Nurses' Self-Reported Attitudes Concerning Transcultural Nursing

LOG-Health Project

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Abstract

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The purpose of this final project was to explore the attitudes towards transcultural care and nurses' self-reported level of cultural competence. The data was collected in the Finnish Helsinki metropolitan area, the participants were nurses, public health nurses and practical nurses. The framework used was the Papadopoulos, Tilki and Taylor model for developing cultural competence. This project is a part of Local and Global Development in Social Services and Health Care (LOG-Sote) –project, which aims to discover how to improve migrants' health and well-being as a part of immigration politics, vocational education and services.

The project was a quantitative project that utilized a previously developed questionnaire as the data collection method. The questionnaire was handed out to nurses from three different wards working with transcultural patient groups in the Helsinki metropolitan area. 44 nurses participated out of the 53 who had received the questionnaire. Therefore the response percentage was 83.0.

The received data was analyzed with the statistical program SPSS PASW Statistics 18. Frequencies, percentages, sum variables and cross-tabulations were used to analyze the data.

In general the findings showed that the nurses' outlook on transcultural nursing was positive. It could also be interpreted that age, work experience and language skills played a role in the participants' attitudes. The importance of additional education in matters of transcultural nursing was recognized.

During the research process it became evident that the utilized questionnaire still needs refinement. In the future the topic could gain from a larger sample size.

Keywords	attitude, migrant, questionnaire, transcultural nursing

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Tiivistelmä

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Tämän opinnäytetyön tarkoitus oli tutkia Suomen pääkaupunkiseudun hoitohenkilökunnan asenteita monikulttuurista hoitotyötä kohtaan sekä heidän itsearvioimaansa kulttuurisen kompetenssin tasoa. Viitekehyksenä käytettiin Papadopouloksen, Tilkin ja Taylorin kulttuurisen kompetenssin mallia. Opinnäytetyö on osa Lokaalia ja Globaalia kehityshanketta sosiaali- ja terveysalalla (LOG-Sote). Hankkeen tarkoituksena on tutkia miten maahanmuuttajien terveyttä ja hyvinvointia voidaan edistää osana maahanmuuttopolitiikkaa, ammatillista koulutusta sekä palveluita.

Opinnäytetyö oli kvantitatiivinen tutkimus, jossa hyödynnettiin tietojenkeruumenetelmänä aiemmin kehitettyä kyselylomaketta. Kyselylomake jaettiin pääkaupunkiseudulla kolmelle eri osastolle, jossa hoidetaan monikulttuurisia potilasryhmiä. Lomakkeita jaettiin yhteensä 53 kappaletta, joista palautettiin 44. Näin ollen vastausprosentti oli 83.

Kerätty aineisto analysoitiin SPSS PASW Statistics 18 tilastointiohjelmalla. Aineisto analysoitiin käyttäen frekvenssejä, prosentteja, summamuuttujia sekä ristiintaulukointia.

Tulokset osoittivat hoitohenkilökunnan suhtautuvan yleisesti ottaen positiivisesti monikulttuuriseen hoitotyöhön. Asenteisiin vaikuttivat vastaajan ikä, työkokemus ja kielitaito. Tuloksista tuli esiin lisäkoulutuksen tarve monikulttuurisessa hoitotyössä.

Tutkimusprosessin aikana nousi esiin kyselomakkeen kehittämisen tarve. Tulevaisuudessa aihetta olisi hyvä käsitellä suuremmalla otoksella.

Avainsanat	asenne, kyselylomake, maahanmuuttaja, monikulttuurinen hoitotyö, transkulttuurinen hoitotyö

CONTENTS

1 INTRODUCTION

Transcultural competence in nursing has increasingly gained attention in the past two decades among Finnish nurses since the population in the country has prolifically become transcultural in a short period of time (Korkiasaari & Söderling 2007: 265). Cultural competence is a new and emerging qualification requirement for most of the Finnish nurses (Sainola-Rodriquez 2009: 5) and the current level of cultural competence of Finnish nurses is unknown. Cultural competence is interplay of many crucial factors and one of these is a positive attitude towards migrants and cultural diversity (Sainola-Rodriquez 2009: 45).

This final project is a part of Local and Global Development in Social Services and Health Care (LOG-Sote) –project. The aim of the project is to explore how to improve migrants' health and well-being as a part of immigration politics, vocational education and services. The project yields a description of the challenges involved with improving migrants' health and well-being. The LOG-Sote project is divided in three phases and it extends from 2007 to 2011. In the first phase systematic literature reviews were undertaken to collect data about challenges to migrants' health promotion. The second phase, including this final project, explores how cultural competence is evident in the social and health care sector. The third phase will give information on the practices that improve migrants' health and well-being. LOG-Sote project is a part of European Union's Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME) -project, which gathers knowledge from migrants and ethnic minorities' well-being from 28 countries.

The proportion of foreign population has doubled in Finland in a ten-year- period starting from the mid-1990's. Supposing the rapid growth continues, the total percentage of foreign population will be an estimated 7.0 by the year 2025 (Korkiasaari & Söderling 2007: 265). In 2008 the total number of people residing in Finland with a different nationality or a birth country other than Finland was 211,958 (Statistics Finland - Population Structure 2008). In this final project, the data collection will take place in the Metropolitan area, and thus, the percentage of people in the capital city area with a nationality other than Finnish should be noted. The proportion of migrants in the population rises most rapidly in the Metropolitan area of Finland (Statistics Finland - Population Structure 2008).

In 2008 the percentage of migrants living in Helsinki was 6.7 % (Helsingin väestö vuoden vaihteessa 2008/2009 ja väestönmuutokset vuonna 2008, 2009: 17).

According to the Act on the Status and Rights of Patients (785/1992), ”every person who stays permanently in Finland is without discrimination entitled to health and medical care required by his state of health within the limits of those resources which are available to health care at the time in question”. The Act also states that the patient has a right to good quality health and medical care, and that he/she shall be treated without violating his/her human dignity and that the patient's conviction is respected. Furthermore, the Act mandates that the patient's mother tongue, individual needs and culture are taken into consideration as far as possible in his/her care.

The nurse is to encounter his/her patients as valuable human beings and to exercise impartiality in her work according to the ethical guidelines of nursing by the Finnish Nurses Association. In the guidelines, impartiality is defined so that the nurse treats every patient well according to the individual needs of the patient irrespective of the illness, sex, age, creed, language, traditions, race, skin color, political opinion or social status of the patient (Finnish Nurses Association – Ethical guidelines of nursing 2010).

The ethical guidelines of nurses and the Finnish legislation state that it is mandatory to provide the best possible and equal nursing care to all patients. Therefore there is an urgent need to explore the quality of care provided to the migrants who are an eminent and continuously growing population group in the country.

The purpose of this final project is to explore the attitudes towards transcultural care and self-reported level of cultural competence of Finnish Helsinki Metropolitan area nurses. A questionnaire is used and it was developed according to the project’s frame of reference, the Papadopoulos, Tilki and Taylor (PTT 2006: 8-23) –model for developing cultural competence. Initially, a primary database search was undertaken to gather knowledge of previous studies, general information and to help define the key concepts concerning the area of the project. The frame of reference was explicated and the statements of the questionnaire were grouped according to the PTT –model. The data provided by the questionnaire will be analyzed according to the frame of reference and presented in a numerical form.

2 KEY CONCEPTS

2.1 Attitude

Traditionally the term attitude has been used to describe an individual's thought and feeling patterns as well as modes of action. One must also consider that attitudes have a target, whether it is oneself or groups of people, etc. (Lahikainen & Pirttilä-Backman 2004: 90). Several studies, which are described here, have focused on nurses' attitudes, but it seems that they have most often been the object of a research when discussed in relation to the patients' coping and well-being. Nurses and patients' opinions often clash when it comes to nurses' attitudes. Nurses are more optimistic than patients and feel that the nurse-patient relationship is extensive. Their view is that they spend a lot of time with patients and treat all patients equally (Shattell 2004: 717). Nurses' attitudes have a direct influence on the patient – if a nurse displays empathy and compassion, the patient starts to feel recognized and respected (Nordby 2007: 18). In a Canadian study by Weerasinghe and Mitchell (2007: 317) patients perceived health care professionals as insensitive, because they shared different views on what health is. Braun, Gordon and Uziely
(2010: E43) researched nurses' attitudes toward death and the way their attitudes correlated with the care they were giving. Memis, Akdolun Balkaya and Demirkiran (2009: E39) had a similar topic focusing on how nurses' own perceptions of the topic they were giving health promotion on affected the given education. In this final project the area of interest lay in attitudes defined as the personal mindset and possible prejudices nurses have towards migrant patients in care situations. In this project the factors affecting attitudes were recognized as participant's age, work experience, linguistic skills and frequency of encountering migrants. The following key concepts also shape respondents' attitudes.

2.2 Culture and transcultural

Leininger and McFarland (2006: 13) referenced Leininger's previous writings (1991, 1997) and defined culture as "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally". Culture could also be defined as the

upbringing and unconscious motives that define actions and thinking (Narayanasamy & White 2004: 104-105). Another important perspective lies in tradition (Taavela 1999: 70).

In this study, the definition of Papadopoulos, Tilki and Taylor (2006: 10) is used. Their definition of culture states that culture is "the shared way of life of a group of people, which includes beliefs, values, ideas, language, communication, norms and visibly expressed forms such as customs, art, music, clothing and etiquette". Also, they state that culture has an influence on an individual's lifestyle, personal identity and it affects the relationships with other people within their culture as well as outside of it.

The term transcultural is used interchangeably with intercultural and multicultural. Literally these terms all deal with reducing cultural gaps and creating cultural synergy (Purnell & Paulanka 2003: 4). Taavela states in her study (1999: 23) that the features of culture and transculturalism can often be defined by an individual's nationality and his/her culture-bound religion and language.

2.3 Transcultural nursing and cultural competence

In her doctoral dissertation Sainola-Rodriguez (2006: 42) explains that transcultural nursing theory uses concepts from anthropology, sociology, biology and nursing science. Nursing science concepts include caring, nursing process and mutual communication, whereas the core concepts of transcultural nursing concern cultural values and beliefs, health and illness systems, interaction between nurse and client and culturally sensitive nursing (Sainola-Rodriguez 2006: 43).

