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## **Abstract**

**Aims.** To explore the challenges faced by community nurses when providing home health care to ethnic minority patients.

**Background.** Like many other European countries, Norway has a growing number of immigrants, including older immigrant patients. Community nurses who provide home care encounter considerable challenges when delivering services to an increasingly diverse patient population.

**Design.** A qualitative study based on a hermeneutics approach.

**Methods.** A qualitative study was conducted that involved 19 nurses in Norwegian home health care districts, which had high proportions of minority patients. The data were collected in 2008.

**Findings.** We identified three critical aspects of the encounters between community nurses and minority patients. The first was intimate care. Nurses perceived the fear of mistakes and crossing boundaries related to the cultural and religious practices of minority patients as particularly stressful. The second was rehabilitation after stroke. The beliefs of nurses in the benefits of rapid rehabilitation conflicted with those of the minority patients and their relatives who favoured extended rest during recovery. Third, the commitment of community nurses to transparency in the care of dying patients was tested severely when they met

relatives who believed in religious explanations for the destinies of patients and who wanted to conceal the true diagnosis from terminally ill patients.

**Conclusion.** Community nurses encountered various challenges due to a lack of experience with highly diverse patient populations. This situation will continue to create difficulties for nurses and minority patients if management support and appropriate training measures are not provided.

**Keywords:** diversity, front-line worker, home care, institutional constraints, transcultural nursing

## SUMMARY STATEMENT

### **Why is this research needed?**

- Care services need to adapt to the unprecedented needs of the rapidly growing population of older patients from ethnic minority groups.
- There is an urgent need to explore the challenges encountered by welfare professionals when providing home care services to an increasingly diverse patient population.
- Structural challenges are often incorrectly assumed to be related to the possible individual shortcomings of community nurses.

### **What are the key findings?**

- The beliefs of community nurses regarding good care services during rehabilitation and palliative care often conflicted with those of the minority patients and those of their relatives.
- Intimate care for minority patients of the opposite sex was often stressful for community nurses because of a lack of knowledge about cultural and religious customs.
- The challenges encountered during home care provision to minority patients were connected to a lack of professional development and cultural competence, as well as wider institutional constraints.

### **How should the findings be used to influence policy/practice/research/education?**

- There is a need for management support based on appropriate training measures to improve the capacities of community nurses when providing care to minority patients.

- Home care services need to create more opportunities for developing the skills of community nurses so they can provide appropriate care to a highly diverse patient population.

## **Introduction**

International migration is increasing the diversity of populations throughout Europe (Rechel *et al.* 2013). Migrants are often younger than the populations in their new countries, but they also age and are sometimes joined by their parents. Thus, the number of older immigrants is increasing in many European countries, which presents new challenges for health and care services. However, Ruspini (2011) showed that the policies implemented to tackle these challenges often fail to keep pace with social change because the structural dimension of everyday experience is not recognized. Without adequate policies, health and long-term care workers are inadequately prepared to deal with an increasingly diverse patient population. In nursing, the field related to care and diversity is relatively new. The concepts and models used are not yet fully developed, especially in Europe (Price & Cortis 2000). In addition, our understanding of the knowledge that nurses should possess and how they should acquire the skills to care for ethnic minority patients is at an early stage (Jackson 2007). Previous research has focused mainly on individuals and to a lesser extent on the organizational framework of the work context (Barbee 2001, Hart *et al.* 2003, Culley 2006, O'Byrne & Holmes 2009).

Norway has a population of approximately five million people and it has been ethnically homogenous for a long time. However, its cultural and ethnic diversity has increased greatly in the last four decades. In addition to sizeable immigration from other European countries, the immigrant population from Asia, Africa and South America increased from about 3,500 in 1970 to over 300,000 in 2011 (Ostby 2013). Thus, health and long-term care services need to adapt to the unprecedented growth in older people in the ethnic minority population (Ingebretsen & Nergård 2007). This also applies to home health

care (Government Report No. 49 2004, Government Report No. 6 2013), which is run mostly by the public sector in Norway (Fagerström & Willman 2013).

This article examines the challenges encountered by nurses when caring for ethnic minority patients. We investigated how the established procedures and routines used by community nurses to deal with patients were challenged when they encountered unfamiliar cultural expressions, norms and values. The most significant problems that emerged from our study were related to nurses lacking experience in the expectations of minority patients regarding rehabilitation, intimate daily care and palliative care.

