Received: 1 January 2023 | Revised: 17 April 2023 | Accepted: 15 May 2023

DOI: 10.1111/jocn.16769

Journal of Clinical Nursing WILEY

EMPIRICAL RESEARCH QUANTITATIVE

Examination of individualised care behaviours and ethnocentrism of nurses caring for refugees: A descriptive and exploratory study

Betül Tosun BSN, MSN, PhD, Associate Professor[1] | Ezgi Dirgar BSN, MSN, PhD, Assistant Professor[2] | Kadiriye Pehlivan BSN, MSN, Research Assistant[1] | Eda Atay BSN, MSN, Research Assistant[1] | Ayla Yava BSN, PhD, Professor[1] | Juan M. Leyva-Moral BSN, MSc, PhD, Associate Professor[3]

[1]Department of Nursing, Hasan Kalyoncu University, Faculty of Health Sciences, Gaziantep, Turkey

[2]Department of Midwifery, Gaziantep University, Faculty of Health Sciences, Gaziantep, Turkey

[3]Department of Nursing, Faculty of Medicine, Universitat Autònoma de Barcelona, Bellaterra, Spain

Correspondence
Betül Tosun, BSN, MSN, PhD, Associate Professor, Hasan Kalyoncu University, Faculty of Health Sciences, Department of Nursing, Hasan Kalyoncu University 8th Km on the Airport Road, Gaziantep, Turkey.
Email: tosunbetul@gmail.com

Abstract

Background: Qualified individualised nursing care should be provided to all communities and ethnic groups with free of ethnocentrism.

Aims: To evaluate nurses' individualised care behaviours and ethnocentric attitudes and predict the relationship between their individualised care behaviours and ethnocentric attitudes.

Design: A descriptive and exploratory study.

Methods: This study was conducted with 250 nurses working in a public and two private hospitals in a city, an area with many refugees. Data were collected using the Ethnocentrism Scale and Individualised Care Behaviours Scale. Structural equation model analysis to test hypothetical model and descriptive statistics were used.

Results: Nurses working in the private hospitals had a higher individualised care decision control mean score. Those nurses who enjoyed spending time with people from different cultures had lower mean ethnocentrism scale scores, higher individualised care clinical status, personal life and decision control status subscales mean scores compared to other nurses. Mean scores of the individualised care personal life and decision control status subscales of the nurses who followed the literature on transcultural nursing was higher. A significant relationship between the ethnocentrism levels and individualised care behaviours was identified. Accordingly, the ethnocentric attitudes of the nurses negatively affected their individualised care behaviours, and the model established between the two concepts is statistically appropriate.

Conclusions: Nurses who work in private hospitals, receive intercultural nursing education and enjoy spending time with different cultures have higher individualised care behaviours and lower ethnocentrism levels. Ethnocentric attitudes of the nurses negatively affected their individualised care behaviours. Care strategies should be

developed that consider the factors that will maximize individualised care practices that minimize ethnocentric behaviours among nurses.

Implications for the Profession: Increasing awareness on individualised care behaviours, ethnocentric attitudes and effected factors will contribute to improve of nursing care quality of nurses while giving care to individuals from different cultures.

KEYWORDS
attitudes, cultural competence, ethnocentrism, individual care, nurse, transcultural nursing

1 | INTRODUCTION

The change in societies as a result of geographical mobility due to various reasons has revealed the necessity of caring for individuals of different cultural and ethnic backgrounds in accordance with their cultural backgrounds and beliefs (Kaya et al., 2021; Nameni, 2020). Health care performed without being aware of the cultural characteristics of the individuals, their families and society can lead to misunderstandings and inequalities, such as misdiagnosis and violation of the ethnic attitudes and beliefs of care recipients (Karasu et al., 2022; Tosun et al., 2021). Nursing philosophy also emphasises that in a globalized world, person-centred and culturally sensitive care is necessary for all ethnic groups within quality and holistic care (Gungor et al., 2021; Yildiz et al., 2018).

