Daniella Olubode

Multicultural competence in Nursing:Experience of Patients and Families.

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Abstract

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Multicultural or Transcultural nursing is globally an important aspect of nursing today. it is very important for all healthcare providers to be aware of the existence of cultural differences and appreciate the differences of multiple and various differentiations in healthcare values, beliefs and customs. This knowledge helps in providing a holistic care to the patients. This final project was a part of the LOG-Sote a large research project that focuses on the health issues of ethnic minorities.

The purpose of this final project study was to describe patients and families experiences of healthcare services received in multicultural environment.
Eight research articles were used for the literature review. The data were collected systematically from OVID, CINAHL AND PUBMED. The articles found described the patients and family members' experiences in different healthcare environment.

Two categories and subcategories were found in the patients' and families' experiences. Stress and culture; they are faced with overwhelming stress such as fear about uncertain outcomes of illness, lack of communication and information, changes in roles and responsibility, vulnerability, emotional turmoil and financial concerns, disappointments from the healthcare setting and societal discrimination and migration. However, they depend on their cultural beliefs and values, it protection and their religious practices and this also increase the anxiety.

Majority of the participants had experienced stress and felt they had been treated in a biased way. Few participant in the research articled analyzed expressed satisfaction in the care received. Hospitalized patients and families are subjected to stress and this invariably affects the quality of care they receive. This signifies there is a need for more educational awareness in multiculturalism and in its competence.

Keywords	culture, multicultural competency, cultural nursing, patients, family member, experience.

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Monikulttuurinen sekä kulttuurien välinen hoitotyö on tärkeää globaalistuvassa maailmassa. On hyvin tärkeää, että kaikki terveydenhuollon ammattilaiset ymmärtävät kulttuuristen erojen olemassaolon ja arvostavat myös erilaisia arvoja, uskomuksia ja tapoja. Tämä edesauttaa hoitamaan potilasta kokonaisvaltaisesti. Tämä opinnäytetyö oli osa laajempaa LOG-Sote projektia, joka keskittyy etnisten vähemmistöryhmien terveydenhuoltoa koskeviin asioihin.

Tämän opinnäytetyön tarkoitus on kuvailla potilaiden ja heidän omaistensa kokemuksia monikulttuurisista terveydenhuoltopalveluista. Kirjallisuuskatsaus käsitti kahdeksan artikkelia. Materiaali kerättiin systemaattisesti OVID; CINAHL ja PUBMED hakemistoista. Artikkelit kuvailevat potilaiden sekä heidän perheidensä kokemuksia erilaisista terveydenhuollon palveluista.

Potilaiden ja heidän perheidensä kokemukset lajiteltiin kahteen kategoriaan ja niiden alakategorioihin. Stressitekijät ja kulttuuri; he kohtaavat ylivoimaista stressiä kuten pelkoa epävarmasta parantumisesta, epävarmuudesta kriittisen hoidon ympäristössä, roolien vaihtumisesta elämäntapojen, muuttumisesta, jännitteitä, monimutkaisuudesta, emotionaalisesta myllerryksestä ja taloudellisista huolista. kuitenkin, Riippuen niiden kulttuurisia uskomuksia ja arvojen, säilyttäminen ja heidän uskonnollisia käytäntöjä myöskin lisää ahdistusta.

Suurin osa osanottajista oli kokenut stressiä ja tunsivat tulleensa hoidetuksi puolueellisesti. Muutaman tutkimuksen osallistuja oli tyytyväinen saamaansa hoitoon. Sairaalassa hoidetut potilaat ja heidän omaisensa kohtaavat paljon stressiä ja tämä poikkeuksetta vaikuttaa heidän hoitonsa laatuun. Tämä tarkoittaa sitä, että tietoisuutta ja pätevyyttä monikulttuurisuudesta tulisi lisätä.

Avainsanat	Kulttuuri, monikulttuurinen ammattitaito, kulttuurin huomioiva sairaanhoito, potilaan omaiset, kokemus

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1 INTRODUCTION

Nursing involves people from many different cultural backgrounds. Therefore, for care to be satisfactory to patients and their relatives and care providers as well, cultural differences have to be taken into consideration. Transcultural nursing is globally an important aspect of nursing today. It is very important for all healthcare providers to be aware of the existence of cultural differences and appreciate the differences of multiple and various differentiations in healthcare values, beliefs and customs and providing a holistic care. This holistic approach in nursing addresses the physical, psychological, social, emotional, and spiritual need of patients. (Gustafson, 2005:2-16). In order to respond to the multicultural world of today, nursing in many countries is embracing the transcultural framework for preparing new practitioners and for continuing education, this mean for the provision of culturally competent care nurses must be transculturally skilled and knowledgeable (Papadopoulos 2006:8).

Multicultural or Transcultural focus makes nurses to think about differences and similarities among people regarding their special needs and concerns to develop different ways to assist clients. As nurses discover the clients particular cultural beliefs and values, they learn ways to provide sensitive, compassionate and competent care that is beneficial and satisfying to the client (Leininger & McFarland 2002:45).

The purpose of this final project was to describe the experience of patients and families of healthcare services received in multicultural environment.
This final project was part of a large research project that focuses on the health issues of ethnic minorities. Local and Global Development Project in Health and social Care (LOG- Sote). The project is part of a large European Union project called HOME
(Health and Social Care for Migrants and Ethnic Minorities in Europe). HOME is concerned with immigrants within Europe and how different European countries are meeting their needs. The project aim was to respond to the challenges of multiculturism in developing the health care services of immigration population in Finland.

2 KEY CONCEPTS

2.1 Culture

The National centre for cultural competence in America (NNCC) defines culture as an integrated pattern of human behaviour which includes thoughts, communication, languages, beliefs, practices, customs, courtesies, rituals, manner of interacting, roles, relationships, and expected behaviours of racial, ethnic, religious, social or political group (Vanderpool 2005:1925). Culture is defined as a composite of multiple differences producing individual identity (Gustafson 2005:3). Culture influences individual lifestyles, personal identity and their relationship with others both within and outside their cultures (Papadopoulos 2006:10).

‘‘Culture defines how health information is received, understood, and acted upon; language is a powerful transmitter of culture’’ (Polacek, & Martinez 2009: 99-100).
"There is direct relationship exists between a patient’s culture and his or her health;
of the many variables known to influence health beliefs and practices, culture is one of the most influential" (flowers 2004:52).

2.2 Multicultural Nursing

Leininger & McFarland (2002:50) multiculturalism refers to a perspectives and reality that there are many different cultures and subcultures in the world that needs to be recognised, valued and understood for their differences and similarities. Multicultural is synonymous to transcultural. Therefore transcultural nursing was use in this study and is defined by Leininger & McFarland (2002: 8,46) which states that transcultural nursing is the focus on comparative differences and similarities among cultures in relation to humanistic care, health, wellness, illness, and healing patterns, belief and values. It aims at providing culture specific and universal nursing care practices for health and well being of people or help them to face unfavourable human conditions, illness, or death in cultural meaningful ways. Gustafson (2005:2) also defined transcultural nursing as "the humanistic and scientific study of all people from different cultures in the world with thought to the ways the nurse can assist people with their daily health and living needs.