To explore the experiences of nurses, we drew upon Schütz's (1973) insights into the structure of everyday life and the changes in routines that occur when people find themselves in unfamiliar settings, as well as Lipsky's (1980) conceptualization of the structural position of front-line workers who deliver care and welfare services. We suggest that home care nurses experienced feelings of inadequacy when they had to cope with situations for which they had not been adequately prepared. We argue that these feelings of inadequacy are related to wider capacity problems in Norwegian home care institutions, i.e., the universal welfare system promises free care services for all citizens but individual workers are presented with the dilemmas of allocating increasingly scarce resources (Vike 2004). The results of this study are important because the immigrant populations in Norway and Europe are continuing to increase in size and age.

## **Background**

Transcultural nursing (TCN) has dominated the discourse on nursing care for ethnic minority groups in Norway and elsewhere (Debesay 2012). This perspective, which was developed by Leininger, focuses on the "differences and similarities in cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures" (Leininger 1995, p. 4). Several models used in nursing and

other health sciences aim to support the theory and practice of TCN based on the concept of “cultural competencies” (Flowers 2004, Bains 2005). These models tend to place a particular emphasis on the need for health workers to reflect on their own norms and values, thereby facilitating the development of a sensitive, open-minded, empathic and curious approach to cultural diversity (Debesay 2012).

TCN has been criticized for various reasons (for example, see Duffy 2001, Cortis 2003, Narayanasamy & White 2005, Browne & Varcoe 2006). One of the most salient criticisms is that TCN subscribes to an individualistic approach to nursing, which largely ignores overarching structures and the wider socio-political context (Mulholland 1995, O’Byrne & Holmes 2009). According to Mulholland (1995), the individualistic perspective of TCN tends to hold individual health workers responsible for problems that have structural causes beyond their control. This parallels the general criticism of nursing science made by May (1990, 2007) who argued that the patient–caregiver relationship is often characterized as a private matter, which neglects the organizational context and occupational culture of formal care-giving. Thus, the challenges of providing care to patients from ethnic minority groups are often portrayed as primarily ethical questions and nurses are expected to have a professional obligation to address these issues (Donnelly 2000, Maze 2004). The resulting neglect of the broader socio-political and structural context leads to a failure to realize that the health system is oriented primarily towards the ethnic majority population. These systemic failures to facilitate equal access to health care for minorities are not due to the ethical awareness of individual nurses and they cannot be overcome solely by improving knowledge of the cultural characteristics of patients (Blackford 2003).

Thus, an analysis of the experiences of nurses during their encounters with ethnic minority patients needs to take into account the context that regulates their work. Lipsky (1980) offers a general theory of various groups of “street-level bureaucrats” or front-line

workers, which places the dilemmas they face in their daily interactions with clients within a larger framework of institutional constraints. Lipsky suggests that front-line workers, such as community nurses, are confronted with two forms of pressure because of demands from above (e.g., management controlling scarce resources) and from below (e.g., clients or patients with unfathomable needs). The challenges that emerge from this structural position are reinforced by the general unpredictability and lack of control that characterize the tasks involved with this form of service work. Front-line workers also have limited control over the patients with whom they interact and it is common for front-line staff to feel a sense of inadequacy about their work. However, this inadequacy is often due to lingering resource problems in human service organizations, rather than being a consequence of their individual skills or capacities (Lipsky 1980). The institutional constraints under which front-line workers operate have a particular relevance for community nurses because they are amplified in the structural setting of home care (Vike *et al.* 2002).

Front-line workers develop routines and procedures to manage their work-load in response to the complex challenges and resource constraints they often face (Lipsky 1980). Routines can be viewed as patterns of repeated interactions between multiple individuals, which represent thoughts and behaviours. Individuals tend to internalize routines and follow them without major deviations (Becker 2004). According to Schütz & Luckmann (1973), routines represent a stable and credible platform, and we return to them when challenged by new situations so we can draw on experiences that worked in similar situations. Thus, routines have important roles to play in reducing the complexity of our everyday life (Schütz & Luckmann 1973). Furthermore, routines are important characteristics of organizations because they provide stable methods for completing tasks (Berger & Luckmann 1995).



