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Original Article

A qualitative study of nurses' experiences of self-care counseling in migrant patients with heart failure

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ABSTRACT

Objectives: This study aims to enhance researchers' and nurses' understanding of how to best support migrant patients with heart failure in self-care management. Previous research on self-care in heart failure patients has highlighted its importance, particularly among migrant populations. Nurses play an important role in informing and engaging patients with chronic conditions like heart failure to support their active participation in self-care. However, nurses' experiences of providing self-care counseling to migrant populations with heart failure have not been studied.

Methods: A qualitative study was conducted. Nurses working with migrant patients with HF ($n = 13$) from different types of facility in Western Sweden were interviewed between October and December 2020. Data were collected using semi-structured interviews and analyzed using inductive thematic analysis.

Results: The main theme that emerged from the interviews was the difficulty for nurses "to find balance" in self-care counseling. The nurses during self-care counseling had: "to accept challenges," "to use creative strategies," faced "problems related to health literacy," and "to work according to their (the nurses') obligations." It was evident that nurses faced several challenges in counseling migrants in self-care, including language and cultural barriers, time resource constraints, low levels of health literacy, and experienced disharmony between the law and their professional norms. They perceived building caring relationships with their patients to be crucial to fostering health-promoting self-care processes.

Conclusions: To increase self-care adherence, nurses must become more sensitive to cultural differences and adapt self-care counseling to patients' health literacy. The findings of this research support and challenge nurses in providing the best counsel to migrant patients with heart failure living in Sweden's multi-ethnic society. Policymakers in the health care organization should act to facilitate mutual cultural understanding between all involved partners for patient-safe self-care counseling.

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What is known?

- Effective self-care is paramount in chronic conditions, such as heart failure (HF).
- In general, migrants have poor knowledge of self-care regimens regarding HF.
- There is a need to understand nurses' perspectives to create cost-effective preventive strategies for the care of chronic conditions.

What is new?

- Nurses' experiences of self-care counseling helped identify the obstacles and facilitators associated with providing self-care advice to migrant patients with HF.
- Mapping patients' health literacy before providing self-care advice is essential.
- Getting to know the person with a specific culture behind a patient with HF is crucial to ensuring that migrant patients successfully adhere to self-care practices.

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1. Background

Effective self-care is paramount in the management of chronic conditions such as heart failure (HF), which requires patients to engage in a range of behaviors to manage their condition, e.g. prescribed medication intake, symptom recognition of deterioration, physical activity etc. [1]. Patients with HF who exhibit more effective self-care behaviors have a better quality of life and lower mortality and readmission rates than those engaging in lower levels of self-care [2]. However, despite the obvious relationship between good self-care and positive health outcomes, many patients find it difficult to adhere to self-care advice due to a lack of motivation, ability, or support. To support patients with their self-care management, both sharing of medical and nursing knowledge and recognition of the value of patient's knowledge and experiences are vital [3].

The recent immigration peak and COVID-19 pandemic have posed a challenge to Swedish health care. Sweden had among the most generous asylum laws within European Union until 2016. As a result, immigration increased for several years, reaching 163,000 individuals immigrating into Sweden in 2016 [4]. The health problems that migrants and other people with low socio-economic status in the population struggle with are similar, but migrants have another risk factor, migration. Migration itself does not count as a risk factor for health, but the circumstances of migration are often associated with physical, mental and social health disorders. Therefore, the provision of medical care for refugees and migrants is a novel and major challenge for the health care systems in Europe [5]. Previous studies have shown that beliefs about health and illness differ between migrant Yugoslavian, Arabs and Swedish diabetic individuals [6]. The greater acculturation of migrants to their host country is also associated with an increase in cardiovascular disease (CVD) [7]. Acculturation measure how much cultural change the individual has experienced, and therefore unfavorable outcomes associated with a greater degree of acculturation are attributed to the stressors of cultural change [8]. One study reported that a lack of awareness of CVD risk factors seemed to be higher among migrants [9]. Moreover, heightened CVD risk is associated with low socio-economic status and limited language proficiency [10,11], low income, hypertension, and diabetes mellitus [12]. Thus, the burden of being an elderly migrant with these risk factors increases the risk of a disadvantaged lifestyle between 50% and 80% compared with Swedes [12]. Helgesson et al. [13] argue for the deteriorating factors for migrants in their new host country, especially non-western migrants, as they usually live under inferior socio-economic conditions compared with the host population. They display higher unemployment figures, worse housing conditions and less access to healthcare, which are also the case in Sweden [14]. WHO stresses the importance of intercultural approaches for migrants to improve health care delivery [15].

Given the highly burdensome chronic conditions such as HF in migrant populations [16], nurses play a crucial role in their care: educating patients, supporting individual needs and abilities, and engaging patients in shared decision-making. Spitzer et al. argued that self-care counseling aimed at improving immigrants' well-being must consider their diverse circumstances [17]. Patients' personal characteristics and coping strategies, as well as the emotional and informational support they received from nurses and relatives, affect their self-care strategies [18,19]. A meta-synthesis of 19 qualitative studies on HF patients found that it was essential to consider patients' individual perceptions of HF to successfully facilitate their development of self-management strategies [20].