Transcultural nursing refers to nursing provided among different cultures or to a nursing community in which the staff and the patients come from different cultures and ethnic groups (Koskinen 2010: 18). According to Koskinen, transcultural nursing and nursing communities in general take into consideration persons' cultural backgrounds, and honor differences and equality, which mark interaction.

Papadopoulos, Tilki and Taylor (2006: 8-23) define in their cultural competence model that competence consists of three separate skill areas: cultural awareness, cultural knowledge, and cultural sensitivity. Adding to the latter the fourth phenomenon, cultural competence, these four themes are all interconnected, creating a continuum of

transculturally efficient care. Cultural awareness is the basis in the model for achieving cultural competence. Its ground stones are acknowledging one's own cultural identity and enabling one to be aware of others' cultural backgrounds. Cultural knowledge consists of the lifestyle choices of individuals and groups as seen by the nurse. The recognition of cultural barriers forms the key to cultural sensitivity, which in its turn creates the basis for mutual trust in a nurse-patient relationship, and creates an improved ability in preventing and controlling conflicts.

Racism plays a part in this area in the sense that a crucial element of the cultural competence is recognizing racism and battling it. The core of the competence is "the capacity to provide effective health care taking into consideration people's cultural beliefs, behaviors and needs" (Papadopoulos et al. 2006: 10). There are several models for culturally competent nursing care, all of which have minor differences in concepts and purpose of use because cultural competence is still evolving as a concept and is not yet explicitly defined (Sainola-Rodriguez 2009: 45). In this project cultural competence is understood as a skill that enables a person to overcome their own attitudes in a clinical setting.

2.4 Ethnocentricity, ethnocentrism and the migrant

A situation where an individual or a group considers his/her own culture and its values better than another ethnic group's culture is called ethnocentricity (Papadopoulos et al. 2006: 12). Ethnocentrism can be also a collective phenomenon. Therefore, ethnocentrism is seen as dominance or intolerance from individual to individual, group to group, region to region and nation to nation (Ray 2010: 170). As one acknowledges the existence of the belief that one's own ethnic group is superior compared to others, the level of ethnocentrism can be decreased.

In transcultural nursing, the patient is often a migrant as well. A migrant is a person moving from one country to another. It is a general concept that applies to all migrants with different reasons for moving (Finnish Migration Service 2010). Migrant is used interchangeable with the terms immigrant and emigrant. In colloquial speech the term migrant is applied often to all people living in Finland who are born elsewhere, have different cultural background or have different appearance than traditional Finnish population (Anis 2008: 24). The Statistics Finland define migrant as a person who has

moved to Finland and has or intends to live in the country for over a year without interruption and who has residence permit (Immigration and emigration 2010). In this final project the term migrant refers to the patient who is of other country of origin than Finland or has a differing cultural background, for example a child of migrant parents.

3 THEORETICAL FRAMEWORK

In this study the theoretical framework is the Papadopoulos, Tilki and Taylor (PTT 2006: 8-23) model for developing cultural competence (Figure 1). In the PTT model, cultural competence is both a process and an output, i.e. it is a continuously developing system of skills and knowledge from professional and personal life so that the nurse is able to provide effective health care by taking into consideration patients' cultural beliefs, behaviors and individual needs (Papadopoulos et al. 2006: 10).

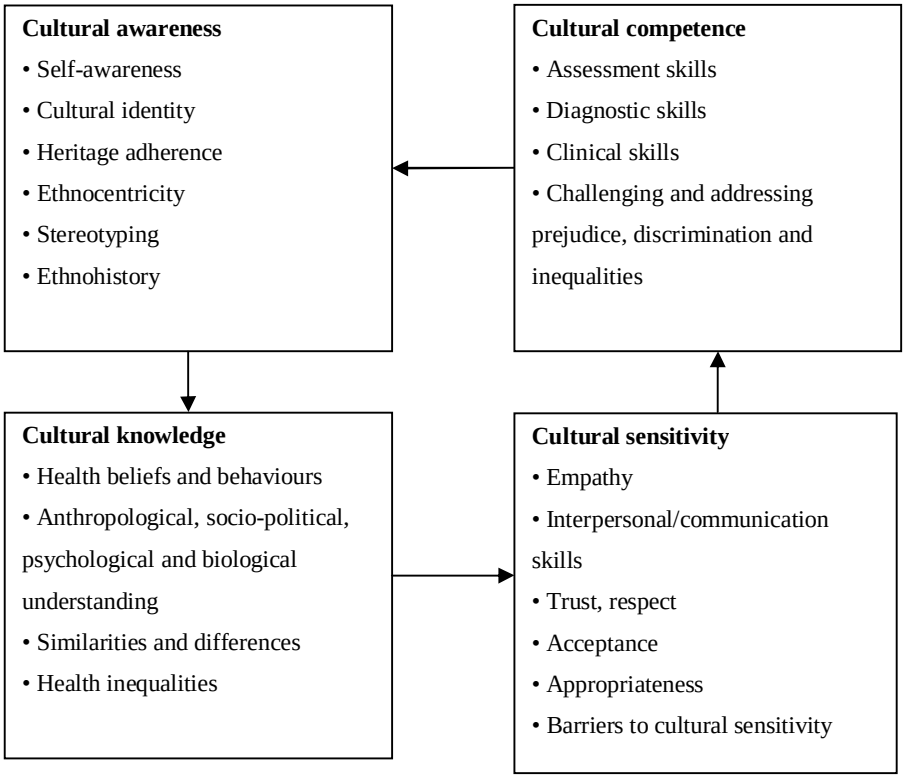

FIGURE 1. The Papadopoulos, Tilki and Taylor model for developing cultural competence (2006: 10).

The PPT model consists of four different levels: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence (Papadopoulos et al. 2006: 10). These four

levels describe a process from awareness to knowledge and then on to sensitivity, all of which then form a basis for cultural competence, described as an output of the model. Since the model is also considered a process, the knowledge and skills connected to all the four levels are seen as an ever growing and deepening circle of continuum.

The first level, cultural awareness, includes the following factors: self-awareness, cultural identity, heritage adherence, ethnocentricity, stereotyping and ethnohistory. In order to start the process of achieving cultural competence, one must acknowledge and examine their own value base and beliefs as well as cultural identity. By recognizing the importance of one's own cultural background and the influence it has on one's everyday life, it is easier to understand the importance of culture in other people's life even if it was different from one's own. This reflection helps one to see how the culture shapes a person's thinking and behavior in many unique ways. The awareness brought by reflection helps to reduce ethnocentricity and stereotyping. Knowledge about ethnic group's ethnohistory aids in the process of understanding a foreign culture. Ethnohistory can be defined as “all those past facts, events, instances, experiences of individuals, groups, cultures, and institutions that are primarily people-centered (ethno) and which describe, explain, and interpret human lifeways within particular cultural contexts and over short or long periods of time” (Leininger 1995: 106). In order to provide culturally competent care, nurses need to know something about the historical, geographical and sociocultural background of their patients (Papadopoulos et al. 2006: 11-13).

The second level contains knowledge about health beliefs and behaviors, anthropological, socio-political, psychological and biological information. It also contains knowledge about similarities and differences between ethnic groups and health inequalities. Cultural knowledge can be gathered in a number of ways since it is a product of several disciplines such as anthropology, sociology, psychology, biology, nursing, medicine and the arts (Papadopoulos et al. 2006: 13).

The third level, cultural sensitivity, consists of empathy, interpersonal and communicating skills, trust, respect, acceptance, appropriateness and barriers to cultural sensitivity. In a nutshell, cultural sensitivity contains the crucial development of appropriate interpersonal skills with the patients. This requires that the nurse sees the patient as an equal partner. It means that the nurse trusts, accepts and respects the patient's knowledge and opinions regarding his/her care. Effective communication is an

important part of the cultural competence, and to ensure this, the nurse must develop transcultural communicative competence. Transcultural communicative competence has two elements, cultural communicative competence and intercultural communication. Cultural communicative competence consists of developing specific knowledge and insights into a specific culture and having the skill to use this knowledge to guide one's understanding of the patient. Intercultural competence is the generic ability to recognize the challenges of communication across cultural boundaries. The most common barrier to cultural sensitivity is often times the ignorance of culturally appropriate communication (Papadopoulos et al. 2006: 16-17).

Cultural competence, the fourth level, consists of the three previous stages and further focuses on the practical caring skills. The most important part of this level is the ability to recognize and to challenge racism and other forms of discrimination and oppressive practice. To assess the patient's needs, several models and tools to appropriately collect cultural data from the patient have been developed. The awareness and knowledge concerning transcultural care, which the nurse has gathered from several sources, expresses itself in the practice in caring skills which are culturally sensitive, thus making the nurse culturally competent and therefore capable of providing nursing of a good quality to his/her patients (Papadopoulos et al. 2006: 18).

4 PREVIOUS STUDIES AND LITERATURE

Background material was acquired via database and manual search. The database used was Cinahl. Eventually articles were chosen based on the relevance of the abstract and the title.

In Taavela's study (1999: 130), health care workers of several different municipalities in Finland reported their own images of migrants. 39% of the images were categorized positive, 22% negative, 24% neutral and 16% difficult to interpret. 48% of nurses thought that transcultural patients were not more challenging than Finns, but over a half of the nurses who participated felt that transcultural patients were "difficult" (1999: 131). Nonetheless Abdelhamid states that racism in nursing can be seen as a presumption to interpret migrant patients as "difficult" because they act and look different than the native citizens (2010: 96). For example Narayanasamy and White

(2004: 102-111) reported that nurses' behavior was less restricting towards white patients and their relatives, and more restricting towards people of other skin colors. However, nurses in the study by Starr and Wallace (2009:53) self-reported that their level of cultural competence was either somewhat competent or very competent.

