signal and communicate to the parents. Trust was described in various situations and in different contexts. The common thing in all these descriptions was that nurses' saw that only way of being able to create trust was to be present, even without a mutual language.

Maybe the most successful situation would be, if parents would feel that their child is safe here and we would treat the child with our best abilities. That somehow we would be able to show them, even though we don't have a mutual language, that we care and do our best for their child.

Another nurse described the building of trust as:

The goal should be to build a feeling of safety, and encounter these families as individuals, no matter where they come from.

Nurses also described the ways they tried to create the feeling of trust, if they did not have an interpreter present. They thought that the most meaningful ways were by looking and touching. Nurses' felt that they were not able or dared to touch the parents due to cultural

habits, but they could show they cared by touching a child with warmth and care. Eye contact and the look in their eyes were the other identified way, how to show your care and to build trust.

It's in your gestures, I think [empathy] is something that you can show in the way you touch and it's in a soft essence.

Eyes are the mirrors to your soul. It's something that can be seen in your eyes, that you care. I believe, that only with a look in your eye, you are able to transmit something to parents.

Another important skill, very close to trust was being present. By being present nurses felt that they were able to take part in parents' sorrow and support them in verbal or non-verbal way.

I think that my job is to nurse for a child in a best possible way; as well as I can and know, and hope to care it back to being healthy. But sometimes it's not possible and then my job is to care for the child and be present and let the child die in a most humane and respectful way as possible.

Presence was not only seen as being close to a child or being available if parents wanted something, it was seen more as being present in that moment. Being there without any hurry and just being close physically and mentally. Nurses' thought that care, safety and information in an understandable way were important parts of good communication and a lot due to their behaviour and presence.

Nurses discussed about cultural sensitivity and how it is needed in their way of working. Cultural sensitivity was seen to be a basis of respectful interaction.

We don't have all the means to change all cultural things, but I think that it's very important that we acknowledge it.

So we need to be culturally sensitive and not to assume that everybody always behaves in the same way.

Nurses pointed out that sometimes, they were even too discreet and did not ask or comment about parents' behaviours in fear of insulting them. The balance of cultural sensitivity and not asking in fear of being indiscreet was seen to be very fine and sometimes challenging. Answer to this challenge was seen to be treating every family with individual way and asking straight if any doubts. Nurses thought that honesty and asking straight if any concerns, were also respectful ways of working.

We keep talking about interculturality and religions, and it's very important. We need more knowledge about these issues, but we also need to remember

that even though a person is a Muslim, it doesn't mean that they all act the same way or have same habits or communicate in a certain manner.

Seeing the other person as an individual human is very important, I think it comes from small gestures and I think we have succeeded in something, if we have succeeded to interact with that person.

Even Finnish people have differences, it always depends on the family, about the person and where they are from. Even we have regional differences in here. ...In the same way intercultural families are different, and it's important that we just start discussing and ask.

Nurses attitudes towards intercultural communication were positive and they saw that they had many personal strengths to cope in these challenging situations. Participants were eager to participate in the research and were open and with a positive attitude discussing the topics given. Nurses' were willing to put out a lot of their own personalities and abilities to improve and help intercultural parents in their visits to PICU. Nurses' also saw that younger colleagues should be supported and helped in these situations and they wanted to show a good example in their own behaviour.

6 Discussion

This research topic was very current as cultural diversity has increased rapidly around Europe in the past few decades and the amount of immigrants in Finland has doubled in the 21th century. Prior to the study, the PICU nurses were expressing their feelings of lack of knowledge and education about intercultural communication and how to provide culturally sensitive and competent care. Children and their families were seen to be very vulnerable when an acute illness or need of intensive care occurs and good understanding of their individual needs, family-centeredness and understandable information were seen to be the key components for a successful and supportive patient-nurse relationship. By understanding different cultures, values and beliefs can the provided care meet the needs of individual patients and their families. Also by understanding nurses' experiences, perceptions and opinions can new skills and attitudes develop and interest rise on the topic.

6.1 Evaluation of the research methods

In a qualitative study the researcher is in the core of the study by choosing participants, theories, methods and presentation formats. Even though the data and analysis of the research are always a reflection of the participants' feelings, emotions and thoughts, the findings are a partial and filtered view of the topic which is researched. The results are a subjective production of its socio-political and historical time. (Puig, Koro-Ljungberg & Echevarria-Doan 2008, 140-142.) In this study, the researcher's previous knowledge of PICU might have affected the results of the study, even though as unbiased position as possible was taken and

the results re-evaluated several times. Evaluation of the data in qualitative research was interpretation of the researcher, even though the results did rise from the data obtained (Grove et al 2013, 280). By aiming to use valid methods, good scientific conducts and by reporting the process by best abilities, this research has aimed to be transparent and retraceable.

The process of this study began by creating and deepening pre-understanding of the topic by building the framework. Concepts, definitions and literature search are presented already in the beginning of the framework, to describe the process and to present the core contents. By doing this, the development of the thesis aims to become visible to the reader and support the structure of the process. On the contrary, it challenged the researcher's analysis process to stay inductive, as pre-understanding of the topics and their correlations were already formed. However, pre-understanding and framework gave a comprehensive knowledge base on the topic and abled own critical thinking and processing to begin. (Grove et al. 2013, 265-266.)