Sweden's healthcare system relies mainly on sophisticated self-care regimens. The legal act (1982:763; 2014:821) stresses the

importance of patients' participation in their own care. To navigate the system and follow self-care advice, patients must understand how to use the information the system contains, which requires health literacy [21]. Health literacy is a dynamic construct that is both content- and context-specific [22], and limited health literacy is an invisible barrier to self-care counseling [23,24]. In a culturally diverse society like Sweden, nurses are increasingly confronted with the challenge of providing suitable intercultural care to migrant patients. One systematic review identified three major problems in high-income countries in healthcare delivery to migrant populations, all of which were related to cultural context: communication, continuity of care, and clinician's confidence [25].

Previous research has rigorously examined self-care management in migrant HF patient populations [18,26,27]. Thus far, the literature has failed to shed light on nurses' perspectives on intercultural self-care counseling programs for migrant patients with HF. In the era of globalization and increasing migration to Sweden, and in a healthcare system that strives for cost-effective healthcare provision, it is crucial to focus on preventive strategies. The limited number of studies that have addressed this issue reported low levels of knowledge about HF self-management among nurses working with HF patients [28,29]. Knowledge of how best to instruct migrant patients in self-care management to meet their specific needs was scarce, making it difficult for nurses to provide person-centered self-care counseling. Thus, the aim of the present study was to gain an understanding of nurses' experiences of self-care counseling with migrant patients with HF.

2. Method

2.1. Design

A qualitative study was conducted using semi-structured interviews to learn about nurses' experiences in counseling migrant patients with HF in self-care management. The current study used inductive thematic analysis (TA) to identify themes in the nurses' experiences [30]. TA provides a toolkit to build a robust, systematic framework for coding qualitative data to identify patterns across the dataset in relation to the study aim. It also enables co-construction: participants and researchers can collaborate to make meaning out of and interpret experiences while simultaneously maintaining a focus on individual experiences.

2.2. Sampling

A purposive sampling of nurses working in western Sweden was conducted between October 2020 and December 2020. The inclusion criteria were: the nurses with at least two years' professional experience work in a ward/clinic with HF patients, have met migrants and use self-care counseling. Nurses in cardiac clinics were given priority because they work continuously with counseling and follow the patients' self-care process. Nurses with the aforementioned patient experience were chosen to contribute information-rich and varied data because such data yield insights and in-depth understanding rather than empirical generalizations [31].

2.3. Data collection

An email with a description of the study, the type of questions to be asked during the interview, and the participant (nurses) information were sent to ward unit managers in Western Sweden. The unit managers informed ward nurses of the study, provided the researchers' contact details and provided contact information about interested nurses to the researchers. Thereafter, the participants were contacted by email or telephone. The interested

participants were given the opportunity to make any queries before scheduling the interview. Verbal consent was obtained from the participants, and instructions for accessing the Zoom call were provided. Prior to all interviews, the trained female interviewer with no relationship with participants informed the participating nurses of the purpose of the study, and oral verbal consent was obtained to make an audio recording of the interview. The interview started with the following question: “Will you tell me about your experiences of self-care counseling migrant patients with HF?” Probing questions were asked for further clarification (e.g. “What do you mean?”, “Will you elaborate further?”). Silent probes allowed participants to reflect on descriptions. Two pilot interviews were conducted by GSO and MLA, transcribed and discussed among all authors. Interviews were conducted in Swedish and lasted between 45 and 60 min. After each interview, the researchers recorded any noteworthy observations or other thoughts related to the interview or the nurse’s responses.

A total of 13 semi-structured interviews were held, after which data saturation was achieved. The interviews were transcribed verbatim, including pauses, stuttering, expressions of emotion such as laughter, and hesitations such as “uh,” as interest was taken in not only what was said but also how it was said. Two of the authors conducted and transcribed the interviews, and the third double-checked the transcriptions against the audiotaped interviews for any potential biases; no significant biases were noted.

2.4. Ethical considerations

The study was carried out in accordance with the Declaration of Helsinki. All nurses gave verbal informed consent and were informed about guaranteed confidentiality and their right to withdraw without providing any reason. Approval to conduct the study was obtained from the Gothenburg Research Ethics Committee (DNr. 2020-02873).

2.5. Data analysis

An inductive TA was used to explore the nurses’ experiences counseling migrant patients with HF in self-care [30]. TA encourages researchers to use their knowledge to inductively analyze data, maintaining a deliberate stance of curiosity that allows for reflexivity and awareness of preconceptions of the data. This was exercised in the present study through a balance of theoretical knowledge, clinical experience, and data. The authors incorporated the nurses’ individual experiences and the meanings they attached to them.

All three authors read and reread the Swedish transcripts to immerse themselves in the data. In the first stage of analysis, descriptive comments were identified in the interview transcripts, which consisted of the identified key phrases, explanations, and emotional responses.

In the second step, the sections of the text were highlighted, and their content was described in the codes. The focus was on more deeply examining previously highlighted sections of the transcripts and noting frequently repeated words or phrases. The analysis focused on “how” along with “what” in the transcript data, which contributed to understanding the meaning of the nurses’ narratives. During this step, particular attention was paid to pauses, laughter, functional aspects of language, and metaphor use.