Although individual-specific, culture-sensitive and culturally safe care are among the responsibilities of nurses, it has been stated that nurses can sometimes be ethnically centred and prejudiced due to a lack of knowledge, understanding, awareness, education and belief about culture and cultural competence (Gungor et al., 2021; Ozdemir, 2019; Yilmaz et al., 2021). Ethnocentrism (Bizumic, 2015; Chen, 2010), which is defined as the individual's believing in the superiority of his/her own culture and judging other cultures with the values of his/her own culture, may lead to patient alienation, inadequate treatment, misdiagnosis (Guner et al., 2021; Nameni, 2020) and culturally inappropriate service delivery (Danaci & Koç, 2020; Ozdemir, 2019).

Nursing science aims to provide humanised, person-centred care considering patients' beliefs and preferences and advocating for patients' rights (Flagg, 2015). Individualised care is the realization of the belief in human individuality, uniqueness and integrity in the field of application that forms the basis of nursing philosophy, values and ethical codes (Acaroğlu & Şendir, 2012; Yildiz et al., 2018).

For individualised care to achieve its purpose, it is necessary not only to provide care for the individual by adapting nursing actions in line with patient's characteristics but also for the patient individual to perceive this approach of the nurse and to experience and feel these perceptions (Papastavrou et al., 2015; Yilmaz et al., 2021).

In the literature, it has been stated that the characteristics of nurses such as age (Altınbaş & İster, 2020), gender, education level, marital status and working experiences (Altınbaş & İster, 2020; Özakgül et al., 2020; Suhonen et al., 2010) do not affect nurses' individual caregiving behaviours. In other studies, nurses' cultural values and beliefs (Papastavrou et al., 2015), conflicts in the working environment, work motivations, leadership and autonomy (Charalambous et al., 2012; Papastavrou et al., 2015), organizational factors (López-Domingo & Rodríguez-Martín, 2021), the collective decision-making process (Köberich et al., 2016), and the experience of the caregiver (Idvall et al., 2012) affect individual caregiving perceptions. A recent Turkish study found there was no relationship between moral distress and individual care behaviours in intensive care unit nurses. In addition, it was emphasised that nurses' ethnocentric attitudes, cultural backgrounds and different factors should be investigated (Işık & Yıldırım, 2023). In the light of this information in the literature, no study has been found that examines the relationship of nurses' ethnocentric attitudes and individualised care behaviours.

Turkish society is multicultural due to population mobility due to its geographical and geopolitical location (Guner et al., 2021; Yilmaz et al., 2021). The number of Syrian refugees with temporary protection status registered in Turkey has been determined as 3.762.385 as of 21 April 2022 (Refugees Association, 2022). It is known that most of these refugees live in Turkish cities on the Syrian border. Nurses provide care services to individuals with different cultural characteristics within this social structure. Ethnocentrism can affect the quality of care and this relationship needs to be investigated and revealed (Karasu et al., 2022). In Turkey, which has experienced an increasing influx of refugees in recent years and has become a multicultural structure, it is very important to examine the ethnocentrism and individualised care behaviours of nurses and to reveal the

What does this paper contribute to the wider global clinical community?

- It was determined that nurses working in the private hospitals had a higher mean score of decision control than nurses working in public hospital.
- Nurses who did not like to spend time with people from different cultures had a higher level of ethnocentrism than nurses who liked to spend time with people from different cultures.
- The ethnocentric attitudes of the nurses participating in the research negatively affect their individualised care behaviours and the model established between the two concepts is statistically appropriate.

relationship between these two concepts with a hypothetical model. This study aimed to evaluate nurses' individualised care behaviours and ethnocentric attitudes and predict the relationship between their individualised care behaviours and ethnocentrism levels.

