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Informing patients about intermittent urinary catheterization in transcultural patient-nurse interactions

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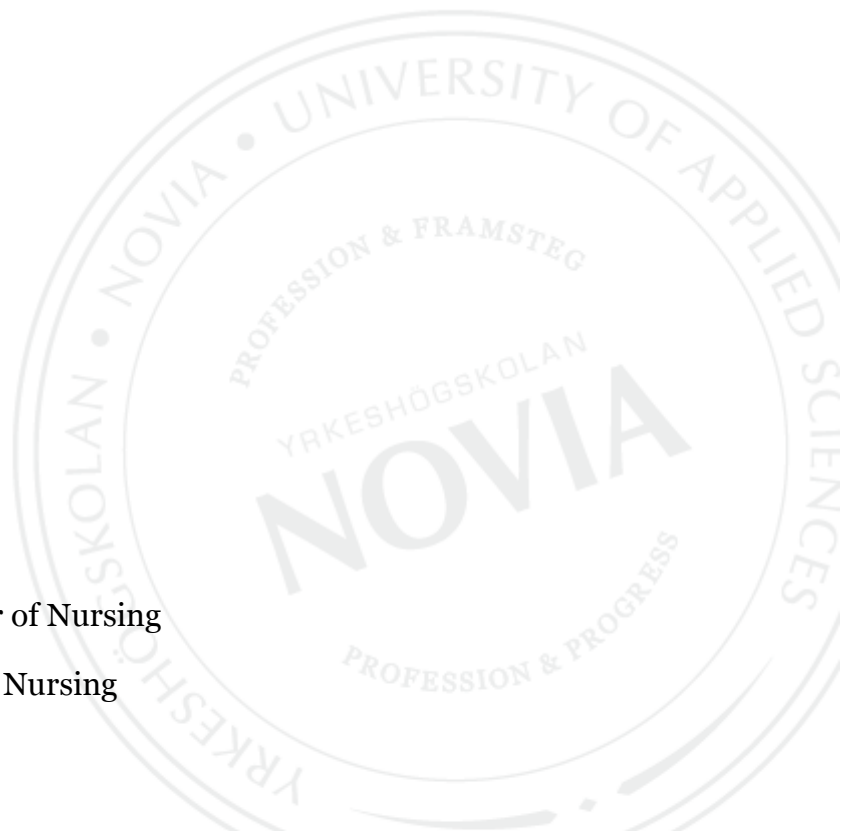
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Summary:

The aim of this study was to explore the methods of informing patients about intermittent urinary catheterization performed by a nurse who has a different cultural background than the patient. It was vital to find out beneficial methods of providing information to the patients and how to consider the patient's cultural background in this process. The theoretical framework used in this study was Joyce Newman Giger and Ruth Davidhizar's (2008) "*Transcultural Assessment Model*".

The study pointed out that difficulties appear in the intermittent urinary catheterization information provision if there is no common language between the patient and the nurse, since written materials and IT-based program information is always combined with oral interaction. Therefore, the communication difficulties were the most significant result of the study. Cultural awareness among nurses enhances the nurses' ability to provide culturally competent care.

Language: English

Key words: Intermittent urinary catheterization, information provision, cultural awareness, communication

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1. Introduction

Urinary catheterization is a procedure of emptying the urinary bladder by using a specialized technique and tubes inserted through the urinary tract. In ancient China, interesting equipment was used to drain the urinary bladder, such as onion stems. However, people started to prepare single tubes made of bronze, silver and gold for catheterization. (Bloom, McGuire & Lapidés, 1994; Doherty 1999)

Intermittent urinary catheterization is a sensitive procedure that may result in multiple thoughts for a patient. In general, all patients are interested in the care they receive and the procedures they must undergo. In fact, the patient's right to get information concerning their care is stated in the Finnish law (The Statute Book of Finland, 1992/785, §5). Therefore, information provision prior to any procedure, such as urinary catheterization, is vital.

Due to the variety of cultures and the increase in migration, people from different cultures are likely to meet in nursing care. It is vital to be aware of them and to be prepared to act in different kinds of nursing situations. Providing nursing care for patients coming from different cultures requires cultural competence. (Holland & Hogg, 2012, 63) A number of issues may have to be considered when informing patients about the intermittent urinary catheterization procedure (Robinson 2007, 51-52). It is, therefore, vital to understand the importance of cultural competence while providing information about the procedure. Information given in a proper way can create better understanding, acceptance and tolerance towards the procedure. The patient who is having this procedure is given feelings of safety and trust. (Tromp, Dulmen & Weert, 2004; El-Amouri & O'Neill, 2011) This means that cultural differences are taken into consideration when informing the patients.

When nurses care for patients from different ethnic backgrounds, it is challenging to inform them about catheterization in a proper way. This study was written in order to explore the methods of informing patients about intermittent urinary catheterization in transcultural patient-nurse interactions.

2. Aim and Problem Definition

The aim of this study is to describe the methods of informing patients about intermittent urinary catheterization performed by a nurse who has a different cultural background than the patient. The research questions are:

- What are the most beneficial methods of informing patients based on current research?
- What factors should be considered when caring for patients from a different cultural background than the nurse?
- What constitutes evidence-based nursing care in intermittent urinary catheterization?

A lot of information about indwelling and self-urinary catheterization can be found in recent research. However, this study focuses especially on how a nurse provides information concerning an intermittent urinary catheterization.

3. Theoretical Framework

The theoretical framework chosen for this thesis work is Joyce Newman Giger and Ruth Davidhizar's (2008) "*Transcultural Assessment Model*" (abbreviated as GDTAM). This model was chosen because it can be directly attached to nursing care in many different patient care settings and it is simple to use. It is globally recognized as an assessment tool and it gives a very good "springboard" for culturally competent nursing care. Consequently, this model can also be attached to transcultural situations where intermittent urinary catheterization information is given to the patient.

3.1 Giger and Davidhizar's Transcultural Assessment Model (GDTAM)

Giger and Davidhizar's Transcultural Assessment Model (GDTAM) has quite a long history starting from 1988 when these two doctors outlined their model. There were not many cultural assessment tools available and a model was needed for educating students to

care for patients from different cultures. GDTAM makes the profound assessment of individuals' cultural aspects possible and, therefore, helps in creating an individual care plan. (Sagar 2012, 57-58)

GDTAM has five metaparadigms;

- *“Transcultural nursing and culturally diverse nursing*
 - *Culturally competent care*
 - *Culturally unique individuals*
 - *Culturally sensitive environments*
 - *Health and health status based on culturally specific illness and wellness behavior”*
- (Sagar 2012, 57).

Six cultural areas, phenomena, are evaluated when using GDTAM. These phenomena are *“biological variations, environmental control, time, social orientation, space and communication”*. (Sagar 2012, 58)

Biological variations include physical characteristics such as body structure, hair color and skin color; enzymatic and genetic existence of diseases; susceptibility to illness and disease; psychological coping, nutritional preferences and deficiencies. (Sagar 2012, 58-59)

Environmental control consists of cultural health and values, as well as individual definitions of health and illness. Individual behavior determined by a person's cultural background has an effect on the person's health status. Culturally-bound beliefs about locus of control are also included in environmental control. It is often unconsciously determined and is either internal or external. A person with internal locus of control believes in possibilities to affect changes in life, while external locus of control is characterized with a belief in fate, luck and chance. (Sagar 2012, 59)

The phenomenon time is evaluated through assessment variables such as measures of time and its nature. Measures of time comprise social time, work time and time orientation whether past, present or future. According to Sagar (2012, 59) past time-orientated cultures dignify traditions and the elderly, while present time-orientation is described as living in the present. Future time-orientation places more emphasis on setting objectives and plans for the future. However, time-orientation constitutes an important parameter while caring for patients with different cultural backgrounds. Many preventive health care procedures,

such as vaccinations, involve future rewards. For a patient with past or present time-orientation this may be difficult to understand.