2.3 Multicultural Competence

This is also synonymous to cultural competence.
Cultural competence is the collection of behaviours, attitudes skills, and policies that facilitate the delivery of services to individuals in ethnically diverse situations (Polacek, & Martinez 2009:98). It is also a process in which healthcare providers learn from and about different cultures, and with this knowledge, they are able to modify their healthcare practices to accommodate and share in the culture of their patients. The health system's ability to deliver culturally competent care is an important dimension of serving the holistic health needs of communities. (Maddalena 2009:153,155.) Cultural competence also begins with being aware of one's own cultural beliefs and practice and recognising that people from other cultures may not share them. To provide culturally competent care, practitioners must be able to provide patient-centred care by adjusting their attitudes and behaviours to the needs of diverse patient groups. (Vanderpool 2005:1925.)

Andrew and Boyle (2003:251) refer to cultural competence as the ability of health care providers and organisations to understands and respond effectively to the cultural and linguistic needs of patients; this also includes providing respectful care that is consistence with cultural health beliefs of the clients and family members.

The reasons for cultural competence in healthcare setting is to assure the provision of appropriates services to individual irrespective of the background and to reduce the incidence of medical errors that could result from misunderstanding differences in culture (Polacek & Martinez 2009:98).

Papadopoulos et al (2006:11,18) as well stated that cultural competence is a process that one goes through in order to continuously develop and refine one's capacity to provide effective healthcare, having in mind people's cultural beliefs, behaviours and needs. The achievement of cultural competence requires the synthesis and application of previously gained awareness, knowledge and sensitivity. A model was also developed for research study into transcultural nursing education; it consists of cultural awareness, cultural competence, cultural knowledge and cultural sensitivity. (Papadopoulos 2006:9-11.)

According to Gustafson (2005:2) cultural competence is represented as a quantifiable set of individual attitudes and communication and practice skills that enables the nurse to work effectively within the cultural context of individuals and families from diverse backgrounds. He also said that a culturally competent nurse performs a nursing assessment, using her or his knowledge and communication skills to identify the client's cultural similarities and differences, and to establish mutual goals for care. "Lack of cultural awareness and failure to provide culturally competent care can greatly increase the stresses experienced by critically ill patients and can result in inadequate care provided by healthcare professionals" (flowers 2004:49).

2.4 Patients and Families experience or Family members

A family or family member was defined as an individual looking after the physical, social, and financial needs and included parents, spouses and any other individual involved in caring for the affected person. The family's initial focus, during the critical period when the patient is in the Intensive Care Unit (ICU), is on the survival of their relative, followed by a focus on the hope that healing will be complete and the person will be restored to their previous level of function. The difficulty that the families experienced was due to many factors including the need to adapt to different staff, the change in pace of the unit, and the perceived delay in care while the patient was being assessed. (Keenan 2010:26,30.)

The experiences of patients and families differs during hospitalization and this could be either satisfying or unpleasant due to the critical illness of the concerned (patient) or the healthcare setting and some the healthcare providers. When illness enforces hospitalization of an individual or a family member such will have to leave their familiar homes and workplaces behind and are confronted with a situation where shared meanings are limited. However, the healthcare professionals' relationship with patients and families is crucial in the end of life situation and this relationship strongly influenced their experiences. Some bereaved family members reported a lack of respect for the patients and insufficient emotional support for patients and themselves in hospitals when compared with home with hospice care. Family members highly praised caring healthcare providers who showed concern and compassion, were sensitive and open, took the time to listen and talk, treated patients and their families with respect, and recognized their unique situations.(Spichiger 2010:195.)

Family members' emotional reaction to the cardiac episode is significant with family members demonstrating a need for information, advice, and support (Mohan, S., Wilkes, L.M., and Jackson, D.2006:191). For multicultural patients and families, double-stress in hospital as well as dependency and raw emotions could be triggered by their previous traumatic experiences as immigrants or refugees (Høye, & Severinsson 2009:25).

Hospitalized patients and their families are subjected to numerous stresses. This reality is especially true in critical care units, where patients with life-threatening illnesses are treated. (Flowers 2004:49.)

3 EARLIER STUDIES

In the united state of American as well as in other developing country is rapidly developing into a multicultural, pluralistic society of mixed peoples. The U.S. Bureau of the Census (1992) predicts that by the year 2020 only 53% of the population will be of White European descent. By the year 2080, 51.1% of the total U.S. population will be comprised of members from three pan-ethnic minority groups, identified as Hispanics, Blacks, and Asians (U. S Bureau of the Census,1990). At present nurses and health care professionals practicing in the U.S. are predominately of White European descent. People in these professions need to become culturally competent in order to provide the care and services due to individuals of all cultures and ethnicities (Zander 2006:50). Migrants from a broad range of social, cultural and linguistic backgrounds have various perceptions of illness and health and a culturally sensitive approach to health care is the most effective way to deliver health care in a culturally diverse society (Mohan et al. 2006:191).

According to Chenowethm, L., Jeon, Y.-H., Goff, M., and Burke, C. (2006:36) a culturally competent nurse recognizes that cultural differences occur across all levels of diversity, both primary (age, gender, language, physical ability and sexual preference) and secondary (socio-economic background, geographical location, education and religion).This nurse will recognize the essential humanity in all persons whatever their

cultural background and therefore will need to learn how to interact effectively with people in providing quality care, despite different social backgrounds, cultures, religions, and lifestyle preferences.

The ANCI (Australian Nursing Council Incorporated. Chenowethm et al 2006:35) competency standards clearly define the principles to achieve culturally competent nursing care; which are combination of skills, knowledge, attitudes, values and abilities that underpin effective and superior performance in a professional or occupational area. And it requires nurses to respect the values, customs, spiritual beliefs and practices of all individuals and groups; however, they are not sufficiently explained or developed to guide nursing practice. What the standards need to make clear is that the constituents of competence are found not in the nurse alone, but in the relationship that exists between the nurse, their colleagues, patients, and families, and with the situation itself.

Maier-Lorentz (2008:41) stated that health care system had to also make changes to accommodate a diversified patient population. One of these changes in the health care system was to protect health care beliefs of persons from various cultures. The Nursing profession has shown support for accommodating other persons from different cultures by promoting transcultural nursing in daily practice. This is also referred to as culturally competent nursing.

Eunyoung (2004:96) mentioned that becoming a culturally competent health care professional is a necessary and demanding prerequisite in this present multicultural society and defined cultural competence as (a) developing an awareness of one's own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds; (b) demonstrating knowledge and understanding of the client's culture; (c) accepting and respecting cultural differences; and (d) adapting care to be congruent with the client's culture. The American Academy of Nursing's (1992:278) Expert Panel on Culturally Competent Care defined culturally competent care as care that is "sensitive to issues related to culture, race, gender, and sexual orientation," achieving self efficacy in communication skills, cultural assessments, and acquisition of knowledge related to health practices of certain cultures.

4 PURPOSE OF THE STUDY AND STUDY QUESTION

4.1 Purpose of the final project

The purpose of this final project is to describe the experience of patients and families of healthcare services received in multicultural environment.

4.2 Research Question

What kind of experiences do the patients and their families have of healthcare provided by different cultural setting?

5 METHODOLOGY

5.1 Literature review

This is the selection of research articles which contains information, ideas, data and evidence written from a particular standpoint to fulfill certain aims or express certain views on the nature of the topic and how it is to be investigated, and effective evaluation of these documents in relation to the research being proposed (Moule and Goodman 2009:138).

This final project was carried out by applying systematic literature review methodology; which adheres to explicit and rigorous methods of identify, critical appraise and synthesis relevant studies. It also a strict scientific methodology to minimize chances of bias but ensuring reliability review (LoBiondo-wood & Haber 2006:87).