The third step represents a more interpretive stage of analysis. Themes were identified and developed by asking questions about meaning, which included “seems” or “may.” These themes demonstrated a coherent and meaningful pattern across the dataset, clustered around a central concept. The sub-themes included nurses’ overarching experiences of counseling. The sub-themes

were intended to be concise but still expressive enough to reflect the original sources from which they had emerged, rather than being represented by abstract codes. The authors looked for connections between the themes within single transcripts and across transcripts. To improve the consistency of the researchers’ analytical procedures, all three authors attended weekly online video meetings to discuss the data analysis process. The authors discussed the themes until a consensus was reached, revisiting the transcripts for accuracy and consistency and raising concerns about data trustworthiness. This was not the last step of data analysis, as it continued throughout the process of writing the findings. After this step, the results and the quotes were translated into English language. [Table 1](#) shows the illustration of the theme development.

2.6. Trustworthiness of the study

Credibility was ensured by establishing a trusting and confidential relationship with participants and through the use of referential adequacy via audio recording [32]. The data analysis has been conducted and described in a precise, consistent and systematic manner. One challenge of conducting this research was that the second and third authors work with this type of counseling in their clinical work. This bias was addressed by the authors’ awareness and mindfulness of their own beliefs, perceptions, and experiences, so they could enrich their interpretations rather than present obstacles to understanding the nurses’ experiences. The authors’ engagement in reflexivity strengthened the adequacy and ethical quality of research. Nurses’ actual names were coded during transcription and in the written notes. The authors’ frequent discussions during the data analysis phase allowed them to compare, question, and probe their analytical insights that strengthened the dependability of the findings. Transferability was ensured by describing the research context and assumptions that were central to the research to enable the reader to assess the findings’ capability of being transferable. Confirmability was ensured by providing rich quotes from the participants to demonstrate that depict each emerging theme represents the participants’ responses.

3. Results

The participants were 13 female nurses aged 35–62 years who had professional experience of 5–38 years, and all were registered nurses (RNs), 3 participants had studied specialization in cardiac care. The nurses worked at the cardiac care unit, HF outpatient clinic, internal medicine, geriatric ward, and primary care. The participating nurses’ ethnicity was Swedish ($n = 11$), Finnish ($n = 1$), and Russian ($n = 1$).

The main theme to emerge from the nurses’ experiences was “To find a balance,” derived from: 1) “To accept challenges,” with a subtheme of “linguistically and culturally related challenges”; 2) “To use creative strategies,” based on the subthemes of “to think outside the box,” “to make use of proven experience,” “adequate use of an interpreter,” “teamwork,” and “building a caring relationship”; 3) “Problems related to health literacy” with the subthemes “patient’s knowledge and responsibility,” and “relatives as an asset”; and 4) “To work according to nurses’ obligations,” with the subtheme “to support the patient in the best way.”

Quotations translated from the transcribed text are provided to confirm and illustrate the findings and richness of data.

3.1. To find a balance (main theme)

There was a consensus among the participating nurses that counseling should optimize patients’ ability to understand and correctly exercise self-care. The nurses adopted a strategy of finding

Table 1
Illustration of the theme development.

Quotes from interviews	Subthemes	Themes
"He and his social support were interested and concentrated during teaching, but understood afterwards that there was a lot of misunderstanding ..." (P 1)	Linguistically related challenges	To accept challenges
"... not everyone is like an open book at the first visit because you have the language barrier ..." (P 3)		
"It was very difficult to activate and convince her to get out of the bed to avoid pneumonia." (P 8)	Culturally related challenges	
"I do not want to talk to a nurse. I want to talk to a doctor." (P 10)		
"They are so grateful for they do not want to be a burden by asking questions." (P 5)		
"Traumatic war experiences make an invisible barrier... have stronger integrity, do not let people in so easily ..." (P 2)	To think outside the box	To use creative strategies
"... so it ended up in that I made a picture of, good morning and good night on the box ..." (P 5)		
"I try as much as possible to prepare the patient. You win in the end if you listen about their actual needs. If the patient does not understand, then you have to find new ways to make them understand by drawing or somehow ..." (P 8)		
"You can't be judgmental when the patient is telling their story about things other than their health; otherwise, the patient stops telling more." (P 2)	To make use of proven experience	
"It's a gut feeling if you have worked for many years, you also see in the eyes and behaviors and understand what patient is talking about" (P 1)		
"Not everyone wants an interpreter... think they have not interpreted what they have said... or they might know each other ..." (P 12)	Adequate use of interpreters	
"It is difficult to move forward in a conversation when it involves three people's views (interpreter, patient & nurse)" (P 13)		
"Especially for the first visit, I always hire a professional interpreter, even if e.g. there are children who accompany their parents, [...] so you know that they understand the given medical information" (P 7)		
"They live with incredible stress... for example, one woman from Syria had so many other issues... I think sometimes do I know what she needs really... she lives in an incredible pressure all the time, so these with her blood pressure or heart worries, they come as a bit (...) secondary." (P 12)	Teamwork	
"It was also about post-traumatic stress disorder after traumatic experiences from home country. This meant that patients could not focus on their own health or information." (P 1)		
"It can be both stresses, financial worries...that overshadow the health which is for me the most important ... I need to work with a psychologist or counselor first to strengthened the patient." (P 4)		
"Before I start talking, I always ask the patient what they have in their heart... Patient sit and think ... it is important that the patient feels involved." (P 6)	Building a caring relationship	
"It's about trying to find the person behind the patient ..." (P 3)		
"Those who do not know the difference between the health center and the emergency room, where to go, what to do ..." (P 5)	Patients knowledge and responsibility	Problems related to health literacy
"Need to help with documents from authorities." (P 11)		
"... Those from overseas countries may have difficulties in understanding organs, how they work and body awareness. Their explanatory model for the symptoms is different." (P 12)		
"I mean a patient has to live with heart failure all his life and needs to understand what symptoms he should be aware of and take appropriate actions." (P 9)		
"Relatives gets the same education as the patient to be able to support ... they should also be able to step in when needed." (P 9)	Relatives as an asset	
"Daughter conveys the message about medication change as the mother did not really have control over her medicines." (P 7)		
"When giving advice, the nurse must make sure that the patient has understood the information. The goal is to get home and be able to manage the system (heart pump) by themselves. How much they can drink, but very difficult when they don't know how much is 1 L." (P 5)	To support the patient in the best way	To work according to nurse's obligations
"Self-care must be adapted according to the patient's level." (P 13)		
"I think you should meet each patient as an individual to meet them for giving information." (P 6)		