The phenomenon social orientation includes one's culture, race, friendships, hobbies and ethnicity, one's role in the family and its function and belonging to social institutions. When a specific culture is assimilated, a person becomes "culture-bound", as Giger and Davidhizar described it (2008, 68). Since ethnocentrism, viewing one's own culture as better than other cultures, is a common way of thinking, health care personnel needs to possess much understanding and respect towards the beliefs and lifestyle of the patient. (Sagar 2012, 63)

According to Sagar (2012, 63) the need for space varies between cultures. In the model, it includes "*degree of comfort observed during conversation, proximity to others, body movement and perception of space*" (Sagar 2012, 59). The degree of comfort is evaluated through one's level of movement or stillness when one's space is invaded. Proximity to others is practically measured in distance. All these aspects are included in one's personal space and vary according to one's culture. Both physical (area surrounding the person's body) and inner (spirit core) space is considered. Patients may even refuse treatments if they experience that these violate their personal space. (Sagar 2012, 63)

Communication includes spoken language, voice quality, pronunciation, use of silence and the use of nonverbal communication. Communication is defined by Giger and Davidhizar (2008, 20) as *the "...continuous process by which one person may affect another through written or oral language, gestures, facial expressions, body language, space or other symbols"*.

However, these phenomena can be related to each other and they can vary in use. GDTAM provides a very practical figure, a questionnaire, called Applications Across Cultures. It describes the six phenomena and provides practical questions for the patient, in order to identify his/her cultural needs when planning the care. All the six areas can, together or separately, be applied to transcultural nursing situations. (Sagar 2012, 60-62, 68)

4. Theoretical Background

This chapter includes the sections “Intermittent Urinary Catheterization”, “Definition of Culture”, “Definition of Cultural Competence and Transcultural Nursing” and “Intermittent Urinary Catheterization (IC) Procedure” and “Pre- and post-catheterization considerations”. Since this study concerns information provision for patients coming from different cultures, the respondents felt it was necessary to write the chapter “Informing the Patient” to emphasize the patient’s lawful right to information.

4.1 Intermittent Urinary Catheterization

According to Berman and Snyder (2012, 1324) “*urinary catheterization is the introduction of a catheter into the urinary bladder.*” Urinary catheterization, as one of the most common intrusive healthcare measurements (Mangnall & Watterson, 2006, 50), is a procedure usually carried out by a professional nurse if the patient condition requires so, and aseptic technique is conducted throughout this procedure (Doherty 2006, 57). These kinds of conditions could be, for example, urinary catheterization prior to a surgical operation, collecting a sterile urine sample, the patient’s inability to empty the bladder completely and as an exercise method in case of incontinence (Winder 2008, 43).

In accordance with the duration of keeping a catheter, urinary catheterization is segmented into intermittent (short-term) urinary catheterization and indwelling (long-term) urinary catheterization. Intermittent urinary catheterization (the respondents used “IC” as the abbreviation of “intermittent catheterization” through this thesis) is performed a few times (four to six times) a day to drain urine from the bladder, or “*from a surgically created channel that connects the bladder with the abdominal surface (such as Mitrofanoff continent urinary diversion)*” (Newman & Willson, 2011, 12). Furthermore, it is known and used as a common and effective intervention for patients suffering from the disability to fully empty the bladder, which is caused by neurogenic bladder dysfunction (Newman & Willson, 2011, 12-13). Intermittent catheterization can be done by the patient him-/herself or by others, like family members or professionals. This study only focuses on intermittent urinary catheterization performed by nurses.

4.2 Definition of Culture

Culture is defined as patterned behaviors and ways of living including specific values, views, language, behaviors, taboos, beliefs, attitudes, rituals, and/or practices which are shared by people in the same cultural group. (Giger & Davidhizar, 1999; Tseng & Streltzer, 2008). According to Tseng & Streltzer (2008, 1), culture affects the way people react to health and illness through their definition of a given disease, and their views on how to ask for help, how to apply the healthcare system, how to relate with the healthcare givers, and how to use the prescriptions of medical treatment.

Culture is a concept but it can be transmitted and expressed in various ways in daily life, for example, through language. When communicating with a patient from a different cultural background, his or her statements are always, to some extent, based on values, belief and attitudes. (Tseng & Streltzer, 2008, 1) It is, therefore, fundamental for a healthcare provider to have knowledge or an understanding of culture and to take it into consideration when communicating with patients from diverse cultural groups.

4.3 Definition of Cultural Competence and Transcultural Nursing

As a healthcare provider, a nurse should know the meaning of culture to be able to take care of the patients coming from different ethnic, cultural, or minority groups. (Tseng & Streltzer, 2008, 1) Even though nurses cannot completely understand or remember all the differences and characteristics among different cultures, health care professionals should be aware of the differences between cultures when encountering patients from different ethnic groups.

Tseng and Streltzer (2008, 18) have defined cultural competence as

“an ongoing process with the goal of achieving the ability to work effectively with culturally diverse groups and communities with a detailed awareness, specific knowledge, refined skills and personal and professional respect for cultural attributes, both differences and similarities”.

Another definition provided by Giger and Davidhizar's (2008, 6) transcultural assessment model (GDTAM) is *“a dynamic process implemented by an individual or health care*

agency by using significant interventions based on the client's cultural heritage, beliefs, attitudes, and behaviors”.

Transcultural nursing is characterized by a practice field for cultural competence which focuses on the client and research. (Giger & Davidhizar, 1999, 6) The healthcare providers should be aware of how patients are viewed, and the result of the care will be influenced by culture, although clients are the focus of the transcultural nursing. (Giger & Davidhizar, 1999, 6)

According to Madeleine Leininger (1978, 8) transcultural nursing care is

“the comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior, nursing care, and health-illness values, beliefs and patterns of behavior with the goal of generating scientific and humanistic knowledge in order to provide culture-specific and culture universal nursing care practices.”

4.4 Intermittent Urinary Catheterization (IC) Procedure

During the IC procedure, certain medical equipment is required including a tube, called a catheter, which is made from plastic or rubber, cotton balls, sterile gloves, waterproof drapes, forceps, water-soluble lubricant, urine receptacle, sample container, syringe, collection bag and tubing. (Berman & Snyder, 2012, 1326-1327)

A catheter is individually chosen according to the patient's clinical situation, the patient's gender and age should be taken into consideration. Other factors such as the duration of catheterization, the purpose of catheterization and/or the necessity for a self-retaining catheter should also be taken into consideration. By considering all these factors the most proper catheter will be chosen for the patient (Alexander, Fawcett & Runciman, 2006, 376). The IC is commonly performed by a nurse 4-6 times per day, based on the patient's individual voided volume. (Newman & Willson, 2011, 26).

Patient education and equipment preparation should be set out before nurse implements IC procedure. Decisions concerning the most appropriate catheter for a patient and the assessment of the patient's overall situation such as vital signs, urine retention, and psychological status, needs to be done adequately. Communication with the patient, especially a patient with a completely different cultural background than the nurse, is essential before and after the IC procedure.

Since an IC procedure is an always time-consuming, the selection of a position is essential prior to the IC procedure. A convenient position enhances the patient's experience of the procedure but also facilitates the nurse's work. Berman and Snyder (2012, 1328) recommends “*Female: supine with knees flexed, feet about 2 feet apart, and hips slightly externally rotated, if possible...Male: supine, thighs slightly abducted or apart...*”.

There are three different types of intermittent catheterization techniques: 1) clean and re-useable, 2) clean and single-useable and 3) sterile techniques. Different type of catheters are required when carrying out different catheterization techniques. (Newman & Willson, 2011, 20)

4.5 Pre- and postcatheterization considerations

This chapter outlines considerations of pre- and postcatheterization. It is necessary for the healthcaregiver to choose a proper catheter in order to cause the smallest level of discomfort and damage to the urethra during the procedure. (Robinson 2007, 50) Meanwhile, a discussion with the patient and the relatives is also essential prior to the procedure. The healthcare professional uses the discussion to provide information about the type of catheterization, the reasons why it is performed, details about implementing procedure, the duration of the procedure and the importance of personal hygiene (Robinson 2007, 52).

Moreover, the patient's fear of pain and feelings of embarrassment should be included within the discussion. Even though the patient has not mentioned these feelings, Robinson (2007, 51-52) suggests that it is advisable for a nurse to explain that this procedure does not actually hurt but may cause discomfort. Feelings of anxiety may also arouse before and during the implementation of the procedure. (Logan, Shaw, Webber, Samuel & Broome, 2007, 34) Based on aforementioned, the co-operation between the nurse and the patient is important in order to have mutual way of proceeding. The nurse should avoid the violation of patient's privacy while exposing the genitals during the procedure.