Focus group and theme interview were chosen as methods in this research to understand nurses' shared understandings and opinions on the matter (Bourgeault et al. 2010, 33). Focus group interview enabled participants to discuss, reflect and generate their experiences, opinions and ideas on the topic. Criticism can be pointed towards the participant selection and their good personal abilities, as they were all selected by the researcher, and partly because of their good communication skills and known interest on the topic.

The decision of using focus group and theme interview as methods in this study were the strengths and the challenges of the process. In the interview, group dynamics were very successful, participants active and the topic raised a lot of discussion in the group. Participants acted in the group as equal participants and discussion and interaction was respectful and encouraging. (Grove et al. 2013, 275.) Members of the focus group interview were called participants rather than interviewees in this report as the atmosphere of the focus group aimed be more discussion than interview like. However, questions were made to the participants to get the discussion started and the participants to relax and freely discuss. Theme interview was found a challenging method by the researcher, as it required a lot of emphases in the selection of participants and also the abilities of the researcher to support but not to rule the discussion and interview situation. (Grove et al. 2013, 272.)

Concideration has been made, concerning that the researcher was part of the work community and how it has possibly affected the dynamics of the interview and the results (Grove et al, 2013, 280). As being the researcher/facilitator, as neutral position as possible was taken and minimal participation in the discussion was obtained. Focus group interview was seen to

be the best method, by the researcher, for this study as it enabled the nurses' to discuss and generate new ideas, but it also required minimum active participation from the researcher. Researcher was able to take a position in the back and observe and record the discussion and only if needed to guide the discussion to wanted themes.

Content analysis as an analysing method proved to be quite demanding. There were several strengths and limitations in the analysing process. Strengths were the flexibility and ability to produce new information from the data by using content analysis. Content analysis was also extremely well-suited for analysing sensitive and multifaceted phenomenon such as intercultural communication in PICU (Elo & Kyngäs 2007, 113). Challenges in categorization and interpretation of the results caused some challenges in the analysis process. The process of analysing did not move in a linear fashion (Elo & Kyngäs 2007, 113) and the researcher was forced to go back several times to the data before finalizing the categories. There were not standardized or simplified guidelines for the process either (Elo & Kyngäs 2007, 113) and lot was put on the personal skills of the researcher. Also in the analysis process information was gathered from both content and theme analysing methods, as both seemed to be equivalent for the research analysis. During the process, content analysis approved to be more appropriate method, and it was chosen.

6.2 Evaluation of the results

Nursing paradigm contains components of health, humans, nursing and environment (Eriksson et al. 2011,16). In this study, nursing paradigm was discussed from the view of intercultural communication. In addition, on being a very essential topic in nursing this study also required comprehensive approach to the knowledge available in nursing, social sciences and communication studies. By building the framework beforehand key components and concepts were identified and understanding on the topic deepen. By understanding the phenomenon, argumentation skills were able to develop and discussion between results and framework begin.

6.2.1 Nurses' experiences on intercultural communication

This study concentrated on nurses' experiences and perceptions on intercultural communication. The participants were able to produce vibrant discussion and bring up new views on the topic. The participating nurses had very similar experiences on intercultural communication, even though they had different personal backgrounds and professional careers.

Acute environment was seen by the participating nurses to have a meaningful effect in communication. Parents' fear and confusement affected their ability to in-take and understand the information given. However, by encouraging parents to participate as much as possible in the child's care, an important part of PICU's nursing culture and also part of family-centered

care were fulfilled. Intensive care units, which are high-acuity, high-stress health care environments the meaning of good communication and family-centered care are emphasised (Flowers 2008, 48). In nurses' experience also the first contact between the health care staff and families were highly important, as trust and communication started in the first encounter. Nurses also wanted to highlight the importance of their own behaviour and kind gestures towards the families, especially in the first moments of crisis. Similar results have been found in Söderström's, Saveman's and Benzein's (2006) study.

One of the fundamental observations made by the participants was the one-sided communication with the intercultural families. They described the discussions to be very fact orientated and feelings and emotions of the parents were not emphasised in the communication. Even though, they sometimes asked the parents to elaborate their feelings, not a wide response was usually gained. However, nurses also pointed out that they did not offer support services to intercultural families as often as to native Finnish families.

Nurses indicated that language studies, which were possible to attend at work time, were highly appreciated. These studies were seen to improve their personal skills, help in daily work and motivate to learn something new. Brach and Fraserirector (2005, 185-186) discuss training, language and culture, to have a remarkable effect on improving culturally competent care. They suggest training to be divided into individual parts, including elements such as language, use of interpreters and cultural knowledge on specific minor groups. Nurses also brought up the need for intercultural staff, which would help in the daily communication with the families as well as bring new cultural knowledge to the work community. Intercultural staff was clearly seen as an asset for the whole unit, and nurses hoped to have more diversity in the nursing staff. Similar results have been found in many previous studies concerning intercultural communication and recommendations (Betancourt 2002, 5,8; Cioffi 2003, 305).

Cultural differences have been raised in previous studies as well as in this one (Meeuwesen & Schouten 2006, 22-26). One of the most visible cultural differences in PICU appointed out by the nurses, was the absence of mothers and the communication mainly happening with the fathers of the children. Nurses described this to be a significant difference in comparison to Finnish families and in communication with the parents. Nurses saw family relations to be very close in intercultural families, and discussed how the concept of core family was wider in intercultural families. This was seen as a value for the family, to have a lot of support from relatives and friends. Azoulay et al. (2005, 187) brought up in their guidelines for improving culturally competent care, that family relations are culturally bound and should be noticed by the health care professionals. By including family/community members in the decision making, an important factor of culturally competent care and in providing the best care for the child can be obtained.