## **The study**

### **Aim**

This study aimed to understand the challenges encountered by community nurses while providing home health care to ethnic minority patients in Norway.

### **Design**

The study used a qualitative design, which was informed by philosophical hermeneutics. One of the significant insights of hermeneutics is that understanding occurs through critical and reflexive interpretation, where one moves back and forth between the whole and its parts until an appropriate meaning emerges (Gadamer 2004). Preliminary conceptions are revised constantly as one acquires more knowledge and a deeper understanding of the subject under study, while keeping in mind one's own prejudices and preconceptions (Debesay *et al.* 2008).

### **Participants**

The participants were 19 community nurses, 17 women and two men. The selection followed a strategy of purposeful sampling (Stake 1995, Silverman & Marvasti 2008) where the aim was to include participants from home health care districts that contained a large proportion of ethnic minority patients. The participants were recruited from four city districts in Oslo, the capital of Norway and its largest city.

### **Data collection**

The study was conducted in March 2008. The data were collected by the first author through semi-structured in-depth interviews, which were audiotaped and transcribed verbatim. The interviews elicited information about how nurses perceived differences or similarities in the way they provided care to ethnic minority patients compared with ethnic Norwegian patients, the situations they found challenging, how they understood the situation for ethnic minority

patients and whether they felt they needed any support or training. Most of the interviews lasted approximately one hour and took place in the participant's work-place.

### **Ethical considerations**

The study was approved by the Norwegian Social Science Data Services before conducting the interviews. Permissions were also obtained from the authorities in all participating city districts. Information letters that outlined the purpose, scope, content, confidentiality clauses and practicalities of the study were provided to all potential participants by the management of the home health care service. Participants were informed that their participation was voluntary and that they could withdraw from the study at any time. All participants signed letters of consent. In this article, pseudonyms are used to replace real names.

### **Data analysis**

The transcribed interviews were coded using NVivo to prepare them for thematic content analysis. The data were organized and analysed, before generating codes and categories by identifying passages in the interviews related to similar subjects or with similar meanings (Miles & Huberman 1994). The categories derived from the data were constructed by continuously switching between reading the individual interviews separately and by reading the data after they were organized into the theme categories in their entirety.

### **Rigour**

All four researchers participated in the data analysis by scrutinizing the data for plausible and less plausible interpretations. They compared all of the interviews to determine whether any patterns emerged, which ensured that all of the eventual interpretations were well supported. The researchers also took a reflexive approach, by discussing their own social roles and the possible impacts of these roles on their interpretations.

## **Findings**

The interviewees ranged from their mid-20s to 60 years old, with an average age of 43 years. Several had extensive experience of working as nurses and community nurses. The two participants with the longest experience had worked in home health care services for 14 and 17 years. The other 17 participants had spent at least one year in home health care services and most had significantly more experience. The majority of participants were white, with traditional Norwegian names. The excerpts presented in this article are the most readable, but the impressions and comments from the rest of the group were also considered in the analysis.

The interviews identified a number of experiences that were considered to be particularly challenging by the community nurses. These included assisting patients with intimate personal activities of daily living, different understandings of activity and rehabilitation, unknown religious practices and different ways of coping with death.

### **Challenges related to intimate care work and religious practices**

The intimate care of minority patients requires that home health care nurses break with their usual knowledge and practices, which are established during their interactions with patients from the ethnic majority population. Fears of mistakes or causing offence when providing intimate care to ethnic minority patients were described as major challenges by most of the participants in this study. It can be difficult to strike a balance between delivering efficient care and respecting the needs of patients because intimacy is a delicate subject in any circumstances, but these challenges are exacerbated when nurses also have to consider unfamiliar cultural and religious practices. The following interview excerpts illustrate the reactions of nurses to such unfamiliar situations.

I know they wear special headgear. They may have a beard too, in which case I may feel uncertain about whether he thinks it's okay that I wash his beard ... How does he really feel about the things I do? [Jorunn]

I know very little about the other side. So, when I visit one that is not of foreign origin, I have some idea about how they want it. However, with those where I do not know the culture ... maybe I might walk right into a trap, by doing something that is completely inappropriate for them. I just go in and say hello ... but should I shake hands? Is it appropriate to greet them by shaking hands? Should I make eye contact? How do they feel about modesty and being undressed, because I am a woman helping a man? Should it have been a man that went to help? Many such things ... [Kari]

These statements exemplify the types of uncertainty that may arise during intimate tasks such as bathing, urinary catheterization and the administering of medications that require the use of rectal suppositories. The participants often worried that they would be crossing the cultural boundaries of patients and described the “discomfort” they observed when patients reacted in a way that suggested the nurses had come “too close”. For example, the nurses considered that touching a patient’s shoulder was a “very natural part” of nursing care but they observed that this behaviour was distressing for some minority patients.