4.6 Informing the patient

According to The Statute Book of Finland, the law about Patient's status and rights (1992/785), a patient must be given (§5) information about his/her state of health, the importance of treatment, different alternatives and their effects and all the other factors related to the patient's care. However, this information shall not be given against the patient will or in a situation where it is obvious that giving the information will induce serious harm to the patient's life or health. (The Statute Book of Finland, 1992/785)

It is also stated that the information has to be given in a way that the patient can sufficiently understand the content of the information. If the health care provider cannot speak the same language as the patient, or the patient cannot be understood due to a sensory- or speech defect, an interpreter must be used. (The Statute Book of Finland 1992/785, §5)

5. Earlier research

The source material used for this chapter consists of books and articles found at the library of Novia University of Applied Science and through electronic database EBSCO. Key words such as "intermittent urinary catheterization", "information provision", "transcultural", were used while searching.

5.1. Intermittent urinary catheterization

When the nurse educates the patients and conducts the IC, his/her professional knowledge and skills, as well as cultural considerations, are vital for a successful therapeutic procedure.

Intermittent urinary catheterization is performed by another individual (can be a nurse, a professional, a caregiver) for patients with excessive residual urine due to their inability to completely empty the bladder, or for the sake of pre- and post-operation preparation (Wilson, 2008, 1140; Winder, 2008, 44; Mangnall 2012, 392). "*Intermittent urinary catheterization*", as Newman and Willson (2011, 13) described, "...is one of the most

effective and commonly used methods of bladder management in patient with a neurogenic bladder". In another article, Winder (2008, 42) also stated that *"intermittent catheterization, especially intermittent self catheterization or clean intermittent catheterization is now considered the 'Gold Standard' when considering artificial drainage of the bladder"*.

Before conducting the IC, one should estimate the volume of urine in the bladder by straight catheterization and an ultrasound scan; the volume should not be over 500 milliliters (Newman & Willson, 2011; Mangnall 2012).

According to Mangnall (2012, 394), *"IC can be used as a short-term option if a patient is unable to self-catheterise owing to ill health, for example, or as a long-term option if the patient has been unable to master clean intermittent self-catheterization"*.

Patients with bladder dysfunction leading to residual urine can be the consequence of any following factors, 1) neurogenic bladder, results from Parkinson's disease, spinal injuries and spinal bifida, etc. 2) obstruction, in urinary tract and/or bladder outfall, e.g. stricture of urethra, prostate enlargement 3) pudendal nerve damage after childbirth 4) side effect of chemotherapy, e.g. anticholinergic, antipsychotic, and antimuscarinic medications 5) post-operation, e.g. pelvic operation, spinal and/or epidural anaesthetic surgeries 6) altered volume and elasticity of bladder due to aging. (Winder 2008; Mangnall 2012)

An IC might also be performed to empty the bladder during childbirth, to regain bladder ability by giving irrigation to the bladder, or to do *"urodynamic investigation, X-ray investigations, videocystourethrography (measurement of bladder pressure under X-ray control)..."* (Winder 2008, 43).

Symptoms shown in patient suffering incomplete bladder venting are reported as frequent and/or urge urination, incontinence, a feeling of incomplete bladder venting or a discomfortable feeling in the bladder, as well as recurrent urinary tract infections (Mangnall 2012, 392).

Every coin has two sides. Intermittent urinary catheterization is greatly favoured for emptying the bladder, but on the other hand, it may bring complications, such as urethral bleeding, urethritis, stricture, leading to formation of a false urethral passage, and UTIs (urinary tract infections) (Winder 2008; Newman & Willson, 2011). The feeling of pain

and discomfort might emerge during catheterization procedure (Newman & Willson, 2011, 16).

Choosing an individually suitable and sterile single-used intermittent catheter can reduce the incidence of catheter-related complications, e.g. UTIs, and urethral bleeding. Applying adequate lubrication on the catheter during procedure can to some extent reduce the pain and discomfort. Age, gender, as well as the patient's clinical situation and economic status should be taken into consideration when choosing a catheter. (Newman & Willson, 2011, 16-19).

The frequency of catheterization is based on the assessment of how it will influence the patient's life. The procedure should be carried out 4-6 times per day, and the urine should void completely after each catheterization. (Newman & Willson, 2011, 26).

5.2 Information provision to the patients

The nurse's way of transmitting information about the IC is essential for the understanding, acceptance and co-operation of the patient. In the following part, the importance of information provision and considerations are described according to previous research.

When Hua, Vormfelde, Abed, Schneider-Rudt, Sobotta, Friede and Chenot (2011, 2) described their study protocol about video-assisted patient education in the use of oral anticoagulation (OAT), several causes were mentioned that commonly led to an unsatisfactory nursing management. Misunderstanding the indications of the therapy, inaccurate documentation and the lack of both communication and co-operation can hinder the process of OAT therapy. Equally, inadequate information provision prior to an IC procedure can result in unsatisfactory interaction or complications.

A proper way of informing patients is a patient-centered approach where the patient's background and psychosocial issues are taken into consideration. Precise and effective information is given in order to have a satisfied patient without confusion (Tromp, Dulmen & Weert, 2004, 213). In addition, the patient's knowledge, expectations, feelings and psychosocial determinants are considered as well as the patient's beliefs and perceptions about risks. (Tromp, Dulmen & Weert, 2004, 220)

The quality of the information is greatly influenced by the personal characteristics of the nurse who takes care of the patient (Fitzpatrick & Hyde, 2006, 674). Through feedback from patients, they found that nurses may have different understandings of the preoperative education process which leads to different procedures and priorities. Nurses' individual characteristics also affect the information giving. Some nurses may give information clearly and in a relaxing way, while others might rush and cannot provide the patient with complete information. In addition, the standard of information depends on the professional knowledge and experience of every nurse. (Fitzpatrick & Hyde, 2006, 674)

Apart from the considerations described above, El-Amouri and O'Neill (2011, 244) also stated other factors, which were also mentioned by Maier-Lorentz (2008, 39) and Tseng and Streltzer's (2008, 35) in the "Culturally competent care"-part, which might affect the nurse-patient communication when providing the information to the patient. For example, the nurse's positive body language in showing empathy and interest in the patient's problem can increase the patient's trust. Moreover, patients from different cultures may need various amounts of personal space. For instance, Asian, Indian, Pakistani and African-American people whose culture backgrounds are more collectivist do not need as much space as those from Southern European, Hispanic and Arab cultures. Furthermore, the difference in social background, concerning factors as socio-economic status, profession, education and language, between nurse and patient can also make the interaction difficult. (El-Amouri & O'Neill, 2011, 244)

Obviously, as a care provider, especially in the multicultural settings, the nurse should realize that the communicative aspects of the transmission of information are not fully controllable, but rather culturally shaped. The nurse should raise self-awareness and treat the patients equally while accepting the different ways in which people may think. (El-Amouri & O'Neill, 2011, 244) Beyond that, in order to support the communication, the nurse can use some visual aids such as symbols, pictures, written cards and video when giving information. The care provider can also encourage the patients to interact, discuss and clarify misunderstandings, as well as express their concerns freely. (El-Amouri & O'Neill, 2011, 246)

5.3 Culturally competent care

Cultural awareness is one of the main characteristics of a culturally competent nurse. Holland and Hogg (2012, 63) suggest that an awareness of several cultures and deeper knowledge in one or more cultures constitute the two levels of knowledge in a health care professional. Therefore culturally competent and sensitive care can be provided.

Same idea is also provided by Tseng and Streltzer (2008, 128). They state that basic cultural sensitivity consist of awareness and appreciation of the *“existence of various lifestyles among human beings, with their diverse views and attitudes towards patterns of living, different types of stress endured, and varying coping patterns for adaption”*.

Awareness of the health care provider’s own culture is a vital characteristic of a culturally competent nurse. All the medical recommendations, decisions, methods and implementations of the care may be affected by one’s personal cultural values, prejudices and personality characteristics. For example counseling about surgical sterilization and artificial abortion are issues that may involve the health care provider’s personal attitude or cultural values. Therefore awareness of the person’s own culture and cultural values is vital in order to separate them from the professional care. (Tseng & Streltzer, 2008, 130)

Cultural awareness is needed in the hospital care settings, since interactions in the hospital have become multicultural. According to Tseng and Streltzer (2008, 27)

“The components of clinical assessment, including observation of the patient, history-taking, physical examination, and laboratory testing, all may be influenced by cultural factors. The cultural issues are most obvious if the patient has distinctly different background from the healthcare provider.”