Nurses were very interested about other nursing cultures and how the learned habits and customs from these cultures affect communication in PICU. As one of the nurses described, the nursing culture in PICU is very caring, and affection is shown to children by the nurses. Nurses' brought up, that in PICU's nursing, nurses' are present with the children all day long, in comparison to many other nursing cultures, where for instance mothers' take care of the child's basic care and cleanness.

6.2.2 Challenges and strenghts in intercultural communication

Even though, nurses' thought that challenges were easier to identify in their communication than strengths, they noticed after an hour's interview that they had a lot of strengths and more skills and tools than they even realized. This was seen as a very positive notice. Nurses pointed out that strengths might not always be easy to identify, but one might still have a lot of knowledge and skills. Attitude towards learning more was also high, as nurses thought that life-long learning was a crucial part of their professional life.

The three main themes that rose from the analysis that seem to cause the most challenge to intercultural communication were; PICU's characters' effects on communication, linguistic challenges and cultural differences. The strengths that the nurses identified were; possibility to language studies during work hours, the possibility to be present for the families and treating them in a family-centered, individual manner and nurses own personal abilities and capabilities.

Nurses' brought up the unique character of PICU; being an acute care setting with rapidly changing situations. This setting was seen by the nurses to cause fear and confusement in the intercultural parents and to challenge communication. Similar findings were found in the research of Azoulay et al. (2005, 981-991) concerning families risk of post-traumatic stress reactions in PICU/NICU/ICU. Nurses elaborated that in acute care setting, lack of time caused stress and due to it they did not always have enough time to call for interpreters. In addition, to fear and crisis that families faced when a child was admitted to an intensive care unit, universal feelings were brought up by the nurses. They discussed how, especially in acute situation cultural values and beliefs went beyond culture in a moment of crisis and fundamental emotions; fear and stress reactions came to surface. Family-centered care can and should be implemented in daily nursing work in PICU, as it has been proved to reduce stress of the families and to improve satisfaction in communication and health care services (Arango 2011, 97-98; Azoulay et al. 2005, 980-981). In addition, by including parents in the care of the child, the guidelines and instructions from ETENE's (2004) Multiculturalism in Finnish Health Care and WHO's (2016) Quality of Care guidelines are implemented.

Linguistic challenges were raised as a challenge for interaction in this study as in the many previous studies made in the field (Hoye & Severinsson 2008, 338; Cioffi 2003, 299; Schouten & Meeuwesen 2006, 22-26). Lack of mutual language has been seen to diminish communication and affect satisfaction in treatment (Schouten & Meeuwesen 2006, 26). In this study nurses' also brought up linguistic challenges and the use of interpreters as one of the major obstacles in communication. Nurses brought up repeatedly, how they tried to make an effort in communication, no matter what strategy they were using; from signing to the use of interpreters.

Nurses' brought up the need for interpreters in daily basis, but were also very conscious about spending money for only on their needs. Even though they saw their work and support for the families crucial in order to build up a successful relationship, they rather used alternative solutions to communicate than used interpreters only for their benefit. Nurses did not indicate that they were feeling lack of appreciation or value at PICU, but rather were very conscious about spending money. Using alternative solutions and methods in communication were seen as a part of their daily work, and none of the participants mentioned it as an additional task to daily regimen. Coming up with these alternative communication methods can put quite a lot of emphasis and pressure on nurses' personal skills and abilities. Previous studies made in the field show that this can also be a stress factor to some of the nurses (Hoye & Severinsson 2008, 346). Even though nurses spent excess time in communication with intercultural families, when trying to come up with alternative communication methods, they did not raise a question of additional time or workload spent on these situations. Similar results were found in Cioffi's study (2003, 305).

One of strengths that the nurses identified in their intercultural communication skills was the importance of creating trust and being present for the families. Nurses pointed out strongly that by providing a safe and trustworthy environment for the families, intercultural communication was able to happen and improve. Improving communication was also seen to improve satisfaction of the care given by the nurses. This conclusion supports the result of Sainola-Rodriguez (2009, 128) who concluded that common goal between intercultural patients/families and health care staff are important to satisfaction of the care. The participating nurses were satisfied with their own possibilities of treating families with individual and family-centered approach.

Individuality and family-centered care were seen important factors of culturally competent care. By seeing patients and families beyond their ethnic background was seen by the nurse's as an important part of respectful and culturally sensitive nursing. Nurses discussed that by showing true interest and respect on cultural issues, successful communication was able to

appear. Even though, nurses had knowledge on certain cultural habits and beliefs, they encouraged to discuss with the families on their personal preferences. Nurses saw that this did not challenge culturally competent care, rather give more value to it. Previous study by Williamson & Harrison (2010, 761) also discuss and verify the participant's views on the issue.

6.2.3 Nurses' intercultural communication competences

Nurses' personal abilities and their effort in intercultural communication in PICU showed great commitment and desire to improve personal skills as well as the care of the intercultural families. All of the participants had a positive outlook towards communication, although they all felt that more education on the issue was needed.