2 | METHODS

This study was conducted as a descriptive and exploratory design. The population of this study consisted of a total of 1150 nurses working in a public hospital (800 nurses) and two private hospitals (350 nurses) in a province on the Syrian border of Turkey, where many refugees live. These hospitals provide equal health services to the population from all ethnic origins living in the region, without any restrictions. The sample calculation was made in the G*Power (Version 3.1) package program. A sample of 288 was appropriate for a 50% heterogeneity, 5% error and a confidence level of 95%. Since there was no previous study investigating ethnocentric and individualised care together when Pearson correlation was predicted to be performed, the inverse relationship between the scale mean scores were calculated as $r > -.2$ (weak), with $\alpha = .05$ and $(1\text{-}\beta) = .80$ power in the 95% confidence interval, while the sample of the study was calculated as at least 198 nurses. Data were collected between November 2021 and February 2022. The inclusion criteria for this study were nurses who were actively working in these hospitals, participating voluntarily to study and working for more than 1 year. In these hospitals, at the time the data were collected 1076 nurses were on active duty and totally 989 nurses had been working for more than a year. The researchers had no connection to the nurses working these hospitals. Face-to-face meetings were used to explain the study's objectives, data collection forms and data collection methodology to the hospitals' nursing directors. The researchers requested the email addresses of nurses who wanted to participate in the study and met inclusion criteria. By providing their email addresses participants gave their consent to receive of the data collection forms. Digital instruments were sent online to 300 nurses working in a public hospital and 200 nurses working in two private hospitals and approved to receive data collection forms. All collected data were anonymous and it was kept confidential following the national policies; only the research team were allowed to access the data and it was not shared with other research teams. A total of 174 nurses from the public hospital and 76 nurses from private hospitals ($n = 250$) completed the forms. The number of nurses participating in the study was suitable for the sample calculation and constituted 25.3% of the total number of nurses who met the inclusion criteria.

In the study, three online instruments were used. First, an ad hoc 15-item questionnaire was created based on the literature review (Guner et al., 2021; Karasu et al., 2022; Ozdemir, 2019). This questionnaire was used to collect descriptive and cultural background? about the participants. Second, the validated Turkish version of the Ethnic Centricity Scale (ES) developed by Neuliep and McCroskey (1997) was used (Üstün, 2011). The instrument has shown excellent validity and reliability scores (.90 Cronbach's alpha coefficient). The total score range of the 20-item 5-point Likert-type scale is 20–100. Items 4, 7, 9, 12, 15 and 19 on the scale are inversely scored. Even though the cut-off score of the scale was not found, the increased score obtained from the scale indicates that ethnic discrimination is heightened (Üstün, 2011). In the current study Cronbach's alpha coefficient was calculated as .78.

Finally, the Individualised Care Scale-Nurse (IC-B) developed by Suhonen et al. (2010) and validated in Turkish by Acaroglu et al., (Acaroğlu et al., 2010) was used. The scores obtained from each section and IC-B subscales are at least 1.0 and at most 5.0 points. The high scores indicate that nurses have a high perception of supporting patients' individuality and individualizing the patient's care during the nursing actions they generally perform. The subscales of IC-B nurse are divided into subscales as 'clinical status', 'personal life status', and 'decision-making control'. Cronbach's alpha coefficients were .93 for Individualised Care Scale-B in validity and reliability study (Acaroğlu et al., 2010) and was calculated as .92 in the current study.

2.1 | Statistical analyses

The data were analyzed using IBM SPSS Statistics for Windows, Version 23.0 New York Licensed package program, and LISREL by Scientific Software International, Inc. Version: 8.8. Descriptive statistics were expressed in numbers, percentages, and mean ± SD. The normality of the distribution was analyzed with the Shapiro–Wilk test. Student's *t*-test and one-way ANOVA were used to compare the scale score means. Bonferroni correction was used to determine which group caused the difference when multiple pairwise tests were performed to compare three or more groups. To test of hypothetical model about the relationship between the relationship between the individualised care behaviours and ethnocentric tendencies of the nurses structural equation model analysis was used. After testing the structural equation model, the data were analyzed by conducting path analysis. Other fit indexes such as $\chi 2/sd$, root mean square error of approximation (RMSEA), goodness-of-fit index (GFI), Normed fit index (NFI), Non-normed fit index (NNFI) and Comparative fit index (CFI) values of the model were employed to evaluate the analysis of the data as a whole.

