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Contents

Back to contents page

Rural health services needing emergency care: Combined paramedic and nursing education a possible solution to rural health profession skill shortage.

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Planning for future health needs for rural and regional communities is a crucial challenge for governments at both Australian state and federal levels. A critical issue faced by many governments across the globe and catching the attention of the Victorian state government is the shortage of skilled health professionals in rural areas. Compounding the problem is the failure to recruit and retain graduates from rural areas in those areas after they enter the workforce. The problem is not just about how few graduates are recruited but also the fact that their scope of practice and skill set is often too narrow to meet the needs of a small community. Australian Catholic University's
Regional campus in Ballarat, a city of ninety thousand people in Western Victoria, in conjunction with the state's rural Ambulance Service has collaborated to offer a course designed to broaden the skills currently possessed by paramedics and nurses and aims to close the gap between pre-hospital and hospital care and to increase the utility of health professionals working in rural communities. The course, a four year dual degree in nursing and paramedicine is a departure from previously implemented programs in that it broadens the health professional's skill set prior to commencement in the workforce rather than when they have gained expertise in their field.

In the rural health context characteristically narrow ranges of skills have been compared metaphorically to silos by some authors (Vichiendilokkul, 2002), perhaps too often according to others (Satterfield and DeBruyn, 2005). Interestingly these same silos in reality are evocative of the physical landscape that forms the context for this paper. As one travels through the rural landscape in Victoria and other parts of Australia tall gray grain silos that adjoin railway lines linking grain growing regions to the ports punctuate the often long distances travelled. These icons of rural life loom on the horizon and mark the traveler's approach to the next town. In some cases they mark the sole reason for the town's existence. For the locals, they represent the place where they

converge as they deliver their grain. In a similar vein community health facilities also act as a hub where dwellers of outlying districts converge. The metaphor therefore acts as a powerful descriptor not just to describe the narrowness of services with sizeable gaps in between but also as a focal point for the meeting of local needs.

Australia, despite its immense size and rural iconography, has one of the most urbanized populations in the world (Ockwell, 2007). The overwhelming majority, seventy percent in fact, live on the seaboard fringe in capital and or principal cities. The remaining twenty six percent live in regional cities and towns with only four percent living in what can be considered rural or remote settings. The sparseness of Australia's rural population combines with large distances between centres to form logistical difficulties when attempts are made to meet rural health needs. To put this into perspective, Australia is thirty two times the area of United Kingdom and holds one third of its population. If Australia's population was perfectly evenly distributed, each Australian would have to walk five hundred metres to his or her nearest neighbour's house. However Australia's population is not evenly distributed, far from it in fact. Even though the overall population is growing, rural population centres are on the decline and as they decline the viability of infrastructure such as hospitals and health centres decline also.

The irony of the Australian rural iconography extends further in that it contains colourful descriptions of the stereotypical country Australian. This person is typically depicted as a hardy, fiercely independent and self reliant individual, often a farmer and often living in considerable isolation. The rural lifestyle often romanticized as being full of stress free days, clean air, empty country roads and social connectedness is not completely accurate. The reality is that country people have significantly poorer health status than their metropolitan counterparts and whilst the reasons for this are numerous, lack of access to regular specialist medical care must be considered. As Keneally, Hanson and Lang (1983 in Smith 2004 p. 55) put it "Just like the temperature, everything increases with increasing distance from the city; including, distance and flies". Rural health needs and the complexity involved in meeting those needs can easily be added to that list. Diabetes, for instance, results in far greater hospital admissions for rural living people than for those living in large cities and mental health needs are in critical need of attention (Dixon and Welch, 2000).

The needs of Australian rural centres are far from unique. Doctors are in short supply in areas outside large cities in many places across the globe. It can be seen in as diverse places as India to the United States (Patel, 2003),(Hart et al., 2002). Whilst the medical

profession is fortunate in its ability to get its message out, other professions have been less vocal. If one focuses on one of these professions, paramedicine, the outlook would have been considerably worse had the initiative not been taken by ACU and Ambulance Victoria.

In its first year of operation, the course has proven to be very popular having an intake of 50 students. This is quite a turnabout given the pattern of declining enrolments in nursing courses in the region over the previous five or six years. It has been suggested that the drought may have partly contributed to declining enrolments. Now, in its twelfth year, the drought may be having an economic impact on the families of potential applicants to these positions.

Similar declines but with quite different circumstances had occurred with Paramedicine. In this case, the Rural Ambulance Service of Victoria had failed to meet its recruitment targets for a number of years as its educational processes and professionalization lagged behind other health professions. The result at the end of 2006 was a workforce diminished in size, that was ageing and preparing to retire. Paramedics had continued to train in an "apprentice-style" vocational model whilst all other disciplines had made the transition to university. It could be argued that the type of training reduced the attractiveness of a paramedicine career. By 2007 two metropolitan universities offered paramedicine and were achieving excellent rates of recruitment and it became clear that a similar response was required from regional Victoria.

The course has been specifically targeted at rural school leavers and mature age students who are from regional areas and wish to experience clinical practicum in or close to their home towns. Ballarat is the ideal location for such a course as it is located on the Western highway, a major gateway to the northern and western regions of the state of Victoria. These regions comprise one third of the state geographically (30 000 km^2) and have no large cities. The majority of the population live in or near small towns of populations of five hundred to fifteen hundred people. Overall the region has one percent of the state's 4.5 million people resulting in a population density of 1.5 persons per km^2 . These regions are a considerable part of Victoria that ACU attempts to recruit from and hopefully return graduates to once qualified.

The campus has had a School of Nursing for eighteen years and has provided the regions with a non metropolitan option for nursing education. Locating a course in the region and undertaking clinical placements in rural areas has increased graduate interest in

practicing in non metropolitan areas both in the nursing course offered by ACU but also in other courses (Critchley et al., 2007). It is hoped that similar patterns will occur with the proposed dual degree.

The combined Bachelor of Nursing Bachelor of Paramedicine (BNBP) builds on the standard three years undergraduate Bachelor of Nursing (BN) by adding an additional nine specialist paramedic units and an extra year to the three year BN degree. Students undertaking the dual degree will engage in a curriculum accredited by the Nurses Board of Victoria and Rural Ambulance Victoria. The course entails theoretical units in both nursing and paramedicine as well as generic science units, inter-professional units and clinical practice units in both nursing and paramedic settings. The course is designed to be integrated and seamless in terms of its disciplinary delivery and is designed to produce graduates capable of working in either discipline. It is hoped that the current gap between rural health needs and rural health services can be reduced with the BNBP aiming to create a more flexible multi-skilled workforce as well as meeting the health needs of an ageing population particularly in the area of chronic illness management.

Of significance is the need to review the current scopes of practice, especially for rural practitioners. An individual's or community's needs remain even if the relevant health professional can't be found. What must occur, and indeed has been occurring, is an examination of what needs exist and who can best meet those needs given the appropriate modification to both training and scopes of practice.

However extending a health professional's scope of practice has never been easy. Significant barriers to this process always exist and as the Productivity Commision (2005) suggests boundaries are defended by powerful interest group and justification for maintaining such rigid professional delineation is the comprise of public safety. No one would argue that public safety is of paramount importance however it is believed that it should not prevent role expansion and new models of care delivery(Raven et al., 2006). It has been acknowledged that changing scopes of practice to better meet the needs of rural areas requires significant educational, service structural and possibly legislative change (O'Meara, 2003) however with this course graduates will be at the ready should such changes be made. It is not inconceivable that paramedics might be involved in services where deficits commonly occur such as: management and advice for chronic and minor illness, immunization services and wellness checks (blood pressure monitoring, wound healing, blood glucose monitoring, ECG tracings)

(Dorsch, 2000). These services are mostly outside the current paramedic scope of practice and range of services offered but well within the range of skills that is within the aims of the dual degree.

A review of the literature reveals a number of pilot projects and more in depth implementation of variations to the paramedic role but two that are commonly cited are the Emergency Care Practitioner (ECP) model and the Physicians Assistance model (PA). Both models have been trialed and evaluated, the former more commonly in the UK and the latter more commonly in the US (Raven et al., 2006). Given that skill shortages exist across a range of health professions in rural and regional Australia and not just doctors the PA model has not been implemented extensively. In addition, given that most of the caution expressed in relation to any profession expanding their practice has come from the Australian Medical Association (Raven et al., 2006), its title is problematic. The closest model to what is anticipated will be produced by the dual degree is the community paramedic model that has been trialed in number of locations in the UK including Yorkshire and East Anglia (Raven et al., 2006). In those programs existing paramedics underwent training and role extension following basic training, recruitment and extensive experience. The difference, however, between those models and the program offered at ACU is that skill set extension occurs as part of undergraduate preparation and prior to entry into the workforce rather than taking an experienced practitioner and providing further training. It is anticipated that the program will produce nurses with paramedic skill set extension, or conversely, paramedics with nursing skill set extension. Both are likely to be far broader in scopes of practice and are likely to reduce the "silo effect" as previously mentioned. Of equal importance is the possibility that this initiative can assist in transitioning health services from illness and emergency focused to a more preventative and wellness focused model, a clearly better option and one that is clearly lacking in many rural areas(Roger P. Strasser, 1994).

The course commenced after lengthy consultation with rural and regional stakeholders. A solution to the failure to recruit/failure to retain problem was to offer a course that was responsive to the regional needs, unique in the region and complementary to pre-existing courses rather than in competition with them. The course has been offered in concert with the single degree BN with equal numbers of BN and BNBP students. Prior to selection the number of applications proved to be in excess of what was anticipated and as a consequence the number of positions was boosted from an anticipated 25 to 65. The course eventually enrolled 50 students. The same number of offers are likely to be made in 2009.

Interestingly the entry requirements were considerably higher for the dual degree than the single degree.

Australian Catholic University is a publicly funded university with a motto of "Open to All". A student (or member of staff) doesn't have to be Catholic to attend and Catholic beliefs are not an inherent part of any of its courses offered by the Faculty of Health Sciences. There are however three compulsory subjects that can roughly be referred to as "mission units" titled Spirituality of Healthcare; Indigenous Culture and Health; and Ethics in Healthcare. These units are common to the BN and the BNBP. Whilst most nursing courses offered in this state study ethics and law, ACU is the only one to offer Spirituality as a core subject. Interestingly, whilst ethics units are common to nursing and paramedic curricula, there is discussion that the importance of spiritual considerations in paramedicine is often misjudged (Jang (jang T. Kryder G. Char D. Howell R. Primrose J. & Tan D., 2004) in that paramedics rate spiritual care as low in their priorities yet their patients disagree by rating it much higher. It is a principle of the university, and specifically this subject, that whilst Catholicity is not explicitly taught, the material and processes taught are consistent with the universally accepted principles of the university's mission. Out of this mission statement comes the principles of social justice, equity, respect for humanity, excellence in service and the dignity of all human beings.

A review of the literature describing the rural health professional shortage reveals a number of solutions designed to meet the needs of rural communities. What became obvious in the review is that each solution is responsive to the needs of its community. The is no one solution that fits all. ACU as a provider of health professionals has offered a preparation for health professionals that has not been tried in its region before and has been created jointly by the university and the community it services. The degree to which this course meets its aims is still yet to be determined.

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Back to contents page

Nursing Students' Approaches to Learning and Studying: A Longitudinal Study

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Background and Context

In 2002, first year students in the Faculty of Health Sciences at one Irish University where invited to participate in a study which aimed to establish their learning profiles at entry to and exit from their respective pre-registration degree programmes in Dentistry, Nursing, Medicine, Physiotherapy, Clinical Speech and Language Studies and Occupational Therapy.

Three questionnaires – the Approaches and Study Skills Inventory (ASSIST) (Tait et al, 1997), the Learning and Study Strategies Inventory (LASSI) (Weinstein, 1987) and the Learning Styles Inventory (LSQ) (Honey and Mumford, 1992) - were administered to participating students during the first and final years of their degree programmes.

Study Objective

This paper presents the findings from one objective from this study, which sought to identify the approaches to learning and studying of the nursing student cohort at entry to and exit from their programme of study.

The questionnaire used in this part of the study was the ASSIST Inventory (1997). The Inventory has undergone a number of changes since it first appeared in 1981 (Coffield et al 2004).

The 1997 version used here begins with a short section requesting the following background information from the respondent: name; student number; age; course and year of study. This is followed by the main body of the Inventory, a series of statements utilising five point Likert scales. The statements are subdivided into three main sections:

- Section A: What is learning? (6 questions)
- Section B: Approaches to Learning and Studying (52 questions)
- Section C: Preferences for different types of course and teaching (8 questions) and one final question which asks the respondent to rate how well they think they are doing on their assessed work overall.

This paper reports on the background information and students' responses to Section B: Approaches to Learning and Studying only.

The statements in Section B. Approaches to Learning and Studying are based on a conceptual model of learning which identifies three possible approaches to learning: deep; surface and strategic (Marton and Saljo, 1976, 1997; Marton, Hounsell and Entwistle, 1997).

The following table summarises the main characteristics of each approach.

Deep Approach **Student Focus**: seeking meaning **Student Intention**: to understand ideas for themselves
Surface Apathetic Approach **Student Focus**: reproducing **Student Intention**: to cope with the requirements of the course
Strategic Approach **Student Focus:** reflective organising **Student Intention:** to achieve the highest possible grades

Adapted from Coffield et al 2004:95

Methods

Design: A longitudinal prospective descriptive study of students' approaches to learning. The ASSIST Inventory was administered to a purposeful sample of undergraduate nursing students at two stages, in their first year of study and again in their final year.

Research evidence for the validity and reliability of the Inventory is discussed at some length by Coffield at al (2004) in their review of the literature on learning approaches and strategies. They conclude, 'Internal and external evaluations suggest satisfactory reliability and internal consistency. Validity of deep, surface and strategic approaches is confirmed by external analysis.' (Coffield et al 2004:103)

Sample: At the first stage of the study, 202 nursing students were registered in the class and the response rate was 75% (n=153). In stage 2, there were 166 registered nursing students and 69% (n=114) responded. Responses were excluded from analysis if the questionnaire was incomplete or students did not complete the questionnaire at both stages of the study. The final sample number was based on matched pairs from both stages and on this basis 67 responses were eligible for analysis.

Data Collection

Collection of student data took place in the classroom during the first term of the academic year for both stages of the study. A member of the research team outlined the details of the study to the entire nursing student class at each stage. Students returned the questionnaires, both complete and incomplete, to the member of the research team before leaving the classroom. Completion and return of the questionnaires was taken as consent to participate in the study. Ethical approval for the study was granted by the University Ethics Committee.

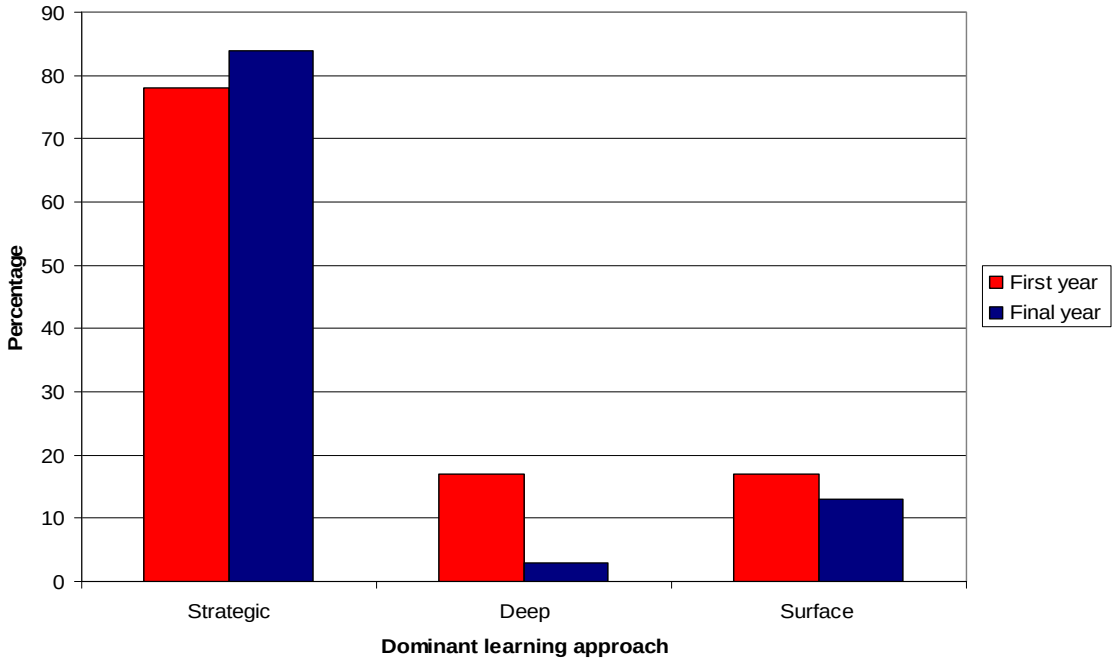
Analysis: The questionnaire responses were analysed using version 14 of the SPSS statistical package. The scores for the responses to each question were summated into thirteen subscales, which were further summated into three learning approaches: deep, strategic and surface. Descriptive statistics were derived from these three scales. T-Tests were used to examine differences between student responses at the two stages.

Results

Student profile and demographics: This cohort was made up of 3% males and 97% females. The average age of students at stage 1 was 20.85 years, the minimum age was 17 years and the maximum age was 49.

Approaches to Learning: The results were analysed to reveal which approach was highest scoring, that is, which approach was dominant for each respondent. For 78% of respondents in stage one of the study, their dominant learning approach was strategic, with 12% exhibiting a dominant surface approach and 9% exhibiting a dominant deep approach. Analysis of the same cohort in their final year of study indicated that for 80% the dominant learning approach was strategic, with 12% exhibiting a dominant surface approach and 8% exhibiting a dominant deep approach

Figure 1: Students' dominant learning approaches at entry to and exit from the nursing degree programme.



These results show that the strategic approach was dominant for the majority of nursing students at both entry to and exit from a four year degree programme. This dominance of the strategic learning approach was also reflected in its higher mean score for the cohort (see Table 1).

Table 1: **Learning approaches means and standard deviations in First and Final year of programme**

	First year	Final year
	Mean ±St Dev	**Mean ±St Dev**
Strategic approach	70.24 ±13.37	69.06±11.98
Deep approach	57.94±10.92	55.88±11.99
Surface approach	49.91±9.12	51.00±9.37

Further analysis using T tests between student responses at each of the two stages indicated that there was no significant difference (level of significance taken for this study was $p > 0.05$) in the deep (p=0.096), strategic (p=0.385) or surface (p= 0.261) scores between the two time points. This signifies that there was no significant change in students' learning approaches at entry to and exit from the degree programme.

Discussion

The dominant approach to learning of the majority of students in this study was strategic. A similar study of Irish nursing students was conducted by Cowman in 1998. He found that Certificate-level nursing students in the Republic had the highest mean scores for either deep or surface approaches to learning while Degree-level nursing students in Northern Ireland had the highest mean score for the strategic approach. In a more recent study of nursing students' approaches to learning in an Iranian university, Mansouri (2006) found most students adopting a deep approach.

The longitudinal exploration of students' approaches to learning in this study revealed that most of them did not significantly change their dominant approach over the course of the programme. Mansouri (2006) examining students from different years of one programme also found no relationship between year of study and approach adopted. Conversely, in a study of nursing students' approaches to learning in an Australian university, Leung et al (2008), found a decrease in deep learning scores and an increase in surface learning scores over time.

The authors of this study found it impossible to make further direct comparisons with similar studies due to the different versions of the ASSIST Inventory which were used as well as the selective presentation of data.

What is clear from the limited comparable data from these studies is that pre-registration nursing students in three different programmes do not appear to share a consistent dominant approach to learning.

According to Entwistle, Taite and McClune (2000) such differences within and across programmes of study are to be expected given the range of factors which influence students' approaches to learning including their previous experience of learning, the effect of their current educational environment (curriculum, teaching and learning methods, assessment methods) as well as their own conceptions of learning and motivation.

In this study, given that there was no significant change in students' dominant approach to learning at entry to and exit from their programme, the extent to which factors such as curriculum, teaching and learning and assessment methods actually impacted on students' learning approaches is questionable. Conversely, factors such as their previous experience of learning, their conceptions of learning and motivation may have been more influential in determining and sustaining students' approaches to learning throughout the programme. The influence of such factors will be explored further as the findings from other objectives related to this study are analysed.

Conclusion

Nurse educators should raise students' awareness of their approaches to learning at the earliest opportunity in order to identify their learning preferences and to assist them to develop their approaches in ways which will maximise their learning.

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Back to contents page

THE SECOND NATIONAL SURVEY OF MENTAL HEALTH IN-REACH SERVICES IN PRISONS IN ENGLAND

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The prevalence of mental disorder amongst prisoners is considerably higher than in the general population. Historically, mental healthcare in prisons has been criticised for not being tailored to clinical need. The policy *Changing the Outlook* envisaged the formation of multi-professional prison mental health teams, commissioned by the local PCT, called in-reach teams. These were intended to manage prisoners with severe mental illness (SMI), and to provide invaluable support to these prisoners thus reducing the need for an acute transfer.

The first survey of prison in-reach teams was undertaken in 2004 by Brooker et al. (2005) as part of a project commissioned by National Forensic R&D Programme, England. This, the second national survey (part of the same project), aimed to capture a variety of data including workforce, team functioning, relationship with prison primary care, role of in-reach, barriers to operation, and the relationship to the wider NHS (emphasising pre-release planning).
A questionnaire was developed after extensive consultation with experts in the field (Department of Health, in-reach team leaders). The survey was distributed electronically. The participants were given three options for completion: return by post; return by email or phone interview. This strategy was devised so as to improve the response rates from the first survey (50%).

Most in-reach team leaders opted for phone interview and a response rate of 73% was obtained. It was found that both the role and activities of in-reach teams changed considerably since 2004.

For example, although in-reach teams were established as the prison equivalent of CMHTs, and intended to focus on prisoners with SMI only, 1/3 of their clients actually had SMI with a substantial proportion diagnosed with personality disorder. This "mission creep" was explained by the lack of in-reach resources, blurred criteria in operational policies, and poor primary reception triage.

The limited resource in in-reach does not, however, fully explain this "mission creep". Quite often those without a severe mental illness are taken onto caseloads largely because of either inadequate triage by primary care or general confusion about the in-reach remit. The scenario to some extent resembles that of mainstream community mental health team provision in the 1980s. The difference is, however, that CMHTs had access to a range of specialist mental health services, which is far from the case with in-reach teams. There are however several solutions to this problem. First, each PCT should review their prison healthcare budget and target the same figures for expenditure on mental health resources in order to achieve 'equivalence' with mainstream mental health. Secondly, community-based mainstream services should examine ways to overcome their natural reluctance to accept those released from prison into their care. Equivalence in funding within prison and equity to accessing mainstream services on release would make a major difference to those who have been imprisoned and who experience a mental illness.

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Back to contents page

GROWING UP HEALTHILY: RISK BEHAVIORS' ASSESSEMENT IN ADOLESCENCE

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INTRODUCTION

Lifestyles change accompanying industrialization, urbanization and increased discretionary income increases the degree of exposure to cardiovascular disease risk factor (Smith *et al*, 2004). An early introduction of a healthy lifestyle as balanced diet, regular physical activity and refrain from the use of tobacco, is essential in the prevention of cardiovascular disease and several other chronic diseases (Kavey *et al*, 2003) since health behaviors track from childhood to adulthood (Kelder *et al*, 1996 *apud* Lindberg, 2006). A reason to target intervention strategies in children is that their behaviors may be influenced more easily than already established unfavorable habits among adults. Yet, cardiovascular disease has its onset already at an early age and disease process may be more effectively altered at relatively young ages (Seidell, Nooyens & Visscher, 2005).

Rationale and Aims for this Health Promotion Program

Since the early 1990's numerous school-based dietary and physical activity interventions have been implemented across the world. A large number of potentially useful interventions have been developed, although without proper evaluation as regards efficacy and long-lasting results. Therefore, funding agencies should realize that their investments are being squandered if the outcomes of theirs funding are not assessed (Lindberg, 2006). It should be mandatory to evaluate long term changes in behavior, knowledge and attitudes as a result of health intervention program and then use both quantitative and qualitative measures when evaluating the outcomes.