White and Schmidt (2005:54) states that a systematic review retrieves, appraises and summarizes all the available evidence on a specific (health) question and then attempts to reconcile and interpret it. The systematic review was specifically developed to try to reduce the influence of the reviewer's own bias. It does this by deciding in advance what evidence to use and how to use it, so these decisions are not influenced by the evidence itself. A systematic literature review as such requires expertise and

double-checking from at least two members of the review team (LoBiondo-Wood & Haber 2006:573).

The important of systematic literature approach to this final project is that all obtained information contained a systematic review of the literature. The main features of a systematic review is that reviewers follow a strict protocol to ensure that the review process undertaken is systematic by using explicit and rigorous methods to identify, critically appraise and synthesize relevant studies in order to answer a predefined question. (Aveyard 2010:13-14). According to Nightingale (2009:381) which says that a systematic review is different from traditional literature reviews because they aim to identify all studies (published and unpublished) that address a specific question and their methodology has been developed to minimize the effect of selection, publication and data extraction bias.

5.2 Database search

The first database search was conducted in 2009; this was the basic phase of the final project and the purpose was to relevant articles for the project outline presentation.
The database search engines used were CINAHL, PUBMED and OVID@ Medline®. The limitations for all literature searches were: Abstracts, Full text the article, English language and the articles published from the year 2004 to 2010. The used keywords are cultural competence, transcultural nursing, healthcare, Families, family member; this was modified later.

The articles for literature reviewing database search was done systematically. The database search engines used were CINAHL, PUBMED and OVID@ Medline®. The main keyword; Cultural nursing, Family members, Patients and Experience. The search on OVID@ Medline® dated (23/10/11) was conducted with the keywords Cultural Nursing* AND Patients* AND Family members* AND Experience*. This gave 22 hits. After limitation, 2 relevant articles were retrieved to be use according to the whole article.

The search on PUBMED dated (25/10/11) was conducted with the keywords Cultural Nursing* AND Patients* AND Family members* AND Experience*, which gave 90 hits and 4 was relevant to be use.

The search on CINAHL dated (21/10/11) was conducted with the keywords Cultural Nursing* AND Patients* AND Family members* AND Experience*, which gave 12 hits and after limitation 1 was to be use. The author found 1 article relevant from the references. The database search resulted in 7 relevant articles +1 from the references. this shown in the database table, (APPENDIX 1).

5.3 Inclusion criteria

Inclusion and exclusion criteria facilitate a literature search by minimizing the relevant articles to a manageable number. The criteria are specified before the formal literature search starts and maintaining the guarantees of the validity of the study (Engström et al. 2007:28).

The following are the inclusion criteria.

1. The articles are empirical research study
2. The research articles written in English language
3. The article abstracts relevant to the study question answers
4. The study is relevant to the final project topic and the study question
5. The research is up to date and published from 2004-2010.

5.4 Data Analysis

According to Lo-Biondo-Wood & Haber (2006:561) content analysis is a technique for the objective, systematic and quantitative description of documentary evidence.

Content Analysis is applied in this final project. Is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action.

The aim is to produce a condensed and broad description of the phenomenon question. It could be used either as deductive or inductive way based on the purpose of the study (Elo & Kyngäs.2008: 108,109.) Elo and Kyngäs (2008:111) say that abstraction means, "Formulating a general description of the research topic through generating categories". In other words, a main category generates generic categories that are divided into sub-categories. Categories are named according to how theme related to their content.

The 8 relevant research articles were read and the data tentatively analyzed according to its 1) Author, year, title, journal, 2) Purpose, 3) Sample, 4) Data collection and analysis 5) Main findings. These were put into table (APPENDIX 2).

The author of this final project adapted inductive content way in analyzing the relevant research articles. I created theme for the main findings while reading the articles in order to create categories. The list of categories was hierarchized into 2 groups in order to reduce similar or dissimilar content. The theme are then transcribed onto a coding sheet and grouped as categories .Open coding was used and themes were put together on a coding sheet. Generic categories and subcategories emerged bring in a logical structure, enhancing clarity of findings. I established 2 generic categories describing the patients and families experiences and each having sub-categories describing the patients and families experiences in detail. Figure 1 summarizes the finding in categories (APPENDIX 3)

6 FINDINGS

Eight research articles were used for the literature review in this final project. These articles described the patients and family members' experiences of services in different healthcare environment and their providers.

6.1 Stressors

Studies from the analysed articles; shows that the family members from diverse culture of critically ill patients generally face overwhelming stressors. These includes the followings; uncertain outcomes of illness, Lack communication and information, changes in roles and responsibility, vulnerability, emotional turmoil and financial concerns, disappointment from the healthcare setting and societal discrimination and Migration.

6.1.1 Uncertainty

Uncertainty was described as of one the stressors experienced by family members when their critically ill relatives was admitted to ICU. This is a negative experience due to suddenness of the event and it leads to anxiety because of the unknown outcome of

the illness as expressed by the some of the family members. (Chan & Twinn 2007:188.) Family members faced difficulties in implementing changes to lifestyle after the cardiac episode. Spouses found it difficult to control their partners' intake of foods rich in fats and sugar and become perplex. (Mohan et al 2006:193).
Perry et al. (2006:178) discovered that because of the nature or severity of the illness some of the patients and family member often did not know about their diagnosis, treatment or expectations regarding recovery or convalescence.

6.1.2 Communication and Information

Patients and family members expressed difficulty in communication. They related this difficulty to their encounters with healthcare professionals. Some participants described these difficulties in the context of the amount or quality of information they received. Others described feelings of intimidation and overwhelming stress when they received information in a way that heightened their anxiety and uncertainty. (Chan & Twinn 2007:189.) Lack of facility with English usually meant patients were not able to explain things to doctors and nurses unless a family member who speaks English was present.

In the absence of information from the staff, patient participants relied on family members in multiple ways (Perry et al. 2006:178). Høye and Severinsson (2010:27) found in their study that information filtered to reduce concern; family members' perceived responsibility to take the best possible care of their loved one by filtering and adapting messages in order to reduce sorrow, stress and anxiety. Kutash and Northrop (2007:388) the waiting room enhance the ability of family members to receive information about their relative by face-to-face communication.

Family member expressed a feeling as "they felt that if they had been able to understand the patient's condition and care plan better, then it would have helped to reduce their unease and worry" (Wong & Chan 2007:2361). Many family described how they found seeking information as one of the most effective coping strategies to reduce their stressors (Chan & Twinn 2007:190).

6.1.3 Change in role and responsibilities

Family members described how the severity of the illness of their partner undermined their ability to perform their usual roles. Many described how they found it difficult to

function physically, socially and emotionally as well as economically. Younger family member were particularly concerned about their parental responsibilities and ability to function effectively (Chan & Twin 2007:189). Family members' participation in decision-making, hospital routines and facilities were described as challenging for some family members, difficulties related to visiting routines (Høye & Severinsson 2010:29).

In almost all Greek hospitals Patients' family members were force to stay at their bedside for many hours, sometimes 24 hours a day, to assist with their care. A study conducted in of the Greek hospital shows patients family member performing informal in-hospital caregivers. Twelve of these patients' family members (15%) stated that they had ceased to pursue their day-time jobs because they had to provide informal care to their relatives. Four of them (5%) had chosen early retirement, 4 (5%) had resigned and the remaining 4 participants (5%) did not specify exactly what this statement entailed in their case. Another 12% of the sample (n =9) answered that they had been able to arrange a long period of unpaid leave without losing their job. Also the caregiving activities provided by family members acting as informal in-hospital caregivers should normally be provided to patients by assistant nurses. (Sapountzi-Krepia et al. 2006:4,6.)