Statistical analyses of the research were made by the authors. These authors are Eda Atay and Betül Tosun. The authors affirm that the methods used in the data analyses are suitably applied to their data within their study design and context, and the statistical findings have been implemented and interpreted correctly.

2.2 | Ethical considerations

Hasan Kalyoncu University Faculty of Health Sciences Non-Invasive Research Ethical Board (Date: 18 November 2021, Decision No: 2021/030) approved this study. Permissions were obtained from the administrators of the nursing departments of the

hospitals where the study was conducted. Nurses were informed of the goals and procedures of the study. All collected data were anonymous and treated confidentially. Online consents were obtained from those who agreed to participate before completing the questionnaires.

3 | RESULTS

A total of 250 valid questionnaires filled online by nurses were received. Most of the nurses were female (78.4%), worked in the public hospital (69.6%), with 1–5 years of professional experience (47.9%) (Table 1). The total mean score of the nurses' Ethnocentrism Scale was 52.50 ± 6.07 (Min: 39, Max: 70). The mean scores of the subscales of the Individualised Care Scale were evaluated; clinical status was found as 4.25 ± .73 (Min: 1, Max: 5), personal life status was 3.74 ± .89 (Min: 1, Max: 5), and decision control was 4.20 ± .73 (Min: 1.83, Max: 5).

It was determined that nurses working in the private hospitals had a higher mean score of decision control subscale than nurses working in public hospital ($t = 2.771$, $p < .01$), (Table 1). A statistically significant difference was found according to the wards the nurses worked for ($f = 2.262$, $p = .04$). In the advanced statistics made with the Bonferroni correction, it was found that the nurses working in the administration units had higher clinical status subscale scores than the nurses working in the internal medicine wards (Table 1). In addition, the total mean score of the Ethnocentrism Scale of nurses who did not like to spend time with people from different cultures was higher than those who liked to spend time with people from different cultures ($t = 2.202$, $p < .01$).

In addition, significant statistical differences were found between the total mean scores of all Individualised Care Behaviour Scale subscales according to spending time with people from different cultures, (Table 1). According to these results, the scores of the subscales of clinical status, personal life and decision control status of the nurses who liked to spend time with people from different cultures were higher than the others ($t = 5.520$, $p < .01$; $t = 4.049$, $p < .01$; $t = 4.720$, $p < .01$, respectively), (Table 1).

It was determined that the mean score of the individualised care personal life and decision control status subscales of the nurses following the current literature on transcultural nursing was higher ($t = 2.697$, $p < .01$; $t = 2.122$, $p = .03$, respectively), (Table 1).

A significant inverse relationship between the independent variables of ethnocentrism and individualised care behaviours was identified ($\beta = -.24$, $t = 3.59$) (Figure 1). In addition, in the evaluation of the GFI, which is a measure of fit between the hypothesised model and the observed covariance matrix, $\chi 2/sd$ was found as 1.85 for the relationship between ethnocentrism and individualised care behaviours of nurses (RMSEA value of Model 1 = .049). Considering the other fit index of the model in which the relationship between ethnocentrism and individualised care was examined according to the results of the research, it can be stated that the GFI = .99, NFI = .99, NNFI = .99, and CFI = .99 values have the perfect fit. Accordingly, the ethnocentric attitudes of the nurses in the study negatively affect their individualised care behaviours, and the model established between the two concepts is statistically appropriate (Table 2).

4 | DISCUSSION

In this study, the ethnocentric and individualised care behaviours of 250 nurses caring mostly for refugee patients on the Syrian border in Turkey were examined. Previous evidence emphasises that nurses should respect the individuality and autonomy of the patients they care for while providing individualised care and that they should provide care in cooperation, bearing in mind the needs, values, cultural backgrounds, and beliefs of the patient and their families (Ozdemir, 2019; Suhonen et al., 2018).

