Fenerbahçe Üniversitesi
Sağlık Bilimleri Dergisi
Cilt 1, Sayı 3, 168-180, 2021

Fenerbahce University
Journal of Health Sciences
Volume 1, Issue 3, 168-180, 2021

FBU-JOHS

Experiences of Intensive Care Nurses In Cultural Diversity: A Qualitative Study*

Yoğun Bakım Hemşirelerinin Kültürel Çeşitliliğine İlişkin Deneyimleri: Nitel Bir Çalışma*

*Bu çalışma 7th European Federation of Critical Care Nursing Associations (**EfCCNa**) kongresinde sözel olarak sunulmuştur.

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Özet

Yoğun bakım ünitesi (YBÜ) hemşireleri genellikle farklı kültürden hastalarla iletişimde kültürel ve dil farklılıkları nedeniyle çeşitli zorluklarla karşı karşıya kalmaktadır. İletişimde yaşanan yanlış anlaşılmalar kültürel çatışmalara neden olmakta ve bu durumlarda da yoğun bakım hemşireleri hastaya en iyi bakımı verebilmek için sorunu çözmek durumunda kalmaktadırlar. Bu çalışmanın amacı, yoğun bakım hemşirelerinin farklı kültürlerden gelen hastalara bakım verirken yaşadıkları deneyimleri ve zorlukları tanımlamaktır. Bu nitel araştırmada veriler, farklı kültürlerden hastalara bakım veren on yoğun bakım hemşiresinden oluşan iki odak grup görüşmesi yapılarak toplanmıştır. Özel ve devlet hastanesinden olmak üzere belirlenen iki odak gruba beş hemşire dahil edilmiştir. Veriler tematik analiz yöntemiyle analiz edilmiştir. Yapılan tematik analiz sonucunda Türkiye'deki YBÜ'lerde farklı kültürden hastaya bakım verirken yaşanan zorlukların tıbbi terminolojide yetenekli tercüman eksikliği, hemşirelerin çaresizlik duyguları, artan iş yükü ve kültürel farklılıklara dair hemşirelerin yeterince farkındalıklarının olmaması şeklinde belirlenmiştir. Elde edilen bulgular, akut bakım ortamlarında, hemşirelerin farklı dilleri konuşan ve farklı kültürel değerleri olan hastalara bakım verirken ve iletişim birçok zorluklarla karşı karşıya kaldıklarını göstermektedir. Kültürel açıdan farklı olan hastaları tanılama ve bütüncül bakımı sağlayabilmek ve kültürel yetkinlik kazandırmak amacıyla standardize eğitim programlarının yoğun bakım hemşirelerine katkısı olacaktır. Ayrıca, kültürel açıdan hastaları tanılama klavuzlarının klinik uygulama sırasında kullanımının klinisyenlere katkı sağlayacağı düşünülmektedir.

Anahtar kelimeler: kültürel farklılık; hasta; yoğun bakım ünitesi; hemşire

Abstract

Intensive Care Unit (ICU) nurses often face various difficulties in communicating with patients from different cultures due to cultural and language differences. Misunderstandings in communication cause cultural clashes and in such cases ICU nurses have to solve the problems in order to give the best care to patients. The aim of the study is to identify experiences of and challenges for nurses caring for patients from different cultures. In this qualitative study, data were collected through two focus group interviews with ten ICU nurses caring for patients from different cultures. Each focus group was composed of five nurses either from only a private or a public hospital. The data were analyzed with thematic analysis method. After the thematic analysis, major themes related to the difficulties experienced by Turkish ICU nurses dealing with patients from different cultures include the following: lack of capable interpreters knowledgeable in medical terminology, nurses' feelings of helplessness, increased workloads, and lack of awareness about cultural difference. The findings show that in acute care settings, nurses face many difficulties in caring for and communicating with patients with different cultural values. Standardized training programs would enable intensive care nurses to diagnose culturally different patients, to provide holistic care, and to gain cultural competence. In addition, healthcare organizations must empower their clinicians by adopting and using structured cultural assessment tools to identify the cultural features of patients. Furthermore, it is

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maintained that the use of culture-sensitive diagnostic guidelines during clinical practice would contribute to clinicians' performance.