According to Cioffi (2006:17) Carrying out in-hospital roles means being with their relative, helping the nurse, acting as an interpreter and being the family representative. This involved staying with their relative for various lengths of time in the hospital.

6.1.4 Emotional turmoil and financial concerns

Patients' family member identifies the contribution of both emotional support and instrumental support in their situation. Four younger participants; who were in paid employment outside the home described how their new roles and additional responsibilities had affected their health both psychologically and physically and how dependent they were on their family members to support them through this time (Chan & Twinn 2007:190.)They needed care and sympathy (Wong & Chan 2007).

Kutash and Northrop (2007:386) Study show that the caring behaviors of the staff towards patients are related to a feeling of comfort and support. Also family members found the waiting room to be a place where they could obtain emotional support. It

was described as a place where ‘one family consoles another family’ and ‘a place where you can be with people in similar situations' and it eases their pain.
Perry et al. (2006:177,178.) family members and in some instances friends, worked to ‘keep close’ e.g. Travelling from distance and taking time off work. The study also points that family members were engaged in supporting the hospitalized person and one another by providing reassurance and by their presence and caring. Patients frequently spoke about the fears and worries they experienced for themselves along with recognition of their kin’s need for reassurance and support. Cioffi (2006:17-18.) relatives facing concerns which are: expressed person-centred about their experience of being with their relative that were varied and include: recognizing they were not able to manage some aspects of their relative's care, shortage of nurses. Also relative - centred being uncomfortable about situations they witnessed such as visiting time, gender of attendant.

6.1.5 Healthcare setting and societal discrimination and Migration

Mohan et al. (2006:197-198) Stated that nursing care was generally perceived to be satisfactory with some family members being particularly appreciative of the nurses for their good quality of care. However another Family member felt they were being discriminated by hospital staff and had no choice but to accept it. Some expressed that”if white person would call they would get an answer straight away but we would have to wait and wait and wait". The Article also stated impact of migration and societal discrimination added to their stress. This was either due to a hectic lifestyle and difficulties getting employment, or due to social factors such as racial discrimination and loneliness. Some patients and family member said they always had to work double hard because of "our colour". ‘It is a different land and difficult to find work if they can’t find a person they will take you. Family members reported health care professionals insisting on having their own way. No one is listening to them or ignoring information about symptoms and changes reported (Perry et al. 2006:178). It also pointed out that system had a powerful role in influencing how things were managed, or not managed, for both the participants and their families and this makes them to face challenges for instance the hospital does not provide translator if the patient doesn't have one.

6.1.6 Vulnerability

According to Perry et al (2006:177) Families from diverse backgrounds who have kin in hospital and will be making the transition to home engaged in a dynamic tension between being pulled toward vulnerability and resisting vulnerability. The pull towards vulnerability was generated by the illness of the hospitalized person with its attendant meanings and worries and the experience of not being heard by professionals. It also stated the health care system itself occasionally facilitated and contributed to the families' resources, but often the system or its embodiment in physicians, nurses and other health care professionals contributed to the movement towards vulnerability. The hospital does not provide translator if the patient doesn't have one. The study also stated that dilemmas can arise when the families' capacities to accommodate caregiving demands are reduced and the hospital social worker is not being of help.

Most of the care-giving activities provided by family members acting as informal in-hospital caregivers should normally be provided to patients by assistant nurses. Some of these patients family member were not giving any special care education or training while some acquired knowledge from hospital staff or previous experiences (Sapountzi-Krepia et al 2006:10).

6.2 Culture

6.2.1 Reliance on cultural beliefs and practices

According to Chan and Twinn (2007:191) cultural beliefs play an important role in the selection of coping strategies in such critical situations. Cioffi (2006:15) stated that in many cultures illness is a family affair and family members play an important role in care-giving. Mohan et al. (2006: 194-195) pointed out in their study that Indian culture has influence on health/health behavior and illness experience. This was described in the Cultural norm; Family member spoke about their dietary habits, they frequently linked the term 'unhealthy' to 'Indian food. Lack of physical exercise and physical inactivity was again culturally accepted and considered to be the norm. Cultural uniqueness; this related to characteristics such as tolerating pain and illness, not taking medi-

cations, not having regular health checks, holding fixed beliefs about the 'right' health behavior. Thinking about other family members, putting themselves last, not having time to look after they were perceived as being exclusive to Asian Indian; Particularly the women. Consequences of a cultural clash; the Indians not being open to changes and being blind to positive aspects of other cultures prevented them from adjusting a new environment. Indian culture not deemed as a barrier to health or recovery; Family member did not consider Indian culture to have any role in relation to recovering from cardiac illness. Influence of culture on coping with illness; was considered to be positive. Family member belief culture was considered to have lot of deep-rooted principles and values, which provided them with the strength and support to cope with even the most difficult situations.

Sapountzi-Krepia et al (2006) study also shows that for cultural reasons a family member becomes informal in hospital care. In addition; according to Wong and Chan (2007) influenced by the cultural belief that a good death is to die in peace while asleep with no pain and suffering and to be surrounded by one's family makes the family member felt that it was vital for the nurse to inform them in time so that they could arrive at the unit to be with the patient as they passed away. The use of rituals as described in Chan and Twinn (2007:190) most family member described how they followed the rituals associated with their cultural beliefs. They followed their parents' practice of ancestor worship, as this practice encompassed the belief that the ancestor could protect their health and life. Some family member described how their parents taught them to keep a shrine for their ancestors and pay their respects to the gods by burning incense everyday especially during the time their critically ill partner was hospitalized. And some blamed themselves because their partner had suffered the consequences of deeds done by their fore-relatives in a previous life.

6.2.2 Protection of Cultural Tradition

Høye and Severinsson (2010:28) protecting cultural traditions brings family cooperation and the family bond which are very important factors in managing stress and crises. The mentioned that participants reported multiple examples of cultural cooperation and use of religious symbols and rituals were often deemed to have a positive impact, which led to various reflections among family members. The family bond was looked upon as stronger in crises triggered by illness and hospital admission. The study

also described family members' perceived responsibility to take the best possible care of their loved one by filtering and adapting messages in order to reduce sorrow, stress and anxiety. Also the patient seemed to rely more on family interpretation than professional interpreters they because of mutual understanding and support from the family members.

6.2.3 Turning to religious beliefs

Family members expressed that they turned to their religious beliefs to cope with such a stressful event as the outcome of a life-threatening diseases. Praying, religious rituals and faith in god were described as giving them inner strength, courage and encouragement to meet the challenges and stressors resulting from their partners' hospitalization. They prayed to their god to guard their partner's health and acquire a source of hope and comfort. (Chan & Twinn 2007:191)

7 VALIDITY AND ETHICAL CONSIDERATION

7.1 Validity

Validity measures the truth or accuracy of a study. Is an important concern throughout the research process Biased can easily go undetected and this makes validity measurement a challenging task (Burns & Grove 2005:214,383). However, Polit and Beck (2004:36) described validity as a crucial tool in research to measure the quality of the study and its findings.

The keywords used were cultural nursing AND Patients AND Family member AND Experience. The search was performed using health related database. The relevant studies used in this final project were conducted in Europe, USA and Asia. The literature search in this final project may not have been large enough because some articles were not freely accessible.

I used a professional and health related database OVID, CINAHL, and PUBMED to obtain scientific articles. The used articles are published in journals. I read the articles

several times and each was considered valid when it answered my research question and within the inclusion criteria.