By adjusting Spencer-Oatey's and Franklin's (2009) components on intercultural communication to the personal abilities of the nurses, high equivalences were found (Appendix 4). The participating nurses in this study were able to discuss critically on their own knowledge levels on intercultural communication and were able to verify their needs on education. All the participants showed skills according to Spencer-Oatey's and Franklin's definition, by having genuine interest, active listening skills and linguistic accommodation. Attitude towards intercultural communication was positive and all the participants had an interest in improving their personal knowledge and skills on the topic. Nurses also brought up that by increasing knowledge levels in the unit, better services can be given to intercultural families, and that services can be better focused on their needs. This also supports the findings of Brach and Fraserirector (2000, 200).

When discussing nurses' cultural competences based on Campinha-Bacote's (1999, 205-206; 2002, 183) model Cultural Competence in the Delivery of Health Care Services, many aspects of the competences were found in the behaviour and habits of the nurses. All the participants showed desire and willingness to make an effort in improving their personal skills. They had desire to decrease marginalization of the families and improve their sensations of equal and quality care. They showed knowledge on cultural issues and how to apply their knowledge into PICU's nursing culture. Nurses indicated their willingness to provide culturally competent care, and to act in a sensitive and respectful manner towards cultural differences.

Improving intercultural communication competences require knowledge, skills and interest in the subject, and not all will ever gain the highest abilities/knowledge on the topic or have the interest to improve their personal abilities. And on the other hand, intercultural communication competences can be different things for different people, so this should also be acknowledged. Nursing staff should be encouraged to improve personal skills and knowledge by training, being interested and taking part in intercultural communication. As Campinha-Bacotte (2002) mentions, the desire to improve personal skills is the most important part of

the learning process. Also nurses should be encouraged to critical thinking of their personal knowledge, skills and attitudes to learn and improve personal abilities.

In Figure 8, the synthesis of the model applied to the results from the focus group interview are presented. Even though the participants showed a lot of competences in the focus group interview towards intercultural communication and their own personal abilities, development in the process is on-going. Campinha-Bacote (2002) states that cultural competences are an evolving procedure, which requires constant assessment and improvement in the skills gained.

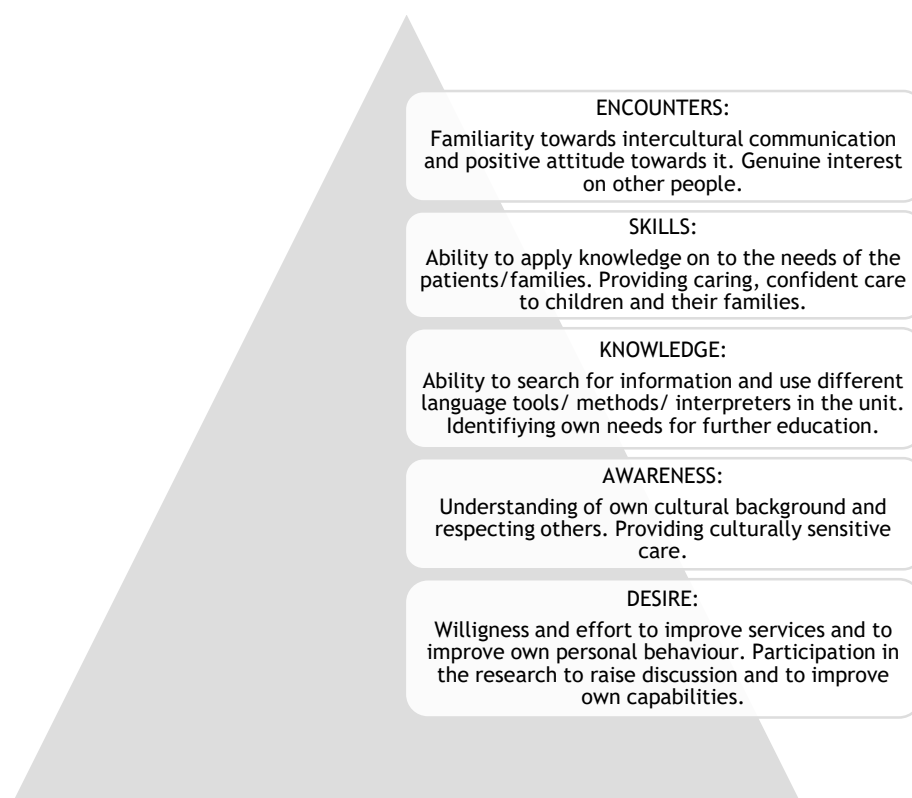


Figure 8: Synthesis of the nurse's cultural competences applied into Campinha-Bacote's (1999, 2002) model Cultural Competences in Delivery of Health Care Services

Even though, the positive attitude that the participants had towards intercultural communication, also feelings of frustration were reported. Nurses felt that in certain occasions, they were not able to produce the best care they wanted or were not able to express themselves properly. Feelings of frustration were reported to be towards their own lack of insufficiency rather than the fault of the families. Similar results have been reported in the study of Cioffi (2003, 305).

6.3 Conclusions from the results

As a conclusion, research questions were met in this study. Nurses produced lively descriptions of their experiences and were able to identify their own strengths and challenges in intercultural communication. They indicated a desire to work in a culturally sensitive manner to decrease marginalization of the families and improve their sensations of equal and quality care.