Keywords: Cultural diversity; patient; intensive care unit; nurse

Atıf için (how to cite): Kebapçı, A., Yalçın, B. (2021). Experiences of Intensive Care Nurses In Cultural Diversity: A Qualitative Study. Fenerbahçe Üniversitesi Sağlık Bilimleri Dergisi 2021;1(3), 168-180.

1.Introduction

Globalization has led to increasingly diverse populations in many countries across the world. International immigration has increased considerably over the last decade and according to the United Nations (UN), the number of international migrants has reached 281 million (UNDESA, 2019). Comprising many different ethnic groups including ethnic Turks, Kurds, Armenians, Greeks, and Jews, Turkey has been a multicultural country for centuries. However, since 2011, Turkey has seen an increasing number of Syrian refugees entering the country (Baban et al. 2017; Knappert et al. 2017). According to the UN Refugee Agency [UNHCR] and the Turkish Refugees Community Center [RCC], Turkey is one of the top ten host countries and it now functions as home to over 3.5 million Syrian refugees (UNHCR, 2019; RCC, 2019). As a result of the increasing number of refugees and the multicultural population in Turkey (Baban et al. 2017), healthcare professionals ordinarily face cultural differences while providing healthcare, which causes greater challenges related to cultural diversity.

Global changes are consequently changing the role of intensive care unit (ICU) providers in health systems (Garneau and Pepin, 2015). Therefore, it is necessary for healthcare administrations and clinicians to respond to the increasing cultural diversity of populations to which they offer care (Renzaho et al. 2013). Providing high quality care to a patient from a different culture is only possible when healthcare providers demonstrate cultural competence. Especially ICU nurses must be able to communicate and interact with culturally different patients (Hemberg et al. 2017; Pottie et al. 2008). It is emphasized that in critical care settings, improved patients' perceptions of care can increase provider's cultural competence (Curwick et al. 2015).

In order to offer high standards of care and to effectively communicate with patients, ICU nurses should recognize the importance of cultural considerations (Shafipour et al. 2014). The Brisbane Declaration, written by the World Federation of Critical Care Nurses Association (WFCCNa) in 2016, called attention to the importance of culturally competent ICU nurses who take care of patients with different cultural backgrounds all around the world. It also highlighted that critically ill patients from different backgrounds have the right to get culturally-based care (WFCCNa, 2016). Research shows that the absence of cultural awareness leads to problems of misunderstanding in ICUs (Vydelingum, 2006; Ogunsiji et al. 2018), hence it has the potential to diminish the quality of care. According to studies, the challenges posed by increasing cultural diversity may lead to misunderstandings, miscommunication, misdiagnosis, increased workloads for ICU nurses, patient anxiety, and increased length of stay, especially for those in acute conditions (Attree, 2001; Hamilton ve Woodward-Kron,

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2010). In the case of critically ill patients or patients' families who are culturally different and speaking foreign languages, patient care demands more time, attention, and focus. The increasing cultural diversity of patients and their families in ICU settings has currently become a problem that nurses have not yet been able to overcome sufficiently. Being unaware of cultural differences can cause many misunderstandings and even mistakes in medical and nursing procedures, and it may eventually lead to low level of patient satisfaction (Ozga and Zdun, 2017). In their review study, Curwick et al. (2015) state that most studies highlight the role of nurses as crucial in providing culturally sensitive care within the healthcare team. However, a study conducted among Turkish nurses and midwives indicated that their level of cultural competency was moderate. According to another study conducted among Turkish nursing students, 91.2% of the students stated that they considered the cultural characteristics of patients; however, 68% of them had communication problems with patients from different cultural backgrounds (Ceylantekin and Öcalan, 2016). In another study, 87.5% of the Turkish nurses questioned indicated that they had troubles communicating with patients from different cultures, and 62.5% of them stated that they did not feel competent in transcultural nursing (Karakuş et al. 2013).