It has been shown that health care professionals' negative attitudes towards migrant patients – i.e. their lack of cultural competence – place the ethnic minority populations at a risk of health care disparity (Sainola-Rodriquez 2009: 45). The health care disparities among population groups appear in many different ways. For instance, negative attitudes prevent the nurse to correctly interpret and listen the patient, which can lead to a lack of appropriate health promotion activities with the migrant patient (Abdelhamid, 2010: 96). Still, according to Haavikko and Bremer (2009: 34), complete tolerance towards migrant patients may not be possible. However, it is important for the worker to be aware of their own attitudes, so that the attitudes can be taken into consideration while working. That way they will not subconsciously guide the working procedures, and will not lead clients into unequal status. For example, according to nursing staff in Hassinen-Ali-Azzani's doctoral dissertation (2002: 153), Somali migrants use health care services abundantly and seek care for minor discomfort. The nursing staff believed this was due to strong confidence to health care services, feeling of insecurity and long-time lack of health care facilities in their country of origin.

Language and interpretation differences have emerged as one of the most troublesome area of transcultural nursing. A study by Tuohy et al. (2008: 167) revealed that according to nurses language barriers were especially challenging in implementing transcultural nursing care. Furthermore, uncertainties concerning differences in the norms of the patients' backgrounds contributed to difficulties in initiating a good quality patient-nurse -relationship. Nurses felt that being understood and being able to understand, both the language and cultural specialties were key factors in delivering optimal nursing care (Tuohy et al. 2008: 167). Furthermore, Ray (2010: 169) explains that miscommunication is often due to inability to understand that language and communication are based on culturally orientated interpretation. The nurse and the patient may have different perceptions what the spoken language actually represents, i.e. both the nurse and the patient interpret each other's speech according to their own cultural background.

Using an interpreter is seen to have a positive effect on the communication with patients with whom the nurses do not share a language (Tuohy et al. 2008: 167). Haavikko and Bremer (2009: 54) state that using an interpreter eases the interaction with a migrant client, because it is possible to reach the relevant issues with an interpreter. A competent interpreter is able to explain culturally-bound behavior that might not be noticed due to cultural differences between the worker and the client.

Health beliefs bring up another issue in the field of transcultural nursing. Patient's health beliefs derive from the ethnic, cultural or religious world views and they help or guide the patient in making choices concerning their health (Culley & Dyson 2010:22). The health care professionals might regard these views as in opposition to scientific medical knowledge and there are various health beliefs, which challenge the care of the patient. For example, a patient may use the traditional healing system of his culture simultaneously with the Western medical care and these together may cause adverse effects (Culley & Dyson 2010: 77). It can be stated also that illnesses are expressed in a culturally orientated way (Dogan, Tschudin, Hot & Özkan 2009: 684). This means that the symptoms of a given illness may be experienced differently according to the patients' cultural background. Dogan et al. (2009: 648) remarks that for delivering culturally competent care the nurse needs to be aware of the health beliefs of the patients they are caring for since they may have a notable impact on the success of the care.

Many studies have displayed challenges with transcultural nursing. A research team has come up with standards of practice for culturally competent nursing care (Douglas et al. 2009: 257-269). The purpose of the article by Douglas et al. is to begin discussion of a set of universally applicable standards of practice for a culturally competent care for nurses. They have also listed 12 standards to start with; social justice, critical reflection, transcultural nursing knowledge, cross cultural practice, healthcare systems and organizations, patient advocacy and empowerment, multicultural workforce, education and training, cross cultural communication, cross cultural leadership, policy development, evidence-based practice and research. The framework of the standards is social justice, that is, the belief that every individual and group is entitled to fair and equal rights. Douglas et al. (2009: 266) also mention that there is a need to educate nurses to deliver culturally competent care. The nurses themselves also recognized the need of further education (Starr & Wallace 2009: 54). Nurses are in general (60%)

interested to have more education on transcultural issues (Dogan et al. 2009: 689). According to nurses the further education should be provided by the organization they work in (Starr & Wallace 2009: 54).

In conclusion, there are some consistent subjects arising from the literature that are seen as the challenges of delivering transcultural nursing. These subjects are the lack of overall cultural knowledge, prejudices and harmful attitudes towards migrant patients, communication difficulties due to inadequate language and interpretation skills and the lack of universally agreed standards of practice for culturally competent nursing. Nurses' conceptions about migrants overall and migrant as a patient have an impact on how they interact with and treat the migrant patients.

This final project explores the nurses' attitudes towards transcultural nursing and their self-reported level of cultural competence in order to find out what are the current challenges of delivering transcultural nursing in Finland. It is important to find out the current challenges of transcultural nursing so that the further education of nurses could be planned to meet their needs in the practice. The findings of this final project will reveal if the nurses in Finland are faced with the same kind of challenges of transcultural nursing as the previously gained information states.

5 PURPOSE OF THE FINAL PROJECT AND RESEARCH QUESTIONS

5.1 Purpose of the study

The purpose of this final project was to explore the attitudes towards transcultural care and self-reported level of cultural competence of Finnish Helsinki metropolitan area nurses according to the Papadopoulos, Tilki and Taylor model for developing cultural competence.

5.2 Research questions

This study attempts to answer to two closely related research questions. The outcome of the questions will give current information about nurses' attitudes concerning the delivery of transcultural care.

■ What kinds of attitudes do Finnish Metropolitan area nurses have towards migrant patients?
■ What is the nurses' average level of cultural competence when providing nursing care to migrant patients?

6 METHODOLOGY

6.1 Developing a questionnaire

The questionnaire used in this final project was developed by Kämäri, Lempinen and Leppänen as a part of a previous phase of the LOG-Health Project (2009: 33-35). It consists of 40 different statements related to transcultural nursing and nurses' attitudes.

Questionnaires are used to collect data from individuals about knowledge, attitudes, beliefs and feelings. Items in a questionnaire must be clearly written, so that they are comprehensible to the respondent. Close-ended items, or questions, are used when a fixed number of alternative responses are chosen. Fixed-response items simplify the respondent's task and the researcher's analysis, but may miss some important information about the subject. In addition, people are known to answer in a way that makes favorable impression, also known as social desirability. Because there is no way to tell what the reality is, the researcher is forced to assume that the respondent is telling the truth. Questionnaires are desirable tools when the purpose is to collect information. They are also inexpensive, allow for complete anonymity, and are free of interviewer bias (LoBiondo-Wood & Haber 2006: 325-328).

There are different phases when developing a questionnaire; naming the matters that are researched upon, designing the structure of the questionnaire, testing the questionnaire, revising the structure and questions, and then coming up with the final form.
When testing the questionnaire, 5-10 people are enough, as long as they actively strive for examining the clarity and unambiguousness of the questions and instructions. In addition, they have to consider the content and functionality of the response options, as well as the burden of filling out the form and the time it consumes. The respondents should also consider if something relevant is missing, or if there are unnecessary

questions involved (Heikkilä 2005: 48, 61). The questionnaire by Kämäri et al. (2009: 17) was tested by 10 third-year nursing students and modified according to suggestions.

Designing a questionnaire requires familiarizing with literature, reasoning a research problem and clarifying it, defining concepts, and choosing a research layout. When planning, one must also consider how the matter is processed (Heikkilä 2005: 47). The statements of the questionnaire used in this final project address the most common problems when giving and receiving transcultural care. The data is analyzed with the Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence (2006: 8-23). Each statement of the questionnaire belongs to one of the four levels: cultural awareness, knowledge, sensitivity and competence.

- Cultural awareness, the first level of the model for developing cultural competence, is assessed through statements 1-13. The first statements, 1-4, chart the respondent's cultural identity. Statement number 8 explores the respondent's ethnocentricity. Statements 9-12 study the respondent's knowledge about Finnish population's ethnohistory.
- Statements 14-20 explore the level of nurses' cultural knowledge, second level of the model. Statements 14-18 study the nurse respondent's all-round education about different cultures and statements 19 and 20 explore the respondent's awareness of cultural differences.
- In the questionnaire statements 21-36 describe the respondent's cultural sensitivity, the third level of cultural competence.
- Cultural competence is explored through the statements 37-40, which is the highest level of the PPT model and includes all previous levels.

In the questionnaire of this final project, a Likert-type scale is used. Likert-type scales contain close-ended questions with lists of statements on which participants indicate their opinion, such as, "strongly agree", "agree", "disagree", and "strongly disagree" (LoBiondo-Wood & Haber 2006: 325). In the questionnaire by Kämäri et al. (2009: 12) also neutral category is introduced to the participants, "do not agree or disagree". Neutral category may create a problem because it is often the most frequent response and is difficult to interpret (LoBiondo-Wood & Haber 2006: 325).

6.2 Modifying the questionnaire

According to Heikkilä (2005: 53), neutral category may be too tempting, and it is recommended to consider leaving it out, and thus force the respondent to take a stance on one way or another. It was decided to remove the neutral category from the questionnaire in order to acquire a wider array of opinions from the participants. Therefore the remaining categories were “strongly agree”, “agree”, “disagree”, and “strongly disagree”.

A good question asks for one matter at a time, is necessary and useful, is not too long or complicated, is not manipulative, and enables receiving results in a desired manner (Heikkilä 2005: 57). In this final project statements were used instead of questions. Some of the pre-designed statements were edited with the intention of decreasing suggestiveness, promoting objectivity and grammar, and clarifying the content of the statements. Statements 5, 23, 31 and 35 were modified in order to clarify them, while statements seven, 11 and 26 were re-examined with the intention of promoting objectivity and generalizing the message of the statements. In order to decrease suggestiveness, statements 12, 16, 21, 22, 26, 29, 30, 38, 39 and 40 were tailored. Grammatical considerations were executed with statements 17, 21, 23 and 28. Also a new statement related to personal information was formed; what is the participant’s nationality, Finnish or other. The rest of the statements in the original questionnaire were left untouched. See Appendix 1 for the modified questionnaire as utilized in this final project.

A covering letter (Appendix 2) was distributed alongside the questionnaire. The purpose of a covering letter is to motivate the respondent to fill out the questionnaire and to explain the background of the study and the means of answering (Heikkilä 2005: 61).