The very same issue is also discussed by Maier-Lorenz (2008, 38). In order to understand other cultures, every nurse needs awareness of their own cultural values, beliefs, practices and attitudes which they have assimilated while growing up. This helps in recognition of personal prejudices and in reduction of stereotyping and discrimination.

The patient has different understanding and different beliefs and values based on his/her cultural background (Tseng & Streltzer, 2008, 27). Therefore many aspects can have different meanings. Maier-Lorentz (2008, 39) states that in some cultures touching other

people may be renounced or limited. For example, in Hispanic and Arab backgrounds a male health care professional is limited from touching specific parts of female patients. Likewise, in both Arab and Hispanic culture females can be limited from caring for male patients.

Additionally, Micronesian islands females wear clothes that merely cover the area between the navel and the knees but expose the chest. However, for them it is very important to have their husband or a female relative present during a medical examination of any part of the covered body-area. This ensures that the health care providers perform the examination with a professional attitude. (Tseng & Streltzer, 2008, 36)

Another case mentioned by Tseng and Streltzer (2008, 35) showed that a Chinese-American man rejected a follow-up physical examination in the local western internal medicine. Instead, he would have wanted to meet a traditional Chinese medical doctor. He explained he was humiliated when physician inserted a finger into his anus. However, it was merely a rectal examination. Distinctly the patient had poor medical knowledge and English communication skills while the doctor did not explain about the purpose of the examination and the actual procedure. As Tseng and Streltzer (2008, 35) mentioned, before examining such a sensitive and private area, the health care professional should always consider the patient's language skills and cultural needs, so that the examination can be implemented in an effective and satisfying way.

Maier-Lorentz (2008, 39) also discusses the importance of space and distance. Hence it can be attached to the earlier chapter about the Tseng's and Streltzer's (2008, 35) Chinese-American man. It can be challenging for nurses to distance themselves from their patient who needs space, while the nurse needs close contact in order to care for the patient. However, an important issue in transcultural nursing is to *"understand and respect the needs of patients from various cultures with regard to space and distance requirements"* (Tseng & Streltzer, 2008, 35).

Another parameter with culturally different perceptions is eye-contact, a vital form of nonverbal communication. For example, American nurses maintain eye-contact when interacting with patients while Arabic persons perceive it aggressive and impolite. (Maier-Lorentz 2008, 38-39)

For Native North Americans silence is a way of showing respect to the speaker, while the Chinese and Japanese use it as a pause after being asked a question in order to show careful attention to the issue. In Asian cultures silence is also viewed as a necessity when speaking with the elderly. However, for a nurse silence may indicate a place of miscommunication, a passive patient or raise suspicions about impaired hearing. (Maier-Lorentz 2008, 39)

In addition to all the factors already mentioned, many further aspects need to be taken into consideration if culturally competent care is to be provided. These aspects are

“cultural empathy, culturally relevant relations and interactions, culturally appropriate health care delivery, cultural guidance, medical universality versus cultural relativism, confronting medically dangerous cultural beliefs, cultural considerations for minorities and cultural considerations for every patient and family”. (Tseng & Streltzer, 2008, 128-131)

Cultural empathy includes an ability to create an emphatic understanding in order to create a genuine connection between patient and nurse. This indicates that nurse needs to try to understand from the patient’s own cultural perspective in order to carry out satisfactory nursing care. This is beneficial in health care in general but especially in mental health and psychological counseling. (Tseng & Streltzer, 2008, 128-129)

Culturally relevant relations and interactions refer to taking into account the cultural background of the patient and the nurse and the cultural aspects of the situation where care is needed. This supports the professional relationship to the patient and decreases any potential complications that may arouse from it. (Tseng & Streltzer, 2008, 129)

The health care provider must assess the cultural adequacy when providing medical care. For example in the case of the Micronesian female patient, it would be culturally proper to invite the patient’s husband or a female relative in order to ensure patient’s safety while gynecological examination is performed. The health care provider should also know that medicines containing alcohol or ingredients of swine origin may be prohibited from some Muslim patients who avoid these substances due to their religious practices. The health care provider should consider alternative medications in these situations in order to achieve Culturally appropriate health care delivery. (Tseng & Streltzer, 2008, 129)

Cultural guidance refers to culturally relevant advice given for a patient in a situation where health problems include cultural factors or disturb medical treatment. Cultural

values, goals and norms may need to be challenged to deliver proper care or solve contradictions in the specific situation. Other options may be introduced, which requires cultural knowledge and clinical acumen. (Tseng & Streltzer, 2008, 129-130)

Even though it is vital to have respect on the patient's cultural background, necessary medical care does not have to be abdicated due to different understandings and beliefs resulting from the culture. The health care provider can help the patient to understand 'medical universality versus cultural relativism'. Health care provider may *"help the patient to accept a compromise between what is considered a universal truth medically and what the patient regards as specifically culturally appropriate"*. (Tseng & Streltzer, 2008, 130)

Confronting medically dangerous cultural beliefs is also one of the important characteristics of a culturally competent health care provider. Sometimes the patient's cultural beliefs and values do not match with universal medical knowledge and they may also be a barrier to the necessary care. For instance, Jehovah's witnesses do not accept blood transfusions, sometimes even not for children in critical conditions. If a life-saving medical treatment is refused due to cultural practices and beliefs, the health care provider's responsibility is to try to make the patient to consider the treatment and bend their cultural beliefs. It is a gradual process. The first stage is to have a discussion with the patient; try to convince the patient why the treatment is important in order to make the patient change his or her mind. After the discussion a meeting with the leaders of the community could be arranged in order to discuss a way to allow the treatment. If these attempts fail and discussions end up without fruitful results, legal means may be used to save the patient's life. (Tseng & Streltzer, 2008, 131)

Cultural considerations for minorities become more and more relevant due to increase in migration and long-distance travelling all around the world. "Minority" in this situation means a group of people who differ from the original population of a certain country, when considering their ethnicity, race, language, age, and physical handicap. Health care providers meet more patients at work who have different cultural backgrounds. Minorities may confront problems in their health care starting with communication difficulties. The health care providers may also be unaware of some certain minorities and cultures, which complicate the delivery of culturally competent care. That is why some additional attention and effort for the minority patient may be required. (Tseng & Streltzer, 2008, 131)

Culture and cultural backgrounds are often seen as a massive context and referred to foreigners. It shall not be forgotten that *“every individual has a unique background and different experiences to a greater or lesser degree... each patient can be seen as having a unique culture within a larger, more general culture”*. This means that culturally competent care needs to be attached to all patients and families, despite the fact whether or not the patient belongs to a minority group or any cultural or ethnic group. Cultural considerations for every patient and family lead not only to culturally competent health care but also to competent healthcare in general. (Tseng & Streltzer, 2008, 128-132)

6. Methodology

This section outlines ethical considerations, data collection and data analysis. Qualitative content analysis was used as a method in the study, because it assisted to deal with the issues of the study in detail. (Patton 2002, 14) The qualitative data can be collected from interviews, direct observation and/ or document analysis. (Patton 2002, 4) In this study document analysis was used. The data for analysis was practical and empirical.

The respondents chose this method since the respondents found the characteristics of qualitative research useful in this study. It's beneficial to search data from the program or clinical records, official reports and publications, personal diaries or other experiential research document. (Patton 2002, 4)

6.1 Ethical Considerations

While implementing a qualitative study many ethical issues may arouse. Usually they are linked to the data collection or the dissemination of the findings, especially when using an interview or observation as methods (Merriam 2009, 230). Confidentiality and privilege are the main issues discussed (Merriam 2009, 233). Merriam (2009, 228) states that ethics has an effect on the validity and the reliability of a study.

According to National Advisory Board on Research Ethics in Finland (2012, 3) a scientific investigation can be ethically acceptable and reliable and the results credible only if the

investigation has been implemented according to good scientific practice. In the central role are honesty, carefulness and accuracy. Additionally, careful courses of action have to be followed when utilizing other researchers' works, achievements and publications. This includes respect and appreciation, and showing the true value and meaning of the research and results when referring to them in one's own investigation. (National Advisory Board on Research Ethics in Finland, 2012, 3-4)

In this study carefully selected scientific articles dealing with the respondents' subject areas are used as data material. Therefore the ethical issues arouse in the utilization, interpretation and quotation of these materials. The respondents try to be as careful and honest as possible when describing and quoting the texts to avoid misinterpreting and misusing the materials.