The idea that lifestyles adopted by child and teenagers may be decisive in future behaviors – putting them in danger for bigger risk of diseases which could be avoidable – and the relevance of nurses' role as privileged actor on the prevention of disease, health promotion and assessment of needs in health motivated the development of this research project.

The main aims of the study are: to identify teenagers' risk behaviours; to define risk factors, to assess teenagers' health condition perception and to develop a health promotion program. The project falls within philosophy from Countrywide Integrated Non Communicable Disease Intervention Programme, spread out by World Health Organization.

The challenge that we have is the development of innovate strategies, its implementation, assessment and, finally, the spread of good practices on health education for children and teenagers, through the inclusion of a curriculum focus to *to be*, *participate*, *decide* and *take responsibilities*. This dynamic corresponds to an education forward to autonomy, to participation and to responsibilization; an education forward to the choice of healthy and

active lifestyles; an education forward to the protection of risk behaviors and to the valuing of alternatives ways.

The pro-active approach focuses on:
- Promotion of personal and social skills, such as interpersonal communication, identification and management of emotions, promote assertiveness and resilience in children and adolescent;
- Revitalizes the dynamis curriculum: curriculum approach to issues related to health;
- Interventions with impacte in reducing the risk and promotion of protection.

Several authors support that health promotion programs in childhood should focus on food habits and obesity (Bowman *et al*, 2004; Kumanyika *et al*, 2008; Lindberg, 2006; Ludwig, Peterson & Gortmarker, 2001) addict behaviors (American Heart Association, 2008; Escobedo *et al*, 1993 *apud* Lindberg, 2006; Russel, 1990 *apud* Lindberg, 2006) and physical activities (Baranowski *et al*, 2000; Blair & Jackson, 2001; Lee, Paffenber & Hennekens, 1997 ; Twisk, Kemper & van Mechelen, 2002; Thompson *et al*, 2003) and, yet, that this interventions should be school-based, because school can provide an excellent setting for promoting healthy behaviors (Lindberg, 2006).

Food habits and Obesity in youngsters

Eating patterns of children and adolescents have changed considerably over time. Child and teenagers are taking an unbalanced diet – rich in fats and carbohydrates and poor in fruit and vegetable content (Bowman *et al*, 2004 and Ludwig, Peterson & Gortmarker, 2001). Obesity is a major influence on the development and course of cardiovascular diseases and affects physical and social functioning and quality of life. The importance of effective interventions to reduce obesity and related health risks have increased in recent decades because the number of children who are obese has reached epidemic proportions (Kumanyika *et al*, 2008). According to the World Health Organization (2005), the number of overweight and obese people worldwide will increase to 1.5 billion by 2015 if current trends continue. Late childhood and adolescence was identified as a period in life when overweight and obesity is frequently developed. Preventive strategies should, therefore, consider implementation prior to the onset of this critical period for founding future obesity. When implementing interventions to promote health and prevent disease, emphasis should be on helping children develop the knowledge, attitudes and behavioral skills they need to establish a healthy lifestyle through life (Lindberg, 2006).

Addict Behaviors (tobacco, alcohol and street drugs)

More than 8 million children aged 12 to 17 drank alcohol in the past year, nearly 5 million used street drugs and more than 4 million smoked cigarettes (SAMHSA, 2007).

Tobacco use also acts with other risk factors to greatly increase the risk for cardiovascular disease. People who smoke cigars seem to have a higher risk of death from coronary heart disease (and possibly stroke), but their risk isn't as great as cigarette smokers' (American Heart Association, 2008). The initiation of smoking prior to teenage years is clearly associated with regular somking in later life (Escobedo *et al*, 1993 *apud* Lindberg, 2006), because smoking in adolescence has been identified as risk factor for the development of nicotine dependence on adulthood (Russel, 1990 *apud* Lindberg, 2006).

Physical activity and inactivity

High physical fitness during adolescence and early adulthood is related to a healthy cardiovascular disease profile later in life (Twisk, Kemper & van Mechelen, 2002). Habitual physical activity prevents the development of coronary artery disease. There is also evidence that exercise reduces the risk of other chronic diseases, including type 2 diabetes, osteoporosis, obesity, depression, and cancer of the breast and colon (Thompson *et al*, 2003). The results are strong, with the most physically active subjects generally demonstrating coronary artery disease rates half those of the most sedentary group. The data demonstrate a graded relationship of decreasing coronary artery disease rates with increasing levels of activity (Lee, Paffenber & Hennekens, 1997). Promoting physical activity in young population is built around four suppositions: 1) child might receive immediate health and social benefits; 2) intervention at critical period in physical growth may enhance adult health; 3) modifying chronic disease risk factor in childhood might lower disease rates and risk factors in adult years and 4) modifying behavioral preferences or practices in childhood might lead to altered behaviors in adulthood that would offer protection from chronic diseases at that time (Baranowski *et al*, 2000).

School based interventions

Community interventions have been proposed to begin with schools. School staff has access to large numbers of children in a learning environment that has the potential to support healthy behavior and is favorable for the implementation of health promotion programs (Garrow, 1991 *apud* Lindberg, 2006). School can provide an excellent setting for preventing obesity and promoting healthy behaviors. Almost all children in developed countries spend too much time in school, so it is a great setting to implement interventions related to the disease prevention and health promotion (Lindberg, 2006). Moreover, schools do not only

influence the attitudes and knowledge of youngsters, they also provide opportunities for experimental learning (Seidell, Nooyens & Visscher, 2005).

MATERIALS AND METHODOLOGY

Due to children grow up at different ways and at a different levels, the program is designed year by year, trying to meet the specific needs of the group of children in study in a diachronic vision of development and addressing issues that we find of great importance to the development of personal and social skills and, yet, health protection and prevention of risk behavior particularly in the areas of food, addict behaviors and physical activity. The program is also directed to parents and bar and canteen staff after identification of training needs and integrated intervention in this context, a synchronous vision focused on space, life and times of individuals who interact with the child / adolescent, being an ecological universe to our analysis and for the definition of needs in terms of training / prevention / protection / promotion.

This program was designed with a dual matrix: the individual and collective. In individual perspective include early diagnosis, counseling and referral. In the collective point of view, consider the important influence of peers, teachers, bar and canteen staff and also the products displayed in the canteen and the bar, so that measures proposed include the training of handlers of food and awareness of the wider educational community.

This is a longitudinal study of research-action, developed in a school from Coimbra to children / adolescents from 10 to 17 years. It is conducted by six nurses-researchers and, also, with participation of nursing students from University School of Nursing (Coimbra - Portugal).

First Sample

All the children and teenagers who are in school from 5th to 9th grade in the school year 2005-2006 (n=216), from these schools: Colégio Imaculada Conceição e Colégio Rainha Santa Isabel, in the city of Coimbra - Portugal.

Second Sample

All the teenagers – which were in the health promotion program – attending the 9th grade in 2009-2010.

Data Collection and Data Analysis

According to Lindberg (2006), programs intended to improve healthy habits may be evaluated in several perspectives and among their ability to induce lasting effective in physiologic, cognitive, affective or behavioral terms respectively. Thus, we used several and systematic methods to collect data.

The collection of data was made through a questionnaire of the Health Behaviour at School age Children – World Health Organization and through evaluation of biological parameters, in particular, capillary blood glucose, blood cholesterol, blood pressure and body mass index. The materials which were used to support the collection of biological data were: balance and class, blood pressure equipment and machinery from reading the blood cholesterol and capillary blood glucose (with support from *Roche Diagnostic Laboratory*®).

We used Statistical Package for the Social Sciences (SPSS) and Excel programs to do a statistical analysis of the data.

Ethic Considerations

All children were informed by the researchers and teachers that the questionnaires were anonymous and that could not participate in this health promotion program. Yet, all youngsters' parents were informed of all study criteria. The research study was approved by the local Ethic Committee of the schools. Further, participants were ensured that they, at any time, could end their participation and that all data would be handle confidentially.

RESULTS AND DISCUSSION

Preliminary data shows some incorrect dietary habits (Table 1), excessive consumption of candies and chocolate (43%), fried foods (36%) and sugar-sweetened drinks (43%). However, it is noted that there is concern in consuming vegetables and fruit, since the data show that children eat fruit regularly (81%) as such vegetables, but not in a so big percentage (48%). This food habits may be responsible for Body Mass Index in the participants: 26.7% were thin, 59.4% were in healthy weight, 9.4% were in pre-obesity, 2.3% were in obesity degree I and 0.5% were in obesity degree II. More than a half of the participants were in a healthy weight, which can be justifiable by the high percentages of the children who consume fruit (83%) and vegetables (48%) often.

Table 1 – Diary Food intake

Diary Food Intake	Positive Answers - %
Intake of fruit	81%
Intake of vegetables	48%
Intake of chocolate and candies	43%
Intake of cream cakes and cookies	32%
Intake fried foods	36%
Intake of sugar-sweetened drinks	43%

In terms of physical activity, 73% of inquired participants watch television 3 to 4 hours a day and 83% spend 1 to 3horas

daily in front of the screen computer. But, it is also notable that 38% do physical exercise every day or 4-5 times a week.

In what concerns to addict behaviors (smoking, alcohol and street drugs), 26% had begun their smoking habits very early, since at the time of the questionnaire they had already smoked cigarettes. It is also worrying that that 2% of the participants related that they smoke 3-4 cigarettes packets per week and that 67% had already tasted alcoholic drinks and 10% had already got drunk.

For health and welfare perception label (Table 2) it is imperative to highlight that 30% of the participants related to feel tired in the morning before to school. Chyho *et al* (2005) says that wrong eating habits in children causes poor sleep, which can be related to the 30% of the sample who feel tired in the morning for not having a repairer sleep. It is also to underline the 12% who feel not so healthy, the 18% who feel unhappy and the 50% of the participants that said that they would like to change something in their body. This results of health and welfare perception, in agreement with Honkinen *et al* (2005), may be responsible for the only 38% of the children who made physical exercise, because the authors says that insufficient physical exercise was clearly associated with poor perceived health.

Table 2 – Health and Welfare perception

Health and Welfare perception	**Positive Answers - %**
Feel tired in the morning before go to school	30%
Think that they are not so healthy	12%
Feel a little sad	18%
Feel unhappy	3%
Don't brush the teethes every day	13%
On a diet or think they would need one	28%
Think that they are fat or very fat	28%
Would like to change something in their own body	50%

As regards to feelings and friendships, 32% feel lonely often, 20% said that they don't have best friends, 25% statement that they don't spend time with friends after school and 2% said that they don't make any friends until now.

Referring to expectations for the future 73% like very much to go to school and 66% want to go to university.

Finally, it is to highlight some of the answers that children gave to the question Why people don't take street drugs? (Table 3). At the top, 160 answered that people don't take street drugs because they don't want to; 94 answered that people don't' take

street drugs because thay're afraid to get a transmissible disease and 42 said that people would be afraid of parents' and friends' reaction to the street drugs' consume by themselves.

Table 3 – Why people don't take street drugs?

Why people don't take street drugs?	Number of positive answers
People don't where to buy	8
It is too expensive	20
People never thought on the issue	36
Their friends don't take street drugs either	23
People are afraid to get a transmissible disease	94
People are afraid of parents' and friends' reaction	42
People wouldn't be able to do what they like	22
People don't want to take street drugs	160

These results are supporting the health promotion program designed for 2005-2010. As said, the health promotion program is designed year by year, trying to meet the specific needs of each group of children in studies, in a diachronic vision of development, addressing issues that are of great importance to the development of personal and social skills and, still, for the protection of health and prevention of risk - especially in the areas of food behavior, addict behaviors and physical activity. To this end, we are developing educational, recreational and interactive activities - training sessions, competitions, pedy-papper - aimed at increasing the knowledge and acquirement of skills to promote health and prevent harmful consequences for their welfare at physical, psychological and social spheres.

CONCLUSION

In health terms, childhood and adolescence are particularly important times of life. Certain behaviors are initiated during the adolescent years, while others, such as eating habits, can be established ever in early childhood. Given this, research into young peoples' health and health behaviors is essential for the development of evidence-based policy and practice.

Growing Up Healthily: Risk Behaviors' Assessment in Adolescence can be seen as a program based on the assumption that improved knowledge will affect behavior. Considering food habits, smoking and exercising spheres it seems inevitable to inform

youngsters about future risks for their health linked to overweight, smoking and lack of exercise.

With the development of this health promotion program we expect to have impact in health behaviors through the educational, recreational and interactive activities that are being promote. We also intend to have impact in health and welfare youngsters' perception, because the propensity of children and teenagers to be physically active, make healthy food choices and refrain from tobacco is connected to the confidence that they have in themselves (Lindberg, 2006). Yet, it is our intention to provide knowledge of importance for the development of future programs aiming to promote a healthy lifestyle in youngsters.

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Back to contents page

Leadership Development Programme for Midwives

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Introduction:

A group of 14 midwives from two maternity units in the HSE Dublin Mid-Leinster region recently completed a six month leadership development programme. The programme was facilitated by the Nursing and Midwifery Planning and Development Unit and a Training and Development Consultant. The programme was funded by the National Council for Nursing and Midwifery and by the National Partnership Forum.

Background:

The need for investment in and preparation of clinical leaders is acknowledged in the Action Plan for People Management (2002), the HSE Transformation Programme (2006) and the Lourdes Hospital Enquiry (2006). Following a review of international leadership literature, Patricia Healy, Regional Practice Development Facilitator for Midwifery, collaborated with Jarlath Duffy, Training and Development Consultant, on the design of the programme. The facilitators decided against the use of a generic leadership programme in the belief, supported by the literature that generic programmes appear to involve overly theoretical, decontextualised learning that can lack transferability to practice. Therefore this particular leadership development programme was designed locally and custom built to meet the specific needs of the local maternity service and midwifery practitioners.

Aim of the Programme:

The aim of the Leadership Development Programme is to facilitate midwifery practitioners and their teams to develop women-centred, evidence-based leadership strategies within the context of their day to day practice, their workplace climate and the broader agenda for health and social gain.

Goal of the Programme:
The overall goal of the programme is the development of people skills that are practical, applicable and beneficial to midwives and their service users.

Programme content:
- Personal development
- Team development
- Organisational development.

Programme Modules:
- Self-awareness
- Communication for leaders
- Empowering and influencing others
- Stress management
- Personal organisation and time management
- Building and leading a team
- Motivation and teamwork
- Negotiating and networking
- Change management
- Managing conflict.

Programme work plan:
The programme, consisting of 8 facilitated study days, was conducted over a six month period. The study days consisted of a combination of facilitation with individual and group reflection. The leadership theory was supported by reflecting on clinical and managerial scenarios to facilitate the integration of theory with the current challenges facing clinical midwifery leaders. The 3 week period between each study day allowed an opportunity for reflection and consolidation of learning. Participants were provided with relevant reading for these 3 week periods. Each participant also undertook a leadership change project in the clinical environment.

Programme evaluation:
A formal evaluation process was used to evaluate the programme to ensure its effectiveness. An evaluation form was completed by each participant at the end of each of the study days. The participants evaluated each day very positively. They described the programme as "interesting, enjoyable, energising, entertaining, fun, informative and thought-provoking". The use of reflection tools proved very beneficial to participants. The participants reported great satisfaction with the practical and clinical elements of the programme and the fact that it was midwifery specific. Participants repeatedly advocated that all their colleagues should undergo leadership development. While participants reported using their new leadership skills in the workplace they did feel that if more midwives had participated in leadership development they

would have greater leadership effect as a larger group. The facilitators hope to meet this need by running the programme again in the future.

A quantitative, descriptive study was also conducted to explore if the Leadership Development Programme had any effect on the leadership behaviour of the participating midwives. This study found that the participating clinical midwives demonstrated statistically significant improvements in leadership behaviour following participation in a leadership development programme. The study also found that the leadership strengths identified by the midwives were around relationship building and providing support and encouragement. The leadership weaknesses they identified were around visioning the future and challenging existing processes. These findings have implications for the role of midwives in both the regional and national agenda for the Irish maternity services of the future.

Overall outcome of the programme:
The 12 participant midwives experienced substantial personal growth during the programme. They also demonstrated statistically significant improvements in leadership behaviour following participation in programme. Their team identity improved and they developed a greater understanding of the strategic agenda of health care. The transformation Programme (2006) advocates creating and implementing leadership and management development approaches which inspire staff innovation, responsibility and accountability. This midwifery leadership development programme is an example of an initiative that does just that. Leadership development initiatives will be instrumental in preparing Irish midwives for the leadership roles implicit in the evolving modern maternity services.

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Back to contents page

Undergraduate Nursing Students' Experiences in Providing Culturally Competent Care in an Irish Multicultural Healthcare System: A Phenomenological Study.

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Abstract

Chapter One: Introduction To The Study

1.1. Background to the problem
1.2. Purpose of the study
1.3. Significance of the study
1.4. Research question
1.5. Definition of terms

Chapter Two: Literature Review

2.1. Introduction
2.2. Cultural competence in healthcare
    2.2.1. Legislative and policy contexts
2.3 Communication with patients
    2.3.1 The importance of good information and communication during patients' care
    2.3.2 Communication difficulties
    2.3.3 Interpretation services
2.4 Cultural and religious differences
2.5 Individualised nursing care
2.6 Preparation of nurses for culturally competent care
    2.6.1 The benefits of adequate educational preparation of nurses
    2.6.2 Inadequate educational preparation of nurses
    2.6.3 Strategies for the preparation of nurses for cultural competence
2.7 Summary

Chapter Three: Methodology

3.1 Introduction
3.2 Quantitative and qualitative approaches to nursing research
    3.2.1 Quantitative research approach
    3.2.2 Qualitative research approach
3.3 Rationale for qualitative research design
3.4 Rationale for choosing phenomenological research design
3.5 Rationale for choice of Heideggerian interpretative research design
3.6 Sampling
3.7 Setting up and negotiation of access
3.8 Ethical considerations
3.9 Pilot Study
3.10 Data collection
3.11 Data analysis
3.12 Data trustworthiness
3.13 Summary

RESEARCH STUDY ABSTRACT

Background to the problem: In recent years, there has been an increase in cultural diversity in the Republic of Ireland. Consequently nurses are challenged to address the complexities associated with multicultural issues such as language, interpersonal interaction and diverse health needs.

Aim: The aim of the study was to explore the experiences of undergraduate student nurses in providing culturally competent care in an Irish health care system and to interpret the meaning the students attribute to their experiences.

Methodology: Heideggarian interpretative phenomenological approach guided the study. Data were collected using audio taped semi-structured interviews with eleven willing participants. Participants were fourth year student nurses who had provided nursing care to patients from different cultural backgrounds. The data were collected between April and July 2006 and transcribed verbatim. Considerations to ethical issues were adhered to and permission to conduct this study was granted by the Human Research Ethics Committee of the research site as well as the Head of the Department of the School of Nursing and Midwifery.

Data Analysis: Data were analysed thematically using the method developed by van Manen. Methodological rigour was addressed as outlined within phenomenological method.

Findings: Data analysis revealed four themes: Communication difficulties between the nursing students and the patients resulted in reduced standard of care given to the patients. Cultural and religious differences of patients had an effect on their healthcare delivery. The third theme revealed the need for individualised nursing care. The last theme dealt with the preparation of nursing students for the provision of culturally competent care.

Conclusions and implications. The nursing students had difficulty in providing appropriate nursing care to patients from other cultural backgrounds because of communication problems and insufficient knowledge about the cultural needs of the patients. Nurses need support from the organisation as well as a deeper understanding of the needs of each patient in the light of the cultural background.

CHAPTER ONE

1. INTRODUCTION

1.1 Background to the problem

The increasing cultural diversity of patients and health care staff in Ireland in recent years presents considerable challenge for nursing profession in general and nursing education and training in particular. Ireland, until recently a monocultural society, did not have to address the complexities associated with multicultural issues such as language, interpersonal interaction and diverse health needs. Many of the patients who are new immigrants speak little or no English and have different customs, values, and beliefs about health and illness (Kennedy and Murphy-Lawless 2001).

There is a sudden reversal of decades of emigration from Ireland to immigration from all parts of the globe (Cullen 2000). According to the 2002 census, the ethnic minority communities make up 5.8 percent of the total population (Central Statistics Office 2003). Several factors such as rapid economic development, better standard of living, refugee and asylum seeking, educational and job opportunities have resulted in the attraction of people from other races and cultures to Irish society in recent years (Department of Justice, Equality and Law Reform 1999). With such increasing demographic and cultural changes in Ireland, nurses and other health care professionals need to be adequately prepared to understand the health care needs of people from other cultures in order to care effectively for them (Boyle 1999, Lalchandani et al. 2001).

Evidence from the literature identifies that some of the explanations given for the failure of nurses in Ireland to meet the needs of ethnic minority patients include lack of understanding of cultural diversities and communication difficulties which has been attributed to inadequate educational and training preparation of nurses (Boyle 1999, Kennedy and Murphy-Lawless 2001). Nursing, increasingly seen as being in the front line of healthcare delivery is challenged to maintain, promote and provide quality nursing care that is culturally congruent to the patients they serve (Cortis and Law 2005). As future nurse practitioners, nursing students are required to develop knowledge and skills that will help them to become culturally sensitive and competent (Baldwin 1999). Nursing education therefore need to produce practitioners who are capable of providing appropriate nursing care within a multicultural context (Gerrish 2000, Lister 1999).

1.2 Purpose of the study

The aim of the study was to explore the experiences of undergraduate student nurses in providing culturally competent care in an Irish multicultural healthcare system and to interpret the meaning the students attribute to their experiences.

1.3 Significance of the study

The study is considered significant given the rapidly growing multicultural population of the Republic of Ireland and the need for nurses to meet the challenges of the diverse health care needs of the society. Nurses also need to meet the mandates of their regulatory body (An Bord Altranais) as well as meeting the national legislative and policy mandates for culturally competent care. Finally, there is no published evidence on the experiences of the undergraduate nursing students in providing culturally competent care in an Irish context till date. The understanding of the experiences of the students will promote the understanding of their knowledge and practice deficits. These will contribute to the creation of more learning opportunities for the student nurses to enhance their preparation for the providing of culturally congruent care to their patients.

1.4 Research question

In order to fulfil the purpose of this study the following question needed to be answered:

- What is it like to provide appropriate nursing care to patients from different cultural backgrounds?
- A topic guide was used to assist the researcher. The topic guide could be seen in appendix 1.

The expectation is that answers to the research questions will provide directions for improving holistic nursing care in general, and the continuous development of multicultural nursing education curriculum in particular.

1.5 Definitions of terms

The following definitions apply to this study:

Culture: Culture is a complex notion of each person's life. It is described as a set of guidelines expressed in the knowledge, beliefs, values, morals, customs, traditions, and habits of persons as members of a society (Bastable 2003). Culture is dependent on time because it is primarily affected by internal and external environmental stimuli (Dowd *et al.* 1998).

Cultural competence: It is the ability of a system to provide individualised nursing care with holistic perspectives, to patients with diverse values, beliefs, and behaviours (Campinha-Bacote 1999, Jeffrey and Smodlaka 1999, Leninger 1997).

Ethnicity: Ethnicity refers to groups of people whose members share a distinct identity and a common social and cultural heritage such as language and tradition, which is passed on to each successive generation (Dowd *et al*. 1998). Although 'ethnicity' is often used interchangeably with the term 'race', ethnicity includes more than biological identification (Bhopal 1997, Dowd *et al*. 1998).

Race: Race relates to biology. Members of a particular group share distinguishing physical characteristics such as skin colour, bone structure or blood group. Ethnic and racial groups overlap sometimes because in many cases the biological and cultural similarities reinforce one another (Dowd *et al*. 1998).