6.3 Data collection

The research was quantitative and took place in the Helsinki Metropolitan area, in three wards that tend patients from different cultural backgrounds. Inclusion criteria were that the participants worked as nurses, public health nurses or practical nurses. The data was collected using a modified questionnaire. It utilizes Likert-type Scale as a measurement

instrument and data was analyzed with the statistical program SPSS. As the questionnaire was in Finnish, participants were required to speak Finnish.

Quantitative research in nature tests relationships, assesses differences, and attempts to justify the cause and effect interactions between variables. It also includes research questions, or hypotheses. The data is received in numerical format and is analyzed using statistics (LoBiondo-Wood & Haber 2006: 28). The population of a research is the target population, of which the information is wanted. Sample is a representative miniature of the population. The sample can never fully describe the population (Heikkilä 2005: 33-34). In this final project, the population was nurses, practical nurses and public health nurses. The sample was the participants in three different wards in Helsinki.

In order to carry out the research, permission from the charge nurse at Helsinki University Central Hospital (HUCH) was needed (Appendix 4). The researchers filled out the standard HUCH form needed for the permission and sent it to one of the heads of the HUCH profit centers. A description of the study was also written and sent to the head of the HUCH profit center to provide background information (Appendix 3). When the permission was received, the head nurses of three selected wards were contacted in order to set a date for data collection. The researchers went to the wards themselves and explained about LOG-Health project to the participants before giving out the covering letter and the questionnaire. The participants placed the filled out questionnaires in sealed envelopes. The researchers themselves collected the questionnaires, in order to guarantee anonymity. Some questionnaires were left for the head nurse to give to the absent nurses, which were then again collected afterwards by the researchers. A sample size of 50 participants was the objective.

6.4 Data analysis

The data of the questionnaire was analyzed according to the Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence (2006: 8-23). The participant's response was placed in one of the levels of the PTT model, which then concludes the respondent's cultural competence in relation to attitudes. There were both positive and negative statements in the questionnaire (2009: 33-35).

Positive statements were questions number 3-7, 10, 17, 18, 20, 22, 24, and 34. For these questions the level of cultural competence was defined so that value four represented the highest level of the model, cultural competence, and number one the lowest, cultural awareness. Negative statements were questions number 1, 2, 8, 9, 11-16, 19, 21, 23, 25-33, and 35-40. The negative statements were evaluated the opposite way to positive, meaning that number four was the lowest level of the model, number one being the highest. In this way the mean value could be calculated, and the level of cultural competence could be measured.

The negative statements needed to be recoded with SPSS; number four became one, number three became two, number two became three, and number one became four. The negative statements needed then to be transformed into positive, so that the message stays the same after recoding the numbers. For example, statement number nine originally was: “The attitudes of my colleagues are negative towards immigrants” and after transforming it: “The attitudes of my colleagues are positive towards immigrants”. The recoding of the numbers and transformation of the statements were done to enable further analysis of the data.

There are different types of measurement scales, of which nominal scale and ordinal scale are used in this project. Nominal scale is used to put data into categories without any kind of order or structure (Polit & Beck 2010: 371). For example, in this project two of the questions in the first section of the questionnaire are categorized using nominal scale: sex and nationality. In the rest of the questions ordinal scale is used. It is used to categorize numeric information in order according to the value of the numbers, i.e. one equals “strongly disagree” and four equals “strongly agree” (Polit & Beck 2010: 371).

6.4.1 Sum variables

Sum variables are used to describe a single phenomenon that is measured with different statements. The variables are summed together to form a mean value that explains the chosen phenomenon (Valtari 2004). In this questionnaire there are four different sum variables, according to the PTT model (2006: 8-23): cultural awareness (statements 1-13), cultural knowledge (statements 14-20), cultural sensitivity (statements 21-36) and

cultural competence (37-40) (see page 14). In order to secure that sum variables and cross-tabulations were executable, the negative variables – i.e. statements – were transformed into positive form. If the mean value of a sum variable is two, the statement option two had been the most often chosen one. Since statement option two equals "somewhat disagree", the sum value indicates that the most often picked statement option was "somewhat disagree".

6.4.2 Chi-square and Fisher's exact probability test

Chi-square is a formula used to determine whether variables differentiate from each other. It defines the frequencies of variables and examines whether they are discernible from response expected by chance. However, if the sample size is small, chi-square cannot be applied. Instead Fisher's exact probability test is implemented to ensure more specific results (LoBiondo-Wood & Haber 2006: 377). In this work Fisher's exact probability test was utilized. A value measuring significance level, p-value, is the result of the test, which explains, "how big is the risk that difference depends only on the chance [sic]" (Leskinen 2008). The risk level needs to be below 0.05 in order for the difference to be significant, i.e. the risk that the difference is due to chance is less than 5% (*SPSS pikaohjeita*). Leskinen (2008) explains that,

- $p \leq 0.001$ = very highly significant
- $0.001 < p < 0.01$ = highly significant
- $0.01 < p\ 0.05$ = statistically significant

In conclusion, with a p-value above 0.05 chance has too big a part in the results and therefore the results are not reliable. Due to the small sample size in this project, some of the response choices displayed for background information and statements had to be regrouped in order to get a better p-value. This had to be done in order to enable the analysis of the collected data.

In the questions on background information, the following changes were made, balancing out the number of respondents in each group:

- Age groups "Less than 20-year-olds", "20-29-year-olds" and "30-39-year-olds" became "39-year-olds and younger". Group "40-49-year-olds" stayed the same. Groups "50-59-year-olds" and "60-year-olds and older" were combined into "50-year-olds and older".
- For work experience, participants had been able to choose from "less than two

years", "from two to five years", "from six to nine years", "10-15 years", "16-20 years" and "21-25 years". These groups were combined into two different categories: "15 years or less" and "more than 15 years".

- As to how often participants encountered migrants, the choice "daily" remained its own group. "Once per week" and "from two to three times per week" became "from one to three times per week". "Monthly" and "less frequently" became "monthly or less frequently".
- The response choices for the question concerning the participants' language skills became "none" (previously the same), "one" (previously the same), and "two or more" (previously "two", "three" and "four or more").

For the statements that were cross-tabulated with the participants' background information, the response choices were condensed from "agree" and "somewhat agree" to "agree". "Disagree" and "somewhat disagree" also simply became "disagree". The statements in question were numbers three, five, six, eight, 12, 13, 14, 18, 28, 32, 34 and 39.

7 FINDINGS

The findings from the project were analyzed with the statistical program SPSS PASW Statistics 18. The questionnaires were collected in person by the authors. The authors also manually handled the data input.

7.1 Sample

Inclusion criteria were that participants worked currently as nurses, practical nurses or public health nurses. All participants took the questionnaire in Finnish. There were 53 nurses altogether on the inspected wards, out of whom 44 participated in the questionnaire. Therefore the response percentage was 83.0. Out of the respondents 95.5% were female and 4.5% were male. All of the respondents were of Finnish nationality, and the majority (63.6%) was 40-59 years of age. 18.2% fell into the category of 20-29-year-olds, 13.6% into 30-39-year-olds, and 2.3% into 60-year-olds or older.

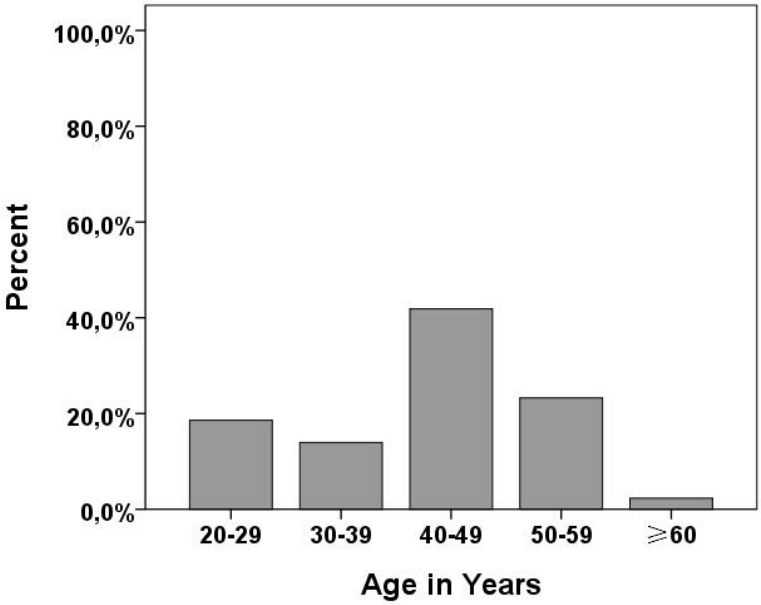

FIGURE 1. The participants'ages in years, portrayed in percentages.

As shown in the figure below, 27.3% had worked in healthcare for over 25 years. 22.7% had a work experience spanning from six to nine years. The third largest group (20.5%) had worked in the nursing field for 21-25 years. Of the respondents, 11.4% had a career of 16-20 years behind them, while 9.1% had worked for 10-15 years in the field. 6.8% had worked from 2-5 years in the healthcare industry, whereas 2.3% of the respondents had work experience spanning less than two years.

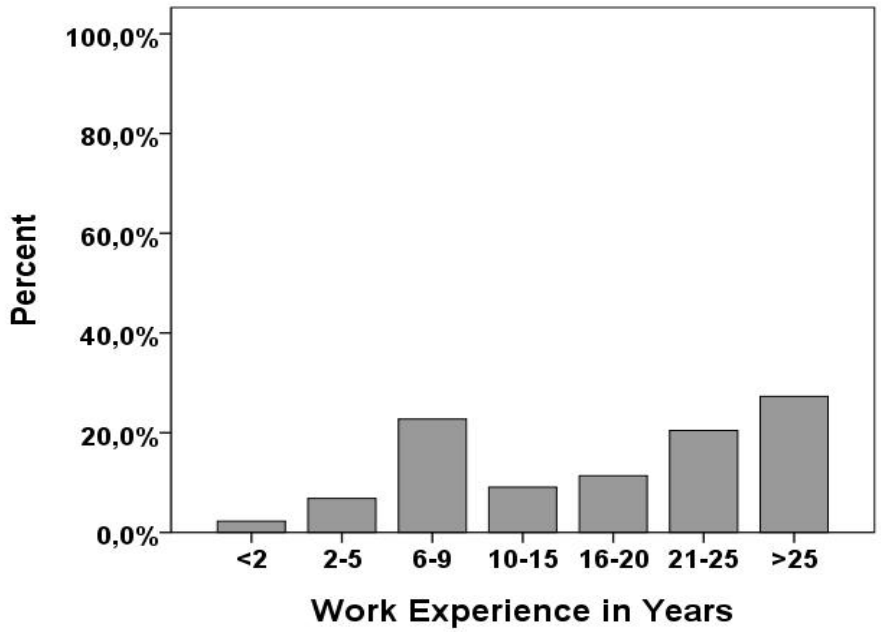

FIGURE 2. The participants' work experience in years, portrayed in percentages.