The 8 research articles that I used are scientific studies and were conducted in hospital settings. The participants are cultural diverse patients and the family members in acute setting. Most of the articles used were qualitative research methods, which described the patients and family members experience in the clinical setting. Findings were based on the scientific articles and my opinion, feelings and personal view was not included.

Writing a systematic literature review must at involve at least two members (LoBiondo-Wood and Haber (2006:573) although all the articles were retrieved and analyzed systematically but I did it alone.

7.2 Ethical Consideration

Academy of Finland (2003) says that the criteria of good and ethical scientific practice are that the researchers must use integrity, carefulness and accuracy when conducting the research, presenting results, and when judging the research.
The chosen articles followed good scientific conduct because anonymity and privacy of the participants was ensured and informed consent was obtained. The information from findings was carefully presented in this final project without filtration.

The author used the Metropolia University of Applied Sciences Guidelines for Writing papers. These findings were based on the used scientific articles and my opinion was not included in the data analysis. The sources and authors were quoted accurately and appropriately referenced.

8 DISCUSSION

The purpose of this final project is to describe the experience of patients and families of healthcare services received in multicultural environment. A research question was developed for this study: What kind of experiences do the patients and their families have of healthcare provided by different cultural setting? Answers to this question are based on the findings achieved from the relevant research articles. Patients and family

members from diverse cultural background having critically ill patients in the hospital experience overwhelming stresses and been treated in a biased way.
Mohan et al. (2006) and Perry et al. (2006) discovered that because of the nature or severity of the illness some of the patients and family member often did not know about their diagnosis, treatment or expectations regarding recovery or convalescence.

"Family member observed the deteriorating condition of their relative and knew that they were going to say their final farewell is deep their sorrow". The family member wished that the nursing staff would be more active in telling them about their relative's condition. They felt that if they had been able to understand the patient's condition and care plan better, then it would have helped to reduce their unease and worry being with the patient at the last moment of life was vita to some family members due to and cultural belief that a good death is to die in peace while asleep with no pain and suffering and to be surrounded by one's family. Most participants are denied of this cultural beliefs which deepens their stress

Family member providing informal in-hospital care due to cultural values and belief of the patients and families and Rehabilitation settings using them instead of hiring more nurse assistant is an abuse of the culture values. (Sapountzi-Krepia et al 2006).

Difficulty in communication and inadequate information was expressed by some of the family members' feelings of intimidation and overwhelming stress; this heightened their anxiety and uncertainty. Lack of facility with English usually meant patients were not able to explain things to doctors and nurses unless a family member who speaks English was present (Chan & Twinn 2007). Some patients prefer their family members to interpret to them while some are vulnerable because their family experience of not being heard by professionals and the hospital is not providing a translator. (Perry et al. 2006; Høye, & Severinsson 2010). The craving for care and sympathy according to Wong and Chan (2007) study shows that some family member lacks emotional support from nursing staff. However, the four younger participants; who were in paid employment outside the home that described how their new roles and additional responsibilities had affected their health both psychologically and physically and how dependent they were on their family members to support them through this time are shows they

were having emotion turmoil which is as well as stress Chan & Twinn (2007).These experiences lessen the qualities of care the patients received.

9 CONCLUSION

Findings from this literature review have described the patients and the families' experiences of healthcare services provided by different cultural setting. The data used in the 8 articles were focused on interview telephone interviews. This method has helped me to gather the information that expresses the experiences of patients and families of diverse cultural background. It signifies that there is a need for more educational awareness in multiculturalism and in its competency. Although, few participant in the research articled analyzed commented satisfaction in the care received but majority of the participant experienced stressor and felt they had been treated in a biased. Hospitalized patients and families are subjected to numerous stresses and this invariably affects the qualities of care receive by the patients.

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References

1 Academy of Finland (2003) Guidelines on Research Ethics. Internet document.<http://www.aka.fi/Tiedostot/Tiedostot/Julkaisut/Suomen%20Akatemian%20eettiset%20ohjeet%202003.pdf > Read 10.11.2011

2 American Academy of Nursing. (1992). AAN Expert Panel Report: Culturally competent health care. *Nursing Outlook 40* (6), 277-283.

3 Andrews, M. M and Boyle, J. J (2003) *Transcultural concepts in nursing care*. 4th ed. Lippincoltt Williams &Wilkins.

4 Averyard, H. (2010) *Doing a Literature Review in Health and Social care*: A practical guide. 2nd ed. England: Open University Press.

5 Bridges, S. J. (2004) Multicultural issues in augmentation and alternative communication and language: *Research to practice* 24 (1), 62-75.

6 Cioffi, J. (2006) Culturaly Diverse Family Members and Their Relatives In Acute Care Wards: A QUALITATIVE STUDY. *Australian Journal of Advanced Nursing* 24 (1), 15-20.

7 Cowan, D., T., and Norma, I., (2006) Cultural Competence in Nursing: New Meanings. *Journal of Transcultural Nursing* 17 (1), 82-88.

8 Chan, K-S., Twinn, S. (2007) An analysis of the stressors and coping strategies of Chinese adults with a partner admitted to an intensive care unit in Hong Kong: an exploratory study. *Journal of Clinical Nursing* 16, 185–193.

9 Chenowethm, L., Jeon, Y. -H., Goff, M., Burke, C. (2006) Cultural competency and nursing care: an Australian perspective. *International Nursing Review* 53, 34-40.

10 Elo, S. and Kyngäs, H. (2008) The qualitative content analysis process. *Journal of Advanced Nursing* 62(1), 107-115.

11 Engström, J., Bruno, E., Holm, B., HellZen, Ove. (2007) Palliative sedation at the end of life-A systematic literature review. *European journal of Oncology Nursing* 11, 26-35.

12 Eunyoung, Eunice. (2004) The Model of Cultural Competence: Through an Evolutionary Concept Analysis. *Journal of Transcultural Nursing* 15 (2), 93-102.

13 Flowers, D.L. (2004) Culturally Competent Nursing Care: A Challenge for the 21st Century. *Critical Care Nurse,* 24, 48-52.

14 Gustafson, D. L. (2005) Transcultural Nursing Theory from a Critical Cultural Perspective: *Journal of Advances in Nursing Science* 28 (1), 2-16.

15 Homby, A.S. (2000) *Oxford advance learner´s dictionary*. Sixth edition.

16 Høye, S. and Severinsson, E. (2010) Multicultural family members' experiences with nurses and the intensive care context: A hermeneutic study*. Journal of Intensive and Critical Care Nursing* 26, 24-32.

17 Mohan, S., and Wilkes, L. M. Jackson, D. (2006) Coronary heart disease in Asian Indians: Perspectives of family members. *Journal of Contemporary Nurse* 23(2), 189-201.

18 Jirwe, M., Gerrish, K., Keeney, S., Emami, A. (2009) Identifying the core components of cultural competence: findings from a Delphi study: *Journal of Clinical Nursing* 18, 2622-2634.

19 Keenan, A. (2010) The needs of family members of severe traumatic brain injured patients during critical and acute care: A qualitative study. *Canadian Journal of Neuroscience Nursing* 32 (3), 25-35.

20 Kutash, M. and Northrop, L. (2007) Family members' experiences of the intensive care unit waiting room. *Journal of Advanced Nursing* 60 (4), 384-388

21 Leininger, M. and McFarland, M. (2002) *Transcultural Nursing: Concepts, Theories, Practices.* 3rd ed. Columbus: Greyden Press.