balance in self-care counseling by performing their legal, ethical, and professional duties while considering patients' autonomy and health literacy. The nurses' main concern was patient safety and avoiding serious injuries caused by misinterpretation of given advice. They used various strategies to recognize, assess, and respond to patients' needs. The nurses aimed to involve the patients in their own care, but this was not always possible due to several factors described in the themes. Self-care counseling prioritized mainly vital aspects like medication and awareness to the deteriorating symptoms. Although lifestyle advice has a place in self-care management, lifestyle was discussed only if patients brought it up because of time availability and concerns about patient receptivity to the given advice.

3.2. To accept challenges

Nurses faced several challenges in self-care counseling for migrants, including not only language and cultural barriers but also time resource constraints. Self-care counseling was not prioritized in emergency care because of lack of time and uncertainty about the patient's receptivity for mediated information.

3.2.1. Linguistically related challenges

Nurses felt their self-care counseling was limited by patients' limited Swedish language proficiency. The content and details of the advice were determined by the level of care, patient health status, time availability, and the patient receptivity. Nurses strived to get patients to tell their stories, so they could identify the patients' needs and resources, but they were often confronted with misunderstandings due to language barriers. In contrast, some patients had outstanding language skills but lacked disease-specific knowledge of HF, which made it difficult to convey the message about the importance of self-care. Nurses adopted the person-centered care approach, in which listening to the patient's story constitutes the foundation of self-care counseling. This approach was not always helpful, as some patients were grateful for all the help they had received and did not dare to express their preferences or even ask questions.

"He and his social support were interested and concentrated during teaching, but I (nurse) understood afterwards that there was a lot of misunderstanding [...] (P 1) //: "[...] not everyone is like an open book at the first visit because you (migrant patient) have the language barrier [...]" (P 3)

3.2.2. Culturally related challenges

Nurses revealed that culture played a huge role in influencing patients' views of their HF. Some patients believed illness to be the will of a higher power, leading to a more passive attitude to self-care. There was uncertainty concerning how to convince patients that self-care management was crucial. Additionally, the patients' priorities posed a great challenge. For example, one of the nurses expressed the following problem:

“Ramadan [...] religion is more important than taking their medications [...]. I rarely talk about fluid restriction (in summer time), I often talk about drinking a lot, and it is a problem during that period (Ramadan) [...] becomes difficult how to deal with the medical versus the person's desire to live by their religion.” (P 12)

The patients' experiences of the healthcare systems in their home countries affected their belief in Swedish nurses. Some patients questioned the nurses' role at the outpatient clinic. Their lack of trust in the nurses' decision-making was obvious when nurses suggested adjusting medication doses or interpreted blood samples during visits to the nurse-led HF clinics. The nurses described how some patients had opinions about what was included in nurses' tasks. For example, some thought that only physicians should make medication adjustments, which would be an outdated way of working in Swedish outpatient clinics. Patients had difficulty understanding the nurses' status and extended responsibilities based on delegation.

Another challenge faced was the person-centered approach, which relies on mutual understanding and patients' participation in their own care. Migrant patients from some cultures have not experienced any approach other than a hierarchical system. They believed that the nurses must lack knowledge when they tried to involve patients in their own care. Despite being given opportunities to play an equal part in making care decisions, the patients found it difficult to converse with nurses. Patients wanted straightforward and clear messages about their problem and how to treat it. This behavior conforms the principle of compliance (following rule) not concordance (following agreements). Sometimes, patients used defense mechanisms, such as withholding (due to culture); this kind of behavior made it difficult to ensure patients understood the advice they had been given. Such circumstances prevented nurses from understanding patients' life situations and identifying their specific needs. One nurse said, *“They may not want to show what they have understood when they are quick to say yes and want to move on.”* (P 9)

3.3. To use creative strategies

Nurses used various strategies in providing self-care counseling. The counseling focused mainly on identifying worsening symptoms; giving simple instructions for inspecting the body for marks at the waist from tight-fitting trousers, marks from socks' elastic bands, swollen legs, and altered ability to move or lie down flat; explaining the importance of regular weighing and physical activity; and when and how to adjust diuretics. Giving advice about lifestyle modification was not routine for all nurses during every counseling visit, as they had to prioritize issues by importance because of limited time and patients' limited language proficiency.