The majority of the participants (43.2%) reported that they met migrants on a daily basis during their work hours. 18.2% of the respondents met migrants from two to three times a week, while 13.6% of the healthcare workers who participated met migrants once per week. Monthly acquaintances were reported by 15.9%, and fewer occasions were stated by 9.1% of the participants.

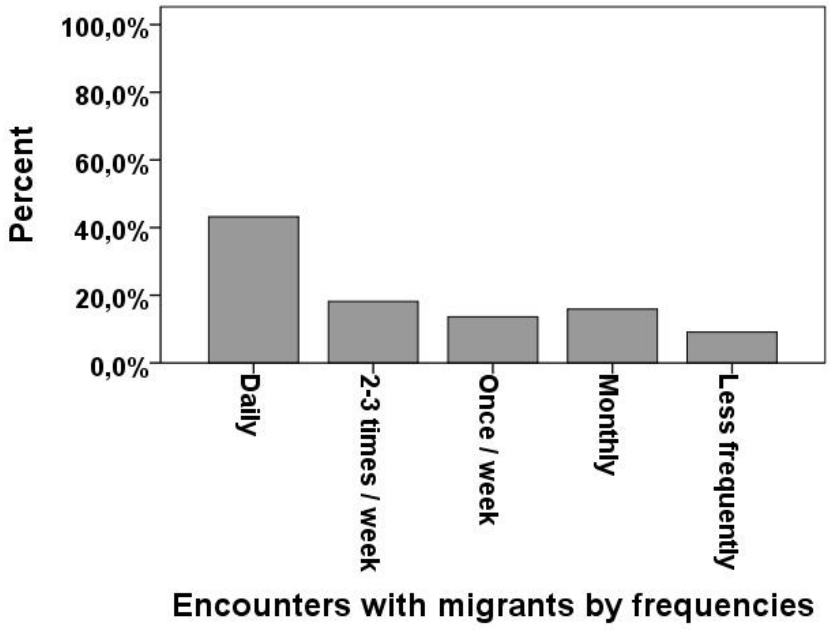

FIGURE 3. A portrayal of how often the participants came across migrants in their work.

40.9% of the participants informed that they are fluent in one language other than their mother tongue, and 29.5% spoke two additional languages. The percentage of those who only spoke their mother tongue was 22.7. Three additional languages were mastered by 4.5% of the participants. 2.3% spoke four or more foreign languages.

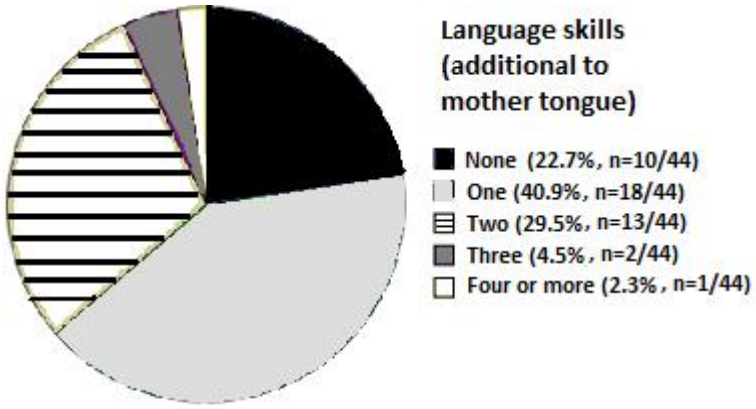

FIGURE 4. Percentages showing the participants' fluency in languages other than their mother tongue.

7.2 Findings according to the levels of the Papadopoulos, Tilki and Taylor –model for developing cultural competence

To determine the sum variables describing the phenomenon “cultural awareness” (PTT model, 2006), statements 1-13 were combined with the statistical program SPSS to get the mean value of the responses. On a scale from 1-4, the self-reported mean from 13 statements was 3.0531. This means that the average chosen response option was “somewhat agree”. Since all statements that were initially negative were changed to a positive form in order to sum up the data, the result indicated that the participants had quite a strong level of cultural awareness. This was according to the PTT model (2006) and the way the model was utilized in this project (see page 14).

For the phenomenon “cultural knowledge” (statements 14-20), the mean value of the responses was 2.9568. Therefore, the participants considered themselves to be quite solid when it came to their level of cultural knowledge. “Cultural sensitivity”, the third phenomenon (statements 21-36), scored a mean value of 3.0283. Once again, it showed similar results to the two previous phenomena. Similar indications were also found in the fourth and last phenomenon, “cultural competence” (statements 37-40). The mean value of the participants’ responses was 2.9605.

In conclusion, “cultural knowledge” and “cultural competence” scored lower than the two other categories. However, the differences of the mean values were minimal. In general, it can be said that the most picked response option was “somewhat agree”, which means that the participants considered themselves to have quite good cultural skills.

7.3 Nurses’ attitudes towards migrant patients

This chapter concerns the first research question of the project (“What kinds of attitudes do Finnish Metropolitan area nurses have towards migrant patients?”). The attitudes were examined according to the statements, by looking at the frequencies and doing cross-tabulations. Percentages are used in the text to portray respondents’ attitudes (n=44).

70.4% of the participants felt that migrants got equal treatment compared to the original population. 71.6% said that they readily cared for migrants. 81.8% (n=36/44) responded that their work community had a positive attitude towards migrant patients. The participants' significant others influenced their attitudes towards migrants in 20.5% of the cases, whereas coworkers' negative attitudes were considered to have a negative impact by 9.1%. However 15.9% felt that their coworkers had negative attitudes on migrant patients. When it came to addressing personal feelings, 31.8% acknowledged that they had prejudices against migrants. As for the presence of religious customs and rituals on the ward, 56.8% responded that they did not feel like the atmosphere on the ward was disturbed by these activities. 72.7% of the participants felt disturbed by migrants' nonconformist behavioral patterns, and loud behavior bothered 59.1%.

The majority of the respondents (56.8%) felt that migrants did not want to understand the Finnish time concept. On the subject of gender, 45.5% of the respondents felt that migrant male patients had degrading attitudes towards women. On the other hand 93.2% (n=41/44) understood that migrant female patients wanted female nurses to take care of them.

Overall the participants had positive outlooks on migrant patients' families: the majority did not feel that significant others perturbed the nursing process (68.2%), they were optimistic about large families visiting migrant patients (61.3%) and felt that families could partake in nursing care (72.7%). The importance of a common language became evident in the responses: 59.1% of the participants said that they would rather care for a patient who shared a mother tongue with them than a patient who spoke a foreign language, and 68.1% acknowledged that they were not pleased in caring for a patient with whom a common language was not understood. However, up to 90.9% (n=40/44) felt it was sensible to care for a migrant patient who did not speak Finnish. The whole participant group (100.0%, n=44) felt that the use of interpreters was necessary. Migrants were considered demanding patients by 52.3% of the participants, but 54.6% did not think that they were difficult clients. 36.4% of the respondents felt that it was easy to care for a migrant patient, and 88.6% agreed that migrants do not seek treatment for small ailments.

All of the 40 statements of the questionnaire were cross-tabulated with the participants' (n=44) background information. The results of the cross-tabulations that had significant

p-values were chosen to be presented in figures shown below. However there were few significant p-values due to the small sample size of the project. In the future a data collection with a bigger sample size is advised on the topic. Of the results of this study it can be said that overall older and more experienced nurses had more positive attitudes towards transcultural nursing. Results showed it easier to approach migrants with extended language skills. However, nurses who were fluent in several languages preferred to nurse patients who shared their own mother tongue.

Figure 5 assesses the participants' ages. It shows that older participants cared more readily for migrant patients. There is a notable progression that shows that the participants' readiness increased with their age. The more mature respondents were, the more they considered it relevant whether a female or a male nurse cares for a migrant patient.

Statement	**Opinion**	**≤39-year-olds**	**40-49-year-olds**	**≥50-year-olds**	**Total % of all responses**	**P-value**
3. I readily care for migrant patients.	Disagree	42.9%	16.7%	0.0%	20.9% (n=9/44)	0.022
	Agree	57.1%	83.3%	100.0%	79.1% (n=35/44)	
21. I do not consider it irrelevant whether a female or a male nurse nurses a migrant.	Disagree	61.5%	16.7%	18.2%	31.0% (n=14/44)	0.015
	Agree	38.5%	83.3%	81.8%	69.0% (n=29/44)	

FIGURE 5. Statements cross-tabulated with the participants' ages in years.

Below is a figure showing the participants' work experience in years cross-tabulated with statement number three. It shows that the respondents who had more work experience also cared for migrant patients more readily.

Statement	**Opinion**	**≤15 years**	**>15 years**	**Total % of all responses**	**P-value**
3. I readily care for migrant patients.	Disagree	38.9%	7.7%	20.5% (n=9/44)	0.021
	Agree	61.1%	92.3%	79.5% (n=35/44)	

FIGURE 6. Statement number three cross-tabulated with the participants' work experience in years.

Several statements showed interesting p-values when cross-tabulated with the questionnaire participants' language skills (Figure 7). The ones who spoke more languages felt it easier to approach migrant clients. They still preferred to nurse a client who shared their mother tongue, whereas 60% of the participants who spoke no foreign languages felt that it did not matter whether the client shared their mother tongue. The same percentage of the ones with less language skills also reported that they were usually not disturbed by migrants' nonconformist behavioral patterns.