Certain materials under copyright are used in this study. Therefore private permissions have been asked from the authors of these materials to ensure ethically right course of action.

6.2 Data Collection

There are many methods being used for collecting data with qualitative studies. This study applied previously published scientific articles as the data source. The method used in this study was to search for references referring to information provision in the intermittent urinary catheterization in cases when the patients come from different cultures than the nurse. The data for this study was collected from library journals in Tritonia library in Seriegatan, Vasa, and electronically through the Nelli Portal in Novia University of Applied Sciences web page. Database called CINAHL with Full Text (EBSCO) was used to search the scientific published articles and journals online.

Inclusion criteria were that all the articles were within nursing or caring science. The respondents only chose articles and journals that were relevant to the aim of this thesis. The chosen articles and journals were published within the last ten years to avoid the outdated information.

Table 1. Findings for key words searching

Database	Key word	Hits	Chosen
EBSCO	Transcultural & Nursing	668	4
EBSCO	Information dissemination & care & patient	20	1
EBSCO	Information provision & patient	15	1
EBSCO	Information provision & patient & dissemination	1	1
EBSCO	Patient education & giving information	33	1
EBSCO	Computer & patient education	157	2
EBSCO	Intermittent urinary catheterization	142	3

The respondents searched for a few scientific published articles concerning urinary catheterization to support the study. In the beginning of the research, the key words “urinary catheterization”, “intermittent urinary catheterization” and “education” had been combined with “cultural difference”, “transcultural”, “intercultural”, and “multicultural”. Unfortunately, only few articles were found with these keywords. Due to this reason, the respondents searched for articles concerning IC, information provision and transcultural nursing separately. The keywords were “Transcultural & Nursing”, “Information Dissemination Care & Patient”, “Information Provision & Patient”, “Intermittent Urinary Catheterization”, and so on. All the keywords are showed in the following table (Table 1),

as well as the given findings. The authors, year, and title of the articles were attached as enclosure. Eventually the respondents combined them for one analysis.

6.3 Data Analysis

Qualitative content analysis method was used to analyze the articles in the study. Content analysis is applied for “*analyzing written, verbal, or visual communication messages...*” and “*In nursing it is mostly used in psychiatry, gerontological and public health studies...*” (Elo & Kyngäs, 2008, 107-108). Content analysis aims at providing cognition, new aspects, a deputy of truth and a practical guideline of implementation by inferring from replicable and valid data to author’s context (Elo & Kyngäs, 2008, 108). Qualitative content analysis has been defined as “*a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns*” (Hsieh & Shannon, 2005, 1278).

In qualitative content analysis there are three main processes: preparation, organizing and reporting. Within the preparation stage, a word or a theme selected grounded on “*what to analyze in what detail and sampling considerations*”. After this is organizing stage including open coding, creating categories and abstraction. This refers to classifying texts into categories and organizing similar categories under several wider headings. During the reporting stage, the analyzing process and the results are presented. (Hsieh & Shannon, 2005, 1278)

In order to make the study result reliable and valid, respondents tried to search as many previous research articles as possible which were related to the keywords. Relevant articles were chosen from the hits. Since it was difficult to find the articles referring all keywords, the respondents collected the articles separately divided into three parts: IC, information provision and transcultural nursing. After this the articles were analyzed, themes and subthemes were created under each part and the headings were defined. In the last process, the respondents synthesized the three parts.

Data analysis was carried out by reading all the chosen articles carefully through. After this similar facts were collected together in groups. This happened by circling and underlining pertinent phrases from the texts that seemed to be similar in each article, or just interesting

to the respondents' study. After this, keywords were manually written at the margins of the articles and finally on a separate paper. All the articles were numbered and the phrases and keywords were marked with the number of the article in order to remember and connect the specific phrase or keyword to the article it was found from.

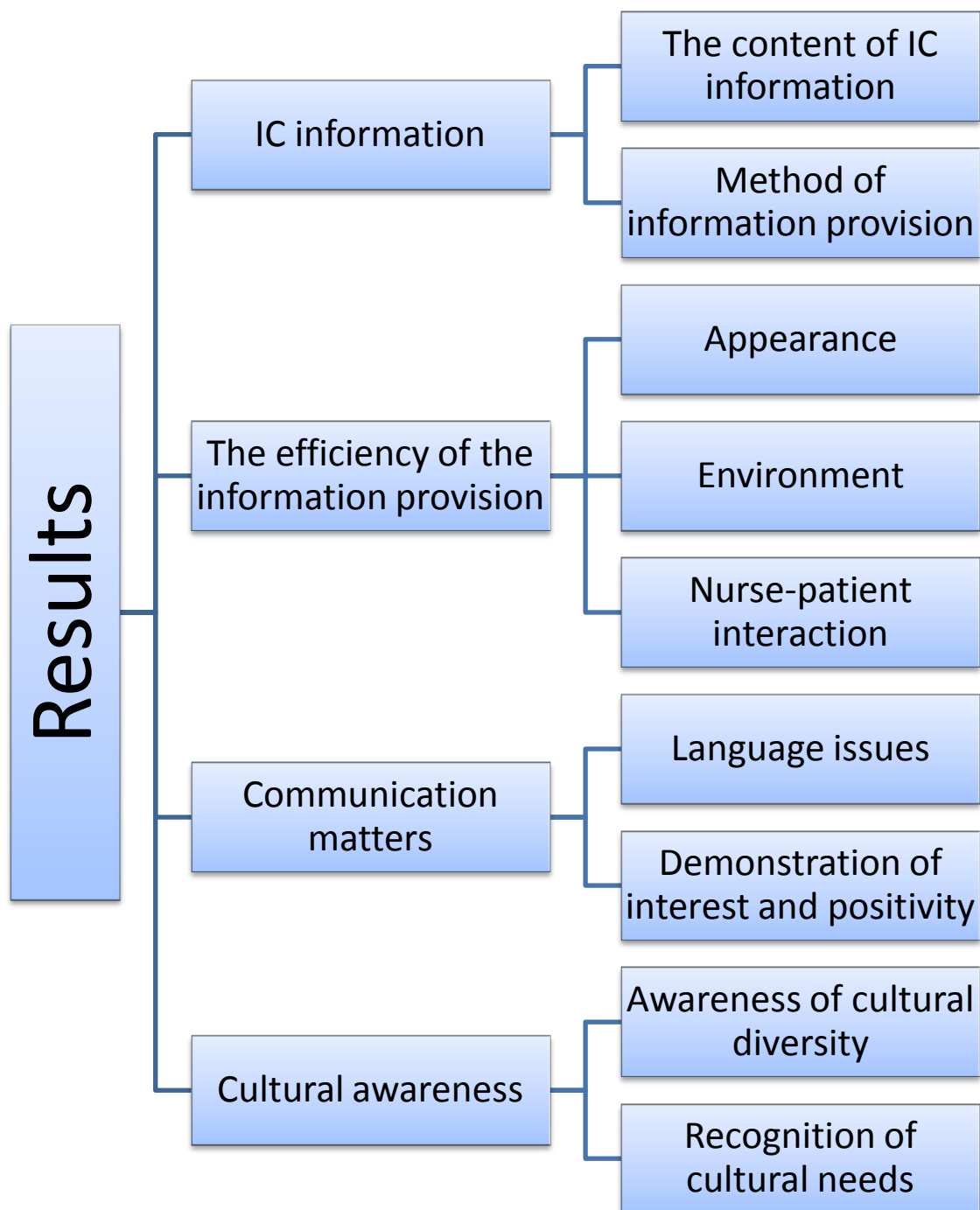
After finding the phrases and keywords they were arranged in groups, which finally formed the themes. Still there were clearly distinguishable themes, which were then divided into subthemes. Discrete keywords and phrases were found which were finally left out, since they did not clearly belong to any of the formed themes and were not enough or similar to each others to form a theme on their own.

7. Result presentation

The chosen articles were analyzed via qualitative content analysis. Quotations from the analyzed articles are used to support the respondents' findings. Some quotations were used more than one time to reinforce and emphasize the findings.

Several themes and subthemes were created based on the aim and the research questions of this study. The themes of results were "IC information", "The efficiency of the information provision", "Communication Matters" and "Cultural Awareness". Subthemes were created to bring out the different dimensions of the theme.