Sociodemographic characteristics of the nurses participating in this study, such as age, gender, marital status and educational status, did not make a difference in terms of individualised care behaviours, as in many studies in the literature (Altınbaş & İster, 2020; Özakgül et al., 2020; Suhonen et al., 2010). However, nurses working in the private hospitals had a higher mean score of decision control than nurses working in the public hospital. In terms of satisfaction with the service provision, the importance of considering patients' preferences and increasing their contribution to care is acknowledged in addressing each patient's problems individually (Ozdemir, 2019; Yildiz et al., 2018). Al-Neyadi et al. (2018) reported that for-profit health institutions should provide competitive services to provide adequate service to clients, enable patients to revisit their facilities or recommend them to their families and friends. However, Sharma and Kamra (2013) found that the services offered by public and private hospitals, emotional support, communication, professional knowledge, accessibility, attention, professionalism and nurses' satisfaction scores were higher in private hospitals. Thus, according to the existing literature (Sharma & Kamra, 2013) and the results of this study, private hospital nurses seem to provide higher levels of nursing care and are more participative in the decision-making process, respecting patients' preferences.

This study found that nurses working in administration units had higher clinical status subscale scores than nurses working in internal medicine wards. In similar studies, it is noteworthy that nurses with higher education levels and life experience are superior in providing individualised care (Danaci & Koç, 2020; López-Domingo & Rodríguez-Martín, 2021). More professional experience, specialized nursing education or postgraduate education is associated with higher individualization of care (Danaci & Koç, 2020; Yildiz et al., 2018). The reported relationship between professional autonomy, leadership skills, experience and provision of individualised care in executive nurses (López-Domingo & Rodríguez-Martín, 2021) coincides with the results obtained in the present study.

Nurses who liked to spend time with people from different cultures had lower ethnocentrism levels and higher individualised care behaviours including all subscales (clinical status, personal life and decision control status) compared to nurses who did not like

TABLE 1 Socio-demographic characteristics of the nurses ($n = 250$).