Statement	**Opinion**	**No foreign languages**	**1 language**	**≥2 languages**	**Total % of all responses**	**P-value**
8. It is easy for me to approach a migrant client.	Disagree	40.0%	16.7%	0.0%	15.9% (n=7/44)	0.018
	Agree	60.0%	83.3%	100.0%	84.1% (n=37/44)	
12. I am usually not disturbed by migrants' nonconformist behavioral patterns.	Disagree	40.0%	83.3%	81.3%	72.7% (n=32/44)	0.047
	Agree	60.0%	16.7%	18.8%	27.3% (n=12/44)	
27. I prefer to nurse a client who shares my mother tongue than one who does not.	Disagree	60.0%	55.6%	12.5%	40.9% (n=18/44)	0.013
	Agree	40.0%	44.4%	87.5%	59.1% (n=26/44)	

FIGURE 7. Statements cross-tabulated with the participants' self-reported fluency in languages.

Figure 8 addresses how frequently the participants met migrants. Out of the ones who met migrants monthly or less frequently, 100.0% (n=44) responded that they did not have prejudices against migrants. The more frequently migrants were met, the more nurses reported prejudices. 76.5% (n=34/44) of the participants who met migrants daily reported that they considered migrants to be demanding clients. Out of the ones who met migrants from one to three times a week, only 28.6% felt similarly. Participants who met migrants daily did not agree that the Western caring conception was the correct one. With a more detailed observation of statement 38, it is shown that the respondents in the categories "1-3 times per week" and "monthly or less frequently" disagreed with the participants who met migrants daily.

Statement	Opinion	Daily	1-3 times per week	Monthly or less frequently	Total % of all responses	P-value
10. I do not have prejudices against migrants.	Disagree	47.4%	35.7%	0.0%	31.8% (n=14/44)	0.016
	Agree	52.6%	64.3%	100.0%	68.2% (n=30/44)	
32. I do not consider migrants to be demanding clients.	Disagree	76.5%	28.6%	54.5%	54.8% (n=24/44)	0.032
	Agree	23.5%	71.4%	45.5%	45.2% (n=19/44)	
38. The Western caring conception is not the correct one.	Disagree	6.7%	69.2%	72.7%	46.2% (n=20/44)	0.000
	Agree	93.3%	30.8%	27.3%	53.8% (n=24/44)	

FIGURE 8. Statements cross-tabulated with the participants' frequency of encountering migrants.

7.4 Nurses' cultural competence

This chapter concerns the second research question of the project ("What is the nurses' average level of cultural competence when providing nursing care to migrant patients?"). Findings that relate to the ongoing process of developing cultural competence are presented. The statements also concern attitudes, but the findings were categorized as cultural competence because the main interest in said statements was whether the respondents were able to overlook their own attitudes and opinions.

88.7% (n=39/44) recognized their own shortcomings when working with clients of a different cultural background. 95.4% (n=42/44) of the respondents answered that all patients deserved equal care regardless of their cultural background. The participants (95.5%, n=42/44) felt that further education on transcultural nursing would be useful. However, the percentage of those wanting additional tutelage to improve their capabilities in working with migrants was 79.5 (n=35/44). All of the participants (100.0%, n=44) responded that they tried to meet migrants' wishes concerning their treatment. Over half of the participants (56.9%) felt that it was easy to cooperate with migrant clients regardless of differing illness conceptions. 38.6% deemed the Western caring conception the correct one. 79.6% (n=35/44) of the participants felt that migrants did not think themselves to be a priority upon entering treatment compared to the

original population. Understanding migrant clients' own caring conceptions was considered agreeable by 90.9% (n=40/44) of the participants.

8 DISCUSSION

In this chapter the findings are discussed and compared with previous studies, along with the PTT model (2006: 8-23), which was the theoretical framework used in this project. Furthermore the reliability and validity as well as legal and ethical considerations are examined.

The study attempted to answer to two research questions, and the objective was that the outcome of the questions gives current information about nurses' attitudes concerning the delivery of transcultural care.

■ What kinds of attitudes do Finnish Metropolitan area nurses have towards migrant patients?
■ What is the nurses' average level of cultural competence when providing nursing care to migrant patients?

8.1 Interpretation of findings

In the first level of the PPT model (2006) cultural awareness is addressed. Dimensions examined by cultural awareness include whether or not the nurses acknowledge their own cultural background and their patients' cultural, historical, and geographical background. The nurses' acknowledgement of ethnocentricity and their use of stereotyping also belong to this level. Nurses (n=44) were disturbed by patients' nonconformist behavioral patterns, but less so when the behavior was centered on religious rituals. Loud behavior was considered disturbing, but a respondent noted in additional comments to the questionnaire that this did not exclude Finnish patients' behavior.

The framework used by Douglas et al. (2009: 266) holds as its central belief that every individual and group is entitled to fair and equal rights. In this project the respondents agreed on the right to equal care, no matter what the patient's cultural background is.

One fourth of the respondents (n=44) admitted that they had prejudices against migrant patients. According to Sainola-Rodriguez (2009: 45) this places the patients at risk of getting lower quality care. However other statements showed that the majority of the participants considered migrant patients to be an enriching aspect of nursing. Four fifths of the respondents readily care for migrant patients. Therefore it can be deducted that they have a positive attitude for the patients. Haavikko and Bremer (2009: 34) state that it is important to acknowledge one's own attitudes, while keeping in consideration that total tolerance is impossible to achieve. Most respondents were conscious of their own shortcomings in working with migrant patients.

The second level of the PPT model (2006: 8-23) concerns cultural knowledge. It includes knowing the similarities and differences between ethnic groups, health behaviors, beliefs and inequalities, and anthropological, sociopolitical, psychological and biological understanding. From the findings of this project it could be interpreted that the respondents were aware of cultural differences, but did not necessarily accept them. The differences were better understood when they addressed women's status. The uncertainty that nurses experience as a result of these differences can hinder the forming of a good nurse-patient –relationship (Tuohy et al. 2008: 167).

The respondents perceived that migrant patients do not easily take advantage of healthcare services. This contradicts e.g. in Hassinen-Ali-Azzani's (2002: 153) doctoral dissertation where it is stated that certain migrant groups seek treatment profusely. In order to give quality care the nurse needs to be aware of the patient's own health beliefs (Dogan et al. 2009: 648). The questionnaire findings show that the respondents were ready to understand foreign health conceptions.

In Star and Wallace's (2009: 54) and Dogan et al.'s (2009: 689) studies nurses recognized their need for further education in transcultural matters given by the organization they work in. In this project most of the nurses (n=44) recognized the usefulness of further education. Four fifths of the respondents wanted to receive such education.

Cultural sensitivity is the third level of the PTT model (2006: 8-23). Interpersonal and communication skills are a part of it, as well as skills in empathy, trust, respect and acceptance. Appropriateness and barriers to cultural sensitivity are also illustrated.

Questionnaire responses show that the nurses (n=44) tried to fulfill migrant patients' wishes concerning their treatment. This portrays features of acceptance and respect towards the patients. The majority of the respondents had positive attitudes towards migrant patients' families and felt that they could be included in the nursing process. Narayanasamy and White (2004: 102-111) reported that nurses' behavior was less restrictive towards Caucasian patients and their relatives, and more restrictive towards patients of other skin colors. The nurses featured in this project did not experience families to be problematic. In Taavela's (1999: 131) study over a half of the participating nurses considered migrant patients to be "difficult", but in this project the percentage of nurses (n=44) who thought so was 43.2. It should be taken into account that over a half of the respondents felt that migrant patients were demanding, while a little over one third stated that it was easy to care for migrant patients.

Over a half of the participants (n=44) did not mind treating a client who did not share their mother tongue. According to the nurses interviewed by Tuohy et al. (2008: 167) it was perceived difficult to care for patients who spoke a foreign language. The findings of this project contradict the previous statement. Ray (2010: 169) explains that miscommunication is often due to inability to understand that language and communication are based on culturally orientated interpretation. According to Papadopoulos et al. (2006: 17), the most common barrier to cultural sensitivity is often times the ignorance of culturally appropriate communication. The nurse and the patient may have different perceptions what the spoken language actually represents, i.e. both the nurse and the patient interpret each other's speech according to their own cultural background. The respondents felt that it was necessary to use an interpreter when there is no common language between a patient and a nurse. Haavikko and Bremer (2009: 54) state that using an interpreter eases the interaction with a migrant client, because it is possible to reach the relevant issues with an interpreter.

The final level of the PTT model (2006: 8-23) is cultural competence. It concerns assessment, diagnostic and clinical skills, along with the capability to challenge and address prejudice, discrimination and inequalities. Starr and Wallace's (2009: 54) study showed similar results with this study when they studied nurses' subjective experience of their own attitudes towards transcultural nursing. Abdelhamid (2010: 96) states that the motives for categorizing some migrant patients as "difficult" can be founded in racism. It was previously mentioned that less than half of the nurses participating in this

project considered migrant patients to be difficult. The majority responded that it was not difficult for them to approach migrant patients, but over a half said that it was difficult to nurse them. These two results give a conflicted view of the participants' clinical skills in transcultural nursing. Shattell (2004: 717) reported that nurses' own view was that they spend a lot of time with patients and treat all patients equally. In the findings of this study the majority of the participants felt that migrant patients were treated equally with Finnish patients, and almost all of the participants answered that all patients deserved equal care regardless of their cultural background. According to Weerasinghe and Mitchell (2007: 317) migrant patients often felt that nurses behaved insensitively towards them, due to differing health conceptions. However in this study the participants said that they acknowledged that the Western health conception is not always the correct one.

The questionnaire in this project measured nurses' attitudes. Attitudes are abstract matter, yet the project took a quantitative approach towards them. When an essentially qualitative topic was handled in a quantitative way, participant feedback for the questionnaire showed confusion in trying to choose responses for the statements. A participant wrote that they tried to see each patient as a human being, instead of e.g. a migrant, and tried to take into consideration all patients' wishes. They continued that even if they treated ten patients with a Somali background, i.e. ten migrants from a similar cultural background, all of those patients were still individuals with their own thought processes. In essence, it proved to be complex to measure the level of cultural competence of the participants. It is challenging to measure attitudes on a linear scale.