Table 2. Themes and Subthemes out of Data Analysis



7.1 IC information provision

This section outlines the theme “IC information provision” which was conducted after the analysis of the articles. The subthemes “The content of IC information” and “The methods of information provision” were created.

7.1.1 The content of IC information

Information about intermittent urinary catheterization should be provided to the patient during pre- and postcatheterization to support the understanding of and co-operation within the catheterized period. A pre-understanding of the IC enhances the patient’s preparedness for IC physically, psychologically and emotionally. Knowledge of potential complications and prevention measurement can minimize the patient’s negative attitude towards IC and negative emotions.

“...Detailed information is required about: anatomy and physiology of the urinary tract, hygiene and tips to avoid infection, predicted complications (pain, blood, urinary tract infection) ...compliance/non-compliance issues, the range/choice of catheters...” (Logan, Shaw, Webber, Samuel & Broome, 2007, 38)

“When patients know what to expect, anxiety can be reduced...” (Sheldon 2013, 114)

The volumes of urine should be measured before catheterization and drained times and volumes should be documented afterward.

“...will assist in developing a catheterization schedule that fits into a patient’s lifestyle and maintains urine volumes below 400 to 500 ml” (Sheldon 2013, 116).

Therefore, the patient has to inform nurse or healthcare provider about the fluid intake.

“The patients are encouraged to drink adequate fluids but may need to limit fluids prior to bedtime so catheterization is not needed during the night” (Sheldon 2013, 116).

On the other hand, signs and symptoms of urinary tract infection, as well as preventive measures, should be stated to patients.

“Signs and symptoms of urinary tract infection are described, and prevention techniques are reinforced with the patient... foul-smelling, cloudy urine (that does not clear with increased fluid intake); blood in the urine; increased spasms; or increased temperature.” (Sheldon 2013, 116).

However, providing too much information will make the patient anxious, as described in the quotation below:

“...giving too much information can also cause anxiety” (Logan, et. al, 2007, 38).

An appropriate and comfortable method of providing IC information to patients helps ease feelings of anxiety and embarrassment.

“A relaxed and informal professional approach was successful at putting patients at ease and alleviating embarrassment” (Sheldon 2007, 38).

7.1.2 Methods of information provision

Effective and practical ways of informing the patients were found through the article analysis. Information can be given through written material, video, IT-based programs and audiotapes. Meanwhile, these methods should always be combined with oral interaction. (Martin, Hoffman & Kaminski, 2005; Logan, et. al, 2007; Logan 2012)

Written material such as booklets and leaflets provided information to patient expediently, as mentioned in the quotations below.

“The use of the leaflets was perceived to give additional support to patient’s information receiving. Patients reported that it was useful to recap information received independently from leaflets.” (Hätönen, Suhonen , Warro, Pitkänen & Välimäki, 2010, 338)

“Information was imparted using a range of modalities, namely booklet...anatomical diagrams, information about catheters, hygiene and complications.” (Logan, et. al, 2007, 36)

“Written pamphlets with diagrams help to explain physical anatomy and reinforce the procedure of catheterization.” (Sheldon 2013, 114)

“Supporting the learning process with verbal question and answer sessions, supplemented with...written...information” (Logan 2012, 19)

The following quotations reflect how video can be used as another beneficial method for providing information:

“Supporting the learning process with verbal question and answer sessions, supplemented with...ISC DVD information” (Logan 2012, 19)

“... and many were also given video.” (Logan, et. al, 2007, 36)

The use of an IT-based program provided additional support for informing the patient. It was proven to be an active method for the understanding of patient. It was also shown that a discussion that brings the patient and nurse closer to each other can clarify the misunderstandings and confusion, which was described in the following quotations:

“The use of a computer was perceived to give additional support to patient’s information receiving,” (Hätönen, et. al, 2010, 338)

“...the IT portal as a broad information source for patients...the IT education

was a self-help aid for patients” (Anttila, Koivunen & Välimäki 2008, 150)

“...the IT learning session...a provider form that identified any sections the patient did not understand to allow for clarification and a patient discussion sheet listing questions to ask the healthcare provider.” (Martin, et. al, 2005, 53)

An audiotape program was, in one article, described as providing a patient with sufficient information, which significantly helped improve his/her physical state and reduce symptom frequency. (Utriya-prasit, Moore & Chaiseri, 2010, 1756)

7.2 The efficiency of the information provision

Whether the patient receives sufficient information about the IC or not somehow depends on the quality of the method through which the information is transmitted. In this theme, the following subthemes “Appearance”, “Environment”, and “Nurse-patient interaction” were conducted to present how to make the information provision effective.

7.2.1 Appearance

The appearance of the information provided through either the computer or leaflets can be attractive, as stated in following quotation:

“...the options of IT...using more pictures, voice clips and interactive tasks in the portal.” (Hätönen, et. al, 2010, 338)

“A combination of written and verbal information with diagrams, photos and/ or demonstration was the favored method for providing information related to motor recovery.” (Gustafsson, Hodge, Robinson, Mckenna K & Bower, 2010, 192)

7.2.2 Environment

The lack of disruption during the transmission of information is one of the most important factors in ensuring that the patient receives complete information, as mentioned in Hätönen', et. al. (2010, 338):

“Patient described an environment that was peaceful and suitable for the purpose as supportive for information receiving while an environment with interruptions and disturbances was perceived to hinder patients’ information receiving.”

Martin, et.al (2005, 56) discusses effective methods for Colposcopy-patient-education and also mentioned that the environment where the communication between nurse and patient takes place is very important.

“While concentrating on educating patients, it is important to provide a warm and caring atmosphere to facilitate a bond between caregiver and patient/family.” (Martin, et. al, 2005, 56)

7.2.3 Nurse-patient interaction

The interaction between nurse and patient improved the information dissemination. The nurse’s personal communication skills had an equally positive impact (Hätönen, et. al, 2010, 338, 339), as described in the following quotations:

“...interaction was described as mechanical information dissemination when it was perceived as delivery of information from nurse to patient rather than a process responding to patient’s needs.” (Hätönen, et. al, 2010, 338)

“Patients noted that interaction could be improved by creating active interaction through open communication and clearing up issues about which patients may be concerned.” (Hätönen, et. al, 2010, 339)

“All respondents said they wanted information to be readily available and to be

provided by a specialist professional who had good communication skills. Some received written information but this was reported as being inadequate to meet their needs.” (Ziecler, Newell Stafford & Lewin, 2004, 124)

“It is also clear that much of the success of healthcare provision depends on the quality of interactions between health professionals and patients.” (Ziecler, et. al, 2004, 125)

7.3 Communication Matters

Communication Matters forms one significant theme in the results. This theme was further sub-divided into two subthemes, “Language Issues” and “Demonstration of Interest and Positivity”.

7.3.1 Language Issues

The lack of a common language between the patient and the nurse was seen as a major obstacle for performing satisfactory nursing care.

“...respondents perceived that language difficulties stood in the way of giving good nursing care.” (Narayanasamy 2003, 192)

“The lack of a shared language created problems for both the nurse and the patient.” (Jirwe, Gerrish & Emami, 2010, 438)

“The ever-present challenge was the variable level of English literacy of the culturally diverse patients...” (Cioffi 2006, 323)

Interpreters were used to some extent, but the use of one was seen more as the physicians’ method of communication, or was restricted due to financial issues.

“...it was the doctors rather than the nurses who used accredited interpreters... nurses made limited use of accredited interpreters because of financial

constraints imposed by the hospital in which they worked.” (Jirwe, Gerrish & Emami, 2010, 439)

“...there were examples where interpreters were used to overcome the communication difficulties...” (Narayanasamy 2003, 192)

“I needed to arrange interpreter services for a patient attending for preoperative assessment who was unable to understand English...” (Narayanasamy 2003, 192)

It appeared that nursing care was not satisfactory for a patient or nurse due to the lack of a common language in the nursing situations. Situations were recorded where a nurse had perceived that the patient had understood the procedure. However, when the nurse started the procedure, the patient was surprised and even started to cry. In this situation the patient was not able to tell the nurse about her concerns, and the nurse could not ask the patient if the procedure hurt or if there was something wrong. This indicated that the lack of a common language obstructed satisfactory nursing care.