Descriptive characteristics	*n*	%	ES	Test *p-value*	Clin-B	Test *p-value*	Pers-B	Test *p-value*	Dec-B	Test *p-value*
Gender										
Female	196	78.4	52.62 ± 6.12	$t = .541$	4.27 ± .72	$t = .901$	3.75 ± .89	$t = .039$	4.20 ± .70	$t = .116$
Male	54	21.6	52.11 ± 5.95	$p = .58$	4.17 ± .77	$p = .39$	3.74 ± .94	$p = .96$	4.21 ± .86	$p = .90$
Marital Status										
Married	102	40.8	52.24 ± 6.53	$t = .567$	4.18 ± .76	$t = 1.271$	3.68 ± .91	$t = .931$	4.12 ± .73	$t = 1.347$
Single	148	59.2	52.68 ± 5.76	$p = .58$	4.30 ± .70	$p = .20$	3.78 ± .88	$p = .20$	4.25 ± .72	$p = .17$
Age (Mean ± SD: 29.74 ± 6,54), (Min: 21, Max: 59)										
< 30	160	64.0	52.97 ± 5.80	$t = 1.625$	4.30 ± .68	$t = 1.481$	3.74 ± .83	$t = .103$	4.21 ± .72	$t = .342$
> 30	90	36.0	51.67 ± 6.48	$p = .10$	4.16 ± .81	$p = .14$	3.75 ± .99	$p = .92$	4.18 ± .75	$p = .733$
Education Level										
Associate degree in nursing	70	28.0	53.30 ± 6.03	$f = 1.365$	4.34 ± .59	$f = .730$	3.84 ± .88	$f = 2.325$	4.34 ± .74	$f = 2.869$
Bachelor of science in nursing	152	60.8	52.40 ± 5.98	$p = .25$	4.21 ± .76	$p = .48$	3.65 ± .89	$p = .10$	4.11 ± .72	$p = .59$
Postgraduate degree in nursing	28	11.2	51.10 ± 6.58		4.22 ± .86		3.99 ± .91		4.02 ± .73	
Hospital type										
Public hospital	174	30.4	52.21 ± 6.15	$p = .25$	4.21 ± .74	$p = .25$	3.68 ± .90	$p = .13$	4.11 ± .74	$t = 2.771$
Private hospitals	76	69.6	53.17 ± 5.88	$t = 1.141$	4.33 ± .70	$t = 1.135$	3.87 ± .86	$t = 1.518$	4.39 ± .68	$p < .01^{**}$
Ward										
Internal medicine wards[a]	88	35.2	52.57 ± 6.35		4.13 ± .80		3.71 ± .94		4.09 ± .84	
Surgical wards[b]	67	26.8	53.35 ± 5.90	$f = .953$	4.19 ± .70	$f = 2.662$	3.64 ± .87	$f = .775$	4.16 ± .74	$f = 1.812$
Administration[c]	24	9.6	51.16 ± 7.35	$p = .41$	4.44 ± .55	$p = .04^{*}$	3.90 ± 1.01	$p = .50$	4.22 ± .71	$p = .14$
Other[d]	71	28.4	52.07 ± 5.39		4.27 ± .90	c > a	3.82 ± .81		4.36 ± .53	
Having friends from different countries										
Yes	132	52.8	52.74 ± 6.03	$t = .644$	4.33 ± .69	$t = .644$	3.74 ± .87	$t = .048$	4.26 ± .65	$t = 1.339$
No	118	47.2	52.24 ± 6.14	$p = .52$	4.16 ± .76	$p = .07$	3.74 ± .92	$p = .962$	4.14 ± .80	$p = .187$
Enjoying spending time with people from different cultures										
Yes	214	85.6	52.16 ± 5.99	$t = 2.202$	4.35 ± .63	$t = 5.520$	3.83 ± .88	$t = 4.049$	4.28 ± .65	$t = 4.720$
No	36	14.4	54.55 ± 6.24	$p = .03^{*}$	3.66 ± .96	$p < .01^{**}$	3.20 ± .79	$p < .01^{**}$	3.68 ± .94	$p < .01^{**}$
Taking education about transcultural nursing										
Yes	61	24.4	52.98 ± 6.59	$t = .702$	4.30 ± .67	$t = .708$	3.91 ± .87	$t = 1.739$	4.30 ± .68	$t = 1.300$
No	189	75.6	52.35 ± 5.91	$p = .50$	4.23 ± .74	$p = .48$	3.68 ± .90	$p = .08$	4.16 ± .74	$p = .176$

TABLE 1 (Continued)

Descriptive characteristics	n	%	ES	Test p-value	Clin-B	Test p-value	Pers-B	Test p-value	Dec-B	Test p-value
Following the literature on transcultural nursing										
Yes	72	28.8	52.0 ± 6.44	$t = .679$	4.27 ± .77	$t = .334$	3.98 ± .90	$t = 2.697$	4.35 ± .65	$t = 2.122$
No	178	71.2	52.67 ± 5.93	$p = .49$	4.24 ± .71	$p = .73$	3.64 ± .87	$p < .01^{**}$	4.14 ± .75	$p = .03^{*}$
Professional experience (in years)										
1–5	119	47.6	52.54 ± 5.80	$f = .307$	4.26 ± .67	$f = .818$	3.65 ± .87	$f = 1.678$	4.15 ± .73	$f = .400$
6–10	48	19.2	51.79 ± 5.29	$p = .73$	4.13 ± .88	$p = .44$	3.71 ± .94	$p = .18$	4.22 ± .67	$p = .67$
> 10	46	18.4	52.10 ± 6.60		4.31 ± .67		3.94 ± .84		4.26 ± .62	

Note: $^{*}p < .05$, $^{**}p < .01$ c > a After Bonferroni Correction nurses working in the administration units had higher clinical status scores than the nurses working in the internal medicine wards.