The types of critical situations that emerged from the interviews demonstrated that the nurses lacked experience and knowledge of ethnic minority patients. Their previous experiences appeared to be inconsistent with the expectations of minority patients regarding care and body contact. The uncertainty of the nurses was expressed when they discussed situations that involved many unknowns and the nurses sometimes expressed uneasiness about meeting these patients.

In addition to the boundary issues related to intimacy, the values of patients regarding religious beliefs and practices were particular issues that triggered a sense of insecurity in several nurses. One of the nurses expressed a feeling of insecurity when describing a situation where a female patient was sitting in her home praying with an imam. The nurse’s task was to ensure that the patient received her medications. She recounted how she entered the patient’s

apartment and saw that the patient was being visited by an imam and they had already started to pray. Several other patients were waiting for her help, but she thought it would be difficult to come back at a later time. Thus, she felt it would be necessary to interrupt the prayer to ensure that the patient received her medication. The incident caused her discomfort, which she described as follows.

I understood that I was now trespassing and that I was destroying something. I thought that this was probably not acceptable at all because it was a thing I did not understand. If an imam is present and saying a prayer, it may be totally unacceptable for someone to interrupt, but I don't know. I know that a Norwegian cleric would have found it acceptable and said: "Then we need to take a break". However, I have no idea how an imam might react! [Hilde]

This experience can be interpreted as a situation that leads to insecurity because of the nurse's inability to predict how the patient or the imam might perceive her behaviour. She understood that the prayer ritual was important for the patient but had no previous experience that might help her to assess whether her behaviour would be considered acceptable or rude. She apologized for the interruption and explained to the patient and the imam that she had to perform her work but in the interview she said that the incident had left its mark: "I can't forget this ... that I had to interrupt".

### **Conflicting beliefs about activity and rehabilitation**

Another situation that was considered to be particularly difficult was related to the provision of exercise to maintain or regain physical functions. Based on the latest medical thinking, several nurses were committed to entering the active phase of rehabilitation as soon as possible after a stroke. However, they found that the minority patients and their relatives preferred as little activity as possible during illness and they had little confidence in improving recovery through their own efforts, which was reflected by the following statement.

Some had the idea that their parents shouldn't have to do anything when they have become old enough. For example, when I visited a lady who had a stroke, where we would normally use training to maintain most of her functionality, we found that her walking frame (an assistive walking tool) had been locked in a cupboard in the hallway. This was because it was not meant to be used (laughter). [Jorunn]

This nurse believed that the relatives did not want the older patient to be bothered with such activities and that they would rather see the 70-year-old being "pushed around in a wheelchair". Another participant recounted a similar experience with a Somali family where several people were living together in an apartment. The patient was an older woman who was lying in the living room surrounded by relatives.

There were 11 people in the apartment and there was a grandma who was very sick and lying on a sofa in the living room. I came in and talked to them and it was actually like ... a large extended family. I thought that it must be very noisy for the sick old lady with all those people around, especially all the kids running about. I suggested that perhaps she should move into the room next to the kitchen. Oh no! She didn't want that. She would lie on the couch and be the patient, and that's how they wanted it. [Tordis]

The patient would not agree to be moved to a quieter room, which is what the nurse would have expected with ethnic majority families. She said that she had difficulties imagining how the patient could rest in the middle of the living room, but she explained later that the patient may have wanted to participate socially by remaining in the same room as everyone else.

### **Different ways of coping with dying**

In their encounters with minority patients, the nurses struggled considerably when confronted with different ways of coping with dying. The nurses were used to being open with terminally ill patients about their prospects. When dealing with minority patients in the terminal phase, and their relatives, the nurses reported that they encountered a taboo area and a lack of openness, which they found difficult to deal with.