22 LioBiondo-Wood, G. and Haber, J (2006) *Nursing Research Methods and Critical Appraisal for Evidence -Based Practice*. 6th ed. St Louis: Elsevier

23 Maddalena, V. (2009) Cultural Competence and Holistic Practice. Implications for Nursing Education, Practice and Research: *Holistic Nursing Practice* 23 (3), 153–157.

24 Maier-Lorentz, M. M. (2008) Transcultural Nursing: Its importance in nursing practice. *Journal of Cultural Diversity* 15 (1) 37-43.

25 Moule, P. and Goodman, M (2009) *Nursing Research-An Introduction*. 1st ed. Sage Publications Inc.

26 Nightingale, A. (2009) A guide to systematic literature reviews. *Determining surgical efficacy*, 381-384.

27 Papadopoulos, I., Tilki, M., Taylor, G. (2006) *Transcultural health and social care*: Development of culturally competent practitioners. 3rd ed. Churchill Livingstone.

28 Perry, J., Lynam, M., J., and Anderson, J., M. (2006) Resisting vulnerability: The experiences of families who have kin in hospital-a feminist ethnography. *International Journal of Nursing Studies* 43, 173-184.

29 Polacek, G. N.L.J and Martinez, R. (2009) Assessing Cultural Competence at a Local Hospital System in the United States: *The Health Care Manage* 28 (2), 98-110.

30 Polit, D.F. & Beck, C.T. (2004) *Nursing Research.* Principles and Methods 7th edition.Philadelphia: Lippincott Williams & Wilkins.

31 Sapountzi-Krepia, D., Raftopoulos, V., Sgantzos, M., Dimitriadou, A., Ntourou, I., and Sapkas, G. (2006) Informal in-hospital care in a rehabilitation setting in Greece: An estimation of the nursing staff required for substituting this care. *Journal of Disability and Rehabilitation* 28(1), 3 – 11.

32 Spichiger, E. (2010) Patients' and Families' Experience of Their Relationship With Professional Healthcare Providers in Hospital End-of-Life Care. *Journal of Hospice and Palliative Nursing* 12 (3), 194-202.

33 U.S. Department of Commerce, Bureau of the Census. (1990). General population characteristics. Washington, DC: U. S. Government Printing Office.

34 U.S. Department of Commerce, Bureau of the Census. (1992). Population projections of the United States by age, sex, race, and Hispanic origins: 1990-2050.Washington, DC: U. S. Government Printing Office.

35 Vanderpool, H. K. (2005) Report of the ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence: *American Journal of Health-System Pharmacy* 6 (18), 1924-1930.

36 White, A. and Schmidt, K. (2005) Systematic literature reviews: *Complementary Therapies in Medicine* 13, 54-

37 Wong, M-S, and Chan, S. W-C. (2007) The experiences of Chinese family members of terminally ill patients -A qualitative study. *Journal of Clinical Nursing* 16, 2357–2364.

38 Zander, P.E. (2006) Cultural Competence: Analyzing the Construct. *The Journal of Theory Construction & Testing* 11 (2), 50-54.

TABLE 1. DATABASE SEARCH

Database	KeyWords	Hits	Relevant Articles: According to the tittle.	Relevant Articles according to the abstracts.	Relevant according to whole article.
OVID DATED:21/10/11 CRITERIAL: Abstract, English Language, Year of Publication (2004-2010).	Cultural nursing* AND Patients* AND Family member* AND Experience*	22	8	5	2
PUBMED DATED:25/10/11 CRITERIAL: Abstract, English Language, Year of Publication	Cultural nursing* AND Patients* AND Family member* AND Experience*	90	13	7	4
CINAH DATED:23/10/11 CRITERIAL: ABSTRACT, English Language, Year of Publication.	Cultural nursing* AND Patients* AND Family member* AND Experience*	12	7	3	1

Total Articles: 2+4+1= 7Articles + I from reference. Total Articles= 8

Table 2: DATA SOURCES (The Approved Articles)

PUBLICATION	YEAR							
	2004	2005	2006	2007	2008	2009	2010	TOTAL
Journal of Contemporary Nurse			1					1
Journal of Intensive and Critical Care Nursing							1	1
Journal of Clinical Nursing.				1				1
Journal of Advance Nursing			2	1				3
Journal of Disability and Rehabilitation			1					1
International Journal of Nursing Studies			1					1
TOTAL			5	2			1	8

DATA SOURCE ANALYSIS

AUTHOR(S), YEAR, TITTLE, AND JOURNAL.	PURPOSE	SAMPLE	DATA COLLECTION AND ANALYSIS	MAIN FINDINGS
Chan, K-S., Twinn, S. (2007) An analysis of the stressors and coping strategies of Chinese adults with a partner admitted to an intensive care unit in Hong Kong: an exploratory study. Journal of Clinical Nursing 16, 185–193.	To identify the major stressors affecting Chinese adults with a partner admitted to an Intensive Care Unit and to understand the major coping strategies employed to manage identified stressors.	A purposive sample of 10 (30 and 67 years) Chinese adults with a partner in (16-bed adult ICU and four-bed high dependency unit of a 959-bed) regional general hospital in Hong Kong.	An exploratory qualitative design. Tape-recorded Semi structured interviews. Data was collected a six-month period from September 2002 to the end of March 2003. The principles of content analysis were adopted to develop a categorization scheme to code the data.	The main findings of study which answers the research question were theme into 2 Stressors and Cultures. STRESSORS. 1) Uncertainty: All participants described feelings of uncertainty when their critically ill partner was admitted to ICU. Suddenness of the event. Outcome of the illness. Anxiety. 2) Difficulty in communication. Participants particularly related this difficulty to their encounters with healthcare professionals. Some participants described these difficulties in the context of the amount or quality of information they received. Feelings of intimidation and overwhelming stress when they received information in a way that heightened their anxiety and uncertainty.

				3) Change in role and responsibilities: Participants described how the severity of the illness of their partner undermined their ability to perform their usual roles. Most participants described how they found it difficult to function physically, socially and emotionally as well as economically. Younger participants were particularly concerned about their parental responsibilities and ability to function effectively. 4) Information: participants describing how they found seeking information as one of the most effective coping strategies to reduce their stress. Healthcare professionals (being well informed about their partner's progress and treatment reduced their levels of uncertainty) and seeking information from the Internet (Obtain a better understanding of the causes of disease affecting their partner. The participant were also satisfaction with the information acquired from websites).