3.3.1. To think outside the box

Nurses stressed the importance of adapting methods to communicate information to individual patients to help them understand the benefits of self-care. The advice was conveyed orally,

using body language, in writing in their language (if possible), and through digital media called [“www.heart failure matters.org”](http://www.heartfailurematters.org). Nurses sometimes consulted an available colleague to speak in the patient's native language. They used handmade drawings and flow charts to avoid errors in medication intake.

“I ended up drawing how often he should have them, drawing on the list with signs like ‘good morning’ and ‘good night’ that are drawn on each box of the dosing jar.” (P 5)

3.3.2. To make use of proven clinical experience

The most important aspect of self-care counseling was to help patients understand the purpose of self-care management to support and motivate them to engage in it. For some patients, a black-and-white approach was used to demonstrate the consequences of failing to adhere to self-care advice, for example, giving a straightforward message about what would happen if they did not manage self-care, such as a worsening of their condition, readmission, or complications. Patients were offered extra visits or telephone follow-ups when shortcomings in their self-care behavior were identified. Other communication methods used were body language to reinforce the information given verbally involving the accompanying spouse or children. Once the nurses learned what worked for a particular patient, they used a similar strategy during follow-up visits. Some of the nurses used a recurring strategy, in which the patient learned through the “teach-back method,” which means they processed the received information about how or when to use the different strategies. Another strategy used by the nurses was to allow patients a few minutes of silence to reflect on the information given and initiate discussion or ask questions; this provided natural confirmation that the content of the conversation had been meaningful to the patient.

“You have to try [...] to pep the patient like this. They themselves have to figure out that it works; maybe [...] they figure out... they lose the weight, swollenness decreases and breathing becomes less strenuous [...]” (P 11)

During the COVID-19 pandemic, most patients had digital visits. Nurses felt it was important to have physical visits, especially for migrant patients, to enable them to correctly assess and adjust medication doses. It was also difficult to make patients understand the advice given and to assess how much they had understood through virtual or telephone meetings. Problems also occurred when a patient's interpretation indicated that the nurse's expectations for the patient's self-care management would cause a financial burden, which could have a deterrent effect on following the advice given. A recurrent experience among nurses was that personal contact via physical meetings with patients was crucial because these physical visits promoted the use of non-verbal communication, body language, and clinical gaze.

“It is a gut feeling if you have worked for many years, then you also see in the gaze and behaviors how much you have succeeded in passing over the information.” (P 10)

3.3.3. Adequate use of interpreters

Some nurses outlined the problems associated with the use of interpreters. Nurses preferred to use interpreters, but this was also associated with concerns about confidentiality issues, especially when the interpreter was from the patient's own community.

Sometimes, the patients wanted to use a relative as an interpreter, or no interpreter at all, because they considered themselves to have sufficient language skills. The nurses felt that information transfer was insufficient when using a relative as an interpreter. However, the nurses stressed that even using an interpreter did not guarantee that the whole conversation would be interpreted correctly. Verification was not possible because of confidentiality and time limitation issues. When nurses had the choice, they preferred to use a professional interpreter over a patient's relative. Relative-mediated information did not give a true picture of the patient's condition, and there was a greater risk of censored and erroneous interpretation in the conversation:

"[...] the patient does not ask questions back (one-way communication) [...] difficult to determine their understanding; have they understood that has been said or do not want to ask or do not know what to ask because the message has not reached them [...] then they may rely on them (relatives). I get very good information from the patient using the interpreter. I never get it when relatives interpret." (P 13)

According to nurses, to obtain high-quality interpretation, the interpreter should be professional, understand the patient's confidentiality needs, and speak the same dialect. Nurses also used Google Translate as an interpreter, specifically in the ward, as a quick solution in the case of emergency.

The nurses described both positive and negative aspects of using interpreters during counseling. The advantages included better information outcomes about the patient's needs and problems, resulting in a more trusting relationship between the nurse and the patient. The disadvantages included the quality of the interpreter and their medical skills. Reliability could also be an issue between the patient and interpreter. Moreover, engaging in a tripartite conversation could be problematic because everyone has a different view of symptoms and illness, creating a risk of misinterpretation. Using an interpreter was sometimes essential to reach the optimal outcome, but patients' unwillingness to use an in-person interpreter sometimes led to the use of the telephone interpreter to solve the problem. In some cases, it was difficult to convince patients or relatives about the benefits of using a professional interpreter who would provide an opportunity for the patient to talk freely about their problem, making correct medical interpretation easier. However, in spite of the summons letter informing patients that they had to notify the hospital if they needed an interpreter, which would be provided free of charge, some patients either did not realize or communicate their need for an interpreter before the scheduled visits. This might be because of previous negative experiences with interpreters:

"Not everyone wants an interpreter [...] or thinks they have interpreted what they have said [...] know each other in other situations (laughs) [...] or they need a special dialect." (P 13)

It was often a challenging task to find an interpreter with the right dialect and of the sex requested by the patient. The nurses preferred that the interpreter be present in person because this facilitated better interaction, through both verbal and non-verbal communication, for many reasons:

"[...] allow to pause (physical interpreter) [...] With a telephone interpreter, you more often get an interpreter with the right skills [...] but it can also be a problematic... the telephone interpreter may not have the best translation either." (P 12) //:"The phones are not always very good [...] you put on speakers, and then patients cannot hear clearly." (P 6)

3.3.4. Teamwork

One of the reasons identified for poor motivation to engage in self-care in many patients was post-traumatic stress disorder. Remaining traces of previous traumatic experiences affected their ability to focus on their own health and motivation. The nurses used a counselor and psychologist to help patients move forward, process their problems, and make it possible to overcome the crisis. Nurses also mentioned that they had to make appropriate contact to help patients obtain financial support to afford their prescribed medicines. In the nurses' view, the mobile or home care team should be involved in self-care management to remind patients to continue, resulting in improved adherence to self-care.