Besides the cultural differences, language barriers have also caused major problems and disparities in delivering effective health care (Pottie et al. 2008). In recent years, healthcare organizations have begun to employ interpreters who are present to explain procedures when a patient does not know, speak, or understand the local language. There are also some methods such as mouthing, nodding, writing, or drawing pictures that nurses can use to communicate with patients who are unable to speak the country's native language (Knappert et al. 2017; Patak et al. 2006). However, nurses still frequently have problems when misunderstandings occur regarding the specific meanings and nuances of patient behaviors, words, or expressions (Ogunsiji et al. 2018; Richardson et al. 2006). As a result, nurses may feel incapable and overworked, and these conditions may lead to job dissatisfaction and therefore to increased difficulty in communicating with patients (Garra et al. 2006). Nurses need to negotiate with culturally different family members to handle conflicts (Høye and Severinsson, 2010). Other studies further emphasized that due to the lack of adequate guidance in clinical settings and of organizational support, ICU nurses face challenges in effectively communicating with patients and understanding their cultures (Vydelingum, 2006; Ogunsiji and Chok, 2018; Crawford et al. 2016).

According to WFCCNa (2016), ICU nurses should have proper knowledge and skills to effectively respond to cultural needs and to provide culturally sensitive care for patient and families in collaboration with healthcare teams. With ethnic minorities composing an increasing proportion of the population, holistic and culturally competent patient care should be a goal of nursing (Doolen and York Nancy, 2007). Therefore, appropriate preparation of ICU nurses in caring for culturally different patients is very important. Considering the rising number of patients with culturally different backgrounds in Turkish ICUs, miscommunication often leads to cultural conflicts demanding urgent resolution. Since there are inadequate transcultural training programs and insufficient guidelines for ICU nursing among patients with different cultural backgrounds, new challenges occur related to

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cultural diversity in Turkey. We aimed to conduct this research in ICUs since nursing care is urgent and critical in ICU settings.

Furthermore, delays and miscommunications can be life-threatening for patients. Therefore, the study aimed to analyze the experiences of and challenges for the ICU nurses giving multicultural nursing care in the ICU environments in Turkey. Knowledge gained from this study may be beneficial for colleagues in the country to develop possible solutions.

1.1. Research Questions

1. What are the experiences of ICU nurses caring for patients from different cultures?
2. How do ICU nurses cope with the challenges related to cultural diversity?

2. Materials and Methods

2.1. Study Design

This qualitative study uses the Consolidated Criteria for Reporting Qualitative Research [COREQ] tool (Tong et al. 2007). A focus group approach was used to gain a holistic understanding of nurses' perceptions of working with patients with cultural backgrounds different from their own culture and to encourage meaningful discussions within the group. This method creates an informal atmosphere in which participants may freely discuss how such topics as norms, values, and beliefs relate to their own lives (Bloor et al. 2001). It also allows for interaction between participants, unveiling differing opinions and new areas for debate (Reed et al. 1997).

2.2. Setting and Sample

The data were collected from ICU nurses divided into two focus groups, one composed of five nurses from a public hospital ICU, and the other group having five nurses from a private hospital ICU. Purposeful sampling, a method commonly used for focus groups, was used to collect data. This method of sampling selects participants based on the purpose of the study (Krueger et al. 2000; Plummer-D'Amato, 2008). As such, the two hospitals included in the study were chosen specifically because of their diverse patient flows. At the time of the study, the government hospital contained 34 ICU beds and employed 60 registered nurses [RNs], while the private hospital contained 14 ICU beds and employed 23 RNs.