Four (4) themes rose from the analysis. PICU's character's effects on communication, linguistic challenges, cultural differences between health care staff and families as well as nurses' personal abilities and capabilities on intercultural communication in PICU. These themes describe the phenomenon from different aspects, building a comprehensive description of the topic.

Linguistic challenges has been identified as one of the most common intercultural communication challenges. Also in this study, lack of mutual language caused challenges in interaction. However, nurses showed desire and willingness to communicate in alternative methods when needed. PICU's nursing culture aimed to support family-centered care and to take into account every families own preferences. Despite of cultural differences, respect for individual needs and culturally competent care were aimed for.

The results of the study indicate that good intercultural communication and interaction were based on nurse's personal abilities and their presence in the moment. If not able to communicate in words or signs, presence in the situation, eye-contact and kind gestures were seen as important part of non-verbal communication. More education should be focused on interpreter services and in the use of different communication tools.

This study also indicates, in addition to previous studies made in the field, that one-sided communication and nurses personal abilities and capabilities had a significant effect in intercultural interactions. These new aspects to communication indicate that special effort must be focused on interaction and emotional support of the intercultural families as well as educating nurses in personal level to improve their skills. Also the use of support services should become more accustomed with the intercultural families.

6.4 Credibility, transferability, dependability and confirmability

In qualitative research the outcomes of the study have usually been evaluated by validity and reliability. Tuomi and Sarajärvi (2002, 133) criticize the use of these measures in qualitative research, as they are more adaptable to quantitative research. Instead Tuomi and Sarajärvi (2002,134) advise the researcher to discuss and evaluate how well they managed to stay in

the study subject, how did they succeed as researchers, how did the gathering of the data go, how did the choosing of the participants go, how is the reliability of the study and how clear and consistent is the reporting of the research. Lincoln and Guba (1985) presented a theory where the evaluation of the research is measured by credibility, transferability, dependability and confirmability. Lincoln and Guba claim that there is no one social construction, but different constructions that build their own realities. As evaluation of the process can be challenging, coherence should be maintained throughout the process.

Qualitative research based on interviews or narratives require co-operation between researcher and the participants. Graneheim and Lundman (2003, 106-110) reviewed literature on trustworthiness of content analysis using Lincoln's and Guba's interpretation of the evaluation. They claim that every qualitative research should be evaluated on its trustworthiness in relation to its process and ability to generate new findings.

By using the theory of Lincoln and Guba (1985) credibility is first discussed in this research. By choosing scientific, validated studies and a multidisciplinary approach to the topic the framework has aimed to be a comprehensive description of the topic. Emphasis on gaining credibility has been focused on the process throughout; in the selection of the studies in the framework, on methodology and selecting the best possible participants in the focus group interview. According to Graneheim and Lundman (2003, 107) this was the first step in gaining credibility in research. The process has aimed to be as transparent as possible and the goal has been to provide evidence-based, new information concerning intercultural communication in PICU.

Methods chosen have supported the goals and aims of the study (Graneheim & Lundman 2003, 109). Data collection and analysing process have been presented and illustrated to provide a clear picture of the process. The results from the data combined with the theoretical framework have aimed to build a comprehensive study and given an opportunity to discuss the issue further. (Graneheim & Lundman 2003, 110.) Open-discussion and transparency have also been an important part of credibility, as they are important parts of good research processes (TENK 2012; Kankkunen & Vehviläinen-Julkunen 2013, 28). Work and supervision has happened in groups and private meetings with the supervisors. A high input has been put in the framework, referencing and adequate use of sources.

Transferability in this research has aimed to be adequate by reporting on selection of participants, data collection and analysis with appropriate quotations from the focus group interview (Graneheim & Lundman 2003, 111). According to Graneman's and Lundman's (2003, 108) instructions, descriptions of the concepts and their definitions have been given accurately to define the research context.

Paediatric intensive care unit K9 can be seen as an individual unit, with its own character, culture and nursing staff. This research has encountered the unit's intercultural communication challenges from nurses' perspective and provides suggestions to improve the services for intercultural families. Even though, this research was made to this specific unit, the goal of this research was to provide information, in addition to this unit, to also other children's wards and similar units across Finland. In national level, Finland has few paediatric intensive and high-dependency care units, where the results from this study might be quite easily benefitted. (Graneheim & Lundman 2003, 110.)

The issues of dependability have been insured by aiming to use approved and well-known methods. A high input has been put on the methodology and the best suited methods were chosen. Various methodology literature sources were used (Grove et al. 2013, Silverman 2005, Stewart & Shamdasani 2015, Kankkunen & Vehviläinen-Julkunen 2013, Elo & Kyngäs 2007 and Tuomi & Sarajärvi 2002) to support the methodological choices and to provide a comprehensive approach from different literature. Finnish authors provided, in comparison to the American authors, more insight on the methodology of qualitative research and the analyzing process. This research process aims to be repeatable with the data and information provided in the method section. More knowledge on methodology would have been required to do more precise research. Acting as a facilitator for the first time in a focus group interview, caused feelings of inexperience, but on the other hand gave a good glimpse of the method. Development in personal skills have also increased during this process.