Let's say, if there is a terminally ill cancer patient who is in need of palliative treatment and you try to get a small insight into that person and ask "What are your thoughts?" ... every time, I'm met with "It is Allah's will". There is no possibility of showing any emotion! [Hilde]

Several nurses recounted that the relatives refrained from talking about dying to give the patient hope of healing and recovery. However, encouraging a dying patient and comforting him or her that they would recover, although in reality they did not have long to live, was an issue that the nurses experienced as challenging because it appeared that they were concealing the truth.

The different approach to death that was expected when dealing with minority patients was described by the nurses as the most challenging to their world-view. This difference was even more apparent in the ways the patients or their families avoided talking about death with children.

There have been a number of situations related to this thing with death, where I have experienced a few things and I thought that they will not come to terms with it. They hope for healing. They will certainly not talk to their kids about it. If they die, it is because Allah wills it, for example. So sometimes it feels a bit tricky, especially if there are small children involved and where for some Norwegians it would be more natural to be more open about it, to talk about it more. [Jorunn]

Many of the participants reported that they had often experienced this lack of openness about death with minority patients. When the older relatives talked about it, for example with children, it was merely to tell them that it was Allah's will if the person died. In the interviews, the nurses said that they would prefer to be more frank about death, particularly with children, because they also felt that a lack of openness would prevent the relatives from coming to terms with death. Overall, the nurses thought that the minority patients approached death in a very different way compared with the ethnic majority patients.

The need for technical aids and devices to make the last hours of dying patients less painful was something else the nurses said they had to reconsider during their encounters with minority patients and their families. When the nurses tried to follow their normal routines in these situations, such as suctioning mucus from the patient's throat to facilitate breathing, the participants said that the families of minority patients often preferred "nature to take its course". In the interviews, the nurses said that, as health professionals, they were trained to "help, help and help", but the families of minority patients told them to stop intervening. They wanted to respect the choices of the patients and their families, but the nurses still felt that they were somehow failing to live up to their own ideals. This dilemma was described by one of the nurses as follows: "It is very hard. It is kind of painful too, because you should certainly pay attention to who [the patient] is. But at the same time you want to try to do a good job".

The nurses' descriptions of their encounters with minority patients indicated that they felt uneasy when faced with unfamiliar ways of coping with illness and death. It seemed that they experienced a dilemma: should they respect the patients' beliefs and values or proceed as usual. Many of these situations could be frustrating because the usual methods employed by the nurses no longer appeared to be adequate solutions when caring for minority patients.

### **Need for cultural competence training**

The interviews identified situations that the nurses experienced as challenging, but most of the participants also expressed the need for opportunities to develop their skills when dealing with a more heterogeneous group of patients. This was evident in the following statements.

I would like to have known a little more about the traditions in other countries in relation to what we do? That we might go to their home and help the patient with a whole body wash. We help with showering, catheterization, suppositories ... so we do come very close to them. [Jane]



We have requested training. We would like to have some form of course about dealing with non-ethnic Norwegian patients. However, I have not been offered any courses yet. I read the newspapers and I watch the news. I try to read different books that deal with other cultures. [Kari]

Another nurse said the following.

I want to learn a lot. For example, it would have been nice to learn about various cultures in general. We could develop a system because I believe that knowledge increases understanding and knowledge is the be-all and end-all. For example, if we had a client who was a Muslim or someone from Eritrea, it would be useful if we could get some information about that culture. I would like to learn a little more about it. I think it would be really smart. [Bente]

It was apparent from the interviews that the nurses had little or no opportunities to update their knowledge or to develop new competencies related to minority patients. The type of training the nurses required was clearly not available in the home care institutions. The interviews indicated that the nurses expected no imminent solution to the situation and that it would not be possible to achieve cultural competence within the existing frameworks of the home care services.

## **Discussion**

Increased immigration demands changes in the routines and procedures of human service organizations to ensure that they continue to meet their overall objectives. Otherwise, a de facto cutback in service provision takes place (Hacker 2004). The uncertainties and concerns that accompany the processes of globalization and international migration resonate with the situations experienced by the nurses in the present study. The nurses had difficulties engaging with ethnic minority patients in the same way as they routinely interacted with ethnic majority patients. Increasing evidence from across Europe shows that these challenges may affect the provision of care (Greenhalgh *et al.* 2007). Our findings are in line those previous

studies in terms of the challenges of intimate (Halligan 2006) and palliative care (Halligan 2006, Skott & Lundgren 2009) for ethnic minority patients, as well as concepts of restoration and rehabilitation (Van Den Brink 2003, Horne *et al.* 2009, Skott & Lundgren 2009). However, although these studies acknowledged the experiences of nurses, they fail to contextualize them within their larger institutional and organizational settings. The everyday disruptions of routines identified in these studies were explained mainly as personal problems that the nurses had to resolve themselves, rather than explained in terms of structural factors (Nairn 2009).