2.3. Participants and Recruitement

Participants were recruited by invitation sent to the ICU nurses' e-mail addresses. Then researchers contacted the ICU manager nurses and obtained the list of nurses along with their e-mail addresses. Participation requests were sent to the nurses via e-mail. Nurses who volunteered to participate were informed about the purpose of the study. The nurses gave verbal and written consent and were contacted by the research team. The study's inclusion criterion was being employed in the ICU as a bedside nurse. Five nurses from each hospital agreed to participate in the focus groups. In total, ten ICU nurses —six females and four males— participated in the study. All nurses were between 23 and 40 years of age and had 2 to 19 years of ICU experience [Table-1]. In order to facilitate themes between and across groups, researchers carefully collected sufficient data from the participants. Since data analysis is commonly conducted across groups of the same participant type (Halcomb et al.

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2007), researchers nominated only two focus groups. A convenience sample of ten ICU nurses participated in the study from one government [focus group [fg]-1] and one private hospital [focus group [fg]-2]. In order to encourage participants to express their views freely, care was taken to ensure that there was no administrational or power dynamic between participants.

Table 1. Demographic Characteristics of Participants

Focus group-1 (n=5)	**Age**	**Experince as an ICU nurse**	**Gender**
Nurse-1	40	19	Male
Nurse-2	36	15	Male
Nurse-3	34	10	Male
Nurse-4	32	7	Female
Nurse-5	25	3	Female
Focus group-2 (n=5)			
Nurse-1	27	4	Female
Nurse-2	25	3	Female
Nurse-3	26	4	Female
Nurse-4	25	2	Male
Nurse-5	26	3	Female

2.4. Data Collection

Sessions were conducted in each hospital's meeting room and to facilitate access and participation, interviews were carried during nurses' non-working hours. During each session, nurses were encouraged to speak spontaneously and were alerted to expect differing views and opinions. In order to create a safe environment of free discussion, the researchers indicated to the participants that the discussion was to focus solely on the participants' opinions about the obstacles they faced during personal interactions with patients from different cultures. After providing a brief introduction, researchers recorded audio in each session.

2.5. Tools

The researchers used existing literature on transcultural and ICU nursing to develop the 11 questions [Table 2] used in focus group interviews. The order and number of the questions were designed using Hurworth's [1996] triangular structure for focus groups. The interview began with a broad opening question about the background of each participant. This was followed by questions about participants' opinions concerning transcultural nursing and their perceptions of the difficulties they experienced while caring for patients from different cultures than their own. In addition, researchers also sought clarification of meaning and further explanation from participants. Furthermore, they took detailed notes during each interview besides audio recordings.

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Table 2. Focus Group Questions Used During Interviews

Focus Group Questions
1. How can you describe your ICU setting?
2. Can you describe your patient population?
3. How do you define the scientific development of patient care in your ICU?
4. How do you communicate with patients who are not native speakers of Turkish?
5. Are there any challenges?
6. Do you think that the culture in which you have grown up influences your nursing practice?
7. What does transcultural nursing mean to you?
8. How important is it to ICU nurses to know the different cultural / spirutual practices?
9. Have you ever provided care to patiens from different cultures?
10. Do you think that they or their families differ in their approach to diseases or treatment?
11. Do you think your patients or their families coming from different cultures differ in their attitudes towards the ICU?

2.6. Data Analysis

Both researchers conducted the interviews in Turkish. Then they transcribed the interviews and translated them into English. A professional native speaker and linguist of both Turkish and English languages provided the back translation of the content. Researchers completed the data-coding process using the Corbin and Strauss (2014) thematic analysis approach, with each researcher independently identifying significant statements and generating initial codes. The researchers then met to discuss their coding and themes. After discussing each theme, the researchers reached a consensus on the final themes. Four themes were established from the resulting codes.

2.7. Ethical Considerations

This study was approved by the Koc University Institutional Review Board [23.02.2016, 2016. 038.IRB3.028]. The managers of both hospitals gave formal and written approval for ICU nurses to participate in the study. Nurses were informed about the study in advance, and their oral and written consent were solicited before each focus group was conducted.