"The woman from Syria has so many other problems to talk about... she should get residence permit and so on. During the visit time, sometimes it is difficult to get hold on her real problem. She lives in incredible pressure all the time, so her blood pressure or heart problems, they become secondary for her." (P 13)

3.3.5. Building a caring relationship

Building a caring relationship with patients enables nurses to identify and mobilize patients' resources to help them understand the necessary self-care activities and become consistent in practicing those activities. The nurses tried to break the ice by asking migrant patients to tell their stories; this helped nurses identify their needs, problems and resources. A prevalent, recurring experience among the nurses was patients' lack of awareness about the Swedish healthcare system and difficulties navigating it to seek an appropriate level of care in a timely manner. Personal contact with the patients was, therefore, a natural step in building a caring relationships and understanding the patient as a person. Physical meetings were preferred to create a positive atmosphere and facilitate mutual understanding:

"[...] When a patient comes for a physical visit, we take blood pressure, we take ECGs, and we take blood samples. It enables you to use more tools, like your clinical senses, and you get a lot of information only on just being in the same room [...]" (P 7)

3.4. Problems related to health literacy

The data revealed that a patient's ability to understand the self-care advice given depended on their health literacy and knowledge.

3.4.1. Patients' knowledge and responsibility

The nurses noted that migrant patients were a diverse group in terms of knowledge, education, and literacy. Some had not learned any language fully because they had been displaced for a long time. Most patients had difficulty expressing their feelings and needs. It was common during clinical visits for them to ask the nurses to explain letters they had received from authorities. However, for most patients, differing understandings of illness and the human body made it difficult to explain self-care strategies. A lack of understanding of the body's constitution also affected patients' ability to grasp the physiological mechanisms explained to them, even on a simpler level.

"[Those] who come from overseas countries have difficulties in understanding organs and how they work. The body awareness and the explanatory model for symptoms and how they are related are not clear." (P 12)

Patients' poor insight into HF further aggravated their understanding that failure to maintain fluid balance and inconsistency in managing medicine doses would lead to deterioration. Nurses also noticed that patients' attitudes toward physical activity were related to their lack of body knowledge. In particular, many women with migrant backgrounds did not understand the benefits of physical activity outside the home. The migrant patients were found to have a perception of physical activity very different from the recommendations in the national guidelines.

The patient's personal responsibility is considered a crucial component of maintaining self-care. Nurses expressed that HF is a chronic condition and that the patient needed to understand the symptoms of deterioration and how to respond in a timely way to avoid hospitalization. Self-care is a crucial, non-pharmacological part of the treatment for HF; it allows patients to control their own illness and manage everyday life. The patients were advised of the evidence that self-care management can increase patients' well-being, stabilize their condition, and help avoid readmissions.

"[...] Self-care, there are positive gains in the long run [...] it is important that the patient feels involved, [...] the patient must have awareness and meaning of 'why self-care?'" (P 8)

Although self-care counseling was difficult to provide, most nurses felt that patients who understood the importance of self-care and had confidence in their self-efficacy could grasp and follow the advice given. The patients' age, background, education, health knowledge, and socio-economic status affected that ability. Patients with past traumatic experiences, lower education, poor body knowledge, higher age, and lower socio-economic status had difficulties following self-care advice and recommendations. Sometimes, loneliness and isolation from relatives affected the patient's interest in and motivation for self-care, as their own health was not prioritized.

"[...] Relatives have not joined (in the host country)... relatives are stuck on the road, or you do not know what has happened. No one else is here (from the family) then it does not matter if you are ill [...]" (P 6)

3.4.2. Relatives as an asset

All the nurses agreed that relatives were an asset for both the nurse and patient. Thus, it was natural to involve them in the patient's self-care. It was important that relatives understand that they must maintain a balance between providing adequate support and ensuring the patient's independence. Helping relatives understand patients' needs seemed to be helpful in gaining this balance. For elderly patients who needed help with their medication or handling medical equipment and practical help in their daily lives due to impaired cognitive ability or multi-morbidity, it was crucial to involve relatives (usually the children) to manage self-care at home.

"Above all, patients who have heart pumps need relative's support, hence even the relatives get same education [...]. It is important for us to know that a patient has someone nearby to step in when needed." (P 8)

3.5. To work according to nurses' obligations

The nurses were aware of their ethical and legal responsibilities and the importance of patient-safe communication during

counseling. Concepts such as patient safety, integrity, a person-centered approach, autonomy, and the right to equal care were recurrent in the interviews.