Confirmability was aimed to be strengthened by doing a pilot group interview and by using one of the nurses as a key informant in the data analysis. As all the participants had a native Finnish backgrounds, the diversity of participants was not optimal in the study. The lack of diversity caused the view of the nurses to be unilateral. If the research would be rearranged with more cultural diversity, more vibrant and different views might rise. However, it must be remembered that in qualitative research the choice of the participants will always affect on the results. Confirmability has also been increased in this study by discussing the framework and results of the study (Elo & Kyngäs 2007, 113). Many of the results gained in this research are very similar to the previous studies made in the field. This research brought up in addition to the knowledge already existing, also one-sided communication and nurses' personal abilities and capabilities and its effects on communication from nurses' view.

6.5 Ethical consideration

In this research the guidelines of Responsible Conduct of Research (2012) by Finnish Advisory Board on Research Integrity were followed by best abilities. Integrity, meticulousness and accuracy have been followed in all steps of the process; recording, presenting and evaluating

the research. Research permit was acquired from HUS-organization to research the topic (Kankkunen & Vehviläinen-Julkunen 2013, 222 & TENK 2012).

Ethical consideration was taken account throughout the process, and especially as humans' were used as informants (Leino-Kilpi & Välimäki 2004, 285). In this research ethical discussions were made during the whole process. Informants chosen to the focus group interview were all voluntary participants and they were told before the interview the purpose of this research. They also got a written participation letter and consent form before the interview. Participants were encouraged to ask if they had any questions before and during the focus group interview. (Kankkunen & Vehviläinen-Julkunen 2013, 218-219.)

World Health Organization states that in research, among many other ethical considerations; risks and possible benefits, selection of study population and protection of research participants' privacy should be considered before the research procedure. (Standards and Operational Guidance for Ethics Review of Health-Related Research with Human Participants 2011, 28.) During the process of this research, the up-coming interview and research was not discussed at the work place. Participants of the interview were all asked to join individually and nobody else in the unit was told about the participants and up-coming interview. This was to protect the identity of the participants. (Kankkunen & Vehviläinen-Julkunen 2013, 221.) As only five (5) nurses joined the focus group interview, identification was considered to be quite easy by showing age details in the quotations, so this was also left out in the report. It was not seen to give any added value to the research.

After the interview and writing the text into paper all audio sound was deleted. The written transcript is in the possession of the researcher and another copy was given to the supervisor in Laurea University of Applied Sciences. Paper transcripts are kept in safe and are unattainable by other people. Transcript does not have any indications what could lead to identifying the participants. (Kankkunen & Vehviläinen-Julkunen 2013, 226.)

In research ethics the focus should be in making reliable and ethically good research (Leino-Kilpi & Välimäki 2004, 285). In this research all results were analysed by the best abilities of the researcher and nothing was left out from the process (TENK 2012). Also the results are being distributed as widely as possible to benefit from them. This research was very practical with a clear goal to investigate nurses' intercultural communication competences and improve services for intercultural families.

6.6 Recommendations

This study contained only a small part of intercultural communication in PICU from nurses' perspective. More knowledge and research would be required in this sensitive and important

subject to understand and improve services for intercultural families. By improving nurses' intercultural communication competences in PICU the quality of the care and services can be improved. More research on nurses' intercultural competences would be beneficial to have in different wards, so that specific education could be provided in the work context. Also other perspectives; families', patients' and health care staffs' interaction development during the past few decades would be beneficial to investigate to see the changes in health care at this section.

To improve nurses' intercultural communication competences in PICU, few changes and improvements are recommended. More education would be beneficial for the staff on cultural awareness, culturally competent care and different nursing cultures. This can be seen to have a positive effect in knowledge, skills and attitudes. Migrant Health and Wellbeing Survey (2014) indicated that migrants' feel that Finnish health care staff have insufficient knowledge about migrants and their culture and specific needs. National Health and Welfare Institute suggested on basis of the survey that education for staff and better accessibility for interpreters should be provided. More education and information should also be given to nurses about the interpreter services and linguistic tools to help in the daily communication. By increasing education can nurses' stress levels towards intercultural communication also decrease (Hoye & Severinsson 2008, 346; Sainola-Rodrigues 2009, 131). Positive and open atmosphere in PICU concerning intercultural issues should also be thrived for. Increasing discussion and sharing successful interaction moments can also help the work community to increase their knowledge levels and attitudes towards intercultural encounters.

At management level, more input should be focused in recruiting intercultural staff and in improving cultural awareness and acceptance at PICU. Also more support should be given to nursing staff on intercultural issues and the possibility of further education should be made available for all staff. Developing new strategies and services for intercultural families and family-centered care should be made a priority before moving to the New Children's Hospital in 2018.

Intercultural communication should be embraced in every day's work and it should not be an independent component of nursing. The goal and responsibility of every nurse should be to improve personal intercultural communication competences and to deliver family-centered, culturally competent and ethically appropriate care for intercultural patients and their families.

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Appendix 1: Participation letter and consent form

10.6.2016

Laurea-ammattikorkeakoulu

Opinnäytetyön ryhmähaastatteluun osallistuminen

Perhekeskeinen hoitotyö on yksi lasten teho-osaston (K9) perusarvoista. Monikulttuurisuuden lisääntyessä on noussut tarve kartoittaa sairaanhoitajien monikulttuurisen kohtaamisen taitoja perhekeskeisen hoitotyön tukemiseksi. Opinnäytetyön tarkoitus on selvittää teorian ja ryhmähaastattelun avulla K9:n sairaanhoitajien osaamista ja asenteita monikulttuurisissa kohtaamisissa hoitotyössä.