CHAPTER TWO

2 LITERATURE REVIEW

2.1 Introduction

The literature review will provide an insight into what is known about cultural competence globally and in Ireland. In particular, the literature review will provide an insight into nurses' experiences in providing culturally competent care in multicultural healthcare systems. In the literature review, the gaps in current knowledge will be identified and the rationale for this proposed study will be given.

The literature review will be presented under the following main headings: cultural competence in healthcare; communication with patients; cultural and religious differences; individualised nursing care; and preparation of nurses for the provision of culturally competent care. A literature search was undertaken to gain an insight into nurses' experiences in providing culturally competent care.[7] The search was limited to studies published in English language. The researcher acknowledges that confining a search in this manner may mean that a significant amount of research is missing from the review and there is therefore a risk that the conclusions drawn are inaccurate or incomplete (Droogan and Cullum 1998). During the review of the literature, a large number of studies mostly qualitative studies and some quantitative studies, which investigated the experiences of nurses and other healthcare workers in the provision of culturally competent care were discovered (Baker and Daigle 2000, Chevannes 2002, Clegg 2003, Cortis 2004, Gerrish 2000, Hultsjo and Hjelm 2005, Kennedy and Murphy-Lawless 2002, Lalchandani *et al.* 2001, Lim *et al*. 2004, Ryan *et al.* 2000, Sargent *et al*. 2005, Tortumluoglu *et al.* 2006, Vydelingingum 2000, Warda 2000). There were only two published studies in Ireland on the healthcare professionals' experiences on the provision of culturally competent care in Ireland. There was no published evidence on nursing students' experience in the provision of culturally competent care in an Irish healthcare system. The main points of the literature review are summarised at the end of the chapter.

[7] A search of the electronic databases Cumulative Index to Nursing and Allied Health (CINAHL), Science Direct, Swetsearch, Pubmed and Medical Literature analysis and retrieval system on-line (Medline) from 1996 to 2006 was carried out. A hand search of the indexes from the journals identified by the electronic search as being rich in articles on the topic was undertaken. Search terms used were: cultural competence, multicultural healthcare, cultural diversity, ethnic diversity and multicultural health education for nurses. The studies included were conducted in Ireland, the United Kingdom, America, Canada, Australia and Sweden.

2.2 Cultural competence in healthcare

Sutton (2000) describes cultural competence as a set of cultural behaviours and attitudes that are incorporated into the practice methods of a system, an agency, or its professionals, which enables them to work effectively in cross cultural situations. In other words, a culturally competent system of care acknowledges and ensures the integration of the importance of culture on all levels including policy, administration, practitioner and consumer (Lester 1998a). Cultural competence includes a substantive knowledge base of cultural values held by a particular group and the ability to adapt individualised nursing care within the cultural context of each client (Arnold 2003c).

In order for healthcare systems to be culturally competent, it is important for the health systems to have the potentials to provide culturally and linguistically appropriate services as well as to reduce racial and ethnic health disparities (Anderson *et al*. 2003). A culturally competent healthcare setting need to include an appropriate mix of the following: a culturally diverse staff that reflects the communities that are served; healthcare providers or translators who speak the patients' languages; training for healthcare providers about the culture and language of the people they serve; signage and instructional literature in the patients' languages and consistent with their cultural norms; and finally, culturally specific healthcare settings (Anderson *et al*. 2003, Essen *et al*. 2002, Irish Nurses' Organisation 2002, Kim-Godwin *et al*. 2001).

To meet the emerging healthcare needs of Ireland's multicultural society, the Government of Ireland has in recent years addressed comprehensive issues of legislative and policy mandates which provide a good context in which the delivery of culturally competent healthcare in Ireland can take place.

2.2.1 Legislative and policy contexts

Several recent health and equality policies highlight the need for culturally appropriate care. Examples of these policies are given below.

Health policy

In Quality and Fairness: A Health System for You, Health Strategy (2001) it is clearly stated that the health care system should reflect and respond to the increasing cultural diversity of Irish society. The National Health Promotion Strategy 2000-2005 highlights the need for targeted approaches to address the need of the disadvantaged

in society and to overcome discrimination experienced by some cultural groups (Department of Health and Children 2000).

Equality policy
The equality legislation covers discrimination and equality in relation to employment (Employment Equality Act 1998) as well as the provision of services, including health care services (Equal Status Act 2000). The legislation covers nine grounds, which include: gender, marital status, family status, sexual orientation, religious belief, age, disability, race and membership of the traveller community. To achieve the health and policy intentions in the context of nursing care, nurses need to be equipped with necessary knowledge and skills including communication skills to enhance culturally appropriate and sensitive care.

2.3 Communication with patients

Communication is described as the exchange of information, ideas, or feelings between two or more people (Boggs 2003, Ralston 1998). It is important for patients to be kept informed of diagnosis, prognosis and all developments throughout their encounters with health care professionals to enable them to make informed choices about their care (Arnold 2003b, Cooper 2001). The quality of information is fundamental to informed choice and consent (Arnold 2003a). The goal of cultural competence is a healthcare system and workforce that are capable of delivering the highest quality care to each individual patient irrespective of cultural background or the dominant language proficiency (Anderson *et al*. 2003, Lester 1998a).

2.3.1 The importance of good information and communication during patients' care

Patients' satisfaction with care is directly related to the amount and content of information they receive from healthcare providers (Warda 2000). Warda (2000) carried out a qualitative study in the United States of America using a grounded theory approach to identify culturally competent concepts from the perspectives of Mexican Americans. Semi structured interviews were used to collect data from four focused groups of Mexican Americans (n=22) involving five registered nurses and seventeen Mexican American lay recipients of health care.

Findings revealed that the healthcare providers' bilingual abilities affected the content of the interaction, the patients' recall of the information exchanged, and the patients satisfaction with interaction. Consequently, the patients were enabled to deal with health-related issues successfully (Warda 2000). The limitation of the study is that the result was obtained from one study site,

therefore the result cannot be generalised to the total population. Other authors such as Ralston (1998) and Tennant and Butler (1999) also support the view that good information and communication are essential for the provision of high quality patient care. Although communication with patients is seen as a key component of culturally competent care, communication difficulties exist as one of the major issues for both the health care professionals and the patients.

2.3.2 Communication difficulties

Studies have shown that nurses have difficulties in providing quality care to culturally diverse groups due to factors such as communication difficulties (Boyle 1999, Chevannes 2002, Hultson and Hjelm 2005, Tortumluoglu *et al*. 2006). Inadequate support of patients and insufficient provision of information to patients on which to make informed choices are worsened particularly if the patients either do not speak the dominant language or are not fluent in the language (Boyle 1999, Chevannes 2002, Kennedy and Murphy-Lawless 2002). Boyle (1999) carried out his quantitative study in a large teaching hospital in Dublin, Ireland, with nurses (n=50) using a questionnaire survey to investigate the level of Irish nurses' professional competence in caring for people of ethnic minority in the hospital. The response rate was 100 percent (Boyle 1999). The limitation of the study is a small sample size and the study being carried out from one study site. Thus it is impossible to generalise the findings to other groups in the same discipline.

Kennedy and Murphy-Lawless (2002) conducted a quantitative survey with refugee and asylum seeking women in Dublin (n=61) using questionnaire and interviews to investigate the maternity care needs of those women. It was reported that communication difficulties led to the Irish public health nurses inability to distinguish whether many of the women they encountered had postnatal depression or depression as a result of other causes.

Chevannes (2002) carried out a qualitative study with a purposive sample of healthcare providers (n=22) working across five health service organizations in the United Kingdom using semi-structured interviews to collect data. Pre- and post-training phases were used in an attempt to find out from healthcare professionals what they know about caring for patients and other service users from ethnic minority groups and their perception of training needs in this area of work.

Hultson and Hjelm (2005) conducted a qualitative study using focus group interviews of 22 women and 13 men working as nurses and assistant nurses at an emergency ward, an ambulance service and a

psychiatric intensive care unit in Sweden, to explore their experiences in the care of immigrants in emergency situations. Tortumluoglu *et al.* (2006) carried out a cross-sectional study in Eastern Turkey with volunteered nursing students (n=263) in first, second, third and fourth years, to investigate the cultural diversities experienced in client care by the nursing students. It was also found that there was a communication difficulty between the first year nursing students (82.7%, n = 105) and the patients, resulting in inadequate patient care ($p<0.05$). The limitation of the study is that it was conducted from one study site, thus making it impossible to generalise the findings to other groups in the same discipline.

A qualitative study was carried out using semi-structured interview in London National Health Service Trust with two teaching hospitals to explore the maternity views and experiences of a snowball sample of minority ethnic women (n=20), half receiving caseload midwifery care and half conventional maternity setting care (Mc Court and Pearce 2000). It was found that some health care professionals in the conventional setting also had difficulty communicating with the minority ethnic women due to lack of time and staff being rushed. Time pressure and the need to accomplish many tasks at once inhibit the type of communication that may be necessary to identify and bridge cultural gaps between healthcare workers and the client (Geiger 2001).

Chevannes (2002) and Mc Court and Pearce (2000) did not report particular qualitative approaches used. According to Baker *et al.* (1992) failure to explicate qualitative methodologies can result in a body of nursing knowledge that is either mislabelled or classified broadly as qualitative and subject to charges that qualitative research lacks rigour. Another limitation of the study conducted by Mc Court and Pearce (2000) is the use of ethnicity as a variable in the research. This puts the study in a danger of categorising patients on the basis for research purposes, without regard for the uniqueness of their experiences (Bhopal 1997, Mc Court and Pearce 2000). In order to provide culturally competent care to patients, it is important for the healthcare systems to provide linguistically appropriate services (Anderson *et al*. 2003).

2.3.3 Interpretation services

Interpretation services are necessary to overcome communication difficulties between healthcare providers and the patients with language differences (Arnold 2003c, Essen *et al*. 2002, Lalchandani *et al.* 2001). The aim of interpretation is to transfer the exact meaning of word from a language to the other to enhance understanding of the meaning of the words by another person (Bowen 2001). In a quantitative study carried out in Ireland by

Lalchandani *et al.* (2001) using a retrospective analysis and focusing on obstetric profiles and pregnancy outcomes of immigrant women with refugee status, it was found that interpreters were employed to help and overcome the language barrier, thus enabling healthcare professionals to provide appropriate care to their patients. Prospective studies are considered to be stronger than retrospective studies because of the degree of extraneous variable that might confound the data (LoBiondo-Wood and Haber1998).

Gerrish (2001) carried out a qualitative study using an ethnographic approach to explore the care provided by district nursing teams (n=6) in an English community National Health Service (NHS) Trust serving a city with an ethnically diverse population. Data collection involved undertaking in-depth interviews with eight managers, a review of caseload allocations and a documentary analysis of local policy directives. This was followed by a participant observational study of nursing practice focusing on six district nursing teams. Purposive sampling was used to identify four teams with high ethnic minority caseloads and two teams with predominately white ethnic majority caseloads. It was found that patients' relatives who could speak English were used as interpreters between the nurses and the patients. Findings also revealed that there was difficulty in accessing interpreters (Gerrish 2001). In their qualitative study, Hultsjo and Hjelm (2005) also reported that it was difficult to find interpreters when they were needed.

Essen *et al*. (2002) carried out a perinatal audit, comparing cases of perinatal deaths among children of African immigrants residing in Sweden, with a stratified sample of cases among native Swedish women. It was found that miscommunication between the African immigrants and healthcare providers and lack of adequate interpretation services contributed to at least five of the infant deaths born by the African women.

In her qualitative study, Warda (2000) reported that healthcare providers' bilingual abilities promoted exchange of information between the staff and patients thus enhancing patient care and patients' satisfaction with care. According to Lester (1998b) a bilingual nurse is an asset to the health care system in overcoming communication difficulties between the patients and other health care workers.

Arnolds (2003b) and Boggs (2003) suggest that healthcare providers also use non-verbal communication such as observation and body languages, facial expressions and gestures to interact with patients. Non-verbal communication gives the clue of what is being communicated and also helps to clarify the meaning of words. In

their qualitative study, Hultsjo and Hjelm (2005) reported that the migrants had more intensive mode of non-verbal communication. Boggs (2003) and Josipovic (2000) suggest that nurses need to be aware that most non-verbal behaviours are culturally specific and that a non-verbal gesture, which is acceptable by one culture, may be considered rude in another culture. Nurses therefore need to be aware of the non-verbal communication method that is acceptable to their patients from different cultures.

2.4 Cultural and religious differences

Bastable (2003) describes culture as a set of guidelines expressed in the knowledge, beliefs, values, morals, customs, traditions, and habits of persons as members of a society. In every nurse-patient relationship three cultures meet. These include the culture of the organisation, the culture of nurses, and the culture of the patient (Holland and Hogg 2001). In Ireland, cultural and religious diversity has significantly increased in recent years, mainly as a result of immigration from all parts of the globe, and religious beliefs are important aspects of many peoples' ethnic and cultural diversity (Central Statistic Office 2003). It is important for nurses to recognise and understand the broad spectrum of cultural and religious beliefs and practices in order to enhance culturally sensitive and appropriate care (Lester 1998a).

Studies have shown that nurses have difficulties providing effective nursing care to patients from different cultural background due to lack of understanding of their cultural issues and their relationship to nursing practice (Baker and Daigle 2000, Cortis 2004, Hultsjo and Hjelm 2005, Tortumluoglu *et al.* 2006, Vydelingum 2000). Baker and Daigle (2000) carried out a qualitative study with patients (n=10) from the Big Cove Mi'kmaq first Nation community in a non-aboriginal institution in Canada using in-depth interviews to investigate the cross-cultural care as experienced by Mi'kmaq patients. The limitation of the study is that the researchers did not report particular qualitative approach used. Baker *et al*. (1992) suggest that failure to explicate qualitative methodologies can result in a body of nursing knowledge that is either mislabelled or classified broadly as qualitative and subject to charges that qualitative research lacks rigour.

Vydelingum (2000) carried out a qualitative study using a phenomenological approach to examine the extent to which healthcare provision was meeting the needs of South Asian patients in a medical directorate of a general hospital in South of England, using a purposive sample of ten patients and six carers. In the United Kingdom, Clegg (2003) conducted another qualitative research using a grounded theory approach and unstructured

interviews to investigate older South Asian patients' and carers' (n=7) perceptions of culturally sensitive care in a community hospital setting with a purposive sample of four patients and three carers.

Findings revealed that religion is a fundamental aspect of the lives of the participants. In particular, they emphasised the importance of staff acknowledging, understanding and catering for their religion. Additionally, it was reported that patients were dissatisfied with food and perceived a lack of understanding by staff of its cultural difference and religious significance. Furthermore, it was found that there were significant cultural variations in the value placed upon privacy and modesty, with South Asian cultures requiring a degree of modesty which is severely compromised by some Western hospital practices such as the use of mixed sex wards (Clegg 2003). The limitation of the study is the use of a small sample size which resulted in unsaturated data.

Holland and Hogg (2001) suggest that it is important for healthcare workers to be aware of the effects of various religious beliefs on health care practices. For example, since modesty is an obligation in Islam, Muslim patients need to be examined by a doctor or nurse of the same sex as the patients if possible during procedures such as the ones involving reproductive systems or during gynaecological examination because nakedness and exposure of the body can cause distress to both men and women (Holland and Hogg 2001). Nurses therefore need to understand the effects of patients' cultural values and religious beliefs in order to promote individualised nursing care.

2.5 Individualised nursing care

Nursing is increasingly seen as being in the front line of health care delivery and is challenged to maintain, promote and provide quality nursing care that is culturally congruent to the patients they serve (Cortis and Law 2005, Lim *et al.* 2004). The need to address the individualised nursing care of each client is reflected in the code of professional conduct for each nurse and midwife (An Bord Altranais 2000a). It is also explicitly stated in the Scope of Nursing Practice Framework (2000b) that nursing care should be provided in a way that respects the uniqueness and dignity of each client within a multicultural society (An Bord Altranais 2000b). If nursing profession is to provide individualised nursing care within a multicultural context, then those responsible for the education and training of nurses have a crucial role in this process (Baldwin 1999, Gerrish 2000, Gerrish and Papadopolous 1999, Lister 1999). Particularly, students need to be encouraged to critically examine the way in which health services are developed and care is delivered

in order to note the ethnocentric biases and structural constraints that will militate against them providing culturally effective individualised nursing care (Gerrish and Papadopoulos 1999).

Gerrish (2000) carried out a qualitative study which used an ethnographic approach to examine the policy directives concerning the provision of individualised care by district nurses to patients from different ethnic backgrounds in an English community National Health (NHS) Trust. The study comprised of two stages. The first stage comprised of an organisational profile, which was undertaken in order to analyse the local policy context. Data were collected by means of in-depth interviews with managers, a documentary analysis of policy directives and caseload profiles. The second stage entailed a participant observational study of nursing practice focusing on a purposive sample of district nursing teams (n=6). Findings revealed six principles underpinning the philosophy of individualised care expounded by the nurses. These principles are: respecting individuality; holistic care which encompasses the physical, social, psychological and spiritual dimension of the person; focusing on nursing needs; promoting independence; partnership and negotiation of care; and equity and fairness (Gerrish 2000). The limitation of the study as an observational study is reactivity, which is also known as Hawthorne effect (Grey 1998).

In a qualitative study which used semi-structured interviews to investigate the experiences of a purposive sample of registered nurses (n=30) caring for hospitalised Pakistani patients in the United Kingdom, Cortis (2004) found that nurses were unable to provide adequate individualised nursing care to their patients due to lack of knowledge about Pakistani patients and inadequate implementation of holistic care. Price and Cortis (2000) and Callister (2001) suggest that holistic approach to health assessment is fundamental to the provision individualised patient care. The limitation of the study is that Cortis did not report any particular qualitative approach used. Baker *et al*. (1992) suggest that failure to explicate qualitative methodologies can result in a body of nursing knowledge that can result in a body of research that is either mislabelled or classified broadly as qualitative and subject to charges that qualitative research lacks rigour. To provide individualised nursing care within a multicultural context, nursing students as future practitioners need to develop and possess the required knowledge, skills, and abilities to provide safe and effective healthcare, irrespective of population or setting (Baldwin 1999).

2.6 Preparation of nurses for culturally competent care

The 1980s was a decade of transition of the training of nurses in the Republic of Ireland. With the hospital apprenticeship system of the

training of nurses at the beginning of the decade, student nurses were essential resources in provision of the hospital-based health services (Fealy 2006). By the end of the decade, the future sustainability of apprenticeship system of nursing training was undermined by factors such as the professional and educational imperatives as well as economic, demographic and cultural changes (An Bord Altranais 1997, Fealy 2006).

In October 1994, the general nurse registration/diploma programme commenced as a pilot study in Galway, leading to a change to the system of nurse education and training in Ireland (An Bord Altranais 1997, Ryan 2000). With this system of education, there was an increase of the theoretical component of the programme from forty weeks to fifty nine weeks. In September 2002, there was another transition in the nursing educational system when a four-year Bachelor of Science degree in nursing became the only route of practice (McNamara 2005). The commission on nursing (1998) recommended this transition. The demographic and cultural changes are some of the factors influencing educational needs of student nurses in Irish multicultural society (An Bord Altranais 1997, National Council for the Professional Development of Nursing and Midwifery 2003).

One obligation of the nursing profession is the preparation of nurses who are competent in taking account of the customs, values and beliefs of patients (Lister 1999). In recognition of such obligation and the important role that nurses play in healthcare delivery, An Bord Altranais (the Irish Nursing Board) has clearly stated in the Requirements and Standards for Nurse Registration Education Programmes (2005) that student nurses must demonstrate the ability to provide culturally competent care by reaching five domains of competence on completion of the education programme for entry to the Register held by An Bord Altranais (An Bord Altranais 2005). The five domains of the competencies include: professional/ ethical practice; holistic approaches to care and the integration of knowledge; interpersonal relationships; organisational and management of care; and personal and professional development (An Bord Altranais 2005). Nursing education is therefore the key to ensuring that nurses are prepared to provide culturally competent care (Baldwin 1999, Blackford and Street 1999, Gerrish 2000, Salimbene 1999). Educational preparation of nurses has many benefits to both the nurses and the patients.

2.6.1 The benefits of adequate educational preparation of nurses

There is an abundance of evidence to demonstrate the benefits of adequate educational preparation of nurses on the effectiveness of

nurses and positive health outcomes for their patients. For instance, in Canada, Majumdar et al. (2004) conducted a quantitative study using a randomised controlled trial involving 114 health care providers and 133 patients to determine the effectiveness of cultural sensitivity training on the knowledge and attitudes of health care providers, and to assess the satisfaction and health outcomes of patients from different minority groups with health care providers who received training. In this trial, 114 health care providers (nurses and home workers) and 133 patients (from two community agencies and one hospital) were randomly assigned to experimental (training) and control groups, and were followed for 18 months. Health care providers completed the cultural awareness questionnaire and the dogmatism scale. Patients completed questionnaires such as patient satisfaction questionnaire. These instruments are valid and reliable (Laisen et al. 1979, Majumdar et al. 1992 and Vacchiano et al. 1967). A qualitative analysis was conducted to identify and analyse themes from the personal journals kept by nurses who participated in the study (Majumdar et al. 2004).

It was found that cultural sensitivity training resulted in improved understanding of multiculturalism. Health care providers showed statistically significant improvement in cultural awareness (p=.0001), understanding of cultural differences (p=.001), cultural beliefs (p=.004), adopting health care literature (p=.001), considering social circumstances (p=.011), and considering culture to be important (p=.001). In addition, there was a significant improvement in the ability of the health care professionals to communicate with patients from minority ethnic groups. In contrast, health care providers in the control group did not show improvement in these categories. The researchers acknowledge the limitations of the study such as high attrition rate of patients due to death or serious illness (Majumdar et al. 2004). On the other hand the use of a randomised controlled trial is the strength of the study because randomisation has the advantage of eliminating bias and aids in the attainment of a representative sample (Watson 1999).

In a Western Australia University, Lim et al. (2004) carried out another quantitative study using a convenience sample of first and fourth year undergraduate nursing students (n=196) and a questionnaire to examine the students' self-efficacy in performing transcultural nursing skills for patients from cultural diverse backgrounds The transcultural self-efficacy tool (TSET) was used to measure and explore nursing students' perception of self-efficacy in performing transcultural nursing skills. TSET is a valid and reliable instrument (Jeffrey 2000, Jeffrey and Smodlaka 1998, 1999). Analysis of the data was conducted using the Statistical Package for

the Social Sciences. Findings revealed that fourth year students, exposed to increased theoretical information and clinical experience had a more positive perception of their self-efficacy in providing transcultural nursing skills than the first year students ((p<0.001) Lim et al. 2004). Although the limitations of the study include the use of convenience sample which impedes the generalisation of the findings (Watson 1999) the findings are encouraging to those responsible for the education and training of nurses.

Brathwaite and Majumdar (2005) conducted a study in Canada, which used a combination of quantitative and qualitative methods for data collected to evaluate the effectiveness of a cultural competence educational programme in increasing public health nurses' cultural knowledge. A convenience sample of 76 nurses (75 females and 1 male) participated in the study and the sample size was adequate to detect a moderate effect size with a beta of 0.80 and alpha 0f 0.05. Cultural knowledge scale, which is a valid and reliable, 25 –item likert scale (Bernal and Froman 2000, Campinha-Bacote 1998) was used to measure cultural knowledge. It was found that the nurses' cultural knowledge was increased through educational sessions that were well organised with adequate time for discussion (Brathwaite and Majumdar 2005). The limitations of the study are the use of convenience sample and the conduct of the study from one study site. Thus, the result cannot be generalised to the total population.

Despite the importance of educational preparation of nurses to meet the needs of patients from various cultures, educational programmes designed to prepare nurses are often inadequate resulting in difficulties for nurses in providing quality care to culturally diverse groups (Chevannes 2002, Lim et al. 2004).

2.6.2 Inadequate educational preparation of nurses

Weaver (2001) conducted a survey to explore the educational preparation of native American nurses and nursing students (n=40). Questionnaire which was tested and validated during the pilot study was used to collect data. Findings revealed that cultural content in the educational programme was quite limited, nurses wanted more cultural content, and sometimes they obtained it from other sources such as reading and contact with other students (Weaver 2001). The limitation of this study is that information obtained in a survey tends to be superficial (LoBiondo-Wood and Haber 1998).