To support the patient in the best way

The nurses used diverse methods to provide counseling. One method was "closed loop" communication. Although considered patient safe, it was difficult to ensure its success. Sometimes, prevailing circumstances, such as the patient's legal status, made it difficult to reach out with the advice in spite of the willingness from both sides. However, professional norms strongly influenced nurses' behaviors despite conflicts with laws that limited illegal migrants' rights to access health services. The nurses felt that they had to be the patient's voice in such a situation, so they tried to help them as well as they could. Awareness of a patient's legal situation puts nurses in an ethical dilemma. Nurses addressed such problems partially by ignoring migrants' precarious legal status and continuing their clinical practice.

"Compliance and language deficiency was not a big problem [...] more with laws and regulations [...] then it was medicines [...] then it was the cost issue [...] so then we had to send him medicines [...]" (P 8)

The nurses considered documentation to be one a patient-safety aspect of care. For example, documenting patients' identified resources, needs, problems, knowledge, literacy, language proficiency, and social networks was perceived as valuable in maximizing the effective use of time resources for self-care counseling.

"[...] I went through the whole medical record without finding any notes about his education (he was illiterate) [...]. This is crucial to plan for an advice session." (P 5)

It is the nurse's legal and ethical responsibility to ensure that patients understand the correct medication intake. The nurses in this study realized that one teaching method does not fit all. Counseling was therefore adapted based on the patient's ability to comprehend the advice given. The nurses stated that their conversations with patients were held respectfully, promoting an ethical and non-judgmental approach to make it easier for the patients to understand the information given.

"[...] The goal is to get home and be able to cope with the system (heart pump) [...] The challenge was to explain how much they are allowed to drink, when they may not know how much 0.5 L is." (P 5)

4. Discussion

To our knowledge, this is the first qualitative study exploring nurses' experiences of providing self-care counseling to migrant patients with HF. The nurses' experiences reflected two perspectives: teaching from a nurse's perspective and trying to understand from a patient's perspective. It was evident that nurses faced several challenges in counseling migrants in self-care, including not only language and cultural barriers, but also time constraints, health literacy levels, and disharmony between the law and their professional norms. When providing counseling, creativity is an essential part of building a caring relationship for health-promoting processes.

The findings highlight the profound problems with communication and the impact of culture on self-care management. In a

systematic review, Alassoud et al. [27] confirm the current study's findings that patients from minority ethnic groups hold different beliefs about illness and its treatment. Other research [33] describes how diverse cultural beliefs, language differences, and limited time resources influence health care providers' perceptions of and attitudes toward migrants. Redman [34] addressed this potential disparity between judgment and reality: "Health professionals often saw the patient experience as failures related to noncompliance, and poor health literacy. Patients, on the other hand, focused on economic hardship, and competing demands." (p. 73). Understanding a patient's culture helps nurses choose the most appropriate method of self-care counseling. Leininger [35] describes nursing as a learned scientific, and humanistic profession focused on caring activities in order to assist, support, facilitate, or enable individuals to maintain or regain their health in culturally meaningful ways.

The nurses in this study did not seem to be aware of what part of patients' cultural values would play a role in self-care beliefs. Misunderstandings may arise when a nurse's cultural background differs from the patient's, along with language barriers and a lack of knowledge about the patient's life situation and priorities. Other researchers have confirmed that healthcare providers' own cultural backgrounds shape their experiences and practices [36,37]. Adapting self-care counseling to a patient's cultural background can have a positive impact, although cultural differences could complicate this process [37]. The COVID-19 pandemic has changed the way nurses interact with patients; there is perhaps a higher need than ever before for nurses to know the patient as a person, as they are facing isolation and are unable to see healthcare providers. Hippocrates quote, "It is more important to know what sort of person has a disease than to know what sort of disease a person has." [38]

Culture provides an important context that aids the interpretation of attitudes, values, beliefs, and behaviors and influences how patients interpret and respond to their symptoms [39]. Dickson et al. [18] found in a study from USA that in the Black population, self-care is influenced by cultural beliefs, including the meaning ascribed to HF, and by social norms [1,18,39]. In certain cultures, patients leave decision-making responsibilities to their healthcare providers, who are held in high regard for their positions of authority [33]. Nurses in the current study said that failure to understand a patient's priorities might lead to guide in less effective tools to manage their self-care. Other researchers have found a relationship between self-care management and the patient's priorities [1] and culture [40]. A study comparing self-care behaviors in HF patients from more than 15 countries confirms that patients with HF might rationalize their HF symptoms based on their religious and cultural beliefs [26,41,42]. Priebe et al. [21] reviewed healthcare professionals' experiences in 16 European countries and found that the main problems in providing care to migrant patients included language barriers, traumatic experiences, lack of familiarity with the healthcare system, cultural differences, and different understandings of illness and treatment.

The nurses explained during the interviews that most of the migrant patients, regardless of ethnicity, showed confidence in their ability to implement and sustain self-care, but a major decisive factor was health literacy. A recent review paper highlighted the fact that health literacy is lower in migrants [43]. In another systematic review and meta-analysis, the authors concluded that the prevalence of inadequate health literacy was high in HF patients in general and was associated with an increased risk of hospitalizations [44]. Because health literacy influences patients' decisions, nurses should map patients' health literacy before initiating self-care counseling to achieve the desired outcomes. Moreover, the concept of health literacy must be integrated into nursing

education curricula to raise awareness of this problem. Migrants are less likely to be aware of their HF risk factors and may therefore be less motivated to practice self-care regimens and modify their behavior to prevent negative HF outcomes. An ongoing study in Iran may provide a feasible tool using traffic light color-coding to improve self-care management [45].