Ryhmähaastatteluun osallistuu kuusi (6) lasten teho-osaston sairaanhoitajaa. Osallistuminen opinnäytetyön ryhmähaastatteluun on täysin vapaaehtoista. Haastattelu tullaan toteuttamaan elokuussa 2016, aika tarkentuu myöhemmin. Haastattelu kuuluu työaikaan, ja se tulisi suunnitella työvuoron alkuun/loppuun. Haastatteluun on varattu aikaa kaksi (2) tuntia. Tarvittaessa voidaan toinen, ajallisesti lyhempi ryhmähaastattelu toteuttaa, mikäli aineistosta nousee tarvetta tarkennuksille. Ryhmähaastattelussa tulee olemaan suomeksi, mutta valmis aineisto käännettään englanniksi. Opinnäytetyön tulokset tullaan esittelemään osaston opintopäivillä ja opinnäytetyö tallentamaan osaston ja HUS:n tietokantoihin.

Tarvittaessa vastaan mielelläni kysymyksiin,

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Global development and management in health care

Laurea, YAMK

Suostumus opinnäytetyön ryhmähaastatteluun

Nimi ja päivämäärä

Appendix 2: Researches selected to the framework concerning nurses' intercultural communication competences, family-centered and culturally competent care

Author(s), Year, Country	Name of the research	Aim and goal of the study	Data analysis method	Main results
Arango, 2011, USA	Family-centered care	To define and conceptualize family-centered care and its benefits	Literature review	Family-centered care improves satisfaction in the care, improves communication and affects positively on health care services.
Arasaratnam & Doerfel, 2005, USA	Intercultural communication competence: Identifying key components from multicultural perspectives	To review past researches in ICC from different theoretical backgrounds.	Face-to-face interviews with participants from 15 different countries. Semantic network analysis	A definition of ICC was derived from the responses and important components of ICC were identified.
Azoulay et al. 2005, USA	Risk of Post-traumatic Stress Symptoms in Family Members of Intensive Care Unit Patients	To identify PTSD factors in family members of ICU patients.	Phone interview, N=284 family members	Family members of ICU have high risk of PTSD and especially in the end-of-life decision making.
Betancourt et al., 2002, USA	Cultural competence in health care: Emerging frameworks and practical approaches	To evaluate current definitions of cultural competence and identify benefits for healthcare. Identify models of CCC and determine key components.	Literature review and interviews, n=37	CCC can be divided into 3 levels; organizational, systemic and clinical cultural competences.
Betancourt et al., 2003, USA	Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care	To reduce racial/ethnic disparities by improving culturally competent care.	Literature review	Demographic changes in population need improvement of culturally competent care.
Brach & Frasier, 2000, USA	Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model	To develop and define a model to reduce racial and ethnic health disparities.	Literature review	A nine step model was introduced and discussed its affects on cultural competences.
Byczkowski et al., 2015, USA	Family-centered pediatric emergency care: A framework for	To identify and describe dimensions of family centered care	Qualitative study, n= 68, focus group interviews,	A framework of 8 dimensions was built to deliver family-centered

	measuring what parents want and value	important to parents in pediatric emergency care.	data analysis was a iterative multi-step process	pediatric emergency care.
Campinha-Bacote, 2002, USA	The process of cultural competence in the delivery of health care services: A model of care	Present the model of cultural competences.	Model	Cultural awareness, knowledge, skills, encounters and desire form cultural competences.
Campinha-Bacote, 1999, USA	A model and instrument for addressing cultural competence in health care	Present the model of cultural competence	Model	Cultural awareness, knowledge, skills, encounters and desire form cultural competences.
Chen & Starosta, 2000, USA	The development and validation of intercultural sensitivity scale	To develop and assess reliability and validity of ISS.	Literature review	Interaction attentiveness, impression rewarding, self-esteem, self-monitoring, perspective taking, intercultural effectiveness and intercultural communication attitude were found important parts of ISS.
Cioffi, 2002, Australia	Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences	To describe nurses' experiences of communicating with CLD patients and their families in acute care setting.	Interviews, n= 23, interpretive-descriptive design in data analysis	Interpreters, bilingual health workers and different tools were used to communicate with CLD's. Empathy, respect and willingness to make an effort in communication and ethnocentric orientation was common for the nurses.
El-Amouri & O'Neill, 2011, United Arab Emirates and Australia	Supporting cross-cultural communication and culturally competent care in linguistically and culturally diverse hospital settings of UAE	To identify the strategies in use to effectively communicate and to provide CCC.	Open-ended questionnaires, n=153, thematic analysis	Nurses' had variety of strategies to support cross-cultural communication, but thought that more communication support and professional development possibilities were needed.
Flowers, 2004, USA	Culturally competent nursing care: A challenge for the 21 st century	To discuss and identify culturally competent care and nursing.	Literature review	Several tools and models can be used to describe and improve CCC.