In her qualitative study, Chevannes (2002) reported that the majority of the health professionals (that is, 65% n = 11) confirmed that no attention was given in their initial education to the healthcare needs of minority ethnic groups while others indicated that there was barely any content about the subject. The healthcare professionals engaged in self-initiated learning to improve their knowledge and understanding. In addition, the participants gained their knowledge of cultural diversity from personal experiences and lessons learnt by day to day work (Chevannes 2002).

In the quantitative study conducted by Boyle (1999) in Dublin, it was found that 81 percent of the nurses felt inadequately prepared from their training and education to care effectively for people of other cultures. Eliason and Raheim (2000) carried out another quantitative study in a university in the United States, with undergraduate students (n=196) beginning their nursing education, to investigate their experiences and comfort with culturally diverse groups. An instrument was developed specifically for the study that included information such as demographic information and questions about exposure to people from different culturally diverse groups. The instrument was tested and validated in the pilot study (Eliason and Raheim 2000). It was reported that the students expressed their lack of knowledge, skill, and exposure to people from different cultural backgrounds as a primary reason for their discomfort with people who are different from them ($p < .001$) (Eliason and Raheim 2000). It is therefore important to use a variety of method to prepare nursing students for the provision of culturally competent care.

2.6.3 Strategies for the preparation of nurses for cultural competence

There are various strategies that could be utilised in the preparation of student nurses for culturally competent care. The starting point is the continuous development of the theoretical aspect of the curriculum to address the multicultural perspectives of healthcare and to incorporate it into nurse education and training. Knowledge development in relation to the nursing curriculum need to address the complex ways in which historical, social and economic factors interact and influence cultural diversity (Gerrish and Papadopoulos 1999, Leninger 1997).

Another strategy that could be utilised to prepare nursing students for culturally competent care is the utilisation of various learning opportunities in the clinical settings (Gerrish and Papadopoulos 1999). According to Gerrish (1998) students have great value on developing cultural competence through caring for patients from different ethnic backgrounds. There are many benefits for students

to work alongside the expert practitioners. Such benefits include support for the students as well as facilitation of students' learning from the expert practitioners (Gerrish 1998, Gerrish and Papadopoulos 1999). Working with nurses from different cultures is regarded as a positive thing in that it enhances patients' care as well as staff development as other nurses can learn a variety of ways in which nursing is practiced around the world (Josipovic 2000). These nurses from other countries and cultural backgrounds can empathize with patients who have undergone the migration experience because they have shared situations and feelings that others who have not undergone similar experiences cannot share (Gerrish and Papadopoulos 1999, Josipovic 2000).

The involvement of people from diverse ethnic backgrounds, such as representatives of community groups, in the delivery of the taught curriculum as well as involving them in the care of the patients also promotes students' learning in the care of the patients (Gerrish 1998, Gerrish and Papadopoulos 1999). Baldwin (1999) suggests that exposing students to patients of other cultures in diverse healthcare settings is a key strategy for the development of skills that will help them become culturally competent.

Another strategy that could be utilised to achieve cultural competence is through cultural immersion (Ryan et al. 2000, Sargent et al. 2005, St Clair and McKenry 1999). Cultural immersion involves students living with and among the people and working within that ethnic culture's health care system (St Clair and McKenry 1999). Sargent et al. (2005) carried out a quantitative study with a convenience sample of 88 first year, 121 fourth year baccalaureate students and 51 faculty members in a large state university in the United States of America using questionnaire to assess the development of cultural competence in students and faculty in this baccalaureate program. The inventory for assessing the process of cultural competence was used to measure the level of self-reported cultural competence. This instrument is valid and reliable (Campinha-Bacote 1994, 1999). It was found that the use of immersion experiences and inclusion of structured cultural content in the nursing curriculum helped to increase students' knowledge of health care needs among various cultures ($p<.0001$(Sargent et al. 2005)). The use of convenience sample and the obtaining of the result from one study site are the limitations of the study because the findings cannot be generalised to the total population.

Ryan et al. (2000) conducted a qualitative study using grounded theory approach and unstructured interviews format to describe the phenomena of being immersed in a different culture during a

nursing educational experience and to explore graduates' perceptions of the effect of this immersion on nursing practice (n = 9). It was found that the respondents learnt to provide culturally congruent care to the patients through cultural immersion. Strategies which helped the healthcare providers to appropriate care to the patients include: preparation activities such as simulating cultural adaptation, dependence on group support, and the use of coping skills such as problem solving skills. Adaptation through learning to communicate and think differently, and learning about different lifestyle and cultures were also strategies which enhanced the provision of culturally competent care (Ryan et al. 2000). The limitation of the study is that it was carried out in one study site, therefore, it is impossible to generalise the findings to the total population.

2.7 Summary

The literature review has highlighted four main factors that influence the provision of culturally competent care. These are communication with patients; cultural and religious differences; individualised nursing care; and preparation of nursing students for the provision of culturally competent care. Effective communication between nurses and the patients is crucial to the provision of culturally competent care. On the other hand, communication difficulties between the nurses and the patients result in reduced standard of care to the patients from different cultural backgrounds (Chevannes 2002, Kennedy and Murphy-Lawless 2002). Interpretation services and the use of non-verbal communication are strategies used to overcome communication difficulties between nurses and the patients.

Cultural and religious differences of the patient have additional influence on the provision of culturally competent care. Studies have shown that nurses have difficulties providing appropriate nursing care to the patients from different cultural backgrounds due to the nurses' lack of understanding of the various cultural and religious issues and their relationship to nursing practice (Baker and Daigle 2000, Clegg 2003, Cortis 2004, Hultsjo and Hjelm 2005).

For years, individualised nursing has become the central component of nursing policy and practice (Gerrish 2000). Evidence from the literature suggests that nurses are unable to provide adequate individualised nursing care to patients from different cultural backgrounds due to the nurses' lack of cultural knowledge about the patients and inadequate implementation of holistic care (Cortis 2004). Nursing education and adequate clinical experience of nursing students are crucial to the preparation of nursing students for the provision of culturally competent care (Lim et al. 2004).

There was no published evidence discovered on undergraduate nursing students' experiences in providing culturally competent care in an Irish healthcare system, thus the need for the conduct of the current study.

Chapter Three

3 Methodology

3.1 Introduction

This chapter places the study within the interpretative phenomenological field of research to answer the research question, which is: what is it like to provide appropriate nursing care to patients from different cultural backgrounds? An overview of quantitative and qualitative research approaches will be given. The rationale for the use of qualitative research approach for this study will be discussed. In addition, the rationale for the use of Heideggerian hermeneutic/interpretative will be discussed and why this approach to phenomenology best suited the phenomenon that was investigated. This will be followed by the description of the sampling and means of data collection. The ethical considerations will be discussed. An overview of van Manen's method of data analysis and the discussion of its appropriateness for the study will be provided. Finally, there will be explanations of the steps that were taken to ensure data trustworthiness.

3.2 Quantitative and qualitative approaches to nursing research

It is important to differentiate between quantitative and qualitative methodologies to enhance the understanding of the researcher's choice of a qualitative approach for the current study. Approaches to nursing research consist not only of the procedures of sampling, data collection and analysis, but they are based on particular ideas about the world and the nature of nursing knowledge, which sometimes reflect competing and opposite views about social reality (Holloway and Wheeler 2002). Since quantitative and qualitative methodologies are based on different philosophical assumptions, it is therefore important for researchers to understand the philosophical ideas on which the research approaches are based in order to make appropriate choice for the study (Bryman 2004, Holloway and Wheeler 2002). A brief explanation of quantitative and qualitative approaches will now be given as well as the rationale for choosing a qualitative approach for the current study.

3.2.1 Quantitative research approach

The quantitative approach is a formal, objective, systematic process in which numerical data are used to get information about the world (Burns and Grove 2003). The quantitative research approach has its root in a branch of philosophy called logical positivism (although most recent studies reflect a post positivistic stance), which operates on strict rules of logic, truth, laws, and predictions of cause and effect relationships. (Burns and Grove 2003, Holloway

and Wheeler 2002, Parahoo 2006). Quantitative researchers believe that 'truth' is absolute and there is one single reality that can be defined by careful measurement. The researcher must be objective in order to find the truth (Burns and Grove 2003).

Quantitative research method adopts a reductionism approach because it reduces a complex phenomenon into a smaller unit that can be observed and measured (Parahoo 2006). Quantitative research is carried out to test theory by describing variables, examining relationships among variables and determining cause-and-effect relationships between variables (Burns and Grove 2001, Porter 2000). In relation to the current study, it was inappropriate to use a quantitative approach, which has its base on positivism, because it is inadequate to answer the research question: what is it like to provide appropriate nursing care to patients from different cultural backgrounds? Quantitative research with its reliance on measurement is inadequate and inappropriate to provide an in-depth understanding of the human experience, hence the need for utilising a qualitative research approach for this study (Parahoo 2006, Porter 2000).

3.2.2 Qualitative research approach

Qualitative research approach is a systematic, subjective approach that is used to describe life experiences and situations as well to give them meaning (Carpenter 2003, Munhall 2001, Parahoo 2006, Speziale 2003). This research approach emerged from the behavioural and social sciences as a method of understanding the unique, dynamic, holistic nature of human beings (Burns and Grove 2003). Qualitative research has its base in interpretivism, humanism and naturalism and is concerned with understanding of the meaning of social interactions by individuals involved (Burns and Grove 2003, Crestwell 1998, Crotty 1998). Qualitative research is carried out in order to enhance understanding of human experiences and situations as well as to develop theories that describe these experiences (Burns and Grove 2003). A qualitative research approach therefore is appropriate for this study because it concerns the subjective experiences of nursing students in providing culturally competent care in an Irish multicultural healthcare system.

3.3 Rationale for Qualitative Research Design

A qualitative approach was adopted for this study due to the nature of the research question: What is it like to provide appropriate nursing care to patients from different cultural backgrounds? This is in contrast to quantitative research questions that ask why something happened and look for comparison of groups (Crestwell 1998). The absence of knowledge about the undergraduate nursing

students' experiences in providing culturally competent care in an Irish multicultural healthcare system meant that an exploratory, qualitative approach was the most appropriate (Crestwell 1998, Parahoo 2006).

The aim of this study was to explore the experiences of undergraduate student nurses in providing culturally competent care in an Irish multicultural healthcare system and to interpret the meanings the students attribute to their experiences. A qualitative design therefore suits this study because it concerns the subjective experiences of the participants (Carpenter 2003). Ultimately, the purpose of the exploration of the nursing students' experiences is to gain a better understanding of their experiences in providing culturally appropriate care to their patients (Parahoo 2006).

There are various approaches to qualitative research. Examples of these approaches are: grounded theory, ethnography and phenomenology (Crestwell 1998, Parahoo 2006). Each of the qualitative approaches is based on a philosophical orientation that influences the interpretation of the data (Burns and Grove 2003). Grounded theory research is an inductive approach to research whereby hypotheses and theories emerge out of, or are grounded in the data (Burns and Grove 2003, Glaser and Strauss 1967, Parahoo 2006). Although grounded theory approach could have been used to develop theories that describe the students' experiences of cultural competency, the researcher did not choose this approach as the purpose of the current study is not to generate hypotheses or theories rather it is to promote the understanding of the experiences of the nursing students in providing culturally competent care in an Irish multicultural healthcare system. Ethnographic study seeks to understand phenomena in a natural environment within a particular culture (Burns and Grove 2003, Crestwell 1998). Given that ethnography involves observational techniques, it would also have been useful for the current study in addition to the phenomenological approach used for the study. However due to the time constraints and academic requirements, the researcher decided to use only phenomenology.

3.4 Rationale for choosing phenomenological research design

The researcher considers the philosophical underpinnings of phenomenology to be an appropriate approach to the study since the aim of the research question is to understand the meaning of an experienced phenomenon. The purpose of phenomenology is to reveal a deep understanding and description of human meaning by bringing the researcher into closer contact with those experiencing a phenomenon. Such an approach is valuable as it helps a researcher

to explore a phenomenon from an experiencing person's perspective and brings to light a greater understanding and awareness of the meaning individuals attribute to their experiences (Johnson *et al.* 2006). Phenomenology is suitable to this study because the aim of the study is to explore the experiences of undergraduate student nurses in providing culturally competent care in an Irish multicultural healthcare system and to interpret and understand the meaning the students attribute to their experiences.

There is no single approach that is subscribed to by all phenomenologists, but in general the methods include identifying the people who are living or have lived the experience of interest and seeking through in-depth interviews their perceptions (Carpenter 2003). The two broad approaches of phenomenology are Heideggerian hermeneutic (interpretive) phenomenology and Husserlain transcendental (descriptive) phenomenology (Crotty 1996). The major difference between the two approaches is that while Heidegger's philosophy focuses on ontology (the nature and relations of being), Husserl's philosophy focuses on epistemology (the theory and validity of knowledge. Husserl emphasises the need for researchers to bracket their presuppositions and preconceptions to enhance the validity of the data and the study (Crotty 1996, Paley 1997) while Heidegger emphasises the need for researchers to use their foreknowledge (preconceptions) to deduce meaning from their phenomena in order to change or improve practice (Crotty 1996). In other words, Heidegger rejects the Cartesian concept of detaching subjects from the world of objects and suggests that it is not possible to understand a phenomenon by bracketing people from being in the world, that is, from 'Dasein' (Crotty 1996, 1998).

3.5 Rationale for choice of Heideggerian interpretative research design

A qualitative approach using Heideggerian hermeneutic/ interpretative phenomenological philosophical principles guided the study (Heidegger 1962).

Based on the review of the Husserlain and Heideggerian phenomenological approaches, and the interpretative, rather than descriptive, purpose of the study, the research approach chosen was that of Heidegger. While Husserlain descriptive phenomenology aims at identifying the structure of experiences as described by research informants, Heideggerian interpretative phenomenology takes the process further by analysing what the participants' descriptions of the participants' experiences mean (Crotty 1996, 1998). Using Heidegger's approach, the researcher would not be concerned about bracketing of her preconceptions rather she would use her foreknowledge (preconception) of cultural competence to

deduce meaning from the students' experiences of their cultural competence. To understand the meaning of student nurses' experiences of cultural competence, it is crucial to understand the meaning of culture. According to Duffy (2001) culture is an elusive concept that is hard to define and understand. Interpretative approach helps in the understanding of culturally important phenomenon (Crotty 1998), hence, the need of using Heideggerian interpretative approach to guide the study.

Heiddegerian hermeneutical nursing research has been criticised at times because many studies failed to provide a robust description of the processes of interpretative research (Draucker 1999). In addition, Crotty (1997) argued that many philosophers and interpretive nurse researchers had misunderstood and misrepresented the work of Heiddegger. Consequently, the researcher will provide adequate information on how the philosophy enriches, as well as guides, the interpretations in order to enhance data trustworthiness.

3.6 Sampling

Sampling is the process of selecting a portion of the population for a research study in such a way that the individuals represent the entire population (Fain 2004, Polit and Beck 2004). Sampling strategies depend on the purpose of the study and method of data collection (Parahoo 2006). In qualitative research, two principles guide the sampling, namely: appropriateness and adequacy (Morse and Field 1996). Purposive sampling was therefore used for the recruitment of the willing participants for this study to enable them inform the study. According to Carpenter (2003) purposive sampling is used most commonly in phenomenological inquiry because it provides information-rich cases for in-depth study.

Participants were fourth year student nurses who had provided nursing care to patients from different cultural backgrounds. The reason for choosing this group of students was that they had completed their clinical placements therefore, were able to inform the study. The first eleven people who responded to participate in the study were chosen as the participants. Participants consisted of ten female and one male Bachelor of Science nursing students and were between the ages of 22 and 35 years.

3.7 Setting up and negotiation of access

The study was conducted in a University in Ireland. After deciding on the research topic, the researcher completed and forwarded letters to the Head of Department of the School of Nursing, Midwifery and Health Systems as well as the Human Research

Ethics Committee of the university to explain the purpose of the study and to request permission to gain access into the study site as well as to conduct the study. Please see appendix 2 for the letter to the Head of Department of the School of Nursing, Midwifery and Health Systems. The letter and application to the Ethics Committee are not enclosed in this piece of work in order not to reveal the identity of the research site. Once access was negotiated and formal ethical approval of the study was obtained, the sample was recruited according to the inclusion criteria. The permission letter from the Head of School of Nursing, Midwifery and Health Systems and the letter of formal ethical approval are also not included in this piece of work in order not to reveal the identity of the study site. However, these letters are available if they are needed.

The inclusion criteria for selecting the sample included the following: the participant must be a fourth year student nurse and must have provided nursing care to patients from different cultural backgrounds. The criteria were based on the need to have participants who had particular knowledge of the phenomenon being explored (Carpenter 2003). The researcher made personal contacts with the potential participants and disseminated the information sheets to them. When the participants responded to take part in the study, an interview time was arranged at a time that was convenient to the participant.

3.8 Ethical considerations

Research can present risks to the participants therefore the researcher has an obligation to ensure that the wellbeing of the participants is safeguarded throughout the research process (Parahoo 2006, Polit and Hungler 1999). Hyde and Treacy (1999) identified the following ethical principles: autonomy, non-maleficence, beneficence and justice. Respect for autonomy of the participants involves informed consent and voluntary participation. Non-maleficence relates to doing no harm to the participants. Confidentiality and anonymity relate to the principle of beneficence and the researcher ensuring the wellbeing of the participants (Hyde and Treacy 1999, Parahoo 2006, Polit and Beck 2006).

In Ireland, it is clearly stated in An Bord Altranais's Code for Professional Conduct for Each Nurse and Midwife (An Bord Altranais 2000a) that nurses' responsibility when conducting research include adhering to the principles of confidentiality and the provision of sufficient information to the participants to facilitate informed consent. It is also the responsibility of the nurse to ensure that that ethical approval of the study is obtained before conducting the study and that the rights of the participants are protected all the time (An Bord Altranais 2000a).

In the current study, formal ethical approval of this study was obtained from the Human Research Ethics Committee of the research site prior to the conduct of the study. Adequate information about the research was given to the willing participants in an understanding manner to enhance their informed consent. The participants were encouraged to ask questions or seek clarification. They were advised of the voluntary nature of their participation and that they could withdraw from the study at any time without disadvantage. They were informed that their participation or non-participation in this study would not affect their grades in their programme of study. Informants were also advised that at any time during the interview they could refuse to answer any question, request that the tape recorder be turned off or terminate the interview. Written consent was obtained from the each participant to tape the interviews. The informants were informed that the researcher may contact them by telephone or mail if there were any follow-up questions after the interview. The participants were informed that there were no known risks to them from taking part in this research, and no foreseeable direct benefits to them. However, it is hoped that the research will benefit future undergraduate nursing students and the profession of nursing.

The researcher explained to the participants that to ensure confidentiality, all information obtained from them during the research would be kept confidential. The participants were also informed that recordings and notes about the research would be stored in a locked file. Each person who participated in the research was given a code number so that the researcher was the only person who could identify who the participants were in the notes. Participants were informed that the key to the code numbers would be kept in a separate locked file. They were also informed that identifying information about the participants would not be used in any reports of the research. The participants were informed that the tape containing the interviews would be destroyed upon completion of the study. The details of information and consent form that was given to each of the participants could be seen in appendix 3. Finally, the participants were advised that if they have any question regarding their treatment or rights as participants or rights in this research project, they can contact the researcher's supervisor. The telephone numbers and e-mail addresses of the contact person were made available to the participants.

3.9 Pilot study

Pilot study refers to a small version of a full-scale study, or trial run, which is done in preparation of a major study (Polit and Beck 2006). As a novice researcher, it was helpful to conduct a pilot study in

order to prepare for the main study. To learn more about the experiences of undergraduate nursing students in providing culturally competent care in an Irish multicultural healthcare system, the researcher explored it by talking with two participants who had had the experience of providing nursing care to patients from different cultural backgrounds. This was in essence a pilot study that illuminated the phenomenon and also helped the researcher to predict the success of the chosen methodology.

During interviews with each of the two participants, the researcher asked: what is it like to provide appropriate nursing care to patients from different cultural backgrounds? The interviews were taped and transcribed. The participants' narratives provided a lens through which the researcher saw aspects of the phenomenon.

3.10 Data collection

Collection of data was through semi-structured interviews, which were taped and later transcribed verbatim for the purpose of data analysis. A topic guide was used to assist the researcher. A topic guide is a list of issues or topic areas to be covered with each participant (Polit and Beck 2004). The topic guide could be seen in appendix 1. The rationale for using semi-structured interviewing and the topic guide was to give the participants the freedom to respond in their own words, provide as much detail as they wished, and offer illustrations and explanations (Polit and Beck 2004, Porter 2000). According to Parahoo (2006) and Polit and Beck (2004) semi-structured interviews enable the researcher to probe and clarify various points with the participants in a more flexible way. Interviews lasted for about 35 to 55 minutes. Once consent was obtained, the interview proceeded with the aim of obtaining a description of the research participants' experiences of providing culturally competent care in an Irish multicultural health care system. Data was collected in a location that was convenient to the participants. The interviews were carried out between April and July 2006.

3.11 Data analysis

The main purpose of data analysis in interpretive research is to locate meanings in a text (Bryman 2004). The process of interpretation involves the researcher immersing her in the data, engaging with it reflectively to identify the themes, or meaning structures of the lived experience (Carpenter 2003, Russell 2004, van Manen 1990). There are different methodological steps in data analysis, which also varies between researchers such as Collaizi (1978), Giorgi (1985), Van Kamm (1984) and van Manen (1990).

The researcher is required to engage in a dialogue with the data and use inductive reasoning and synthesis while using any of the methods for data analysis (Russell 2004).

There is no best method for data analysis however, it is important that the chosen method of analysis is congruent with the philosophical position that underpins the study in this case, phenomenology. As the aim of this study was to interpret and understand the meaning that nursing students attribute to their experiences of providing culturally competent care in an Irish healthcare system, the researcher chose to analyse data thematically using the method developed by van Manen (1990) in order to locate meaning in the text. This approach outlines six activities for phenomenological research that are congruent with the philosophical underpinnings of Heideggerian phenomenology:

- Turning to a phenomenon which seriously interests us and commits us to the world, formulating the phenomenological question, and explicating assumptions and pre-understanding;
- Investigating experiences as it is lived rather than as we conceptualise it;
- Reflecting on the essential themes which characterise the phenomenon;
- Describing the phenomenon through the art of writing and rewriting;
- Maintaining a strong orientated pedagogical (or nursing) relation to the phenomenon; and
- Balancing the research context by considering parts and whole.

In applying van Manen's six steps to data analysis, the first step, turning to a phenomenon of interest involved deciding upon the topic and the research question. The second step, investigating experiences as it is lived involves the conduct of the eleven interviews. The third and fourth steps are concerned with the data analysis. The third step was to reflect on the essential themes, which characterise the nursing students' experiences of providing culturally competent care. The fourth step was to describe the phenomenon through writing and re-writing which is the process of analysis currently being described. The fifth step, maintaining a strong orientated relation to the phenomenon in the case of this study was that the researcher was on track with the research question: what it is like to provide appropriate nursing care to patients from different cultural backgrounds? The sixth step, balancing the context by considering parts and whole, referred to the data analysis of each of the individual interviews as well as all the eleven interviews together seeking key words, concepts, sub-themes and themes.

According to van Manen (1990) when a phenomenon is being analysed, the researcher is trying to grasp and make clear the meaning as well as trying to determine what the themes are, the experiential structure that make up the experience. To fully engage in the analytic process, it is important that the researcher dwells with and become immersed in the data (Carpenter 2003). After the transcription of the interviews, each transcript was read several times in order to gain an understanding of each participant's story. Reading and re-reading the transcripts of the eleven participants, and also listening to the tapes helped the researcher to become familiar with the data as the participants' thoughts, feelings and stories were going through the researcher's mind.