2.8. Rigor and Trustworthiness

In qualitative research, trustworthiness means dependability and credibility. Initial data analysis was undertaken independently by the researchers. In order to achieve dependability and credibility, results were discussed until reaching an agreement on the major themes. Using these strategies enhance dependability and credibility of the study (Holloway and Freshwater, 2007).

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3.Results

Nurses in both focus groups expressed similar problems and experiences during interviews; therefore, same themes were reached. The four major themes relating to the experiences of and challenges for nurses caring for patients from different cultures than their own are as follows:

(I) Lack of Capable Interpreters Skilled in Medical Terminology. All participants indicated that while interpreters were capable of translating conversations, they were not qualified to translate medical terminology. Due to interpreters' lack of experience in clinical practice, patients and their families often did not understand the seriousness of the patients' conditions. Such misunderstandings can then lead to conflict. One of the nurses working in a private hospital said that "*There was a patient from Iraq with a serious condition who did not speak Turkish. The family and the interpreter wanted to transfer the patient to another hospital. We tried to explain the risk of transportation through the interpreter. Due to friction with the ICU team over the issue, he had trouble translating and just forced the family to sign the papers"* [fg-2: Nurse-1].

Language barriers also have negative effects on patient outcomes, and problems generally occur when interpreters are not present. One nurse, for example, shared her experience with a patient scheduled to undergo brain surgery: "A*ctually, the patient's arm was broken, and we noticed that after surgery*" [fg-1: Nurse-3]. These types of misunderstandings generally occurred when patients and family members were not able to effectively communicate their needs, leading to frustration between patients and the healthcare professionals. One participant from a private hospital said that "*If the patient's family is hard to deal with, interpreters don't want to engage with them, and for me, communicating only through my limited English and gestures is very overwhelming" [*fg-2: Nurse-3]. Nurses emphasized that the need to be treated humanely is a mutual value for all cultures, despite the challenges related to language barriers. One nurse expressed that "*It doesn't matter the culture. The question asked by the families is always the same: 'Are they in any pain?'*" [fg-2: Nurse-4].

(II) Nurses' Feelings of Helplessness. Participants indicated that language barriers generally occurred when interpreters were not present. One nurse said that *"caring for a patient from a different culture makes me feel completely helpless."* [fg-2: Nurse-2] This is especially significant, as the inability to understand a patient's needs interrupts nursing care. One nurse shared the following anecdote: "*If the patient has been intubated, there is no problem... however, it is a desperate situation for me if he/she is conscious and can communicate with me simply because we don't know each other's language. Not being able to communicate with my patient or the family makes me feel helpless."* [fg-2: Nurse-5]

Such misunderstandings can often make nurses feel desperate.

(III) Increased Workloads. Feelings of helplessness and difficulties in understanding patients may lead to increased workloads for nurses. Participants stated that their workload increases when they are required to communicate with patients who do not speak Turkish or who have a different

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cultural background than their own. One female nurse said the following: *"For example, a patient needed a bedpan, but due to his culture and beliefs, he didn't want me, as a female nurse, to help him. I didn't have anybody else to help me and spent quite a while trying to find a solution. I insisted, and the patient involuntarily accepted the situation because there was no male nurse to help."* [fg-1: Nurse-5]

The inability to communicate with patients [especially when interpreters are not available] often results in decreased quality of care. One participant stated that "*In the absence of a qualified interpreter, nurses' resort to using simple gestures and words, in the manner of Tarzan and Jane*" [fg-1: Nurse-5]. One nurse shared the following anecdote: "*I had a patient who knew very little English. We tried to communicate with the patient in English but it took hours to understand her, and she was just trying to say that she wanted to see her four-year-old child."* [fg-2: Nurse-1]

Another nurse [from a government hospital] stated, *"Of course caring for a patient who doesn't understand your language increases my workload. Right now, I have a patient in CVICU who isn't supposed to lie on his side, and whenever I try to use gestures to tell him not to, he understands the complete opposite."* [fg-1: Nurse-2] If the patient is conscious, however, they must attempt to verbally communicate with him/her.