Insufficient self-care management perceived by nurses in the current study might be a product of cultural beliefs, ability to self-care, and a lower level of health literacy. Other studies have found a relationship between a low level of acceptance of illness and a low capability for self-care [46] and cultural background [47]. Nurses should have a good understanding of health literacy and cultural differences that could influence patients' conformity to self-care counseling.

Patients with HF generally need individualized advice adapted to their health literacy. Patel et al. [48] studied patients who sought emergency care and found that only 4% could relate their symptoms of deterioration to HF. In spite of the need for in-hospital care, as many as 42% of patients preferred to wait before presenting themselves in hospital [48]. Nurses need to combine their medical knowledge with an understanding of personal factors that influence patients' decision-making processes, such as ethnicity, adaptation to a new country, and socio-economic status [1]. A recent study from Denmark stated that the advice nurses give for cardiac rehabilitation is steered by their knowledge of the patient [49]. Jaarsma et al. [26] emphasized that nurses need to consider migrant patients' experiences, skills, motivation, habits, cultural beliefs and values, functional and cognitive abilities, and confidence to help them successfully adhere to advice about self-care.

The nurses in our study described the importance of adapted skills for communication with patients and that self-care advice works if the patient is motivated and could associate the self-care to their own benefits. The nurses also expressed the need to be creative when providing counseling. Nurses must ensure that self-care advice is understood and valued and that the counseling given is used adequately and in a timely manner. Previous research has found that communication gaps and a lack of health literacy, in addition to language and cultural barriers, influence migrants' ability to grasp information communicated to them [50]. It is nurses' moral responsibility to ensure that patients receive and understand the information essential to the daily management of their disease. Patient education is central to nursing philosophy and practice, and nurses should play a major role in removing barriers to self-care management [34].

In a position statement, Jaarsma et al. [51] stated that self-care is not meant to be synonymous with doing it all by yourself. The nurses in the current study involved the patients' family members but understood that this was not always favorable, as the family's support could be negative if they are over-protective. It is, therefore, even more important that family members be made aware of the value of self-care. Future research should focus on developing more efficient ways of delivering self-care counseling that keeps migrant patients' cultural differences in mind.

Some of the nurses in the current study used the teach-back education method to reinforce self-care advice in the patients. Evidence supports the use of the teach-back method to maximize the disease understanding of people with chronic disease and promote their knowledge, adherence, self-efficacy, and self-care skills [52,53]. Use of the teach-back method, in addition to building caring relationship and providing continuity, can be the key to migrant patients' effective adaptation to self-care management. In a systematic review of qualitative research, Currie et al. [54] observe that nurses' caring approach and responsiveness to patients' individual needs in counseling could positively affect patients' self-care strategies.

4.1. Methodological considerations

The strengths of this study include the use of purposive sampling with a sufficient sample size for the method deployed, which allowed the researchers to gain insight into the experiences of nurses working with migrant patients with HF in everyday clinical practice. Moreover, the study illustrates themes relevant to nurses providing self-care counseling in a Swedish context. The nurses were recruited from different settings to gather data from a broader array of experiences.

4.2. Limitations

We also acknowledge certain limitations. During the interviews, probes might have been missed that could have enabled a broader exploration of certain aspects of the nurses' experiences. It is likely that nurses, out of respect for their patients, did not disclose the full extent of their experiences. The findings generated by this study are based on western Sweden, but they should be generalizable to other settings in which nurses' work independently to provide preventive self-care counseling for migrant patients with HF or other chronic diseases.

5. Conclusion

The findings of this study indicate the importance of mutual understanding to avoid misinterpretations and provide patient-safe self-care counseling. Nurses must become more aware of patients' cultural differences. Many problems could be solved by making it mandatory to learn the language of the host country, which would facilitate good communication. This might not always be possible if a patient is illiterate in his or her own language, to be expected to become fluent in another language. If they have a learning disability or lack time for tasks outside of work, or if they are illegal residents, might be difficult to learn the language.

6. Clinical implications

Successful self-care counseling demands a mapping of patients' health literacy and circumstances. It is only by understanding the meaning migrant patients assign to their ill health that nurses can influence their self-care behavior. More studies are needed to improve nurses' cultural competence and to develop culturally adapted HF self-care strategies. It would also be interesting to follow up on the findings of this study from the patient's perspective by conducting an intervention study to identify successful methods of self-care counseling among migrants with HF. In Sweden, person-centered care is increasingly being implemented within healthcare; in this type of care, it is important to involve patients in their self-care with a decisive mandate that requires a migrant patient to master the Swedish/English language. Moreover, with appropriate training, nurses could better support migrant patients' needs, thus enhancing person-centered care.

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Data availability statement

The dataset supporting the conclusions of this article is not freely available, due to requirements of the ethical approval obtained. However, the authors can be contacted at the addresses shown, by bona fide researchers seeking information.

CRediT authorship contribution statement

Harshida Patel: Design, Data curation, Methodology, Writing – original draft, Writing – review & editing. **Grazyna Szkinc-Olsson:** Design, Data curation, Methodology, Writing – review & editing. **Madeleine Lennartsson Al Liddawi:** Design, Data curation, Methodology, Writing – review & editing.

Declaration of competing interest

The authors have declared no conflict of interest.

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Appendix A. Supplementary data

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