The text was analysed by reflecting on it to find significant themes, while also engaging in the process of writing and rewriting. Initially each of the eleven individual interviews was analysed and written separately and key words and concepts were pulled out, considering the parts as highlighted by van Manen. After that, the eleven participants' narratives were gathered and analysed together while looking for the themes and sub-themes, and considering the whole as van Manen (1990) suggested. This involved a coding process as the researcher was reading and continuously interacting with the data. According to Morse and Field (1996) it is important for the researcher to read and re-read the interviews in their entirety, then to step back and reflect on the interviews as a whole in order code for a theme. To make sense of the experiences of the participants in providing culturally competent care in an Irish multicultural healthcare system, it was necessary for the researcher to move backwards and forwards in the hermeneutic circle (as described by Heidegger (1962)) by reading and re-reading each transcript, listening to the tapes as well as analysing the data over and over again.

Van Manen (1990) identified three methods for isolating thematic statements. These are: the detailed or line-by-line reading approach; the selective or highlighting approach; and the holistic or sententious approach. All the three approaches were used in this study in different ways to obtain different information about the phenomenon.

In the detailed reading approach, the researcher is required to look at every single sentence or sentence cluster and try to find out what the sentence or sentence cluster reveal about the phenomena (van Manen 1990). The researcher went through each transcript and assigned key words and concepts to each sentence or cluster of sentences that had a new idea. This was the researcher's first approach to the data analysis. In the selecting or highlighting

approach, the researcher read the text many times and asking which statements or phrases appeared to be particularly revealing about the phenomena. These statements were underlined and highlighted and copied from the transcripts.

In the preliminary analysis, which involved analysing each interview separately, or going from parts of the text to the whole (van Manen 1990), the quotes were highlighted, copied and pasted, and became linked to the key words, which led to the concept. In the final analysis, the highlighted statements became part of the sub-theme, and then the theme.

Other quotations were taken from the text, grouped together according to the similarity of ideas, and analysed together in the same way. The summary of how the themes were developed from the key words to concepts to sub-themes and then themes is presented in table 1 in appendix 4. This is to enhance the reader's ability to audit the researcher's decisions made throughout the analytic process (Koch 1994)

The holistic approach was done at the end of the data analysis. In the holistic reading approach, the researcher looked at the text as a whole while asking which phrase captured the fundamental meaning or main significance of the text as a whole. For instance, in searching for the implicit themes in the data, the researcher found the phrase "individualised nursing care", to be an important representation of the data in the third theme. This is because all the participants shared the experiences of what they identified as appropriate nursing care to each patient regardless of cultural background as presented in the study findings in chapter four.

3.12 Data trustworthiness

Qualitative generally use three criteria to judge the validity and reliability (more commonly referred to as trustworthiness) of qualitative data. These include credibility, auditability and fittingness (Carpenter 1999, Marcus and Liehr 1998, Streubert 1998).

According to Carpenter (1999) credibility of the data could be achieved by returning to the participants to verify the accuracy of the material. The researcher established credibility by using the participants for member checks in order to confirm the accuracy of the themes. They were also asked to further explicate meaning throughout the interview process. An expert in phenomenological research was also asked to validate the interpretation of the themes.

Auditability: This refers to the ability of the reader to follow the thinking, decisions and methods used by the researcher (Yonge and Stewin 1988). The researcher has provided the themes to allow the readers to follow her line of thinking. Adequate account of the research processes has been provided. This will enable readers to determine whether the data analysis procedures were carried out appropriately (Streubert 1998). In addition, the researcher provided a table in appendix 4, of how the themes were developed during the data interpretation. This is to enhance readers' ability to audit the researcher's decision made throughout the analytic process (Koch 1994).

Fittingness of the study refers to how well the findings fit outside the study situation (Streubert and Carpenter 1999). To demonstrate the fittingness of the findings, the researcher placed the study in context by providing the reader with examples of other studies that described and interpreted similar phenomena. Although the study and other qualitative studies cannot be generalised to other populations due to sample size and because qualitative data is quite specific and particular to a context, place, time and person, they can be extremely valuable in enhancing understanding of the human experiences and social processes inherent in nursing practice situations (Meehan 1999).

3.13 Summary

In this chapter, there has been a discussion, in a step-by-step fashion of how the current qualitative research was carried out. Quantitative and qualitative research approaches were discussed and the rationale for using a qualitative approach and specifically Heideggerian interpretative phenomenology to guide the study was given. Ethical issues were addressed in order to protect the participants. The researcher used a purposive sample of eleven willing participants, that is, fourth year student nurses who had provided nursing care to patients from different cultural backgrounds. Data was collected using semi-structured interviews. The data was transcribed verbatim and analysed thematically using the method developed by van Manen (1990). Steps were taken to ensure data trustworthiness. The findings of the study are presented in the next chapter.

Chapter Four

4. Study Findings

4.1 Introduction

The aim of this chapter is to present the findings of this study which was aimed at exploring the experiences of undergraduate nursing students in providing culturally competent care in an Irish multicultural healthcare system and interpreting the meaning the students attributed to their experiences. Data was analysed thematically using the method developed by van Manen (1990) as discussed in chapter three. In the preliminary analysis, which involved analysing each interview separately, or going from parts of the text to the whole (van Manen 1990), different quotes were highlighted, copied and pasted, and became linked to the key words which led to the concepts. In the final analysis, the highlighted statements became part of the sub-theme and then the theme.

Other quotations were taken from the text, grouped together according to the similarity of ideas, and analysed together in the same way. Table 1 has been included to demonstrate the steps in the analysis and how the themes were developed from the key words to concepts to sub-themes and then themes. This is to enhance the reader's ability to audit the researcher's decisions made throughout the analytic process (Koch 1994). The table could be seen in appendix 4. In this chapter the findings of the study are presented and structured under main themes and sub-themes. Four main themes that emerged from the data are: Communication difficulties; Cultural differences and religious differences; Individualised nursing care; and Preparation of the nursing students for the provision of culturally appropriate care.

Communication difficulties contain three sub-themes: lack of proficiency in English language; interpreters; and non-verbal communication. Cultural and religious differences have two sub-themes namely: preference for the same sex nurses or doctors; and issues with food. Individualised nursing care contains two sub-themes: respecting individuality; and holistic approach to care. The fourth theme, preparation of nursing students for the provision of culturally competent care comprises two sub-themes: formal education of the student nurses; and learning opportunities in the clinical settings.

4.2 Communication difficulties

This theme refers to difficulties with exchange of information between the nurses and the patients from different cultural backgrounds due to patients' lack of proficiency in English language.

Communication difficulties were identified by all participants (n=11) as a major problem encountered when caring for patients from different cultural backgrounds. The participants also identified the use of interpreters and non-verbal communication as the important measures used to interact with the patients. Thus communication difficulties encompass three sub-themes namely: lack of proficiency in English language; interpreters; and non-verbal communication. Each of these sub-themes is described below.

4.2.1 Lack of proficiency in English language

This finding in this sub-theme indicates that all participants (n=11) identified their inability to communication effectively with the patients from different cultural background mainly as a result of the patients' lack of English language or lack proficiency in English language. This led to difficulty with interchange of information between the staff and the patients and inadequate provision of information to the patients. Additionally, communication difficulties between the nurses and the patients resulted in reduced standard of care given to the patients by the nurses. Two participants stated:

> "I remember a person from (name of the country) we had who couldn't speak any English at all and it was hard to try and find an interpreter because obviously it was difficult for them as well as for you because they can't get across what they want or need and you can't explain what you are doing really either, so it was difficult on both sides, so communication thing was a big issue". (Participant E p.1)

> "…but when there is a language barrier I think a lot of nurses kind of would try not to ignore but kind of hold off, just do the bare minimum with them because they know that the language barrier is there". (Participant J p.4)

Many participants (n=5) identified that it took more time to care for patients from different cultural backgrounds because of the communication problems. This is because nurses had to find ways around to the explain things to the patients. In addition, there were times when it was difficult for nurses to find means of communication with the patients due to lack of time on the busy wards. Consequently, family members were left to deal with the patients' problems of communication.

> "It was time consuming because anytime you were explaining something you got a blank expression back that they didn't really understand, then you would try and go off to get something, say like catheter and try to act it out and that was more time consuming". (Participant E p.2)

> "…especially on a busy ward like a busy surgical ward like, you don't have the time to be going off and reading up the different language you know, so it was left to the family and whoever". (Participant L p.4)

A participant was concerned with the issue of obtaining informed consent from the patients who were unable to speak English language since informed consent is dependent upon the quality of information between the staff and patients.

> "Ehm (pause) consent was given in each of the areas but it wouldn't have been informed consent because ehm if a patient didn't speak English …". (Participant G p.2)

Communication difficulties as a result of language barrier emerged as a major issue for both the nursing students and the patients from different cultural backgrounds. This was a major problem because it was difficult for nurses to interact with the patients. It was also time consuming for the nurses to find other ways to explain things to the patients. Consequently, patients from different cultural backgrounds were given less information than other patients. In addition, nurses were unable to provide adequate support to the patients from other cultural backgrounds due to the language barrier. One of the strategies used by nurses to overcome the communication difficulties between them and the patients was the use of interpreters.

4.2.2 Interpreters

This sub-theme discusses how the nursing students and other nurses used interpreters to overcome communication difficulties with the patients who had poor proficiency in English language or who were unable to speak English language at all. Professional interpreters were used as a strategy to improve communication with the patients. In addition, family or relatives and healthcare staffs with bilingual abilities were used as informal interpreters.

All participants (n=11) mentioned that they were aware of the professional interpretation services available to them and how to access them. They also stated that they would call them when necessary. However many of the participants (n=7) commented that the interpreters were limited in number thus making it difficult

for the staff to have access to them when they were needed. Two participants explained:

"Ehm in terms of interpreters you might get them once for things like history or that sort of thing, you wouldn't have daily access or even weekly access to them". (Participant G p.1)

"There wasn't any (interpreter) provided at that time, ehm I think there are very limited with interpreters because even when we had a patient who was from (name of the country) and she had no English and actually it was another patient who decided to try and interpret for her …". (Participant K p.2)

A participant raised a concern about the quality of the service provided by the interpreters.

"… and I found any of the translators that I came into contact, they weren't very empathetic towards the patients' situation that they were in the hospital". (Participant J p.4)

Seven participants identified that family members or relatives who could speak English were used as interpreters in order to enhance communication between the patients and the staff. A participant stated:

"…she didn't really have any English so her younger brother or her cousin would come in. Nobody was too sure what relationship they were but ehm he would translate for her". (Participant H p.2)

Despite the benefits of using a relative as an interpreter to overcome the communication problems between the staff and the patient, a participant commented on the adverse effect of using such a strategy on the patients.

"Sure they found it frustrating, frustrating to have everybody talking about them and not knowing what they were saying, you know". (Participant L p.2)

Many participants (n=8) commented that when formal interpreters and patients' relatives who could speak English were unavailable, bilingual healthcare staffs were also used as interpreters. One of the participants said:

"Ehm yea I find actually some cleaning staff and a lot of them would be Polish or Chinese and so at odd times they were actually very good ehm helping us with communication with basic stuff like

explaining to the patients that we were going for x-ray …". (Participant M p.6)

Some participants (n=3) also expressed that they learnt few words and phrases from the patients or through the interpreters and tried to communicate with the patients with those words and phrases or even tried to improvise when the interpreters were unavailable.

"… your interpreter can leave you with certain words and you can set out your own little dictionary of words for pain in different languages, necessary words like that, that you can ask the person basic things and they can tell you basics otherwise it's hard when the interpreters were not there". (Participant G p.5)

"… when the interpreter was there you try to learn some words that both you and the patients could communicate with, you know, they try to learn few of your words and you try to learn some of their words". (Participant L p.1)

Minority of the participants (n=2) identified that their bilingual/ multilingual abilities were beneficial in alleviating the communication difficulties for the patients.

"… I was speaking Spanish with her and I was saying to her does it hurt? Do you need some pain killers? Basic stuff. It made it easier for her rather than to think just after general anaesthesia in English". (Participant M p.4)

Professional interpreters and informal interpreters were used to improve communication between the staff and the patients. However, because of the limited numbers of the professional interpreters and lack of access to the professional interpreters, nursing staff relied on family or relatives as well as bilingual healthcare staff as informal interpreters in order to overcome the communication difficulties. In addition to the use of interpreters, nurses also used non-verbal communication as a method to overcome the communication difficulties between the staff and the patients.

4.2.3 Non-Verbal Communication

This sub-theme addresses how nurses used various forms of non-verbal communication method to interact with the patients in order to improve communication between the patients and the staff. Majority of the participants (n=10) identified non-verbal communication as another strategy used in overcoming the communication difficulties between them and patients from different cultural backgrounds. The participants (n=10) identified the use of

non-verbal communication methods such as sign languages, observations, pictures, body languages, gestures and actions as ways used to communicate with the patients and said:

"You communicated through pictures or through actions". (Participant L p.1)

"Like it is helpful and you realise the little things that you do really make a difference like just kind of like a smile or looking in a room and saying like, thumbs up, you are okay". (Participant J p.10)

Despite the benefits of the use of non-verbal communication, minority of the participants (n=3) commented on the limitations of the use of non-verbal communication method.

"… but it doesn't do the job half as well as the interpreter might be able to communicate with them (the patients). (Participant G p.1)

"… and that was more time consuming". (Participant E p.2)

Non-verbal communication method was used to overcome communication difficulties between patients and the staff. Although it was a useful strategy, there were limitations associated with its use, including time consumption.

A participant acknowledged that one of the hospitals is trying to alleviate the communication problem by providing language classes in the hospital. However she suggested that there should be better arrangement of such classes that suits the staff better to enhance their availability for the classes.

"I know that they do hold classes in the hospital so may be if they were more available to it or try to arrange it at the time that suited people". (Participant M p.8)

Communication difficulties as a result of language barrier emerged as the biggest challenge for both the nursing students and the patients from different cultural backgrounds. It was difficult for nurses to interact with the patients due to the language barrier. Consequently, patients from different cultural backgrounds were given less information than other patients. In addition, the standard of care provided to the patients from other cultural backgrounds was reduced as a result of the language barrier. The communication difficulties were overcome through the use of strategies such as interpreters and non-verbal communication.

4.3 Cultural and religious differences

This theme, cultural and religious differences discusses how participants identified the effects of patients' different cultural values and religious beliefs on their care. This theme is made up of two sub-themes namely: preference for the same sex nurses or doctors and issues with food.

4.3.1 Preference for the same sex nurse or doctor

This sub-theme addresses the issue of patients' preference for the same sex nurse or doctor mainly due to the patients' religious beliefs. Minority of the participants (n=2) identified that some patients and their family, specifically Moslem patients, had preference for the same sex nurses or doctors to look after them.

"I say sometimes because people obviously have different religions, people from some cultures, some patients (women) will prefer to see women doctors…" (Participant E p.3)

"Moslems …, if her husband came he didn't want male nurses looking after her". (Participant J p.3)

The participants (n=2) also identified that the health care staff had openness to different beliefs and cultures and showed an acceptance and understanding of the patients' preferences. However the provision of female doctors for the patients occurred either by chance or after a long waiting by the patient.

"Ehm the ward that I was on, they were very open to different beliefs and cultures and whatever, so they just kind of said, that's her opinion. As it happened there were two SHOs and one was male and one was female so it was like well the female SHO would go and examine her and report back and whatever". (Participant J p.9)

"but sometimes we had only male doctors on the round, so the patients who want to see women doctors may have to wait longer for someone else to come down, that kind of thing, so that's frustrating for them". (Participant E p.4)

Some patients, specifically Moslem patients preferred to have the same sex nurses or doctors caring for them mainly as a result of the patients' religious beliefs. Healthcare staffs were open to patients' different religious beliefs and showed an acceptance and understanding of the patients' preferences.

4.3.2 Issues with food

This sub-theme discusses the problems that were associated with the dietary needs of the patients. All participants (n=11) identified that the kitchen staff tried to accommodate the dietary needs of the patients as much as they could. However, minority of the participants (n=2) commented that the dietary needs of the patients were not always met by the hospitals' catering staff due to patients' cultural and religious variations.

"Ehm I guess the food was I remember with ehm the Chinese man food was a major issue. He really had problem with it. It turned out that his mother used to bring food to him then the other patients will give out about the smell of it so that was one issue. Also patients who were supposed to be fasting and they didn't understand why". (Participant M p.5)

"Ehm I work in (name of the hospital) and there were occasions of hallal meal, but if a, when a Moslem person comes in they wouldn't get a hallal meal, but it would be the same meal everyday, they (hospital) only offer one". (Participant G p.1)

Dietary needs of patients from different cultures and religions were not always met by the hospitals' catering staff because of patients' cultural and religious variations. However the healthcare staffs were open to patients' different beliefs and cultures and showed understanding of patients' preferences.

4.4 Individualised nursing care

This section consists of the participants' conceptualisation of individualised nursing care which comprises the following values and principles: respecting the individuality; and holistic care. These values and principles formed the sub-themes.

4.4.1 Respecting individuality

This sub-theme addresses the participants' awareness of the uniqueness of each individual patients and the need to focus care around the patient's needs.
Majority of the participants (n=8) identified the need to respect each patient as an individual as well as to treat each patient according to his or her needs.

"… you always have to respect everyone's beliefs". (Participant E p.1)

"… different people have different cultures and they looking after someone to try and understand and even eating habits and things like that, in corporate those beliefs as well". (Participant K p.5)

Participants (n=3) identified that to enhance the provision of individualised nursing care, it was important to carry out nursing assessment in order to identify the patient's needs.

"Well I suppose that we find out from the patients when we are assessing them what kind of religion they are or ehm what kind of diet they would like". (Participant K p.6)

Some participants (n=6) commented that it was difficult to implement individualised care due to lack of experience and cultural/religious understanding, and stated:

"I didn't want her to feel or think that I was treating her any different but yet I wanted her to know that I knew she had different beliefs. I don't know what it was. There was a difficulty like talking about are you okay with having a male doctor to examine". (Participant J p.8)

"… personally like I came across ehm a Moslem family. The husband was there and I hadn't a clue whether to talk to him or whether to talk to the wife (the patient) so I just talked to him and I kind of felt bad may be that I was ignoring the wife, I was unsure". (Participant H p.6)

One participant also commented that it was hard to provide individualised nursing care due to lack of time.

"Ehm just not having enough time (pause) just to sit down with the patients and trying to understand them, yea not having enough time …" (Participant L p.5)

Participants highlighted the uniqueness of each individual patient and the need provide nursing care according to the patient's needs. However it was difficult for the nursing students to provide individualised nursing care as a result of lack of experience, lack of knowledge on various cultural/religious issues, and lack of time.

4.4.2 Holistic approach to nursing care

This sub-theme discusses the participants' conceptualisation of holistic care. All participants (n=11) acknowledged that individualised care takes into consideration the total aspects of the patients and responding not only to the specific health problems but also to the socioeconomic and spiritual needs of the patients, as these are also determinants of the health of the patient. Minority of the participants (n=3) identified that the involvement of other

healthcare multidisciplinary team members enhanced holistic care of the patients.

"Sometimes when the social worker was involved it kind of made things easier. May be the social workers are more aware of (pause) their needs and may be their status as well in Ireland, whether they were refugees or whether they are workers or whether they are asylum seekers or that sort, but that did help in planning their care because a big part of nursing care for example is discharge plan so it kind of helped to know where you are working towards with these patients …". (Participant H p.7)

One participant identified that the care given by healthcare staff to patients from different religions was not always holistic in nature unless the family took the initiatives to incorporate the religious needs of the patients.

"Ehm I haven't ever seen anyone from their religion (Moslems' pastoral minister) coming to them unless the family has organised it". (Participant G p.1)

Another participant (n=1) commented that holistic care was impeded due to communication difficulties between nurses and the patients.

"I don't know whether it is because of the extra effort needed to explain things or if it is, I don't know what it is, but it seems that people would kind of try and ignore the patient almost, may be not ignore them but they would do the bare like they would give them their medication, they would smile, they would tell them what it is in English. That's kind of the far they would go". (Participant J p.4)

Nurses are challenged to provide appropriate and holistic nursing care to each individual patient irrespective of the cultural background. This could be achieved through nursing assessment of each patient and making efforts to meet the needs of each individual patient as much as possible.

4.5 Preparation of nursing students for the provision of culturally competent care

This theme deals with how the student nurses were prepared to provide culturally appropriate care to the patients. All participants (n=11) acknowledged that during their formal educational programme in the university, they were made aware of the cultural diversity in Ireland. However, the participants (n=11) felt that there were gaps in their knowledge on how to provide culturally

appropriate nursing care. In addition, clinical exposures of the nursing students helped to promote their knowledge and skills on how to appropriate nursing care to people of diverse cultural backgrounds. This theme contains two sub-themes namely: formal education of the student nurses; and learning opportunities in the clinical settings.

4.5.1 Formal education of the student nurses

This sub-section discusses how the participants gained their knowledge about the increasing cultural diversity in Ireland. All participants (n=11) confirmed that they were made aware of the changing Irish multicultural society during their formal educational programme in the university. However they (n=11) also indicated they only had basic education on cultural and religious diversity, which was insufficient to prepare them for the provision of culturally competent care. Two participants said:

"Ehm I think we were made aware that there are many different cultures. Ehm I don't think we were prepared enough". (Participant K p.3)

"… we had very minimal education on that" (Participant J p.6)

All participants (n=11) commented that there was no formal module on cultural diversity instead cultural issues were incorporated into different lectures. They all (n=11) felt that their education did not prepare them adequately to cater for the needs of patients from different cultural backgrounds. For these individuals, most their knowledge was as a result of personal experiences, social contacts with colleagues and other people from different cultural backgrounds, lessons learnt from day to day work and as a result of self-initiated learning. Two participants explained:

"there was no formal module but I kind of read a couple of things". (Participant H p.3)

"I would have some ideas mostly from ward experience or just information you picked up on the way but there was very little in terms of college education, specific". (Participant G p.3)

Some of the participants (n=4) commented that their previous exposures to people from different cultural backgrounds contributed to their awareness of different cultures and said:

"I have done a bit of travelling and I think that the travelling obviously helped ehm so it wasn't totally strange meeting people from other cultures". (Participant M p3)

While all participants (n=11) commented that their formal education was inadequate to prepare them for the provision of culturally competent care, minority of the participants (n=2) acknowledged the positive aspects of such inadequate preparation as well, in that it was a challenge for nurses to increase their knowledge and skills of cultural competency and be aware of the different cultural needs.

"I think in general what I found was people like the staff would actually try harder for the patients, you know, and made more of efforts to try and find out their wants you know, their needs really and I think it could be positive that there wasn't that much knowledge …". (Participant H p.6)

All participants (n=11) acknowledged that there was a need for more formal education on cultural issues to enhance their understanding of the cultural differences and religious differences. However minority of the participants (n=2) acknowledged that it may not be possible to have an in-depth programme for all the various cultures in Ireland since there is a lot of cultural diversity in Ireland.

"May be have it more concrete say like this is the lecture on intercultural differences and this is what one religion believes and this is what another, and just having it like, you can't really go into too much depths because there are so many cultures but even I think just having a general idea I think and just kind of been aware of the differences". (Participant J p.6)

"They could probably be a bit specific because there are large populations of certain groups here so it would be, there would be about one hundred and twenty thousand Polish people here and I think there would be Chinese, ehm there would be a lot of Philipinos working with us, they would be working in other areas also not just nursing. They probably could have given us specific ehm things on their care if there are differences because it is more than likely that you would come across them and care for them more than people from smaller groups". (Participant G p.3)

Two participants were uncertain if the university could have had any further preparation for the students rather these two participants felt that there should have been more preparation in the hospital.

"… I don't know if the college could have done something, may be within the hospital they could have been more helpful because it is a practical area, I think you know, we pick up all our practical

work in there and our experience so I think it is up to the hospital more than the college". (Participant M p.8)

Some of the participants (n=5) also identified that there was a need for continuing education on cultural issues for all nurses working in the hospitals. A participant said:

"I think the staff in general need constant updating on different things ". (Participant K p.5)

The nursing students had a minimal education on the increasing cultural diversity in Ireland. This was inadequate to prepare them to provide culturally competent care in an Irish multicultural healthcare system. The exposure of the students to patients from other cultures during the students' clinical placements helped to increase the students' knowledge and skills of cultural competency.