The nurses also felt that they did not engage in normal social interaction during procedures with patient who was from a different culture, as they did with patients that could speak the same language as them. Neither could the patients express their culture-bound behavioral actions, such as opposite-sex restrictions during nursing care.

“...the normal social intercourse that they would engage in during the procedure where they shared the same language as the patient was missing.” (Jirwe, Gerrish & Emami, 2010, 439)

“The patient knew that she was going to get a new intravenous line, we showed her with gestures. But when she started to put the intravenous line she just screamed...” (Jirwe, Gerrish & Emami, 2010, 439)

“It became difficult as the patient was unable to speak English and explain that she was not able to wash or be taken to toilet by a man, other than a member of her family...” (Narayanasamy 2003, 192)

7.3.2 Demonstration of Interest and Positivity

Even though significant difficulties in the communication can be found, a positive attitude and willingness to learn appear to make situation easier. The nurses can recognize their own incompleteness in understanding patients coming from diverse cultures, and want to do something about it.

“Participants who entered cross-cultural care encounters with a positive approach usually found it easier to cope with communication difficulties.”
(Jirwe, Gerrish & Emami, 2010, 441)

“The purpose is to increase nursing students’ knowledge...a study of transcultural nursing with focus on care, health and other environmental context is needed among the varied ethnic groups in the world.” (Agbedia 2008, 37-38)

“If you take your time and are interested in the patient then you can understand them.” (Jirwe, Gerrish & Emami, 2010, 441)

“...a significant number of participants (84%) have the motivation to request for courses in transcultural health care.” (Narayanasamy 2003, 193)

The need for education in transcultural nursing is recognized and nurses are motivated to seek for schooling. Nurses are also interested to make the effort in individual patient cases and sacrifice a little bit more time with their patient who comes from a different culture, in order to understand them.

7.4 Cultural Awareness

Cultural awareness is plenty discussed in the collected articles. Therefore it forms a noteworthy theme. The theme was also further developed through subthemes “Awareness of Cultural Diversity” and “Recognition of Cultural Needs”, which are presented in the next chapters.

7.4.1 Awareness of cultural diversity

The findings revealed that there is a prevailing awareness of cultural diversity among patients.

“...65% (n=82) of participants claimed they had recognized a cultural characteristic of their patients from past week to past month and this is encouraging.” (Narayanasamy 2003, 189)

“Most participants emphasized how an understanding of different cultural norms and traditions helped them to appreciate that people behave differently and have different world views. Cultural knowledge gave them more confidence...” (Jirwe, Gerrish & Emami, 2010, 441)

“...examine one’s own culture carefully and become aware that alternative viewpoints are possible.” (Agbedia 2008, 36)

This indicates that nurses are aware of cultural differences in their patients quite well. The awareness of cultural differences helps nurses also accept that people can behave differently and react to different things in a different ways. Awareness of cultural diversity helps nurses to carry out culturally competent care.

7.4.2 Recognition of Cultural needs

Under the theme Cultural Awareness a subtheme Recognition of cultural needs was found. To show the importance of this result for the study, the respondents thought it is worth mentioning that according to Narayanasamy (2003, 185) cultural needs are *“the need for equal access to treatment and care; respect for cultural beliefs and practices, including religious, dietary, personal care needs, daily routines; communication needs; and cultural safety needs.”* According to the results cultural needs and their individuality are somewhat well recognized by nurses.

“A significant number of participants (80%) agreed that their patients had cultural needs.” (Narayanasamy 2003, 188)

“..It shouldn’t be that everybody is alike within a culture. You have to recognize that there are differences...education can tend to categorize patients and the individual perspective is lost.” (Jirwe, Gerrish & Emami, 2009, 441)

However, continued investigation also obviously showed that the recognition of the cultural need is more or less limited to certain needs, and not fully understood or accepted. Educational level in transcultural nursing in nursing education also varies from country to country. This is why this subtheme required careful conduction.

“...suggests that the respondents’ descriptions of their clients’ cultural needs were limited to religious and dietary practices and problems such as language difficulties associated with giving nursing care... a closer examination reveals that cultural needs are interpreted and responded within a restricted frame of reference...” (Narayanasamy 2003, 189)

“She has a lot of family members. They want to stay with her all the time. They do not help with her and just sit there. They use their language as a barrier to understanding what we are asking.”(Cioffi 2006, 321)

“Nursing curricula in use in most nursing schools in Nigeria lack a transcultural perspective” (Agbedia 2008, 37)

Having family members visiting in the hospital can be included as cultural needs; ‘cultural practices’, but also ‘personal care needs’.

“I love visitors most of the time. I don’t feel relaxed and happy except when I see my family when they visit. I want my wife here to explain things.” (Cioffi 2006, 321)

8. Discussion

The results show that information can be provided through written material, such as booklets and leaflets, IT-based program, video and audiotape. Video and audiotapes are effective methods for patients to receive information, while written information and IT-based program enhance the patients' independent information capture (Anttila, et. al, 2008; Hätönen, et. al, 2013).

Nevertheless, information can be designed with diagrams, pictures and voice clips in IT-based program. Furthermore, in order to assess the amount and quality of information, it was strongly recommended to combine the methods with oral interaction (Hätönen, et. al, 2013, 338). The interaction was not merely nurse's responses to the patient's needs, but it was information transmitted to patient through open communication and discussion. Hence nurses were able to acquire more information about the patient. According to patient's perception described by Ziecler et. al (2004, 124), good quality of interaction between nurse and patient resulted to successful nursing care.

Thus, peaceful and suitable environment as well as warm and caring atmosphere enhances the quality of information patient received. It is important to provide quiet and proper environment when patient is receiving IC procedure information from written or IT-based program materials. Materials about physical anatomy of urinary system and different types of catheters can support the patient's understanding about the IC procedure. However, excessive information may be overwhelming and result in anxiety. In order to provide proper amount of information a careful evaluation of the patient's needs shall be implemented.

The importance of cultural competence is discussed in the earlier research of this study (Tseng & Streltzer, 200; Maier-Lorentz, 2008). In order to carry out satisfactory and therapeutic nursing care, cultural competence has to be emphasized. IC is a sensitive procedure where patient's integrity is encroached on. Therefore feelings of fear and embarrassment may appear (Logan, et. al, 2007, 34) which require cultural competence.

Complications associated with IC are bleeding, inflammation of urethral, UTIs, etc. Good personal hygiene can reduce the risk of UTIs; therefore, frequent hand washing with soap is suggested to patient. Changed color or smell of urine might indicate the beginning of

urinary tract infection (Wilde, Brasch, & Zhang, 2011, 1258).

Booklets or leaflets about importance of personal hygiene and complications can be handed to enhance patients' understanding and knowledge of how to take care themselves. Expression of IC information provided by oral explanation and video might easily be forgotten over time. Nevertheless, if patient has booklets or leaflets when IC is performed, especially when IC is long-term clinical issue, he or she could read through information to have a better understanding of the procedure. Consequently, IT-based program was described to be time consuming (Martin, et.al 2005; Anttila, et.al 2008), because it is time consuming for a nurse to teach a patient how to use it independently.

An interpretation of results emerged that the biggest challenge to information provision about IC procedure is the communication issues. Therefore, communication matters can be characterized as the most significant theme of the results. Plenty of discussion about communication can also be found in in the theoretical framework, theoretical background and earlier research in this study. It is one of the six cultural phenomena that are evaluated in Giger and Davidhizar's Transcultural Assessment Model (GDTAM) (2008) and means of communication, such as eye-contact and silence, are also discussed by Maier-Lorentz (2008, 38-39) in the chapter of earlier research.

As described by Giger and Davidhizar (2008, 20), communication is "*...continuous process by which one person may affect another through written or oral language, gestures, facial expressions, body language, space or other symbols*". Maier-Lorentz (2008, 38-39) uses the concept of space as one dimension of communication which is also one of the six phenomena in GDTAM. Without communication in any possible form, proper nurse-patient interaction and information provision will not occur. The patient's rights according to Finnish law are not fulfilled either, since a patient must be given (§5) information about his or her state of health, the importance of treatment, different alternatives and their effects and all the other factors related to the patient's care (The Statute Book of Finland, 1992/785). Communication is an area that has been investigated a lot within nursing field and it appears in the respondents' results. Therefore, its significance in nursing care is obvious.