(IV) Lack of Awareness of Cultural Differences. The ability to effectively communicate with patients involves not only a common understanding of language but also a consideration of different cultural customs. Participants stated that this is also true for Turks coming from different ethnic and cultural backgrounds. One nurse said that "*Even in Turkey, there are many people from different ethnic backgrounds, and we can't know all of them. The key is that we don't forget that in the end, quality care doesn't have a language, and we have to do our best for our patients."* [fg-1: Nurse-3]. Healthcare professionals may not be aware of some cultural customs; however, they should anticipate differences and be willing to learn more about them.

4.Discussion

In the research, we focused not only on Syrians or Arabic patients but also all cultural groups; however, participants wished to talk especially about the challenges of dealing with patients from Syria or Iraq. The reason is that in the year we conducted the interviews, the most common non-Turkish cultural group in ICUs were Syrians due to Turkey's refugee policy and the high number of refugees living in Turkey. This result can be interpreted as pointing to the possibility that the ICU nurses could manage cultural practices more easily if the patients were Armenian, Jewish, or Greek—groups who have been living in Turkey for centuries and whose mother tongue is Turkish (alongside Armenian, Ladino, and Greek). It was seen that the nurses did not consider this as an issue since they did not have a language problem with these groups. Furthermore, this made us conjecture that ICU nurses may be less aware of the cultural characteristics of these minorities and consider that every patient who speaks Turkish has a similar culture.

Effective use of language is an essential requirement in order to build communication-based nurse-patient trusting relationships. However, language problem is the most common barrier in ICUs (Garra

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et al. 2010) and communication breakdowns may occur with patients suffering from acute conditions and/or with those coming from different cultures (Crawford et al. 2017). In a study, it was pointed out that if nurses could not understand patients' expression, they could communicate using many other ways, such as gestures, facial expressions, or pictures (Hemberg and Vilander, 2017). In this study, similarly to the previous study, one nurse expressed that they used gestures and simple words in the manner of Tarzan and Jane. If nurses are not able to understand a patient, they generally prefer to communicate through an interpreter. Furthermore, the participants in this study stated that interpreters were not able to meet the needs of nurses, patients, or patients' families because they lacked the experience pertaining to clinical practice and were not able to translate medical terminology. It is still sometimes difficult, however, to foster therapeutic communication through a third party (Jirwe et al. 2010). The primary responsibility of a hospital interpreter includes not only translating language, but also generating therapeutic communication between patients and healthcare professionals, despite cultural differences. The challenges associated with increasing cultural diversity in the workplace can often lead to feelings of frustration and anxiety (Brown and Holloway, 2008). Goodman and Agazio (2015) found that nurses expressed frustration when interpreters neglected to translate meanings expressed through a patient's emotions or inflections. In addition, interpreters may take a back seat if the patient or their family is not pleased or is asking too many questions. Brisset et al. (2013) emphasized that interpreters face many ethical dilemmas regarding confidentiality and trust. This may be so because they are required to solve difficult situations while at the same time trying to fulfill their various roles. Interpreters are generally helpful but they may not understand certain cultural considerations, and this gap in understanding may result in misinterpretations of what the nurse or the patient really means to communicate. It is essential, therefore, that hospitals employ qualified teams including bilingual and bicultural members and translators who are not only skilled in medical terminology, but also capable of sharing languages, cultures, and beliefs (Angelelli, 2006).