				5) Emotional support: participants identifying the contribution of both emotional support and instrumental support. Four younger participants, who were in paid employment outside the home; described how their new roles and additional responsibilities had affected their health both psychologically and physically and how dependent they were on their family members to support them through this time. CULTURE. 1) Reliance on cultural beliefs and practices: Most participants described how they followed the rituals associated with their cultural beliefs. "They followed their parents' practice of ancestor worship, as this practice encompassed the belief that the ancestor could protect their health and life." They described how their parents taught them to keep a shrine for their ancestors and pay their respects to the gods by burning incense everyday especially during

				the time their critically ill partner was hospitalized. Participants described how they blamed themselves because of their partner had suffered the consequences of deeds done by their fore-relatives in a previous life. Other participants believed their partner's severe illness was associated with evil spirits .Most participants also described how they had asked for a special charm or an amulet or talisman to protect their partner and how it would be kept close to their partner putting it under the pillow or in a pocket. The use of a fatalistic attitude; Some participants described how they adopted a fatalistic attitude to cope with their partner's illness. They linked their partner's disease to 'Tien' (heaven) and believed their partner's destiny was dominated by heaven. 2) Turning to religious beliefs: Most participants described that they turned to their religious beliefs to cope with such a stressful event as the outcome of a life-threatening

				diseases. Praying, religious rituals and faith in god were described by participants as giving them inner strength, courage and encouragement to meet the challenges and stressors resulting from their partners' hospitalization. Participants described how they prayed to their god to guard their partner's health and acquire a source of hope and comfort.
Mohan, S., and Wilkes, L. M. Jackson, D. (2006) Coronary heart disease in Asian Indians: Perspectives of family members. *Journal of Contemporary Nurse* 23(2), 189-201	To report the experiences of the family members of Asian Indians with Chronic Heart Disease.	Five family members (who were above 18 years of age) /carers of Australian Indians who had CHD.	Semi structured, in-depth audio taped interviews were conducted. Transcribed data were entered into the data management software package QSR NUD*IST Vivo (NVivo 1999).	STRESSORS. 1) Vulnerability: A period of complexity for family member, the participant described the period after the occurrence of the cardiac event as a hard, terribly difficult and very vulnerable time in their lives. The cardiac incident was described by participants as that which came as a shock and was difficult to go through. Family members faced difficulties in implementing changes to lifestyle after the cardiac episode. Spouses found it difficult to control their partners' intake of foods rich

				in fats and sugar. And being Perplex; Family members who participated in this study were unsure why some people developed CHD and others didn't, even though they had comparable dietary habits and lifestyle. Another family member could never imagine her husband could have a heart attack as she considered his dietary and exercise habits, to be healthy. 2) Impact of migration and societal discrimination: It was struggle and was stressful after migration. This was either due to a hectic lifestyle and difficulties getting employment, or due to social factors such as racial discrimination and loneliness. In particular, difficulties getting employment, living a discriminatory world, some said they always had to work double hard because of our colour. 'It is a different land and difficult to find work. If they can't find a person they will take you. 3) Disappointment with health care services and the health system: some family members reported

				disappointment with the healthcare system. However, nursing care was generally perceived to be satisfactory, with some family members being particularly appreciative of the nurses for their good quality of care. While another family members felt they were being discriminated by hospital staff and had no choice but to accept it: If a white person would call they would get an answer straight away. But we would have to wait and wait and wait. CULTURE. 1) Indian cultural beliefs and practice: Its influence on health/health behavior and illness experience. A cultural norm: Family members perceived Indian culture or 'Indianness' as being liable for having an unhealthy lifestyle. Participants spoke about their dietary habits they frequently linked the term 'unhealthy' to 'Indian food. Lack of physical exercise and physical inactivity was again culturally accepted and considered to be the norm in Indians cultural. Lack of physical

				exercise and physical inactivity was again culturally accepted and considered to be the norm in Indians. Cultural uniqueness: Characteristics such as tolerating pain and illness, not taking medications, not having regular health checks, holding fixed beliefs about the 'right' health behavior. Thinking about other family members, putting themselves last, not having time to look after they were perceived as being exclusive to Asian Indians, particularly the women. Not being open to changes, and being blind to positive aspects of other cultures prevented them from adjusting to a new environment. Participants did not consider Indian culture to have any role in relation to recovering from cardiac illness. Participants perceived that their spouses' parents and siblings residing in India would have a lot of expectations from them and this is perceived stressful. The impact of culture on coping with illness was considered to be positive, with their culture providing them with strength and support.

				The culture was considered to have lot of deep-rooted principles and values, which provided them with the strength to cope with even the most difficult situation.
Perry, J., Lynam, M., J., and Anderson, J., M. (2006) Resisting vulnerability: The experiences of families who have kin in hospital-a feminist ethnography. International Journal of Nursing Studies 43, 173-184.	To open up a dialogue by providing a family focused view of what happens in families of linguistically and culturally diverse backgrounds when a family member is in hospital, and subsequent to discharge home.	Study 1) 60 in-hospital patients and 56 health care professional and 25 who had recently been discharged Study 2) 38 people who had recently been dicharged from the hospital. Family members participated in both studies Participants: Chinese Canadian, Indo Canadian, Anglo Canadian.	Feminist ethnography. Researcher examining the individuals' experiences and then proceeds to explore how the broader social relations have shaped them. Preliminary code categories - Two primary coders coded data independently- Ensuring final coding and captured differences in interpretations and reflecting the perspective of the patients and their kin.	STRESSOR. 1) Vulnerability: The pull towards vulnerability was generated by the illness of the hospitalized person with its attendant meanings and worries and the experience of not being heard by professionals. It was expressed by all study participants, including the Anglo–Canadian, English speaking families. 2)Healthcare system: The health care system itself occasionally facilitated and contributed to the families' re-

			We used QSR Nud*IST 4 software to support data management.	sources, but often the system or its embodiment in physicians, nurses and other health care professionals contributed to the movement towards vulnerability. Because of the nature or severity of the illness some of participants often did not know about their diagnosis, treatment or expectations regarding recovery or convalescence. Participants and family members reported health care professionals insisting on having their own way. No one is listening to or ignoring information about symptoms and changes. The system had a powerful role in influencing how things were managed, or not managed, for both the participants and their families and this make them to face challenges. The hospital does not provide translator if the patient doesn't have one. Dilemmas can arise when the families' capacities to accommodate care giving demands are reduced and the hospital social workers are not being of help. The work that family members do is complex and demanding and the presence of

				an identified caregiver or network of caregivers is critical to activating the resources to do the work that will keep the patient and the family from becoming vulnerable 3) Communication: Lack of facility with English usually meant patients were not able to explain things to doctors and nurses unless family members who spoke English were present. In the absence of information from the staff, patient participants relied on family members in multiple ways. Communication with health care professionals about the illness was the greatest focus, 4) Support and cultural belief: Family members and in some instances friends, worked to 'keep close' e.g. Travelling from distance and taking time off work. Upon discharge however, as the following quotes suggest, there is an expectation that 'a' caregiver will have time and be available, to provide needed support. Family members were engaged in supporting the hospitalized person and one anoth-

				er by providing reassurance and by their presence and caring. but there was also a more daily need to cope and manage with the day-to-day care exchange while the person was in hospital. Anticipating consequences and preparing for transition to home: Many patients were being discharged home with their illness in an acute stage with associated limitations, or were discharged home requiring technically complex care and, there was extensive variability in the preparation families received.
Sapountzi-Krepia, D., Raftopoulos, V., Sgantzos, M., Dimitriadou, A., Ntourou, I., and Sapkas, G. (2006) Informal in-hospital care in a rehabilitation setting in Greece: An estimation of the nursing staff required for substituting this care. Journal of Disability and Rehabilitation 28(1), 3 – 11	To explore (a) The type and the frequency of care-giving activities provided by family members to patients during their hospitalization in the Rehabilitation Setting(RS). (b) The opportunities given to family members to receive a certain amount of training in care-giving activ-	Convenient sample of 80 informal in-hospital caregivers.	Designed questionnaire was used to interview informal caregivers Eligible for participation in the present study was agreed to be informal carergivers who cared for a hospitalized family member in the RS at least for 15 days. Data was analyzed using	Cultural reasons and nursing staff shortage led 78.8% (n =63) of the sample to provide informal in-hospital care. In almost all Greek hospitals Patients' family members were force to stay at their bedside for many hours, sometimes 24 hours a day, to assist with their care. Another important aspect of families' involvement in hospitalized patients' care is the reduction of