4.5.2 Learning opportunities in the clinical settings

This sub-theme discusses how the participants learnt by caring for patients from different cultural backgrounds and by working with the qualified nursing staff including staff from other cultural backgrounds. All participants (n=11) acknowledged that they all provided nursing care to people from different cultural backgrounds during their clinical placements and that they all learnt by caring for patients from different cultural backgrounds. Two participants explained:

"But ehm I suppose you can learn from experience as well though. It gets better, you know, once you talk to them and see how they talk you pick up some skills to talk to different people". (Participant K p.3)

"… every experience you get you say, like you learn with each one, you pick up little bits of information on what their cultural practices are …". (Participant G p.5)

Some participants (n=4) identified that the nursing staff were very supportive of the students learning during their clinical placements. Particularly, students learnt how to provide nursing care to the patients from other cultures from the nurses.

"The staff were very supporting because they was always somebody above you who have looked after many people than you have so they could help you with that". (Participant E p.3)

Majority of the participants (n=7) commented that it was beneficial to work with the nursing staff from other cultural backgrounds who

have undergone migration experiences because students learnt from them how to provide nursing care in different ways to the patients.

"… and I think it is good to learn from different people, and different people have different strengths and abilities and I think it is really good you can learn lots of things from different people from different cultures". (Participant K p.8)

Two participants suggested that there was a need for more support for the nursing students from the nursing staff, preceptors and clinical skills coordinator, in order to promote their knowledge and skills of cultural competency.

"… having a support network in the hospital is important like having your CPC, even the preceptors and all that kind of stuff". (Participant L p.7)

Some of the participants (n=3) suggested that it would be helpful to involve people from different cultural backgrounds such as community networks in the care of patients from different cultural backgrounds, to help nurses learn how to provide effective nursing care to the patients from other cultural backgrounds as well as helping overcoming communication difficulties between the patients and the nurses.

"I suppose if the hospital had some kind of may be a specialist nurse or a person who dealt with it like or other groups of people you know, that they could come and talk to them or they could bring someone from the community or someone like into the hospital who could help the nurses to communicate with the patients or something like that, you know. That might be a help because (pause) sometimes you know it is left to the nurses and they don't have the skill so they don't know how to do it, do anything about it". (Participant L p.4)

Minority of the participants (n=3) commented that they did not come across any policy or guideline on the wards or hospitals on how to look after people from different cultural backgrounds. Another participant (n=1) mentioned that there were more policies in some hospitals than others. This participant suggested that there was a need for guidelines in the hospitals or even other sources through which information could be provided to nurses in the hospitals on multicultural issues in order to help them know how to provide culturally appropriate care to their patients.

"… there needs to be some sort of guidelines in the hospitals or at least people need to be made aware that that there are resources such for example, books and that, that if you do come across someone from another culture, you really should kind of to do a bit of research into that, into what is best way of doing it …" (Participant H p.10)

During their clinical placements, student nurses learnt how to provide culturally appropriate care to the patients by looking after patients from different cultural backgrounds and by working with the qualified nursing staff including staff from other cultural backgrounds.

4.6 Summary of findings

In this chapter, four themes emerged from the findings of the study. These are: communication difficulties; cultural and religious differences; individualised nursing care; and preparation of nursing students for the provision of culturally competent care. The first theme, communication difficulties emerged during the participants' encounters with patients from different cultural backgrounds while they were in the hospitals. The sub-themes that emerged were lack of proficiency in English language; interpreters; and non-verbal communication. Communication difficulties as a result of patients' lack of proficiency in English language were identified as a challenge and inhibiting factor to the provision of effective nursing care. The use of interpreters and non-verbal communication were strategies utilised to overcome the communication difficulties.

The second theme, cultural and religious differences emerged when participants identified that patients had different belief and value system in various cultural and religious issues, which had effects on the patients and their care. The first sub-theme, preference for same sex nurse or doctor, highlights how the participants perceived the effect of religious beliefs such as Islamic beliefs on healthcare practice. The second sub-theme, issues with food, illustrated participants' identification of food provided to the patients while in the hospitals as a problem to patients from different cultures and religions.

The third theme, individualised nursing care emerged from the participants'
acknowledgements of their awareness of the need to provide appropriate nursing care to each patient irrespective of cultural backgrounds. The sub-themes, respecting individuality, and holistic approach to nursing care are the values and principles of how the participants conceptualised individualised nursing care.

The fourth theme, preparation of nursing students for the provision of culturally competent care, emerged when the participants acknowledged that they were made aware of the cultural diversity in Ireland during their formal educational preparation. The first sub-theme, formal education of the student nurses, emerged when participants acknowledged that they had a basic education on multicultural issues, which was inadequate to prepare them for the provision of culturally competent care. The participants identified their needs for more education on various cultural issues in order to meet the health care needs of Irish multicultural society. The second sub-theme, learning opportunities in the clinical setting emerged when participants identified that during their clinical placements, they learnt how to provide culturally appropriate care to the patients by looking after patients from different cultural backgrounds and by working with the qualified nursing staff including staff from other cultural backgrounds.

Chapter Five

5. Discussions, Conclusion, Limitations And Recommendations

5.1 Introduction

In this chapter, there is a discussion of the findings of the current study in relation to the existing literature on experiences of nurses in caring for patients from different cultural backgrounds. The discussion is presented under the headings of the four themes previously identified in chapter four which comprise the findings of the study. These themes are: communication difficulties; cultural and religious differences; individualised nursing care; and preparation of nursing students for the provision of culturally competent care.

5.2 Discussions

This first theme, communication difficulties emerged during the participants' encounters with patients from different cultural backgrounds in the clinical settings. Communication difficulties were identified as a challenge and inhibiting factor to the provision of effective nursing care to patients from different cultural backgrounds. Communication difficulties consist of three sub-themes namely: lack of proficiency in English language; interpreters and non-verbal communication.

All participants (n=11) identified communication difficulties as the biggest issue in their experiences while caring for patients from different cultural backgrounds mainly due to language barrier. This resulted in difficulty in interchange of information between the staff and the patients and inadequate care and support of patients by the nursing staff. Within the literature, this finding is supported by findings on the subject reported by Boyle (1999), Chevannes (2002), Gerrish (2001), Hultsjo and Hjelm (2005) and Kennedy and Murphy-Lawless (2001). Boyle (1999) and Kennedy and Murphy-Lawless (2001) carried out their studies in Ireland. Boyle (1999) reported that nurses had practical difficulties in caring for people of ethnic minority due to communication difficulties while Kennedy and Murphy –Lawless (2001) reported that communication difficulties resulted in the Irish public health nurses inability to distinguish whether many of the women (patients) they encountered had postnatal depression or depression as a result of other causes.

Chevannes (2002) and Gerrish (2001) conducted their qualitative studies in the United Kingdom while Hultsjo and Hjelm (2005) conducted their qualitative study in Sweden. In her study, Chevannes (2002) found that communication difficulty between the

staff and the patients affected the sufficiency of caring for the patients, leading to the healthcare providers' dissatisfaction with the care they provided to the patients. Gerrish (2001) reported that communication difficulties between the district nurses and the patients and the carers resulted in reduced psychological support of the patients and their carers. This also led to the nurses' dissatisfaction with the situation. In relation to Irish situation, lessons can be learnt from the countries such as the United Kingdom and Sweden where is a much longer history of multicultural and multilingual society and more expertise in dealing with multicultural issues such as communication problems.

In the current study, one participant reported that the lack of time on the busy ward resulted in the provision of inadequate information to the patients by the staff. McCourt and Pearce (2000) also had similar finding and reported that inadequate communication between staff and patients at times was associated with the staff being rushed. Mc Court and Pearce (2000) conducted their qualitative study in the United Kingdom. According to Geiger (2001) time pressure and the need to accomplish many tasks at once inhibit the type of communication that may be necessary to identify and bridge cultural gaps between healthcare workers and the patients. Some participants (n=5) in the current study reported that it was time consuming to care for patients from different cultures due to communication problems. This may have implications for the hospital resources. According to Arnold (2003c) it is important for health care providers to be aware that when looking after people from different cultural backgrounds, they tend to think in their native language, translating back and forth from English to their native language. This results in a delay in response that needs to be taken into account when speaking and responding.

In the current study a participant commented that although consent was obtained from the patients, such consent could not be classified as informed consent due to language difficulties between the staff and the patients. Arnold (2003a) suggests that informed consent involves giving the client enough information on which to base a knowledgeable decision. It makes sense then that a patient cannot give an informed consent if he or she has insufficient information on which to make an informed choice (Cooper 2001).

All participants (n=11) in the current study identified that communication with patients was a key component of culturally competent care especially keeping the patients fully informed of what was going on with their treatment and care in order to help the patients make informed choices. In addition all participants (n=11) identified that effective communication between the staff

and the patients was necessary to enhance the quality of patients' care. This finding supports the finding of the qualitative study conducted in the United States by Warda (2000) who found that patients' satisfaction with care is directly related to the amount and content of information they receive from the healthcare providers. The United States, which is already one of the most diverse societies in the world, is still becoming increasingly multicultural and multilingual (Lester 1998a). The finding of the study conducted by Warda (2000) can be applied to Irish context because there is increasing cultural diversity of patients and staff in Ireland in recent years. Moreover lessons can be learnt from other countries such as the United States where there is a long history of cultural diversity and more expertise in dealing with multicultural and multilingual issues.

The finding of the current study also supports the finding of carried out in Sweden by Hultsjo and Hjelm (2005) who reported that nurses and other healthcare workers require sufficient information from the patients about their health problems and other specific health and cultural needs in other to effectively provide care for them. Sweden has changed into a multicultural and multilingual society within the last few decades (Ekblad *et al.* 2000, Hultsjo and Hjelm 2005) therefore the findings of the study could be used to enlighten nurses as well as all those responsible for the provision of healthcare on what needs to be done to enhance effective communication between healthcare staff and the patients.
One of the strategies used to overcome communication difficulties between the nurses and the patients from other cultures was the use of the professional interpreters. All participants (n=11) were aware of the professional interpretation services available to them and how to access them. In their quantitative study carried out in Ireland, Lalchandani *et al.* (2001) reported that interpreters were employed to help and overcome the language barrier, thereby enabling the healthcare professionals to provide effective care to their patients. In the current study, many of the participants (n=7) identified that there was a difficulty in accessing the interpreters when they are needed due to the fact that there are limited in number. This is similar to the findings of Gerrish (2001) and Hultsjo and Hjelm (2005) where there were also difficulties for the healthcare providers to access the interpreters because there were not enough interpreters available. However, Gerrish (2001) also found that the district nurses were reluctant to use interpreting services due to the nurses' lack of confidence in the detail and accuracy of the translation provided by the interpreters.

In another study carried out in Sweden, Essen *et al.* (2002) also found that there was a lack of adequate interpretation services. This

lack of adequate interpretation services led to a more serious consequence such as contribution to at least five of the deaths of infants born by the African women. This can serve as a lesson in Irish multicultural healthcare. In the current study, seven participants expressed that they used relatives who could speak English as interpreters between the nurses and the patients in order to overcome the communication difficulties. However one participant commented on the use of relatives as interpreters due to the issue of confidentiality. Gerrish (2001) also reported similar findings.

In the current study, many participants (n=8) reported that health care providers who could speak English language as well as the patients' languages were used as interpreters when professional interpreters or relatives who could speak English were unavailable. Bilingual/multilingual abilities of some of the participants and other health care providers helped in alleviating the communication difficulties for the patients. This finding is consistent with the findings of the study of Warda (2000) that reported that the healthcare providers' bilingual abilities enhanced exchange of information between the staff and the patients thus enhancing patients' care. Lester (1998a) suggests that a bilingual nurse is an asset to the healthcare system in overcoming difficulties between the patients and other healthcare workers.

Non-verbal communication such as sign languages, observations, pictures, body languages, gestures and actions emerged as another strategy used by the participants and other nurses to communicate with patients from other cultures who had communication difficulties. Boggs (2003) suggests that non-verbal communication gives the clue about what is being communicated as well as clarifying the meaning of words. In their study, Hultsjo and Hjelm (2005) reported that the migrants had a more intensive mode of non-verbal communication. Boggs (2003) and Josipovic (2000) suggest that nurses should be aware that most non-verbal behaviours are culturally specific and that a non-verbal gesture which is acceptable by one culture may be considered rude in another culture. Nurses therefore need to be aware of the non-verbal communication method that is acceptable to their patients from various different cultures to enhance effective interaction with their patients.

The second theme, cultural and religious differences emerged when participants identified that patients from different cultural backgrounds had different belief and value system in various cultural and religious issues, which had some effect on the patients and the care they received while in the hospital. This theme is made

up of two sub-themes namely: preference for the same sex nurses or doctors and issues with food. Minority of the participants (n=2) identified that some patients and their family had preference for the same sex nurses or doctors looking after the patient due to the patients' cultural values and religious beliefs. In addition the two participants noted that the healthcare staff were open to the different beliefs and cultures of the patients and showed an acceptance and understanding of patients' preferences. Holland and Hogg (2001) suggest that it is important for healthcare workers to be aware of the effects of various religious beliefs on health care practices. For example, modesty is an obligation in Islam, therefore Muslim patients prefer to be examined by a doctor or nurse of the same sex as the patients if possible during procedures such as the ones involving reproductive systems or during gynaecological examination because nakedness and exposure of the body can cause distress to both men and women (Holland and Hogg 1998). In her qualitative study carried out in the United Kingdom with South Asian patients, Clegg (2003) also found that there was also a great cultural value placed upon privacy and modesty, with South Asian cultures requiring a high degree of modesty.

In the current study, all participants (n=11) identified that the kitchen staff tried to accommodate the dietary needs of the patients as much as possible. Nevertheless, some participants (n=2) commented that dietary needs of these patients were not always met by the hospitals, as there were problems with food with patients from different cultural or religious groups. In her study, Clegg (2003) also reported that patients were dissatisfied with food and perceived a lack of understanding by staff of its cultural difference and religious significance. According to Holland and Hogg (2001) three cultures meet in every nurse-patient relationship. These are: the culture of the organisation, the culture of the nurses and the culture of the patients (Holland and Hogg 2001). As a part of the organisation culture, the hospitals' catering staffs were responsible for the provision of food for the patients during the patients stay in the hospital as identified by all participants (n=11) in the current study. The dietary needs of the patients were not always met due to cultural and religious variations as identified by two participants in the current study.

To be patients advocates and to be able to provide appropriate care to them, nurses need to understand the religious and cultural needs of their patients since culture and religion are fundamental aspects of the patients' lives (Clegg 2003). The desire and effort to render services in a manner that respects the cultural and religious diversity of the patients is known as cultural sensitivity (Clegg 2003,

Kim-Godwin *et al.* 2001). Cultural sensitivity is an important factor to the provision of individualised nursing care.

The third theme, individualised nursing care is concerned with the provision of appropriate nursing care to each patient irrespective of the cultural background. This theme consists of two sub-themes namely: respecting the individuality; and holistic care. These sub-themes are the values and principles, which the participants conceptualised as individualised nursing care. The profession of nursing, which is increasingly seen as being in the front line of health care delivery is challenged to maintain, promote and provide quality nursing care that is culturally congruent to the patients they serve (Cortis and Law 2005, Lim *et al.* 2004).

In the current study, majority of the participants (n=8) identified the need to respect each patient as an individual as well as to focus care around the patient's needs. It was apparent that the participants' conceptualisation of respect of individuals as a principle of individualised nursing care and the subsequent nursing practice was strongly influenced by the professional code of conduct for each nurse and midwife (An Bord Altranais 2000a) and the Scope of Nursing Practice Framework (An Bord Altranais 2000b). For example, it is clearly stated in the Scope of Nursing Practice Framework (2000b) that nursing care should be provided in a way that respects the uniqueness and dignity of each patient within the multicultural society (An Bord Altranais 2000b). In her qualitative study carried out in the United Kingdom, Gerrish (2000) also found that nurses expounded respect for individuals as one of the principles underpinning the philosophy of individualised care. This involved taking account of the uniqueness and dignity of each patient while providing nursing care to the patient (Gerrish 2000).

Some participants (n=6) in this study commented that it was difficult to implement individualised care due to lack of experience as well as lack of cultural and religious understanding. This is similar to the findings of Clegg (2003) who reported that healthcare providers lacked an understanding of various cultural differences and religious significances, thus, resulting in ineffective patient care. In the qualitative study also conducted in the United Kingdom, Vydelingingum (2000) also found that nurses lacked the knowledge about the significance of the patients' cultures and religions, thereby making it difficult for the nurses to provide appropriate nursing care to each patient. Other studies have also shown that nurses have difficulties providing individualised nursing care to patients from cultural backgrounds due to lack of understanding of patients' cultural issues and their relationship to nursing practice (Baker and Daigle 2000, Cortis 2004, Hultsjo and Hjelm 2005,

Tortumluoglu *et al*. 2006). Baker and Daigle (2000) carried out the study in Canada. Cortis conducted her study in the United Kingdom. Hultsjo and Hjelm (2005) conducted their study in Sweden, while Tortumluoglu *et al.* (2006) carried out their study in Eastern Turkey. These countries have experiences of cultural diversity in their various societies therefore evidenced-based lessons from these studies could be used to inform nursing students and nursing practice in Irish multicultural society.

All participants (n=11) in the current study acknowledged that individualised care takes into consideration the total aspects of the patients and responding to their specific health problems as well as the socioeconomic and spiritual needs of the patients since these are various determinants of the health of the patient. Three participants mentioned that the involvement of other healthcare multidisciplinary team such as the social workers was a strategy used by nurses to promote holistic patient care. In her study, Gerrish (2000) also reported that holistic care was regarded as one of the values and principles that underpinned the individualised nursing care. This involved the assessment and provision of the physical, psychological, social, pastoral and other health care needs of the patients. Callister (2001) and Price and Cortis (2001) suggest that holistic approach to health assessment is fundamental to the provision of individualised patient care.

The fourth theme, preparation of nursing students for the provision of culturally competent care discusses how the nursing students gained their knowledge and skills for the provision of culturally competent care. Two sub-themes emerged from the theme. These are: formal education of the student nurses; and learning opportunities in the clinical settings. The finding in the first sub-theme, formal education of the student nurses showed that during their formal educational programme of the nursing students in the university, they were made aware of the changing Irish multicultural society as confirmed by all participants (n=11). This awareness of cultural diversity of patients in the healthcare system helped the students to realise the need to provide appropriate nursing care to each patient regardless of the cultural background.

The findings of the current study support the findings of Brathwaite and Majumdar (2005), Lim *et al.* (2004) and Majumdar *et al.* (2004). Brathwaite and Majumdar (2005) conducted their quantitative study in Canada and found that the nurses' cultural knowledge was increased through educational sessions that were well organised with adequate time for discussion. Lim *et al*. (2004) carried out their quantitative study in Australia and found that fourth year students, exposed to increased theoretical information

had more positive perception of their self-confidence than the first year students in providing nursing care to patients from other cultures. Majumdar *et al.* (2004) conducted their quantitative study in Canada and reported that cultural sensitivity training of nurses and other health care workers resulted in improved understanding of multiculturalism.

Although all participants (n=11) confirmed that they were made aware of the changing Irish multicultural society, they all indicated that there was no formal module on cultural diversity in their curriculum, instead multicultural issues were incorporated into different lectures. All participants (n=11) commented that they only had basic education on cultural and religious diversity, which was insufficient to prepare them to cater for the needs of patients from different cultural backgrounds. For these individuals, most their knowledge was as a result of personal experience, lessons learnt from day to day work and as a result of self-initiated learning. Previous studies have shown that nurses felt that their education and training did not prepare them adequately for the provision of culturally competent care (Boyle 1999, Chevannes 2002, Eliason and Raheim 2000, Weaver 2001).

Boyle (1999) carried out his study in Ireland and found that nurses felt inadequately prepared from their education and training to care effectively for patients from other cultures. Chevannes (2002) conducted her qualitative study in the United Kingdom and reported that majority (65 percent) of the healthcare professionals confirmed that no attention was given in their initial education to the healthcare needs of minority ethnic groups while others indicated that there was barely any content about the subject. The healthcare professionals engaged in self-initiated learning to improve their knowledge and understanding. Additionally, the participants gained their knowledge from personal experiences and lessons from day to day work (Chevannes 2002). Weaver (2001) carried out her survey in the United States and found that cultural content in the educational programme of the nursing students was quite limited and nurses wanted more cultural content, and sometimes they obtained it from other sources such as reading and contact with other students.

While all participants (n=11) acknowledged that their education and training did not prepare them adequately for the provision of culturally competent care, they all suggested that there was a need for more formal education on multicultural issues to enhance their understanding of the cultural differences and religious differences. However minority of the participants (n=2) acknowledged that it might not be possible to have an in-depth programme for all the

various cultures in Ireland since there is a lot of cultural diversity in Ireland. Two participants were uncertain if the university could have had any further preparation for the students rather these two participants felt that there should have been more preparation in the hospital. Five participants also identified that there was also a need for continuing education on cultural issues for all nurses working in the hospitals to enhance their cultural competency.

Findings from the current study are consistent with other studies that have demonstrated that appropriate education and training of nurses is an important determinant in the provision of culturally competent care (Lim *et al.* 2004, Weaver 2001). It is important to draw some lessons already learnt from the United Kingdom, the United States, Australia, Canada and other countries where the above mentioned studies were carried out. These lessons could then be tailored to the situation in Ireland based on the existing evidence and new results from this study (Boyle 1999).

The second sub-theme, learning opportunities in the clinical settings emerged when the participants acknowledged that they learnt by caring for patients from different cultural backgrounds and by working with the qualified nursing staff including staff from other cultural backgrounds. Some of the participants (n=4) identified that the nursing staff were very supportive of the students learning during their clinical placements. Particularly, students learnt how to provide nursing care to the patients from other cultures from the nurses. In addition, majority of the participants (n=7) commented that it was beneficial to work with the nursing staff from other cultural backgrounds who have undergone migration experiences because students learnt from them how to provide nursing care in different ways to the patients. According to Gerrish (1998) students have great value on developing cultural competence through caring for patients from different ethnic backgrounds. In addition there are many benefits for students to work alongside the expert practitioners. Such benefits include support for the students as well as the student learning from the expert practitioners (Gerrish 1998, Gerrish and Papadopoulos 1999).

Experiences and expertise of nurses from other cultures are of great value to the healthcare system in terms of patient care and a source of learning for students on how to provide competent care to patients from different cultures (Gerrish 1998, Gerrish and Papadopoulos 1999). According to Josipovic (2000) working with nurses from different cultural backgrounds is regarded as a positive thing because it promotes staff development as other nurses can learn a variety of ways in which nursing is practiced around the world. In addition, these nurses from other countries and cultural

backgrounds can empathize with patients who have undergone the migration experience because they have shared situations and feelings that others who have not undergone similar experiences cannot share (Gerrish and Papadopoulos 1999, Josipovic 2000).

Some participants (n=3) suggested that there it would be helpful to involve people from different cultural backgrounds such as community networks in the care of patients from different cultural backgrounds to help in overcoming communication problems as well as helping nurses to learn how to provide effective appropriate nursing care to the patients. The involvement of people from diverse ethnic backgrounds, such as representatives of community groups, in the delivery of the taught curriculum as well as involving them in the care of the patients promotes students' learning in the care of the patients (Gerrish 1998, Gerrish and Papadopoulos 1999). Baldwin (1999) suggests that exposing students to patients of other cultures in diverse healthcare settings is a key strategy for the development of skills that will help them become culturally competent. In her study, Chevannes (2002) reported that the healthcare professionals learnt from their day-to-day work. Lim *et al.* (2004) also found that in addition to relevant theoretical information, sufficient clinical exposure of the nursing students during their undergraduate programme helped to promote their knowledge and skills for the provision of culturally appropriate care to their patients. As mentioned previously, lessons could be learnt from the United Kingdom and Australia where the above studies were conducted and where there is a long history of multicultural issues. These lessons could then be applied to the Irish situation as required.