Foster et al., 2016, New Zealand and Australia	The parents' hospitalized child's and health care providers' perceptions and experiences of family-centered care with in pediatric critical care settings: A synthesis of quantitative research	To improve FCC and to optimize the best outcome for the child, family and institution.	A systematic appraisal between years 1998-2014, n= 59, literature review	Review highlighted that communication tailored to meet the parents' and child's needs is the key facilitating FCC and positive health outcomes.
Frivold et al., 2015, Norway	Family members' experiences of being cared for by nurses and physicians in Norwegian intensive care units: A phenomenological study	To describe how family members feel like taken care of by the health care staff in Norwegian ICUs.	Interview, n= 13	Two main themes were found: being in a receiving and being in a participating role. Family members who had a feeling of participating were more satisfied in the care given.
Guerrero et al., 2010, USA	Racial and ethnic disparities in pediatric experiences of family-centered care	To compare racial and ethnic disparities between family-centered care and children.	Linked data from National health survey were used (2003-2006)	Black and white children had similar experiences from family-centered care.
Hoye & Severinsson, 2008, Norway	Intensive care nurses' encounters with multicultural families in Norway: An exploratory study	To explore nurses' perceptions of their encounters with multicultural families in ICU's.	Focus group interviews, n= 16, interpretive content analysis	Nurses' challenges were mainly due to linguistic, cultural and ethnic differences.
Meeuwesen et al., 2009, International study	Can dimensions of national culture predict cross-national differences in medical communication?	To investigate at country level how cross-national differences in medical communication can be understood using Hofstede's cultural dimensions.	Medical communications were videotaped, n=307 general practitioners and n=5820 patients, Roter's interaction analysis system	Countries differ considerably from each other in terms of cultural dimensions. By understanding these differences, medical miscommunication be reduced.
Nicholas et al., 2014, USA	Connection versus disconnection; Examining culturally competent care in the neonatal intensive care unit	To identify the perceived care-related experiences of newly immigrated parents whose child was treated in NICU as well as	Focus group interviews, n=58, thematic analysis	Results identified core process of connection and disconnection. This had a substantial bearing on NICU experience and interaction.

		health care providers perceptions.		
Perry & Southwell, 2011, Australia	Developing intercultural understanding and skills: models and approaches	To provide an overview of current theories and empirical findings, as well as gaps in the literature.	Literature review	Conceptualizing, developing and assessing intercultural competences continue to be topical.
Saha et al., 2008, USA	Patient centeredness, cultural competence and healthcare quality	To explore the history of cultural competence and patient centeredness from interpersonal and conceptual model levels.	Literature review	Cultural competence and patient centeredness both have features that aim for the same goal; improving quality of healthcare for individual patients, communities and populations.
Sainola-Rodriguez 2009, Finland	Transnationaalinen osaaminen: Uusi terveydenhuotohenkilöstön osaamisvaatimus	To describe transnational knowledge and competences of Finnish health care staff.	Interviews	Asylum seekers had more psychiatric problems than other immigrants. Cultural competences should be developed to improve services for immigrants.
Schouten & Meeuwesen, 2006, Netherlands	Cultural differences in medical communication: a review of literature	To investigate more details about cited barriers between patients and health care staff.	Literature review	Five-key predictors for miscommunication were identified from the literature review.
Söderström et al. 2004, Sweden	Interactions between family members and staff in intensive care units- An observation and interview study	To describe and interpret interactions between family members and staff in ICU's.	Interviews, n= 24	Family members who understood the messages from the staff, adjusted well in the system and were consoled by the staff.
Truong et al., 2014, USA	Interventions to improve cultural competency in healthcare: a systematic review of reviews	To gather and synthesize existing reviews to guide future interventions and research in the area.	Systematic review of reviews between 2000-2012, n=19 studies, thematic analysis	Interventions to improve cultural competency can improve patient/client health outcomes.
Williamson & Harrison, 2010, USA	Providing culturally appropriate care: a literature review	To explore concept of culture and incorporate recommendations	Systematic review	Two main approaches to culture apply: the first focuses on cognitive aspects and the

		tions to cultur-ally appropriate care.		second one incor-porates culture into a wider struc-tural framework.
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Appendix 3: Examples of the nurses quotations applied into the model of intercultural communication competences according to Spencer-Oatey and Franklin (2009)

COMPONENT	EXAMPLE	QUOTATIONS THAT INDICATES THE COMPONENTS
Knowledge	Knowledge about values, norms, behaviours	<p>“Touching would be so easy way to indicate that you care, but in some cultures its just not possible.” Nurse 2</p> <p>“We all have our own responsibility about our personal education” Nurse 1</p> <p>“We need more intercultural staff to improve our cultural diversity” Nurse 3</p> <p>“We have to also realise that people might have compiltely different view on child mortality than we do. For example if you come from a country that has a high child mortality rate.” Nurse 4</p>
Skills	Active listening, linguistic accommodation, managing relationships, showing emotional interest	<p>“These language courses that we are able to take are so beneficial and help us in the daily work.” Nurse 3</p> <p>“Everyone of us makes this job with their own personality” Nurse 1</p> <p>“You need to have a lot of creativity and willingness to come up with alternative communication methods” Nurse 1</p> <p>“We must put effort in communication, come up with hand-signals or something.” Nurse 5</p> <p>“A successful interaction is when you have been able to show to the family that you care.” Nurse 2</p>
Attitude	See others from different perspectives	<p>“I find it so important that we make an effort, just one or two words and a smile, it makes such a difference.” Nurse 2</p> <p>“Seeing the other person as an individual person is very important.” Nurse 3</p>