The Turkish Ministry of Health provides a "*Translation phone line*" service for nationwide use by both healthcare providers and patients or families. It is available 24 hours a day, every day of the week, and interpreters speak six different languages: English, German, French, Russian, Persian, and Arabic. Although interpreters are generally present in the hospital, nurses are sometimes unable to reach them when needed or do not have time to wait (Goodman et al. 2015). While they are generally available during working hours, they are only reachable by telephone during night shifts (Nailon, 2006). Because of the shortage of skilled interpreters, nurses often feel helpless and incompetent. In order to prevent misinterpretations and enforce consistency of communication, hospitals may consider hiring interpreters specifically appointed to the ICUs. Because, As Al-Amer et al. (2015) point out, employing multiple interpreters may cause problems in semantic and content equivalence. A qualitative study conducted among ICU nurses indicated that language barriers increase their workload because they are torn between caring for patients and organizing interpreters to come and help them to understand patients' and their families' needs (Listerfelt et al. 2019). Due to such challenges, nurses are obliged to allocate most of their time to communicating with critically ill patients instead of actually providing holistic care. Since they often spend significant amounts of time attempting to communicate with patients who may not speak the local language, they are less

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stressed when caring for sedated patients. Samarasinghe (2011) notes that, in addition to causing feelings of helplessness, cultural conflicts may also pose a variety of ethical dilemmas for nurses.

When the essential concerns of the ICU patients and families are considered, it becomes clear that cultural differences are not perceived as a barrier. According to one participant in this study, for example, a family's most important concern is often whether the patient is in pain. Nurses can usually alleviate such worries by simply showing signs of respect, attentiveness, and empathy. In doing so, they can demonstrate genuine concern for patients' thoughts and feelings (Pasco et al. 2004; Wikberg and Bondas, 2010). Hemberg and Vilander (2017) emphasize that when the patient and the nurse speak different languages, love may serve as the basis of patient care.

The majority of healthcare professionals in Turkey are Muslim and non-native English speakers. However, this study found that despite the obstacles related to cultural difference, nurses keep striving to give the best possible care. Nevertheless, high quality nursing care requires that hospitals provide nurses with training programs and support systems. Nurses cannot be familiar with all cultures and their defining characteristics, but they can follow a general framework in order to assess and understand cultural diversity. Most hospitals, however, lack systematic cultural evaluation tools or culturally competent approaches specific to use in the ICUs. Culturally competent health care also requires a common sense of cultural respect between patient and nurse (Hemberg and Vilander, 2017). In order to establish caring relationships, therefore, it is important that nurses acquire the necessary knowledge and understanding regarding cultural difference (Tuohy et al. 2008). The implementation of training programs might encourage nurses to become more aware of the values and beliefs of patients from different cultures (Goodman et al. 2015). In this way, hospitals/ICUs may improve the quality of nursing care and the success of patient outcomes.

5. Limitation

This was a qualitative study which, by its nature, required willingness by the ICU nurses to participate. A total of 10 participants were included in the study. Therefore, the low participation rate is a limitation of the study. Second limitation of this study was that we aimed to get data regarding the experiences of nurses with all patients, including Christians, Alawites, and Sunnis; however, all the nurses included in the study shared their experiences with Syrian refuges due to the increasing number of Syrian patients at that time.

6. Conclusion

This study shows that nurses experience various challenges in communicating with patients from different cultures. It also confirms that communication with culturally diverse patients is more difficult in acute care settings. The findings show that in acute care settings, nurses face many difficulties in caring for and communicating with patients with different cultural values. Standardized training programs will enable the ICU nurses to gain cultural competence and skills in assessing culturally diverse patients. In addition, healthcare organizations must empower their clinicians by adopting and using structured cultural assessment tools. These tools can be used to identify cultural features of the patients in ICUs.

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Acknowledgement

We thank all the participants for their contributions to this study. We are also very grateful for all contributions of ***Prof. Aysel Badır.***

Author Contrubitions

Study design and planning AK, BY; data collection AK, BY; data analysis AK, BY; analysis of the article AK, BY; review AK, BY

Conflict Interest

It has been declared that there is no conflict of interest between the authors.

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