	ities from the nursing staff. (c) To what extent caregivers feel free to ask the nursing staff for help (d) to estimate the number of nursing staff required for the provision of the care provided by these caregivers to hospitalized patients and thus to estimate the money saved by the RS due for the in-hospital informal care.		SPSS for Windows	hospital costs. Twelve informal in-hospital caregivers (15%) stated that they had ceased to pursue their day-time jobs because they had to provide informal care to their relatives. Four of them (5%) had chosen early retirement, 4 (5%) had resigned and the remaining 4 participants (5%) did not specify exactly what this statement entailed in their case. Another 12% of the sample (n =9) answered that they had been able to arrange a long period of unpaid leave without losing their job. STRESSORS. Most of the care-giving activities provided by family members acting as informal in-hospital caregivers should normally be provided to patients by assistant nurses. Some of these patients family member were not giving any special care education or training while some acquired knowledge from hospital staff or previous experiences. Statistics of some the duty per-

				formed; Oral and facial care (67.5%), help with getting dressed (62.5%), help with feeding (61.25%, n = 49), making patients' beds (57.5%, n = 46) and assistance with transferring patients from one hospital department to another (56.25%, n = 45) was provided on a daily basis by the subjects. 48.75%, (n= 39) changed sheets 1 – 2 times per week, while assistance with transfers from bed to wheel-chair and vice-versa (43.75%, n = 35) was provided 3 – 4 times per week. The estimated total time spent per week by the subjects on care-giving activities was 34,034 minutes that corresponds to a total of 75.6 working days or 15.12 working weeks. In order to substitute this care, the RS would need to hire 17 more assistant nurses, entailing a cost of from e14,450 to e20,060 per month.

Høye, S. and Severinsson, E. (2010) Multicultural family members' experiences with nurses and the intensive care context: A hermeneutic study. Journal of Intensive and Critical Care Nursing 26, 24-32.	To illuminate the experiences of multicultural family members in intensive care units in Norwegian hospitals when a loved one was acutely and critically ill. What are the experiences of multicultural family members of critically ill patients when they encounter nurses in the ICU?	Five family members with different cultural background were recruited from three university hospitals and one regional hospital in Norway. Somalia, Chinese, Sri Lankan, Vietnamese, Eritrean. Age between 18-70years	Gadamerian hermeneutic design (Hermeneutics is used in studies where the purpose is to understand experiences and gain knowledge of a topic). In-depth interviews which lasted for 1.5hours. The text of each interview was scrutinized by means of naïve reading on several occasions in order to gain an understanding of the meaning of the content as a whole. The text was then divided into meaning units, which were condensed and sorted, abstracted and compared with each other, on the assumption that some of the content would not be relevant to the research question.	STRESSORS Communication and Information: Filtering information to reduce concern. family members' perceived responsibility to take the best possible care of their loved one by filtering and adapting messages in order to reduce sorrow, stress and anxiety. Understanding and being understood; the participants took the initiative to support their loved one by making practical arrangements to increase mutual understanding. Also the patient seemed to rely more on family interpretation than professional interpreters. CULTURE. 1) Protecting cultural traditions: Participants reported multiple examples of cultural cooperation and use of religious symbols and rituals, which led to various reflections among family members. The family bond was looked upon as stronger in crises triggered by illness and hospital admission. For

				those who have strong religious beliefs, symbols and rituals were often deemed to have a positive impact. Interacting between roles, rules and while for others they represented a struggle. It was especially difficult when the family members had been involved in the care process. The participant also highlighted the importance of being aware of the contextual challenges facing family members in ICUs. It is possible that these challenges were more difficult for those with a non-Norwegian cultural background and family tradition. expectations; family members' participation in decision-making, their expectations of the nurses as well as issues related to hospital rules. A few family members found decisions related to the withdrawal of treatment emotionally difficult.

Kutash, M. and Northrop, L. (2007) Family members' experiences of the intensive care unit waiting room. Journal of Advanced Nursing 60 (4), 384-388	To explore family members' perspectives of adult intensive care waiting rooms and describe their experience of waiting while their relative was in an intensive care unit.	6 Women was used in a large urban teaching hospital in the south-eastern United States of America in.	A qualitative design using semi-structured interviews and the constant comparative method were used. Data was collected 2004.	STRESSORS 1) Emotional support: Family members found the waiting room to be a place where they could obtain emotional support. It was described as a place where 'one family consoles another family' and 'a place where you can be with people in similar situations and it eases their pain. The caring behaviors of the staff towards patients are related to a feeling of comfort and support. Several talked about 'being able to peek in' and 'closeness is comforting' Some expressed the need for the patient to have them close. 2) Hospital environment: Perceptions were mostly negative and frequently described as cold, dirty, a small space and a place to go and not to stay. 3) Information: The waiting room enhances the ability of family members to receive information about their relative by face-to-face communication.

				1) CULTURE Roller coaster of emotions: It was expressed in relation to their relative's condition. Holding back their feeling and pretended to be fine.
Wong, M-S, and Chan, S. W-C. (2007) The experiences of Chinese family members of terminally ill patients -A qualitative study. Journal of Clinical Nursing 16, 2357–2364.	To describe and understand the experience of the Chinese family members of terminally ill patients during the end of life process in a palliative care unit.	20 Bereaved family member of Palliative care units in the Hong Kong Special Administrative Region of the People's Republic of China. Age between 18-20 years.	Phenomenological methodology. Interviewed between 60-90 minutes. From September 2004 and May 2005.	STRESSORS 1)Grief reactions: Family members felt that the doctors had not tried their best to treat the patient, with the result that the patient had entered the advanced stage of cancer. Observed the deteriorating condition of their relative and knew that they were going to say their final farewell soon and this deep their sorrow. Although no medication or therapy could cure the cancer, but they would like to help their relative suffer less and did not know how to. 2) Communication and Information:

				They felt that if they had been able to understand the patient's better, then it would have helped to reduce their unease and worry. They needed care and sympathy. The family member wished that the nursing staff would be more active in telling them about their relative's condition. CULTURE 1) Cultural belief: Being with the patient at the last moment: They felt that it was vital for the nurses to inform the family in time so that they could arrive at the unit to be with the patient as they passed away. This is probably influenced by the cultural belief that a good death is to die in peace while asleep with no pain and suffering and to be surrounded by one's family.

Cioffi, J. (2006) Culturaly Diverse Family Members And Their Relatives In Acute Care Wards: A qualitative study. Australian Journal of Advanced Nursing 24 (1), 15-20.	To describe the experiences of culturally diverse family members who make the decision to stay with their relatives in acute care wards.	Eight culturally diverse family members who stayed with their hospitalized relatives for at least four shifts or the equivalent hours.	Qualitative study In-depth interviews of approximately 45 minutes	STRESSOR 1) Carrying out in-hospital roles: Being with their relative; helping the nurse; acting as an interpreter; and being the family representative. This involves involved staying with their relative for various lengths of time. 2) Adhering to the ward rule: They were extremely aware of the ward rules that arose from hospital policy and considered them when making decisions to be with their relatives as privilege. Some tensions were associated with obtaining permission and their actual presence at the bedside. 3) Facing concerns: Each family member expressed person-centred concerns about their experience of being with their relative that were varied and include; recognizing they were not able to manage some aspects of their relative's care, shortage of nurses. And relative -centred; being uncomfortable about situations they witnessed such as visiting time,

				gender of attendant due to the cultural values. Finding the strength to continue to support their relative; and being worried.

Figure 1: CATEGORIZATION