5.3 Conclusion

With the growing cultural diversity in the Republic of Ireland, nurses are challenged to provide culturally congruent care to the patients they serve (Boyle 1999, Kennedy and Murphy-Lawless 2001). As future practitioners, student nurses are required to develop knowledge and skills that will help them to become culturally sensitive and competent (Baldwin 1999, Lim *et al.* 2004). In this chapter, there has been a discussion of the undergraduate nursing students' experiences in providing culturally competent care in an Irish multicultural healthcare system. Communication difficulties between the nurses and the patients from different cultural backgrounds, and lack of adequate professional interpretation services were identified as problems that hindered effective nursing care to the patients. Nurses used family and relatives as informal interpreters occasionally to overcome the communication difficulties. Although this strategy helped to overcome the communication problems, patients were not always comfortable

with the strategy due to issue of confidentiality. Nurses also used other strategies such as the utilisation of bilingual healthcare workers and non-verbal communication to overcome the communication problems between the nurses and the patients.

Patients' cultural values and religious beliefs had an effect on the healthcare delivery of the patients. For example, some patients, specifically Moslem patients had preference for the same sex nurse or doctor looking after them. Although healthcare staffs were open to the various beliefs and cultures and showed an acceptance an understanding of the patients' preferences, the provision of the same sex doctor for the patients occurred by chance or after a long waiting by the patients. There were problems with the dietary needs of the patients due to cultural and religious variations. The dietary needs of these patients were not always met due to the healthcare staffs' lack of understanding of the cultural variations and religious significance of the patients' diet.

Participants were aware of the need to provide individualised nursing care to each patient regardless of the cultural backgrounds. The participants' conceptualisation of individualised consisted of the following values: respecting individuality; and holistic care. It was difficult for the nursing students to implement individualised care due to lack of experience, lack of cultural and religious understanding and lack of time on the busy wards.

Theoretical information and the clinical placements contributed to developing the students' knowledge and skills required to provide effective nursing care to their patients. During the formal educational programme of the nursing students in the university, they were made aware of the changing Irish multicultural society and healthcare system. This awareness helped the students to realise the need to provide appropriate nursing care to each patient regardless of the cultural background. Although the students were made aware of the changing cultural diversity of Irish society, there was no formal module to deal with multicultural issues. In addition, the students only had basic education on cultural and religious diversity, which was insufficient to prepare them to cater for the needs of patients from different cultural backgrounds. Nursing education and training is therefore the key to ensuring that nurses are well prepared to provide culturally competent care (Baldwin 1999, Blackford and Street 1999, Gerrish 2000). Knowledge development in relation to the nursing curriculum needs to address the complex ways in which historical, political, social and economic factors interact and influence cultural diversity as well as the healthcare system (Gerrish and Papadopoulos 1999, Leninger 1997).

5.4 Limitation of the study

The main aim of the study was to explore the experiences of undergraduate nursing students in providing culturally competent care in an Irish multicultural healthcare system and interpret the meaning the students attribute to their experiences. There is a limitation recognised in the study and this should be put into consideration when interpreting the findings of the study.

The limitation of this study is that the findings cannot be generalised to other populations due to sample size and because the qualitative data is quite specific and particular to a context, place, time and persons. However, the findings of this study and other qualitative studies can be extremely valuable in enhancing understanding of the human experiences and social processes inherent in nursing practice situations (Burns and Grove 2003, Meehan 1999).

5.5 Recommendations

In this section, the recommendations for practice, education and further research are discussed.

5.5.1 Recommendations for practice

The findings of this study provide a tool through which nursing practice could be improved. Given that communication difficulty was a major challenge to the provision of effective nursing care to patients from different cultural backgrounds, it is recommended that suitable professional interpretation services be provided on a twenty four basis to facilitate communication between the nurses and the patients. In the absence of professional interpreters, it is also important to make more use of the bilingual healthcare staff to overcome communication difficulties between nurses and the patients. However, the use of healthcare staff as interpreters should be on a voluntary basis and the issues of patients' confidentiality should be discussed and agreed. There is also a need to a have standardised patients' information leaflets on various conditions and procedures translated into different languages on all the wards and hospitals to help patients who can read, to understand their conditions, treatment and nursing care.

There is a need for evidenced-based policies and guidelines on various multicultural and religious issues on the wards and hospitals to facilitate effective nursing care to patients from different cultural backgrounds.

In the light of the increasing cultural diversity of patients and nursing staff in the Irish healthcare system, it is important to utilise

the nursing staff from various cultural backgrounds who have undergone migration experiences to help in the provision of nursing care to help in the provision of nursing care to the patients from other cultures as well as helping to provide training and support to the nursing students during their clinical placements. The involvement of support networks from the communities of people from same cultural backgrounds as the patients during the provision of patients' care will be helpful in the delivery of appropriate nursing care to the patients.

There is a need for support from the organisational structures in terms of collaboration between organisational cultures and patient's cultures, particularly, putting into consideration the effects of various cultural values and religious beliefs on healthcare practices. Healthcare organisations need to understand the expectations of the patients and to seek out and manage areas of conflict between the organizational values and individual patient's cultural requirements. This is to enhance the provision of appropriate cultural care to the patients.

5.5.2 Recommendations for education and training

In the light of the finding that the nursing students felt inadequately prepared to cater for the needs of the patients from different cultural backgrounds, it is recommended that there is a need for improvement in the educational and training system for the student nurses. As the nursing students' knowledge was found to be deficient in various cultural and religious issues of the patients, it is recommended that curriculum developers include adequate content related to various multicultural and religious issues in order to enhance the preparation of the students for the provision of culturally competent care. The use of various innovative education and teaching strategies will be beneficial in the promotion of students' knowledge and skills on provision of effective nursing care to the patients of diverse cultures. Given that the student nurses found their clinical placements beneficial in terms of gaining knowledge and skills for the provision of culturally appropriate care, it is recommended that there is adequate clinical placements and exposure of students to diverse cultural groups. This is to enable the students to have the experience of the provision of nursing care to people from different cultures, which will in turn promote students' knowledge and skills on the provision of culturally competent care.

In the light of the growing cultural diversity of patients and healthcare staff in Ireland, it is recommended that there is a need for on going education and training of both nursing students and

qualified nurses on various multicultural issues to promote their cultural competency.

5.5.3 Recommendations for further research

Given that the findings of this study cannot be generalised to other settings due to sample size and because the qualitative data is quite specific and particular to a context, place, time and persons, it is recommended that further research is be conducted on a broader scale, with different populations and also using other research designs and methodologies in order to build on the findings of this study.

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Appendix 1

Topic guide

Warm up
I appreciate you giving up time to attend this interview. As a postgraduate nursing student, I am required to complete a research project as a part of the programme of the course. I am interested in exploring your experiences in providing nursing care to patients from different cultural backgrounds. There is no right or wrong answer. Anything you say is totally confidential and will not be discussed with anybody else. Before we begin, is there any question you would like to ask? We can stop at any time, just let me know.

Question one
Could I start by asking you to tell me about your experiences of looking after patients from different cultural backgrounds.
What was it like to look after these patients?

Question two
How were you prepared to be able to look after these patients?
What learning opportunities were available to prepare you for the provision of individualised nursing care to these groups of patients?
How adequate was your preparation?
Was there any particular gap or area where further preparation was required?
What type of previous exposure to people from different cultures did you have that helped you to provide nursing care to the people that you looked after?
Question three
During your clinical placements, were there nursing issues that required cultural understanding?

Question four
What were the facilitating factors to the provision of individualised nursing care?
What were the challenging factors to the provision of effective nursing care?
What were the inhibiting factors to the provision of effective nursing care?

Question five
Have you anything else to add about your experiences of providing nursing care to patients from diverse cultural background?

Thank you for your time and interest in this research.

Appendix 2

Letter/Request to the Head of the School of Nursing, Midwifery and Health Systems to gain access

Researcher's address

Date

Name and address of the Head of the School

RE: ACCESS FOR RESEARCH PROJECT

Dear ---,
I am currently in the second year of the Master's of Science (Nursing-Education) programme in (name of the school and university), and I am required to complete a thesis in part fulfilment of the requirements for this award. Ms --- is the supervisor for my proposed research project.

I am writing to request permission for access to the students on the 4th Year of the BSc. (Nursing) degree, for my research project. The proposed title of my thesis is: 'Undergraduate nursing students' experiences in providing culturally competent care in an Irish multicultural health care system: a phenomenological study'.

I hope to access at least ten willing participants who have provided nursing care to patients from different cultural backgrounds. These participants will be asked to take part in a semi-structured interview about their experiences of providing appropriate cultural care. In line with the requirements of the ethics committee in (name of the research site), I wish to forward my proposal for consideration by this committee. If approval is granted, I propose to carry the interviews before the students complete their programme of study.

Thank you for your consideration. I look forward to hearing from you in due course.

Yours Sincerely,

_____
Felicity Agwu Kalu
2nd year MSc. Nursing (Education)

20th April 2006.

INFORMATION SHEET AND CONSENT FORM

My name is Felicity Agwu Kalu. I am currently in the second year of the Master of Science (Nursing-Education) programme in (the name of the university), School of Nursing, Midwifery and Health Systems and I am required to complete a research project in part fulfilment of the requirement for this award. I am inviting you to participate in my research study, which is exploring the experiences of undergraduate student nurses in providing culturally competent care in an Irish multicultural health care system.

The data collection will be through in-depth interviewing. The interview will last for about one hour at a location within the school. All information obtained from you during the research will be kept confidential. All names or any identifying features will be removed from reporting of the information. With your permission, this data will be recorded (audio) and will be stored in a secure location in the university. Interviews will be transcribed; tape and all documents will be destroyed on completion of my research.

Your participation in this research is completely voluntary. You are free to refuse to take part, or refuse to allow your feedback to be used, at any time, without giving reason. Your participation or non-participation in the research will not affect your grade in your programme of study.

If you have any questions about the research, please telephone me (Felicity Agwu Kalu), at 087 7756003 or contact me by e-mail: (cityak2000@yahoo.co.uk). You can also contact my supervisor (name of the supervisor) at (phone number and address of the supervisor), if you wish, for further clarifications about the research.

DECLARATION

I have read the consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary and that I am free to withdraw from the research at any time without disadvantage. I agree that the data collected can be used in scientific publication and that I am aware that interviews, where appropriate will be recorded.

I agree:

To be interviewed on my experiences in caring for people from multicultural backgrounds.

Please Tick ☐

Name of the Participant (in block letters)
_____
Signature
_____
Name of the Researcher (in block letters)
_____
Signature
_____
Date / /

_____
Signature

Appendix 4

The development of themes from keywords to concepts to sub-themes and then themes.

Key words	***Concept***	***Sub-theme***	***Theme***
Patients could not speak English	Language barrier	Lack of proficiency in English language	Communication difficulties
It was hard to find interpreters	Difficulty in accessing interpreters	Use interpreters	Communication difficulties
Family member who spoke better English came in to help with communication	Family/relatives used as interpreters	Use interpreters	Communication difficulties
Healthcare staff that spoke different languages helped in overcoming communication difficulties	Healthcare staff used as interpreters	Use of interpreters	Theme Communication difficulties
Key words	Concept	Sub-theme	
Observations, gestures, pictures, actions, body languages	Alternative forms to verbal communication	Non-verbal communication	

Female patients wanted female nurses or doctors to look after them due to cultural and religious beliefs Problems with food	Effects of religious and cultural beliefs on healthcare practices Dietary needs of patients	Preference for the same sex nurse or doctor Issues with food	Cultural and religious differences Cultural and religious differences
Key words Respecting everyone's beliefs and wishes Responding to the total aspects of the healthcare needs of the patients	Concept Respect of each patient and tailoring care to meet the needs of the patient Moving beyond physical care to the whole aspects of patient care	Sub-theme Respecting individuality Holistic approach to care	Theme Individualised nursing care Individualised nursing care
Students had only basic education on multicultural and religious issues	Inadequate educational preparation	Formal education of the students	Preparation of the student nurses for the provision of culturally competent care

Back to contents page

A Study to Assess the Effectiveness of Self-Esteem Therapy on Self-Esteem Among The Orthopaedically Handicapped Adolescents

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BACKGROUND

WHO(2002) reported that adolescence is a critical stage life when life style choices are established, including health related behaviours with impacts throughout life. Evidence from 25developing countries shows that adolescents who report having a positive connection to a trusted adult (parent or teacher) are committed to school, have a sense of spirituality and exhibit a significant lower prevalence of risky behaviours. This is in addition to being more socially competent and showing higher self esteem than adolescents without such a connection.

Self-esteem alteration is also associated with role alteration and the need to depend on public assistance. Often, the disabled are more than capable of doing a job but perceived by others to be incapable. This devaluing of the person with a disability can have a devastating effect on self-esteem.

A program was designed to improve self-esteem by providing teenagers with social skills training and the modelling of appropriate behaviours to reduce drug use and other related negative behaviours, such as truancy. Effectiveness of group work on adolescents is manifold.

OBJECTIVES

1. To assess the existing level of self-esteem among the orthopedically handicapped adolescents.
2. To test the effectiveness on level of self-esteem before and after administering the self-esteem therapy module among the orthopedically handicapped adolescents.
3. To find the difference among the selected background factors and the effectiveness of self-esteem therapy among the orthopedically handicapped adolescents.

METHODOLOGY

Research Design: Pre-experimental design was used. All the subjects were given a pre-test, receive the treatment, and are the post test. In the absence of a control group, subjects act as their own controls and pre-treatment and post treatment data are analyzed for differences.

Setting : The study was conducted in the specialized school for orthopedically handicapped.

Sample : The sample size for this study was arbitrarily decided to be thirty. Convenience sampling technique was used.

Research Tool : Self- esteem scale was used after necessary modification and considering background factors with reliability and validity. Self esteem scale includes two parts such as Background factors and self esteem scale. Self esteem scale was a self administered questionnaire with statements regarding self-esteem on various aspects like personal self-esteem, school self-esteem, social self-esteem and self confidence.

Intervention : Self-esteem therapy module was formed and analysed by experts.

ANALYSIS AND INTERPRETATION

Inferential statistics was used to estimate the parameters of a population from the sample statistics. It is inferred that the areas of self-esteem in the post test had improved in all the areas of self-esteem after the intervention of self-esteem therapy module. Also, the self-esteem therapy was found to be significant in all the areas of self-esteem, personal self-esteem, school self-esteem, social self-esteem and self confidence.

CONCLUSION

On the basis of the findings of this study, the following conclusion was drawn:

1. Majority of orthopedically handicapped adolescents had moderate self-esteem in the pre test
2. Majority of orthopedically handicapped adolescents had improved self-esteem on various areas after self-esteem therapy
3. There were no significant difference between the effectiveness of self esteem therapy among the background factors such as sex, degree of dependency, using instruments, vocational training and skill training of orthopedically handicapped adolescents.

4. There was significant difference between the effectiveness of self-esteem therapy module and various affected parts of the orthopedically handicapped adolescents.

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Back to contents page

'Secondary Prevention in Heart Disease: Learning Needs of Angioplasty Patients'

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Background and context The recent EUROASPIRE III survey demonstrates the distance yet to be covered with regards to lifestyle changes in those with established coronary artery disease (CAD). One fifth of cardiac patients continue to smoke, with a lack of improvement evident over the 12 years of the EUROASPIRE surveys (Wood 2007). The problem of obesity is evident in EUROASPIRE participants, with an increase from one quarter obese (BMI ≥ 30 kg/m2) to a third of all patients (Wood 2007) between 1996 and 2008 (European Society of Cardiology 2008). Hypertension, dyslipidemia and diabetes are negatively affected by obesity (Wood 2007). At an international level Bhatt et al (2006) researched patients' risk factor profiles through the 'REACH' registry where European and worldwide participants from north and South America, Austral-Asia and the Middle-East were accessed. Patients who had CAD, cerebrovascular disease, peripheral arterial disease or three or more risks for atherothrombosis, demonstrated unmet lifestyle targets on a worldwide scale for those with established atherothrombotic disease.

Increasingly patients are accessing percutaneous transluminal coronary angioplasty (PTCA) as a technique for treating cardiovascular disease. There were 5346 per million angiograms in 2007 in 29 European countries and it is estimated 1,599 per million will require PTCA and 1214 per million will require stent procedures (Faulkner & Werduch 2008).

Research into patients learning needs, has stemmed from studies that investigated if cardiac rehabilitation programmes achieved their function, and the international drive for disease prevention through

healthier lifestyles (Timmins 2005). The EUROASPIRE III study shows that although cardiac rehabilitation is effective in reducing mortality, only a third of patients are able to access such programs in Europe and 'Prevention Centres' are needed to address risk factor and lifestyle issues (Wood 2007). Yet in-hospital education has a significant role as Cowman (2008) argues that practising nurses can enable patient self care and discharge planning by assessing individual cardiac health needs of patients.

Nurses who care for cardiac patients feel a duty to educate patients of prevention and pitfalls of cardiac disease prior to discharge and Timmins (2005) stresses that information should be given on the basis of the patients need. Prioritising patients learning needs may indicate to nurses what issues patients most urgently need to know, and what is appropriate in the post PTCA period.

Aim of the study To identify the perceived learning needs of Irish patients post PTCA, and their required learning needs as perceived by their nurse educators.

Methods Data collection using the NIS scale- PTCA version, a convenience sample of 33 patients and 13 nurses was included in the study, which was undertaken 24-48 hours (day of discharge) post the procedure. Permission was granted from the Clinical Research Ethics Committee.

Analysis Mean scores, Spearman correlation coefficient and Mann Whitney U tests were used.

Results Overall nurses and patients considered all items in the instrument important, with patients indicating that overall their learning needs are being adequately met. Ranking of the mean items indicated that on the day of discharge, patients place higher priority on their immediate state, such as the PTCA procedure, the current state of their heart, and except for smoking, and gave remaining secondary prevention issues a lower ranking than nurses. Nurses placed a higher ranking on secondary prevention items than patients. Statistical tests proved the high value that patients placed on individual counselling and time spent with nurses.

Conclusions Identifying patients' learning needs may equip health professionals to provide appropriate health education to patients post PTCA.

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Back to contents page

The Journey for At Risk Clients between Community and Geriatrician Services- a Triangulation Approach to Assessment

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BACKGROUND

In February of 2007 an episode based home care nursing unit forged links with a community geriatrician and gerontology CNS in order to fast track comprehensive geriatric assessments to at risk elderly clients in North Dublin. Traditionally referrals for hospital based services (including geriatrics) were accessible only by medical referral. We recognized the ability of nursing assessment skills as paramount to prioritizing those at risk. This innovative approach has led to the development of a structured process that is holistic and client centred. The authors' intention is as follows:

- To develop a structured nursing assessment approach that facilitates comprehensive client care between primary and geriatric services
- To provide an example of cross service nursing care planning to maintain clients in their own homes
- To propose a continuum of nursing care in the community setting
- To identify early interventions essential to maintaining clients in their own home, thus avoiding crisis intervention

The Department of Health and Children (2008) proposed a goal that no more than 4% of the older person population would remain in long term care (LTC); this would be achieved by various measures to keep people at home. Our shared services provide an example of such a measure.

COMPREHENSIVE GERIATRIC ASSESSMENT AND HOME INTERVENTIONS

Geriatric health care emerged as a unique specialty in the 1970s and 1980s, evolving to form a significant portion of our modern health service efforts. The initial aim of the Comprehensive Geriatric Assessment (CGA), according to Osterweil (2003), was to

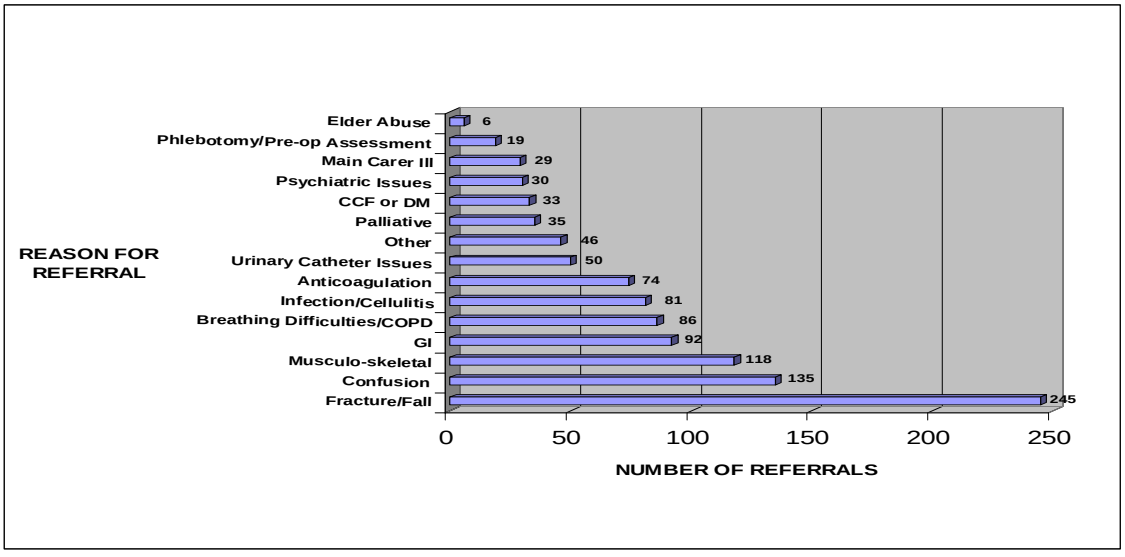
"identify elders at high risk and develop programs combining rehabilitation and improved care coordination". Osterweil goes on to say that CGA should not be seen as an "intervention" per se, but rather a "process" whereby care can be tailored to each client's needs and follow-up as well as setting for assessments are individualized.

Of particular concern are both the profile and arena for identification of older persons deemed *at risk*. With current resource constraints, prioritization of the older persons most likely to benefit from home nursing interventions, social support increases and consultant geriatric review can often over look cases managing marginally in their own community. In the Australian DEED II study (2004) emergency department attendees age 75 and older were tracked over 18 months to measure the effectiveness of CGA followed by coordinated social and nursing interventions at home; results showed lower emergency dept. attendance as well as lower hospital admission rates for the intervention group. Although there were no differences to nursing homes outcomes, the intervention group showed greater physical and mental functioning than the control group overall.

ABOUT THE TWO SERVICES

CIT- In November of 2006 The North Dublin Community Intervention Team (CIT), a rapid response home-based nursing program, began operation to address the growing and continued wait time at local accident and emergency departments. The referred client had to be deemed medically stable and fit for discharge. Examples of Diagnosis or Complaint types on referral can be seen in below: (fig. 1.)

Fig. 1



The program accepted referrals 7 days a week, including after hours. In addition, nursing interventions not traditionally undertaken by the community nursing service were added to the CIT nurses' scope of practice. These included the following: in-home phlebotomy, subcutaneous fluid infusions, male and supra-pubic re-catheterizations. The team generally responded to referrals within 1-2 hours. Home support workers were used to provide in home carer services up to 4 times daily. Each referral was targeted to be transferred to the local PHN services within a 72 hour period; however flexibility existed where a longer period of time was needed. Two emergency response beds were secured in the residential care home in which CIT was based, to use in the event of client deterioration that necessitated 24 hour nurse monitoring but did not require acute hospitalization. However, these beds did not allow access to physiotherapy, occupational therapy or medical input (unless the client's GP agreed to treat while there). After one year, a medical social worker was added to the team to facilitate the complex social needs of the CIT clients.

Both Katon(2001) and Thornlow et al (2006) identify the importance of nursing roles in caring for the older adult. The ultimate role of the CIT nurse in relation to the older adult is to further prioritize clients most at risk and in need of CGA. It was recognized that a gap in the CIT service existed in relation to diagnostic, curative and palliative assessment and intervention. A link was established with the Community Liaison Clinic at St. Mary's hospital to address these needs for at risk clients.