The results indicate the ways of giving information about IC to patient through written material including leaflets and booklets, video, and means of IT. These methods were invariably combined together with oral interaction (Martin, et.al, 2005; Logan, et.al, 2007;

Logan 2012). It can indicate that information is provided and orally explained to patient. The patient is also given possibility to ask questions and express potential concerns, as could be assumed.

If no common language exists between the nurse and the patient, information about IC procedure cannot be delivered to the patient. It is also a challenge for the patient to ask clarifying questions and express potential concerns which may create feelings of insecurity and uncertainty. Problems about absence of normal social interaction during procedures also appeared in the results. The absence of possibly calming and stress-reducing conversation during procedures may create fear and insecurity. Therefore, nursing care is unsatisfactory both to the patient and the nurse.

An interpreter could be used in these situations but as stated in the results, the use of an interpreter was seen more as the physicians' method of communication, or it was restricted due to financial issues. Sometimes an interpreter is not available or there is no time to acquire one to explain the information in the patient's own language. This is very problematic since informing the patient is necessary to fulfill the patient's rights and needs.

Positivity and willingness for education helps nurses to overcome the communication difficulties. Perhaps, communication inabilities are easier to accept when an individual can admit an existence of a field where development is needed. It would be a very challenging task to learn all the existing languages only to be prepared to meet a patient who speaks foreign language. Unfortunately, that could be insufficient since the nurse should also consider all the other dimensions of communication which are aforementioned by Giger and Davidhizar (2008, 20). Hence, communication incorporated in the patient's culture can vary from country to continent and from individual to another, as Tseng and Streltzer (2008, 128-132) describe in earlier research.

Cultural Awareness formed an important theme in the results. It is a widely investigated area in nursing field and presents itself in the theoretical framework and earlier research as well. The theoretical framework, GDTAM, is designed for assessing the patient's individual cultural needs in order to create an individual care plan. (Sagar 2012, 57-58) The use of the model helps nurses to carry out individualistic care, and to understand the differences in the other culture. In other words, it increases cultural awareness.

According to earlier research one cornerstone of cultural awareness and culturally competent care is knowledge in cultures (Tseng & Streltzer 2008; Holland & Hogg, 2012), starting from the nurse's own culture. (Tseng & Streltzer, 2008; Maier-Lorenz 2008). However, in reality not much education in cultural knowledge is provided for nursing students. For instance, in Nigeria a transcultural perspective is absent from the nursing curriculum (Agbedia 2008, 37).

The results show that nurses are quite aware of cultural diversity and understand connection between good care and awareness of the patients' cultural background. Understanding of variable cultural behaviors and traditions can help nurses to appreciate the fact that people are different and behave according to their world views. People with different cultural background than the nurse may react differently to different things. Awareness of cultural diversity helps nurses to keep this in mind. Consequently, nurses are ready to accept different reactions from their patients who receive information concerning IC procedure and possibly find alternative ways of actions. In other words, carry out culturally competent care.

Examination of one's own culture was mentioned only in one article hence it can be assumed that nurses do not consciously notice the characteristics of their own culture. They may be able to recognize what is different in the patient's courses of actions compared to the actions they are used to see and implement when sharing the same cultural background with their patient.

According to the results cultural needs and their individuality were somewhat recognized among patients from different cultures. Perhaps this is thanks to some kind of education provided in transcultural nursing in nursing education to plant a seed of understanding and interest in nurses. However, this is not prevailing since education varies from country to country. This allegation is given confirmation by the results of the study showing that the recognition of cultural needs are more or less limited to specific needs or they are not fully understood or accepted.

What was seen as cultural needs was restricted to certain needs, such as dietary and religious needs, and language problems. Essential cultural needs such as the need for equal access to treatment and care, some dimensions of respect for cultural beliefs and practices, and cultural safety needs are not consciously recognized by nurses (Narayanasamy 2003,

185). For example, the presence of family members in the patient's room was seen negatively, while it was a cultural need and a factor influencing the patient's wellbeing positively. It was seen that the family members were only sitting in the room without helping in the care and consuming space unnecessarily. The patient's and the family members' language was seen to be used as a barrier for understanding what the nurses are asking.

Based on the discussion, it is determined that things which have to be taken into consideration when informing a patient with different culture than the nurse are not unambiguous. The greatest challenge is the communication; proper information cannot be provided if no common language between the nurse and the patient exists. Even though the patient receives information by other methods such as written materials or IT-based program, the patient has a smaller chance to become verbally understood by the nurse. It can be deduced that knowing all the existing cultures is impossible. Therefore, the nurse needs cultural awareness in order to understand that variable cultural backgrounds may have effects on the IC information provision.

9. Critical review

Lincoln and Guba's framework of quality criteria was used to evaluate the trustworthiness of this study. Lincoln- Guba framework offered the primary platform to the currently controversial rigor situation. It includes four criteria such as credibility, dependability, confirmability and transferability. (Polit & Beck, 2010, 492)

Credibility describes the truth and interpretations of the data while dependability refers to stability and constancy of the findings. The third criterion in the Lincoln-Guba framework is confirmability which involves objectiveness of the data. Hence two or more individuals verify the data accuracy, relevance or meaning. In other words, the findings should not be fictional or subjective, but reflect the research. Transferability describes that the data can be transferred to other settings or communities. (Polit & Beck, 2010, 492)

This thesis is credible, since scientific materials have been used and three respondents have collected and analyzed them by using qualitative content analysis. The data is empirical and good scientific practice has been carried out through the study. This study is

dependable because the chosen articles used in data analysis will not change so much over time. It is also confirmable, since proper amount of data has been analyzed, which include similar dimensions that are relevant to this thesis. The results of this study can be transferred to other groups or situations, meaning they are transferable. The results presented in the thesis are the outcome of an analysis that has been carried out scientifically. Hence no personal opinions or assumptions are included in the study.

The aim of this study was to describe the methods of informing patients about intermittent urinary catheterization performed by a nurse who has a different cultural background than the patient. The results of this study have fulfilled the aim and answered the research questions.

10. Conclusion

According to the literature review, urinary catheterization is an area where cultural awareness is particularly important, since it is such a sensitive performance. It is a procedure that can result in a lot of feelings and thoughts both to the patient and the nurse. The way of transmitting information about the IC is essential for the patient's understanding, acceptance and co-operation.

Nursing care is more successful if the procedures are carried out with consideration to the cultural differences between the nurse and the patient. Particularly urinary catheterization is a procedure where much co-operation is needed by the patient, thus, a great need for cultural competence and awareness among the nursing staff.

Even though nurses cannot completely understand or remember all the differences and characteristics among different cultures, health care professionals should be aware of the differences between cultures when encountering patients from different ethnic groups. However, the level of transcultural nursing education among nurses varies from country to country. It indicates that improvement in this field is needed in order to create awareness of cultural differences, which can assist nursing process and promote nursing care including information provision.

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Enclosure 1

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Enclosure 2

Authors	Year	Article
Agbedia C.O.	2008	Transcultural Nursing: Insight and perspectives
Anttila, M., Koivunen, M., & Välimäki, M.	2008	Information technology-based standardized patient education in psychiatric inpatient care
Cioffli, J.	2006	Culturally diverse patient-nurse interactions on acute care wards
Narayanasamy, A.	2003	Transcultural nursing: how do nurses respond to cultural needs?
Gustafsson, L., Hodge, A., Robinson, M., Mckenna, K., & Bower, K.	2010	Information provision to clients with stroke and their caregivers: Self-reported practices of occupational therapists
Hätönen, H. Suhonen R., Warro, H., Pitkänen, A. & Välimäki, M.	2010	Patients' perceptions of patient education on psychiatric inpatient ward: a qualitative study
Logan, K.	2012	An overview of male intermittent self-catheterisation
Logan, K., Shaw, C., Webber, I., Samuel, S. & Broome, L.	2007	Patients' experiences of learning clean intermittent self-catheterization: a qualitative study
Jirwe, M., Gerrish, K. & Emami, A.	2010	Student nurses' experiences of communication in cross-cultural care encounters
Martin J. T., Hoffman M. K. & Kaminski P. F.	2005	NPs vs. IT for Effective Colposcopy Patient Education
Sheldon, P.	2013	Successful intermittent self-catheterization teaching: one nurse's strategy of how and what to teach
Utriyaprasit, K., Moore, S.M. & Chaiseri, P.	2010	Recovery after coronary artery bypass surgery: effect of an audiotape information
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