Abbreviations: Clin-B, Clinical situation; DecB, Decisional control; ES, Ethnocentrism Scale; PersB, Personal life situation.

to spend time with people from different cultures. Nurses need to develop direct interactions with individuals/families/society from different cultures to change their beliefs about different cultures and avoid prejudiced behaviours (Campinha-Bacote, 2019; Sharifi et al., 2019). The frequency and content of cultural encounters increase nurses' awareness of different cultures, enrich their experiences and improve their competence in individualised care (Papastavrou et al., 2015; Sharifi et al., 2019). In light of this information, it is striking that nurses who have experienced more encounters with different cultures have lower ethnocentrism levels and are better at individualised care.

This study showed that the mean scores of the individualised care scale personal life and decision control status subscales of the nurses who followed the current literature on transcultural nursing were higher than those who did not. Many studies emphasise that nursing students should receive training during undergraduate education and after graduation on transcultural nursing care to provide holistic professional care (Gungor et al., 2021; López-Domingo & Rodríguez-Martín, 2021; Tosun et al., 2021). It is considered that nurses' following the current literature after graduation contributes to the development of professional behaviours that reflect the beliefs and values of the patient individual and that take into account habits, activities, preferences, and families cultural safety (Yilmaz et al., 2021).

The hypothetical model conducted in this study showed that the nurses' ethnocentric attitudes negatively affect individualised care behaviours and that these two concepts had an inverse relationship. Culturally sensitive and adequate care is a process that allows individuals or families to be open to the preferences of other people by showing empathy for their life experiences, values, and beliefs (Charalambous et al., 2012; Çiftçi et al., 2021; Guner et al., 2021; Gungor et al., 2021).

Patient-oriented, individualised care plans can be implemented, meeting patients' needs by considering patients' beliefs and values and enforcing positive collaborations between clinicians and patients. Culturally adequate, patient-oriented, individualised care plans can increase the likelihood of better health outcomes and treatment (Çiftçi et al., 2021; Ozdemir, 2019; Papastavrou et al., 2015). The negative relationship between ethnocentric and individualised care in this study shows that the mutual existence of these two concepts neutralizes each other and should be approached attentively. Therefore, it is considered that nurses with prejudices and ethnocentric behaviours cannot provide culturally safe and individualised care.

The results of this study are limited to the findings obtained from nurses working in three hospitals in a province on the Syrian border, and study results could not be generalised. Also, the statistics collected were not based on observational data but rather only the nurses' judgements. In practice, nurses' opinions and attitudes may be different. Participants may have contributed to the social desirability bias in the research results by responding in a way they thought the researchers would find favourable (Waltz et al., 2016). It was highlighted that participation was anonymous, and study data collection forms were sent via an external 'Google Forms'

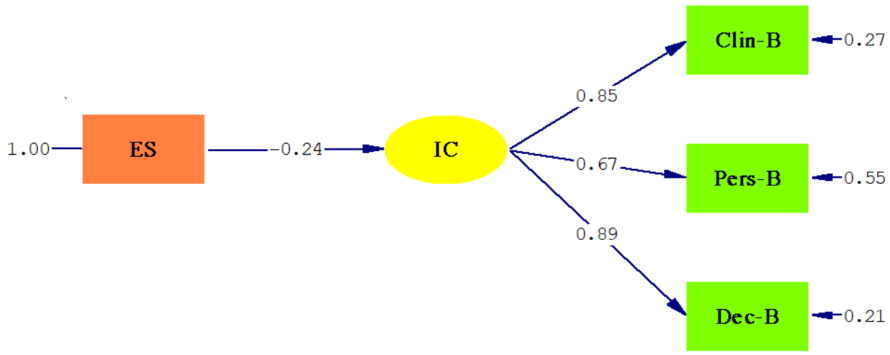

FIGURE 1 Ethnocentrism and Individualised Care Behaviours model. [Colour figure can be viewed at wileyonlinelibrary.com]

TABLE 2 Fit indexes regarding the structural equation model analysis.