Furthermore, the challenges that nurses face in dealing with ethnic minority patients entail much more than gradual and minor adjustments. Ultimately, their ability to act is at stake when their established routines cease to be adequate. Thus, more than technical or instrumental changes are necessary for nurses dealing with patients who have different perceptions of intimacy, rehabilitation or death. If the underlying standards are challenged, the preparedness of nurses to act is also challenged. The nurses' resulting uncertainty and insecurity in these situations can interrupt their flow of work (Sennett 1998), thereby exacerbating job stress.

The argument developed in this study does not preclude the view that nurses' perceptions of challenges reflect the *social construction* of differences related to prejudice and everyday racism in society (Culley 2006, Racine & Perron 2012). However, we aimed to acknowledge the subjective experiences of nurses, and we analysed how institutional constraints exacerbated their feelings of uneasiness. These feelings are induced largely by structural problems and ultimately may even lead to the categorization of ethnic minority patients as "difficult" patients (Kelly & May 1982, Khalil 2009). Thus, we contend that these challenges and the disruptions to the routines experienced when nurses encounter different

preferences for care from a more heterogeneous patient group might be better explained if we take into account institutional constraints.

Home health care services appear to be poorly adapted to meeting the needs of ethnic minority patients. These needs exacerbate an already demanding working situation. The nurses have little time to come to know their patients, so they must rely on the routines and standards they internalized during their training and previous experience, mainly with ethnic majority patients. These challenges grow greater when they have to deal with ethnic minority groups with whom they are not familiar. The established routines and frameworks they use for coping in their working environments are further challenged. However, no participant suggested that these challenges were insurmountable. Instead, their statements indicate that their encounters with diversity lacked prior institutional adjustments. Although their routines were challenged and their professional orientation was temporarily impaired in some cases, they may in the end comprehend and eventually accept the differences they experience. An alien culture is, in principle, rarely entirely different from a familiar one (Kazmi 1997). Gaining more experience and competence, nurses should be able to meet the needs of different patient groups and develop better routines. However, given that the participants stated that they lacked organizational support and in view of the documented lack of opportunities for the development of skills in Norwegian home care services (Vike *et al.* 2002, Haukelien 2013), the conflicts experienced by community nurses are likely to persist in the foreseeable future.

### **Limitations**

Our study was based on the opinions and information provided by the participants (Creswell 2007). The interviews only gave access to subjective information, i.e., what the participants were able to remember and wanted to share. The critical situations identified in the data are likely to reflect events that had strong effects on the nurses. However, the participants may

have emphasized dramatic experiences disproportionately and given less weight to the similarities between minority and majority patients, as well as situations that did not involve any problems (Maynard-Moody & Musheno 2003).

## **Conclusion**

The theoretical framework used in this study allowed us to be sensitive to the structural constraints that prevailed in home care services, which reflected the work-related challenges experienced by the community nurses. Crucially, the limitations when giving care to minority patients during home health care may reflect more than the inability of individual nurses to provide appropriate care. It is important that institutional changes are made if community nurses are expected to be more receptive to the needs of minority patients. However, routines and standards are essential during front-line work and it is not easy to change them for the benefit of new patient groups. Moreover, the TCN perspective of promoting greater cultural competencies (i.e., sensitivity, open-mindedness, empathy and curiosity about cultural diversity) in individual front-line workers might be insufficient to address the challenges encountered when facing diversity. Instead, community nurses and their organizations need to clarify which of their principles related to the independence, active participation and informed awareness of patients are fixed and which are negotiable. This will allow them to be better prepared for the critical situations that emerge in everyday patient interactions. Otherwise, nurses might be discouraged to invest in efforts to balance their stable routines with necessary changes. The number of older immigrant patients is increasing throughout Europe, so a growing number of home care services will need to address these challenges.

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