CLC- Community liaison clinic is a hospital based consultant/nurse specialist level comprehensive geriatric assessment service offering priority appointments to CIT. As our population ages so to does the catalogue of chronic diseases that go with it. Functional decline is part of normal aged-related changes, however, older adults with chronic conditions and multiple co-morbidities are at increased risk of functional decline. Nikolaus (1999) refers to the importance of CGA and home intervention in maintaining client functionality. Focus can sometimes be towards the medical problems and not enough attention paid to functional ability; according to Benedict (2006) the comprehensive geriatric assessment addresses this.

Each client referred has a comprehensive nursing and medical assessment carried out providing a baseline of ability while also identifying deficits. Appropriate investigations take place in a timely manner to ensure treatment/services are implemented in order to maintain independent living. Thome (2003) carried out a literature review on home care and identified the need for CGA as a means to identify the person's level of needs, with the ultimate goal of not

only contributing to quality of life but also to prevent hospitalization. Stuck et al (2002) carried out a systematic review of the literature also indicating the importance of CGA in maintaining the person at home. Occasionally a short admission is required for further assessment and intervention and that facility is available to the CLC directly. (*See fig. 3 below for outcome results*.)

Outcomes				
	2007			2008
Admissions 25%	29	21%	28	
Discharges	14		15	
Long Term Care <1	8	7%	1	
Deaths	5		4	
Nursing Homes	2		0	
Rehab ongoing	0		8	
Sources of referrals :		Community Intervention Team		
		GP		
Waiting times for appointments		currently 10 days - new referral		
		Next clinic day - for reviews		

Fig. 3

CLC accepts referrals from the nurses in CIT, whom having carried out a home assessment identify the need for CGA. Most hospital based consultant clinics require a medical referral letter. By accepting nursing referrals directly this reduces the delay in appointment for the older adult which can be a difference between staying at home and hospitalization. Hsu-Ko Kuo(2004) and Stuck et al (2002) report that the outpatient CGA did not show *life prolongation*, but did highlight the potential benefits on other outcomes such as delayed institutionalization, reduced costs and improved quality of life. The direct referral process acknowledges nurse's abilities thus supporting Katon's (2001) recommendations.

The reasons for assessment are various but include:

CCF
Falls
Reduced mobility
Pain management
Diarrhoea and Vomiting

Abdominal discomfort
Urinary tract infection
Confusion, new onset
Anxiety, Panic attacks
Elder Abuse

Linking the community based nursing services to the specialist Geriatric service has shown that early interventions are essential to maintain clients in their own home, thus avoiding crisis intervention. This is achieved by the continuum approach by nurses in the community and the hospital setting; thus representing shared care.

Garavan et al (2003) highlighted that the majority of older adults had a preference to remain at home rather than going to nursing home or hospital long term care. Thome (2003) referenced World Health Organization's 1994 definition of home care as:

'…an array of health and social support services provided to clients in their own residence. Such coordinated services may prevent, delay or be a substitute for temporary or long-term institutional care'. Thus home care is the link in allowing the older persons preference to stay at home long term. In order to identify the needs of each individual client and to ensure appropriate extra supports are provided to allow successful home care a CGA is required.

Community Liaison Clinic Attendance

	2007	**2008**
	Feb – Dec	**Jan - June**
Number of referrals	155	135
Actual numbers seen	139	111
Return patients	834	434
Review each patient 2 – 3 times		Discharge to GP

Fig. 2

Figure 2 above shows the overall utilization of the CLC service over a one and 1/2 year period. CLC acts as a *continual* point of access providing advice and guidance as required for clients post assessment. Visits to clinic are not always necessary but reassurance provided via phone link is paramount. In addition, a bilateral referral process enables the CLC staff to access CIT when concerned about clients returning to or remaining in the community

that possibly require further supports; these frail patients might otherwise end up in hospital. Examples cited in case studies below.

CASE STUDIES

Case 1

- Mr S. is a 89 year old client assessed in CLC
- Diagnosis Parkinson's Disease and main concern was falls
- CLC received phone call from daughter. Mr S. had reduced mobility and unable to get upstairs where bathroom facilities exist
- Referred to CIT for nursing assessment and potential carer support
- Exam revealed anxiety related to potential for falls and reassurance given and client maintained at home
- Follow-up in CLC achieved later in the week

Case 2

- Mrs P. is a 92 year old woman assessed in CLC
- Diagnosis Dementia
- CLC received phone call from daughter (main carer) worried as mother agitated
- Following conversation it evolved that the client had no bowel movement for 3 days, similar episode 1 year ago resolved following hospitalization –caused great distress to client
- CIT contacted for home assessment – treatment provided, education on preventing constipation given and signs to watch given to daughter to prevent further occurrences
- Situation resolved –patient remained at home no added distress caused to patient or her daughter.

Case 3

- Mr G. 75 year old man assessed CLC
- Diagnosis Parkinson's Disease , bradycardia, polypharmacy
- Short admission required for further assessment and medication management
- Ready for discharge Friday but unable to commence home care until monday
- CIT contacted to provide care over weekend
- Earlier discharge from hospital

Although Mistiaen (2007) took a more negative view of 'discharge interventions' in their meta-review it was concluded that in order for discharge planning to be successful there must exist a combined

hospital community link. Case 3 highlights the importance of this community/hospital link.

Conclusion

Through at risk identification and prioritization of enhanced nursing interventions available both at home and in clinic settings, the linking of our two services has shown positive outcomes for shared clients. In order to gain success in meeting the Dept. of Health strategy goal there is a need for expansion of community/hospital shared care. Our linking of a community and a hospital based service, utilizing nursing competencies to identify, prioritize and provide best care enables older adults in our area to meet their desire to live at home. The recognition of nurses ability to directly refer clients for CGA has resulted in earlier intervention and benefited the client by maintaining them in an appropriate setting, usually their own home.

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Back to contents page

Developing psychometric rigor: An instrument development project.

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Background: The National Institute for Nursing Research's (NINR) Priority Expert Panel D: Symptom Management -- Acute Pain supports the notion that inadequate pain management is an ongoing, common problem for the majority of hospitalized patients and *especially* an issue with older surgical patients (NINR, 1994; 2003). The Agency for Healthcare Research Quality (AHRQ) has determined there is a rich and strong research base to support the use of certain complementary interventions as enhancements to drug therapy for surgical patients, but they are underused in practice (AHRQ, 2001). Little research has focused on the use of nondrug methods to aid in postoperative pain management in older populations. One reason for the lack of research in this area is the lack of a psychometrically sound instrument to measure older patients' knowledge and attitudes about using complementary methods. In a previous study (Tracy, et. al., 2006) piloted a survey instrument (*Non-Drug Complementary Pain Interventions Survey [NDCPI])* that measured older patients' knowledge and attitudes regarding the use of music, self-guided imagery, and massage as complementary nondrug methods for pain management. While results of that study were very promising, the small sample size in the original study suggested a larger instrument trial was necessary to determine its true psychometric strength and go forward with a randomized controlled trial of the study.

Specific Aims: The specific aims of this research are to 1) test the revised *Non-Drug Complementary Pain Interventions (NDCPI-R) Survey* with a larger sample of well olders, and 2) to determine the psychometric quality of the revised instrument to measure older patients' knowledge and attitudes about soothing music, slow stroke massage, and self-guided imagery for pain management.

Methodology: This was an IRB approved quantitative study using survey research to determine (a) the levels of knowledge about the purposes and benefits of music, self-guided imagery, and massage in well olders (55 and older), and (b) the attitudes of well olders

toward use of nondrug methods a as portion of a pain management plan. Processes for revisions of the instrument included review by an expert panel in pain management for construct and content validity, as well as formulation of a content validity index using Lynn's (1986) approach.

‡ **Setting & Sample:** Data collection sites in the southern part of New Hampshire included a community senior activity center, a local college holding classes specifically for older adults, and at a local church. Three hundred revised surveys were distributed to well olders 55 years of age or older in settings; one hundred eighty (180) surveys were returned for a 60% response rate.

Analysis: Data was collated and quantitatively analyzed using version 15 of the Statistical Package for the Social Sciences (SPSS). Whole scale and subscale scores were obtained.

Findings: Mean population age was 70.1 [SD = 7.36], nearly half were married (49%), most were female (71%), most were white – non-Hispanic (91%), and most had college level education (66%). Expert panel input and statistical analysis reduced the revised instrument to 25 from 28 items. With a 95% confidence interval, the reliability of the revised survey was 0.90 vs. 0.814 in the original instrument, factor analysis using Varimax rotation yielded 5 factors explaining 62.3 % of the variance in the revised instrument vs. 9 factors explaining 74.8% of the variance in the original instrument. The grand mean of expert content validity scores of 7 expert panel members was 3.78/4.0. Inter-item correlations were strong in the revised instrument and instrument can now be deemed psychometrically strong for use in pending research.

Conclusions: Development of strong instruments to measure factors related to the use of CAM methods for pain management must continue. Revisions of the NDCPI showed that the development, testing and refinement of measurement tools within nursing science must continue to ensure empirical evidence is based on the analysis of data emanating from rigorous processes that use reliable and valid instrumentation.

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Back to contents page

Does Procrastination bring positive or negative affects to adolescents?

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Abstract

The aim of this study was to examine the effect of procrastination on adolescents' positive and negative feelings. In this regard, the Procrastination Assessment Scale-Student (PASS) and Positive and Negative Affect Scale (PANAS) were administered to 223 (120 female; 103 male) high school students with an age range between 14 and 17. Results showed that 55% (122) of the adolescents reported to be frequent procrastinator. No gender difference was found on procrastination scores. The regression analyses indicated that the predictors namely; procrastination and its 4 reasons together significantly contributed to both positive and negative affect scores. Specifically, reason of risk taking accounted for significant amounts of the positive affect; while procrastination level and reason of risk taking accounted for significant amounts of the negative affect.

Key words: Procrastination, Positive and Negative Affects, Adolescent

Procrastination is a tendency to postpone what is necessary to reach goal (Lay, 1986). The growing body of literature has demonstrated it as a personality characteristic far more than time management (Ferrari, Johnson, & McCown, 1995). It is a complex process with affective, cognitive, and behavioral components (Rothblum, Solomon & Murakami, 1986). The idea underlying procrastination is that 'later is better' and this is also a common illusion behind 'tomorrow outlook'. However, when tomorrow comes, the pattern resurfaces, and procrastinators excuse themselves by promising that 'I will do it tomorrow'. Hence, procrastination is seen as a 'tomorrow syndrome' (Knaus, 2002).

Procrastination appears to be a significant problem especially among university students (Bishop, Gallagher, & Cohen, 2000; Onwuegbuzie & Collins, 2001). Although there are many possible reasons for the occurrence of procrastination in students, researchers suggested that fear of failure and task aversiveness are two district reasons for procrastination. Fear of failure incorporates concerns about meeting other people's expectation, about meetings perfectionist standards, and about lack of self-confidence. Task aversiveness is another reason which students engage in when presented with boring or overwhelming tasks (Ferrari, et. al., 1995). Still another view why particularly university students procrastinate is that probably they have done it before and it worked. Generally students look back on several years of high school in which they have done consistently well despite constantly procrastinating. Then they might discover that in high school they could do things well even at the last minute (Palmer, 1998).

Most of the existing literature on procrastination has concentrated on the negative side of procrastination. Ferrari and Tice (2000), for instance, have depicted on procrastination as a form of self-handicapping or it might be engaged in to protect the threatened self-esteem (Ferrari, 1991). Hence, particularly the university population frequently seeks help from counselors and they complain about how badly this habit makes them feel (Ferrari, 2004). On the other hand, some other researchers (e.g., Sigall, Kruglanski, & Fyock, 2000; König & Kleninmann, 2004) have seen procrastination in a positive side. According to the researchers (e.g., Pychyl, Lee, Thibodeau, & Blunt, 2000) it is generally acknowledged that putting something off quite rational and makes individuals feel good. This is particularly true when they put some aversive tasks off and do some enjoyable instead. Some researchers identified procrastination as one means to regulate negative emotions in short term (Tice & Baumeister, 1997). In a similar vein, Sigall, et. al. (2000) suggested that procrastinators are optimistic wishful thinkers. Students delay studying for the exams due to their preference of another activity such as socializing with friends. They postpone studying aided by the wishful believes that they would

adequately learn the material in one night, or that the exam will be easy, etc (Sigall, et. al., 2000). When procrastinating, students don't report unhappy feelings because they would be engaged in relatively enjoyable and pleasant activities (König & Kleninmann, 2004; Pychyl, et. al., 2000).

To conclude, the literature related to procrastination suggests some implication for further research. First, research studies have shown a somewhat mixed picture of procrastination associated with its components in college students (e.g., Tice & Baumeister, 1997) and adults (e.g., Harriot & Ferrari, 1996). Procrastination in adolescents, however, has drawn less attention in the literature. Considering the role of adolescence in the life of adulthood, which provides a base for forming future performance, procrastination tendency in adolescence might be given more attention. In the second line of research, the purpose of procrastination seems to make the one's life more pleasant but it nearly always adds the stress, disorganization and failure (Clayton, 2000). So the findings have shown that procrastination has double faces giving short term pleasure but long term stress (Tice & Baumeister, 1997). In this regard, the present research attempts to expand the earlier focus by looking at the positive and negative affect associated with procrastination in adolescents.

Method

Participants

The present research was carried out with a sample of 223 (120 female, 103 male) students enrolled in a public high school in the capital of Turkey. The average age of the participants was 15.4 years old (*SD* = 1.78) with an age range between 14 and 17.

Instruments

The Procrastination Assessment Scale-Student (PASS) and Positive and Negative Affect Scale (PANAS) were used as the data collection instruments.

Procrastination Assessment Scale-Students (PASS, Solomon & Rothblum, 1984) is a 5-point Likert type, self-report measure including 44 items divided in two parts. The first part consisting of 18 items assesses the *prevalence of procrastination.* The scale was developed for the university population; hence, the first part assesses the procrastination in six areas of academic functioning: a) writing a term paper, b) studying for an exam, c) keeping up weekly reading assignments, d) performing administrative tasks, e) attending meeting and f) performing academic tasks in general. However, the researchers in the field of procrastination (e.g., Owens & Newbegin, 1997; 2000; Wesley, 1994) suggested that the scale might be appropriate for the high school sample when some of the items are deleted. In this regard, in the present study the items suitable for the college sample namely; performing administrative

tasks, attending meeting and performing academic tasks in general were deleted to administer to high school students.

The second part of the PASS, *the reasons of procrastination*, provides a procrastination scenario which is about delaying on writing a term paper and then lists a variety of possible reasons for the procrastination on the tasks. In this part, which consists of 26 items, two statements are listed for defining each of such reasons as evaluation anxiety, perfectionism, difficulty in making decision, dependency and help seeking, aversiveness of the task, lack of self-confidence, laziness, lack of assertion, fear of success, poorly manage time, rebellion against control, risk taking, and peer influence.

There are a number of studies indicating that PASS possesses adequate reliability and validity. Onwuegbuzie (2004), for example, found .82 for the first and .89 for the second part of the scale. For the present sample, Cronbach Alpha coefficients were found as .69 and .87 for the first and the second part of the scale, respectively.

Positive Affect and Negative Affect Schedule (PANAS, Watson, Clark & Tellegen, 1988) is a 5-point (1 = Never; 5 = Always) Likert type, self-report measure including 10 positive and 10 negative feeling items. Cronbach Alpha coefficients of the scale were found .88 for the positive and .85 for the negative affect subscales. Test-retest reliability was .47 for both subscales.

Results

The overall academic procrastination mean of the sample was 17.6 (*SD* = 4.3) with the scores ranged between 6 and 30. The median split of the first part of the PASS which was 18.0 was used to determine the procrastinators and non-procrastinators as used in most studies for self-reported scales (Beck Koons & Milgrim, 2001; Brownlow & Reasinger, 2000; König & Kleninmann, 2004; Van Eerde, 2003). Hence, the students who have scoring under 18.0 were defined as non-procrastinators and students scored above 18.0 were defined as procrastinators. Level of procrastination among students was calculated and the result showed that 55% (122) of the adolescents claimed to be frequent procrastinator, while 45% (101) reported to procrastinate rarely. Results of the independent-sample t-test performed to examine the difference between female and male participants' procrastination level revealed no significant gender difference on procrastination scores.

The reason why students procrastinate was investigated through examining the factor structure of the second part of the PASS. In other words, factor analysis was carried out with 223 participants on the second part. The rotated solution yielded four interpretable reasons with eigenvalues of 6.5, 2.1, 1.8, and 1.6 for perfectionism, difficulty in making decision, laziness, and risk taking, respectively. The *perfectionism factor* accounted for 25.1%

of the item variance and included evaluation anxiety, rebellion against control, poorly managed time and lack of self confidence; *difficulty in making decision* factor accounted for 8.0% of the item variance and included lack of assertion, dependency and help seeking, the *laziness* factor accounted for 7.1% of the item variance and included aversiveness of task and peer influence, and the final factor, *risk taking*, accounted for 6.2% of item variance and included evaluation anxiety. The names of the causal factors were assigned to a given factor when loading on that factor was higher than the loading on the other factors (Milgram, Marshevsky, & Sadeh, 1994).

In order to assess the degree that procrastination, its reasons and affect scores are linearly related, bivariate correlation was calculated by using Pearson Product Moments Correlation Coefficient. Result of the bivariate correlation is presented on Table 1.

Table 1
Correlation among procrastination, reasons of procrastination, positive and negative affect scores (N = 223)

	1.	**2a**	**2b**	**2c**	**2d**	**3a**
1. Procrastination						
2. Reasons of Procrastination						
2a. Perfectionism	.19*					
2b. Difficulty in making decision	.15*	-.19*				
2c. Laziness	.36**	.31**				
2d. Risk Taking		-.24**		-.22**		
3. Affects						
3a. Positive Affect	-.30**				-.20**	
3b. Negative Affect	.20**	.15*		.19*	-.24**	-.17*

** $p < .01$, two tailed; * $p < .05$, two tailed

As seen on the table, significant relationship between positive affect score and procrastination level (r = -.30) were found, besides relationship between positive affect and risk taking as a reason of procrastination (r = .20). Significant relationship were also found between negative affect score and procrastination (r = .20) and some of the reasons of procrastination such as perfectionism (r = .15), laziness (r = .19), and risk taking (r = .24).

Based on the correlation analyses, multiple regression analyses were independently performed on both the positive and

negative affect scores to examine the effect of procrastination on the adolescents' affect scores. The results yielded that the predictors namely; procrastination level and its reasons including perfectionism, difficulty in making decision, laziness and risk taking accounted for a significant amount of the positive affect, R^2 = .12, $F(5,170) = 4.404$, $p < .01$. Similarly, these variables accounted for a significant amount of the negative affect, R^2 = .16, $F(5,170)$ = 6.495, $p < .01$. More specifically, when standardized regression square (β^2) was taken into account, the reason of *risk taking* (β^2 = .24, $p < .01$) was found to be a significant predictor of *positive affect* of the adolescents. Similarly, result of the regression analysis conducted on negative affect scores revealed that procrastination (β^2 = .30, $p < .01$) and reason of *risk taking* (β^2 = .22, $p < .01$) were significant predictors of *negative affect* of the adolescents.

Discussion

The main purpose of the present research was to examine the effect of procrastination on positive and negative affects of the adolescents. In this regards, procrastination and positive negative affect scales were administered to high school students aging between 14 and 17 as representative of individuals who are in adolescence period.

The results of the descriptive statistics showed that the overall mean of the sample was 17.6. A total of 122 out of 223 participants (55%) scored high on procrastination, based on the median split criteria. In other words, 55% of the participants reported to be frequent procrastinator. When compared the university students population (Solomon & Rothblum, 1984; Uzun Özer, Demir & Ferrari, 2008) the present findings might support the idea that high school students procrastinate more since they discover that they can do things quite well even at the last minute (Palmer, 1998).

The literature regarding gender differences on procrastination has been showing some differences. To date, plenty of research studies have been conducted with varied samples and each has showed unique results. The present findings was found consistent with some research indicated no significant gender difference in the incidence of procrastination (e.g., Ferrari, 1991; Haycock, McCarty, & Skay, 1998; Hess, Sherman, & Goodman, 2000; Johnson & Bloom, 1995; Rothblum, Solomon, & Murakabi, 1986; Watson, 2001) and inconsistent with the others suggested that females procrastinate more as compared to males (Effert & Ferrari, 1989; Solomon & Rothblum, 1984).

The principal component analysis was used to reveal the reasons of adolescents' procrastination pattern (as does in studies to find cause and reasons of self reported scales, e.g. Çırakçıoğlu, Kökdemir, & Demirutku, 2003). The results yielded four causal

factors which were perfectionism, difficulty in making decision, laziness and risk taking. When considered the procrastination literature, fear of failure including the items regarding evaluation anxiety, perfectionism, and low self confidence, is found the primary reason besides task aversiveness to excuse more than others (Onwuegbuzie, 2004; Solomon & Rothblum, 1984). On the other hand, some other researchers (e.g. Brownlow & Reasinger, 2000; Watson, 2001) found that students put the school works off due to difficulty in making decision, rebellion against control, risk taking.

Moreover, the effect of procrastination on adolescents' positive and negative affect was investigated through regression analysis. First, association between procrastination and participants' positive and negative emotions were investigated through correlation analysis. Inconsistent with the previous findings (e.g. Pychyl, Lee, Thibodeau, & Blunt, 2000), significant relationships were found between procrastination and positive affect (r = -.30) and negative affect (r = -.30). The results showed that 12% of the variance in positive affect and 16% of the variance in negative affect could be predicted by procrastination and its reasons. This slight difference found as the effect of procrastination on positive and negative affect mean that procrastination bring both positive and negative affects to adolescents. In other words present findings validated that procrastinators feel better while postponing the aversive tasks (Chun Chu & Choi, 2005) but then they may feel badly after procrastinating or while doing the things at the last minute (Nicholson & Scharff, 2007) under time pressure. The findings were also validated the study conducted by Lay (1992) who reassigned some of the PANAS terms as agitation-related emotions and some others as dejection-related emotions. Similar to present findings, results (see also in Lay, 1995) revealed that procrastination was related both to agitation-related emotions (semi partial r = .15, p < .001) and to dejection (semi partial r = .30, p < .0001). Although the correlation results revealed relationships among the reasons of procrastination such as perfectionism, laziness and risk taking and negative feelings, regression analysis only produced risk taking as a prediction of negative affects. In other words, results demonstrated that whereas taking the risk alone explained 24% of the variance in the positive affect; it explained alone 22% of the variance in the negative affect. As the adolescence period is taken into consideration, the findings might be support the main characteristics of this period which brings relative differentiation from family, increased demands for freedom and enjoyment (Ericson, 1968). It might be speculated that when they procrastinate by taking the risk of possible failure or negative evaluation, they might have both positive and negative emotions.

Several implications may be drawn from the findings for the school counselor, psychologists and health care officers. The results

of the present study pointed that more than half of the high school students frequently engage in procrastination. Hence the results may provide valuable data for school counselor and educators to be aware of the procrastination levels of the students particularly in academic setting. Another important implication may be drawn from the present study is on the reasons of procrastination. Consideration of the reasons in procrastination will aid the counselors to find appropriate techniques and treatment goals. Finally, making inferences from the results from the present study that point the personality difference among the students with respect to some factors, it can be suggested that overcoming procrastination workshops should arranged for students by taking into consideration the effect of procrastination on both positive and negative side.

Further research with larger and more demographically diverse populations would strength the findings of the study. Furthermore, future direction for research with students may include studies that examine the relationship between procrastination levels and the actual behavioral procrastination. As mentioned earlier, there has been intense body of literature on procrastination with wide range of psychological variables such as perfectionism, locus of control, self-esteem, stress and illnesses, self-handicapping, and learned helplessness among university students, but not among adolescents. Considering the role of adolescence, which provides a base for forming future performance, procrastination tendency with such variables are suggested to study.

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