Fit indexes									
	x^2	*Sd*	χ^2/sd	*p*	RMSEA	GFI	NFI	NNFI	CFI
MODEL	3.18	2	1.59	.20	.049	.99	.99	.99	.99

Abbreviations: CFI, Comparative fit index; GFI, Goodness-of-fit index; NFI, Normed fit index; NNFI Non-normed fit index; RMSEA, root mean square error of approximation.

connection was employed to minimize response and information bias (Keough & Tanabe, 2011).

5 | CONCLUSIONS

For Turkish nurses working on the Syrian border, ethnocentric and individualised care behaviours are moderate and better than those reported in other studies. It was found that nurses working in private hospitals gave patients more say in controlling clinical decisions, and nurses working in management units had higher clinical status scores. In addition, the lower ethnocentric and better-individualised care behaviours of nurses who received training on transcultural nursing revealed the importance of postgraduate education.

This study shows that ethnocentric and individualised care behaviours, which have not been investigated together before, are two intertwined concepts that affect each other. Therefore, it is recommended to conduct intervention and observation studies by maximizing individualised care practices that minimize ethnocentric behaviours among nurses. Furthermore, qualitative evidence is required to understand nurses' ethnocentric and individualised care behaviours.

AUTHOR CONTRIBUTIONS

Betül Tosun: Conceptualization; formal analysis; methodology; supervision; roles/writing-original draft; writing—review & editing. Ezgi Dirgar: Conceptualization; formal analysis; methodology; data collection; roles/writing—original draft. Kadiriye Pehlivan: Conceptualization; methodology; roles/writing—original draft; writing—review. Eda Atay: Conceptualization; methodology; roles/writing—original draft; writing – review. Ayla Yava: Conceptualization; supervision; roles/writing—original draft; writing—review & editing, critical revisions for important intellectual content. Juan M. Leyva-Moral: Conceptualization; supervision; roles/writing—original draft; writing—review & editing, critical revisions for important intellectual content.

ACKNOWLEDGEMENTS

We would like to thank all the nurses who participated in this study and all the hospital managers who agreed to disseminate the study.

FUNDING INFORMATION

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

PATIENT OR PUBLIC CONTRIBUTION

No patient or public contribution.

ETHICAL STATEMENT AND CONFLICT OF INTEREST STATEMENT

Before starting the study, ethical approval was received from the Hasan Kalyoncu University Faculty of Health Sciences Non-Invasive Research Ethical Board (Date:18 November 2021, Decision No:2021/030) and the Chief Physician of the Research and Application Hospital where the study was implemented. We conducted according to the ethics guidelines set out in the Declaration of Helsinki. All the nurses participating in the study were informed about the study, their written/verbal consents were taken, and they were also informed that they could leave the study at any time. The authors declare that they have no competing interests. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

REPORTING METHOD

EQUATOR strobe rules were followed in the reporting of this article.

ORCID

Betül Tosun https://orcid.org/0000-0002-4505-5887
Ezgi Dirgar https://orcid.org/0000-0001-8214-7441
Kadiriye Pehlivan https://orcid.org/0000-0001-8596-5837
Eda Atay https://orcid.org/0000-0003-2592-8254
Ayla Yava https://orcid.org/0000-0003-3468-6779
Juan M. Leyva-Moral https://orcid.org/0000-0003-4241-4992

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How to cite this article: Tosun, B., Dirgar, E., Pehlivan, K., Atay, E., Yava, A., & Leyva-Moral, J. M. (2023). Examination of individualised care behaviours and ethnocentrism of nurses caring for refugees: A descriptive and exploratory study. *Journal of Clinical Nursing*, *32*, 5084–5092. https://doi.org/10.1111/jocn.16769