The interpretation the authors came to considering the findings was that in theory the participants were more migrant-friendly than in practice, i.e. almost all of the respondents considered that everyone deserved equal treatment regardless of their cultural background but over a half would rather care for a patient who shared their mother tongue. A participant admitted that transcultural nursing was at times challenging and even difficult, but that the challenge should not hinder good care from happening. The findings and the participants' feedback proved that the topic at hand is very sensitive. Comments given by the participants included that the questions were provocative and that no matter what the respondent chose as their answer, the statements still gave the impression that the respondent did not like migrants. Taking all this into consideration, it must be remembered that the questionnaire was modified

before distributing it to the wards. The previous version had been piloted with ten participants, but the tool at hand was still deemed too suggestive, hence the modification.

The findings showed that the participants who interacted the least with migrants had the most affirmative attitude towards them. Conflictingly, more negative attitudes were found in participants who were relatively young, as well as with those who had the most linguistic prowess. However, the participants recognized their need for further education on transcultural issues almost unanimously. They also admitted that they want additional education. Participant feedback addressed language skills, and one question raised as well was, “what kind of education?” Papadopoulos et al. (2006: 11-13) explain that in order to provide culturally competent care, nurses need to know something about historical, geographical and sociocultural background of their patients. This suggests that the basis for developing culturally competent nursing care would be to educate the nurses on the culturally specific aspects of their patients. It remains to be seen to what extent the participants want more education on transcultural nursing itself, or whether they feel like additional language courses would aid them in their work. Additionally, Star & Wallace (2009: 54) found out in their study that nurses wish to have further education provided by the organization they work in.

8.2 Reliability and validity

Issues of reliability and validity are of great concern to the researcher as well as to the reviewer of the research, as invalid and unreliable measurement instruments result in invalid conclusions, which will not advance the development of nursing theory and evidence-based practice. Validity refers to whether an instrument measures what it is supposed to measure. When an instrument is valid, it truly reflects the concept it is supposed to measure. The reliability of a research instrument is understood as the extent to which the instrument yields the same results on repeated measures. A measure can be reliable but not valid; however a valid instrument is reliable (LoBiondo-Wood & Haber 2006: 336-345).

It is difficult to assess validity afterwards; it must be ensured beforehand with careful planning and thoroughly considered data collection. The statements of the questionnaire must measure the correct matters in an unambiguous manner, and they must cover the

whole research problem. Furthermore the careful definition of the population, getting a representative sample, and high response percentage assist in a valid research coming true (Heikkilä 2005: 29). The questionnaire had been piloted and changed according to improvement suggestions by the 10 third-year nursing students (Kämäri et al. 2009: 33-35). The researchers of this final project modified the questionnaire to answer to their needs, which enhanced the validity of this project, as well as the beforehand planning of data collection and definition of the population.

In this project the sum variables were analyzed based on the categories as explained on page 15. As the analysis proceeded, it was noticed that the statements as categorized, discussing each phenomenon (cultural awareness, cultural knowledge, cultural sensitivity and cultural competence), did not in fact measure what they were supposed to measure. Compared with the above, this decreases the validity of the project. Ideally this would have been noticed before the data collection process. Were this study to be repeated, the validity needs to be taken into consideration.

The researcher is required to be exact and critical thorough the whole research. Errors can happen when collecting, entering, handling, and analyzing data. Results are random if sample size is very small (Heikkilä 2005: 30). These issues are a threat to the reliability of this research. The factor of social desirability (LoBiondo-Wood & Haber 2006: 325-328) was taken into consideration in the theoretical part of this project, but its effect cannot be pinpointed in the findings. Examinations of correlations performed in this project were done mainly out of interest to the data analysis process. Due to the small sample size these processes proved to be largely futile. Because of this, figures showing correlations were omitted from the final work. In the future the sample size can be increased, granting a more thorough chance to look at the values. A sample size of at least a hundred would already provide more reliable results.

8.3 Legal and ethical considerations

Before the data collection process was possible, the research had to gain the approval of the HUCH profit center, because the data collection concerned employees of that profit center. Had patients been the subjects of the data collection, an ethics committee approval would have been needed. (LoBiondo-Wood & Haber 2006: 303). Prior to the data collection, the questionnaire had been tested on Metropolia students.

Research must be performed with the utmost beneficence, honesty and objectivity (Heikkilä 2005: 29). Once the questionnaire was distributed in the chosen wards, it was accompanied by a covering letter that assures the participants consent to the study. As informed consent serves human rights issues (LoBiondo-Wood & Haber 2006: 297), the letter explained all facets of the research process that the participants needed to know in order for the process to follow the ethical principles of research. The meaning of the questionnaire was explained, as was the results utilization. The benefits of the study needed to be highlighted in order to increase the motivation of possible participants. The participants had assurance of the fact that the results would be handled with anonymity and confidentiality. No detailed or independent results were published, but rather the data was managed as a group. To further increase interest and trust in the study, the researchers introduced the study in person in the chosen wards, as well as picked up the filled-out forms.

9 CONCLUSIONS

Due to the small sample size (n=44) of this project, generalization of the findings is not possible. The first research question concerned the kinds of attitudes Finnish Metropolitan area nurses had towards migrant patients, and there were some distinctions that came up in the findings. Generally the participants' outlook on transcultural nursing was positive. Less experienced respondents, as well as the ones who were linguistically skillful, had more negative attitudes toward migrant patients than their counterparts. The largest reported problems in transcultural nursing were language barriers; the participants reported that utilizing the services of interpreters was useful. The majority was eager to get additional education on the topic.

The second research question examined the nurses' average level of cultural competence. The categories to which the statements were grouped in the questionnaire proved invalid. Therefore an average level of cultural competence could not be determined. However, the findings showed that the participant nurses had fundamental qualities needed in the process of developing cultural competence, e.g. recognizing their prejudices.

It is recommended that further studies utilizing the questionnaire should commence.

Given some modification, the questionnaire is an apt tool for measuring attitudes and cultural competence. The statements in the questionnaire would need to be regrouped according to the PTT Model (2006: 10), so that the statements actually correspond to each level of the model. A larger sample size is also recommended in order to acquire more generalizable findings.

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KYSELYLOMAKE

Kyselyn ensimmäinen osio koskee taustatietojanne. Ympyröikää parhaiten Teille sopiva vaihtoehto. Toisessa osiossa on väittämiä.

Olkaa hyvä ja valitkaa ympyröimällä sen vastausvaihtoehdon numero, joka parhaiten vastaa Teidän henkilökohtaista mielipidettänne.

TAUSTATIEDOT

1. Ikä **A)** <20 **B)** 20-29 **C)** 30-39 **D)** 40-49 **E)** 50-59 **F)** ≥60

2. Sukupuoli **A)** Mies **B)** Nainen

3. Kansalaisuus **A)** suomi **B)** muu, mikä? _____

4. Työkokemus hoitajana (vuosina)

A) < 2 **B)** 2-5 **C)** 6-9 **D)** 10-15 **E)** 16-20 **F)** 21-25 **G)** >25

5. Kuinka usein kohtaatte maahanmuuttajataustaisia työssänne?

A) päivittäin **B)** 2-3 krt. viikossa **C)** 1 krt. viikossa **D)** kuukausittain **E)** Harvemmin

6. Kuinka montaa kieltä osaatte puhua sujuvasti äidinkielenne lisäksi?

A) En yhtään **B)** Yhtä **C)** Kahta **D)** Kolmea **E)** Neljää tai useampia

VÄITTÄMÄT

Ilmoittakaa mielipiteenne ympyröimällä sopivin vaihtoehto: 1 = täysin eri mieltä, 2 = jonkin verran eri mieltä, 3 = jonkin verran samaa mieltä, 4 = täysin samaa mieltä. Toivomme teidän vastaavan jokaiseen väittämään.

	täysin eri mieltä	jonkin verran eri mieltä	jonkin verran samaa mieltä	täysin samaa mieltä
1. Maahanmuuttajataustaiset saavat mielestäni tasavertaista hoitoa kantaväestöön nähden.	1	2	3	4
2. Lähimmäisteni asenteet maahanmuuttajataustaisiin ihmisiin vaikuttavat omiin asenteisiini maahanmuuttajataustaisia kohtaan.	1	2	3	4
3. Hoidan mielelläni maahanmuuttajataustaisia asiakkaita.	1	2	3	4
4. Koen työyhteisön suhtautuvan positiivisesti maahanmuuttajataustaisiin asiakkaisiin.	1	2	3	4
5. Suhtaudun positiivisesti maahanmuuttajataustaisiin asiakkaisiin työssäni.	1	2	3	4
6. Koen maahanmuuttajataustaiset asiakkaat rikkaudeksi hoitotyössä.	1	2	3	4
7. Kaikki asiakkaat ansaitsevat yhdenvertaista hoitoa kulttuuritaustastaan huolimatta.	1	2	3	4
8. Minun on vaikea lähestyä maahanmuuttajataustaista asiakasta.	1	2	3	4
9. Kollegoideni asenteet maahanmuuttajataustaisia kohtaan ovat negatiivisia.	1	2	3	4

	täysin eri mieltä	jonkin verran eri mieltä	jonkin verran samaa mieltä	täysin samaa mieltä
10. Minulla ei ole ennakkoluuloja maahanmuuttaja-taustaisia asiakkaita kohtaan.	1	2	3	4
11. Mielestäni asiakkaiden suorittamat erilaiset uskonnolliset rituaalit häiritsevät osaston ilmapiiriä.	1	2	3	4
12. Toisinaan minua häiritsevät maahanmuuttajataustaisten asiakkaiden poikkeavat käyttäytymistavat.	1	2	3	4
13. Mielestäni maahanmuuttajataustaisten asiakkaiden äänekäs käyttäytyminen on häiritsevää.	1	2	3	4
14. Maahanmuuttajataustaiset asiakkaat eivät halua ymmärtää suomalaista aikakäsitystä.	1	2	3	4
15. Maahanmuuttajataustaisten asiakkaiden uskontoa määrittelevät normit eivät saa vaikuttaa hoitotyöhön.	1	2	3	4
16. Mielestäni monikulttuurisuusopinnot eivät ole hyödyllisiä käytännön hoitotyön kannalta.	1	2	3	4
17. Haluan lisäkoulutusta, jotta voisin helpommin kohdata maahanmuuttajataustaisia asiakkaita työssäni.	1	2	3	4
18. Tiedostan omat puutteeni työskennellessäni eri kulttuuria olevien asiakkaiden kanssa.	1	2	3	4
19. Maahanmuuttajataustaisten miespotilaiden suhtautuminen naisia kohtaan on alentavaa.	1	2	3	4

	täysin eri mieltä	jonkin verran eri mieltä	jonkin verran samaa mieltä	täysin samaa mieltä
20. Ymmärrän, että maahanmuuttajataustainen naisasiakas haluaa naishoitajan.	1	2	3	4
21. Mielestäni on yhdentekevää hoitaako maahanmuuttajataustaista mies- vai naishoitaja.	1	2	3	4
22. Pyrin toteuttamaan maahanmuuttajataustaisen asiakkaan toivomuksia koskien hänen hoitoaan.	1	2	3	4
23. Koen maahanmuuttajataustaisen asiakkaan omaisten häiritsevän hoitotyötä.	1	2	3	4
24. Suhtaudun myönteisesti maahanmuuttajataustaisen asiakkaan luona vierailevaan suureen sukuun.	1	2	3	4
25. Maahanmuuttajataustaisen asiakkaan sukulaiset eivät voi osallistua hoitotyöhön.	1	2	3	4
26. Maahanmuuttajataustaisen asiakkaan sukulaisia ei voida huomioida hoitotyössä.	1	2	3	4
27. Hoidan mieluiten omaa äidinkieltäni puhuvaa asiakasta.	1	2	3	4
28. Hoidan mieluiten asiakkaita, joiden kanssa osaan jonkun yhteisen kielen.	1	2	3	4
29. Mielestäni tulkin hankkiminen on tarpeetonta.	1	2	3	4
30. Suomen kieltä osaamattomien maahanmuuttajataustaisten asiakkaiden hoitaminen ei ole mielekästä.	1	2	3	4

	täysin eri mieltä	jonkin verran eri mieltä	jonkin verran samaa mieltä	täysin samaa mieltä
31. Aiemmat kokemukseni vaikuttavat negatiivisesti suhtautumiseeni maahanmuuttajataustaisiin asiakkaisiin.	1	2	3	4
32. Maahanmuuttajataustaiset ovat mielestäni vaativia asiakkaita.	1	2	3	4
33. Maahanmuuttajataustaiset ovat mielestäni vaikeita asiakkaita.	1	2	3	4
34. Maahanmuuttajataustaista on helppo hoitaa.	1	2	3	4
35. Kollegoiden negatiiviset kokemukset maahanmuuttajataustaisista asiakkaista vaikuttavat kielteisesti mielipiteisiini.	1	2	3	4
36. Mielestäni maahanmuuttajataustaiset hakeutuvat useasti melko pienen vaivan takia hoitoon.	1	2	3	4
37. Maahanmuuttajataustaisten asiakkaiden erilaisista sairauskäsityksistä johtuen heidän kanssaan on vaikea tehdä yhteistyötä.	1	2	3	4
38. Länsimaalainen hoitokäsitys on oikea.	1	2	3	4
39. Maahanmuuttajataustaiset asiakkaat ajattelevat olevansa etusijalla hoitoon tullessaan.	1	2	3	4
40. Maahanmuuttaja-taustaisten asiakkaiden omien hoitokäsitysten ymmärtäminen on epämieluisaa.	1	2	3	4

APPENDIX 2

METROPOLIA AMMATTIKORKEAKOULU SAATE

Terveys- ja hoitoala
Hoitotyön koulutusohjelma 7.4.2010

Arvoisa hoitaja

Opinnäytetyömme tutkii hoitajien kulttuurista osaamista ja se on osa Lokaalia Globaalia kehityshanketta sosiaali- ja terveysalalla (LOG-Sote). Hankkeen tarkoitus on vastata kansainvälistymisen haasteisiin ja kehittää maahanmuuttajataustaisten henkilöiden sosiaali- ja terveysalan palveluita. Olemme opiskelijoita Metropolia Ammattikorkeakoulun sosiaali- ja terveysalan englanninkielisestä sairaanhoitajakoulutuksesta. Valmistumme syksyllä 2010.

Opinnäytetyömme aineisto kerätään oheisilla kyselylomakkeilla, ja pyydämme Teitä vastaamaan kyselyyn. Antamanne vastaukset käsitellään nimettöminä ja ehdottoman luottamuksellisina. Kyselylomakkeet hävitetään analysoinnin jälkeen asianmukaisesti. Tulokset julkaistaan kokonaistuloksina, joten kenenkään yksittäisen vastaajan tiedot eivät paljastu tuloksista. Opinnäytetyötämme ohjaavat THM Eila-Sisko Korhonen (eila-sisko.korhonen@metropolia.fi) ja TtT Lea-Riitta Mattila (lea-riitta.mattila@metropolia.fi).

Kyselylomakkeen voitte jättää joko allekirjoittaneille tai osastonhoitajalle. Noudamme kyselylomakkeet henkilökohtaisesti osastoltanne. Tarvittaessa lisätietoja saatte allekirjoittaneilta.

Kyselyyn vastaaminen kestää noin 15 minuuttia ja on vapaaehtoista.

Kiitos etukäteen vastauksistanne!

Ystävällisin terveisin,

Marjo Ritala, sairaanhoitajaopiskelija (marjo.ritala@metropolia.fi)
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APPENDIX 3

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[redacted] klinikan johto
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Aineistonkeruulupapyyntö klinikan hoitohenkilökuntaan liittyen opinnäytetyötä varten

Opinnäytetyön tarkoitus on tutkia sairaanhoitajien asenteita monikulttuurista hoitotyötä kohtaan. Tutkimus on osa Lokaalia ja globaalia kehityshanketta sosiaali- ja terveysalalla (LOG-Sote), jonka tarkoituksena on vastata kansainvälistymisen haasteisiin ja kehittää maahanmuuttajataustaisten henkilöiden sosiaali- ja terveysalan palveluita. Tutkimuskysymykset ovat:

- Millaisia asenteita pääkaupunkiseudun alueen hoitajilla on maahanmuuttajataustaisia asiakkaita kohtaan?
- Mikä on hoitajien keskimääräinen kulttuurisen kompetenssin taso maahanmuuttajataustaisia asiakkaita hoidettaessa?

Tutkimuksessa käytetään teoreettisena viitekehyksenä Papadopouloksen, Tilkin ja Taylorin kulttuurisen kompetenssin kehittämisen nelikenttämallia. Nimettömyys turvataan keräämällä aineisto kyselylomakkeiden avulla ja tulokset analysoidaan SPSS tilasto-ohjelmalla. Tutkimussuunnitelman ovat hyväksyneet THM Eila-Sisko Korhonen ja TtT Lea-Riitta Mattila. Liitteenä tutkimuslupahakemus, tutkimussuunnitelma sekä kyselylomake.

Helsingissä 7.4.2010

Marjo Ritala	Sandra Siimeslahti	Suvi Tolvanen

HELSINGIN JA UUDENMAAN SAIRAANHOITOPIIRI
HYKS-sairaanhoitoalue 2009-2010
[redacted]

TUTKIMUSLUVAN MYÖNTÄMINEN 1 (1)

§ 96
3.5.2010
[redacted]

Hakija	AMK-sairaanhoitajaopiskelija Marjo Ritala [redacted]
Esittelijä	va johtava ylihoitaja [redacted]
Asia	**TUTKIMUSLUVAN MYÖNTÄMINEN SAIRAANHOITAJAOPISKELIJA MARJO RITALAN AMK-OPINNÄYTETYÖHÖN LIITTYVÄLLE KYSELYTUTKIMUKSELLE "ATTITUDES CONCERNING TRANSCULTURAL NURSING"** HUS-vastuuhenkilö osastoryhmän päällikkö [redacted]
Perustelut	Kyseessä on hoitoalan AMK-opinnäytetyö, jossa tarkoituksena on kyselytutkimuksen avulla selvittää sairaanhoitajien asenteita monikulttuurista hoitotyötä kohtaan. Tutkimus on osa sosiaali- ja terveysalan LOG-Sote kehityshanketta. Opinnäytetyön ohjaajina toimivat THM Eila-Sisko Korhonen ja TtT Lea-Riita Mattila Metropolia ammattikorkeakoulusta ja HUS-vastuuhenkilö on osastoryhmän päällikkö [redacted]. Tutkimuksesta ei aiheudu HUS:ille kustannuksia.
Päätös	Edellä olevan mukaan päätän, että AMK-sairaanhoitajaopiskelija Marjo Ritalalle myönnetään tutkimuslupa esitetylle kyselytutkimukselle ajalle **3.5.2010 - 30.9.2010.**
Ehdot	Tutkimuksesta tulee sen valmistuttua toimittaa lyhyt yhteenveto osastoryhmän päällikkö [redacted]
Sovelletut oikeusohjeet	HUS Yleiskirjeet 22/2000 Tutkimuslaki 488/1999; muutos 2004 Henkilötietolaki 523/1999
Päätösvallan peruste	Hallintosääntö § 20, Toimialajohtajan päätösvallan siirto § 85/2009 [redacted] ylilääkäri, tutkimus ja opetus
Jakelu	AMK-opiskelija Marjo Ritala opinnäytetyön ohjaajat Eila-Sisko Korhonen ja Lea-Riitta Mattila@metropolia.fi va johtava ylihoitaja [redacted] osastoryhmän päällikkö [redacted] sihteeri [redacted]
Lähetetty tiedoksi	3 / 5 2010
Lisätietoja antaa	sihteeri [redacted] HUS