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Research Article

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Correlation between Nurses' Perception of Individualized Care and Xenophobia

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Abstract

Background

The aim of this study is to investigate the relationship between nurses' perception of individualized care and xenophobia.

Methods

The data of this descriptive and cross-sectional study were collected at intensive care unit between December 2019 and March 2020, using the nurse descriptive information form, the nurse version of the individualized care scale, and the xenophobia scale. The sample of the study consisted of 411 nurses working at the specified hospital and agreeing to participate in the study.

Results

The mean age of the nurses was 28.33±5.16 years, and 76.6% of them were in the 18-30 age group. 78.1% of them were at undergraduate education level and their average professional experience was 5.34±4.37 years. 73.0% of the nurses stated that they did not receive training on transcultural care and 77.6% stated that they encounter patients from different cultures every day, and that they had the most difficulty in communication (95.4%) while caring for these patients. The mean score of the scale Individiualized Care Scale A version (ICS-A) was 3.58±0.67, and the mean score of the Individiualized Care Scale B version (ICS-B) was 3.77±0.67. The total mean score of the nurses' xenophobia scale was 47.14±10.04. There was a weak positive correlation between ICS and xenophobia scale mean scores ($p<0.05$). It was found that the education level of the nurses, receiving transcultural care education, wanting to live in another country, preferring to care for foreign patients, and the time they spent in the care of these patients were factors that significantly affected the xenophobia and ICS score averages.

Conclusion

Nurses' perceptions of supporting the individuality of patients and individualizing care were found to be at a good level, but the risk of xenophobia was high. The high risk of xenophobia in nurses was considered as a hindering factor in the individualization of care. The high number of immigrants in the region where the study was conducted reveals the urgent need to meet the training needs of nurses on transcultural care.

Keywords: Nurse, İndividualized Care, Xenophobia, Nursing Care.

1. Introduction

Nursing care is a professional relationship established between the patient and the nurse to protect and improve the individual's health and cure diseases. While standard protocols are utilized in the nursing care given to the individual, the uniqueness of the patient as an individual should not be ignored [1]. In nursing care, it is possible to consider the individual in all dimensions and to plan the interventions specific to the individual by individualizing the care. The concept of individualized care, which has become an important concept in nursing since the 1960s, originated when Florence Nightingale separated nursing from medicine by focusing on the individual rather than the disease [1,2].

When the uniqueness of the patient individual is considered and the patient care to be given is specifically individualized, a quality

care concept can be mentioned [2-4]. Individualized care is defined as providing nursing care in collaboration with the individual and in a respectful manner, taking into account all of the patient's and his/her family's needs, values, cultural backgrounds, and beliefs (3,4). Individualized care develops more as a result of patient-nurse interaction (4). The nurse's long-term care with the patient increases the quality and safety of health care, provides disease management, reduces anxiety, increases patient satisfaction, strengthens the emotional and trust relationship between the patient and the nurse and improves the quality of life. It also has a positive impact on costs through a reduction in the use of health care services [4-6].

In recent years, with the increasing population mobility due to reasons such as employment, a better life and wars, people who have migrated from their own homelands have had to migrate to foreign countries whose language and culture they do not know. Along with positive concepts such as integration, harmony and social integration, negative concepts such as "xenophobia" have come to the forefront with international migration and have started to be discussed extensively on the agenda of the international community [7-9]. Xenophobia is used as "fear or hatred of foreigners, people from different cultures, or strangers", which is formed from the Greek words "xenos" meaning foreigner and "phobos" meaning fear. It is defined as having negative feelings and thoughts towards people from other countries and cultures or being prejudiced against them. It is considered as hostile attitudes arising from individuals within the group positioning those outside the group as a problem in terms of their socioeconomic status, culture, identity and values. Xenophobia is based on the belief relationship between the individual's own identity and social identity [8,9]. In other words, while social identity causes an individual to show favoritism and tolerance towards the group to which the person belongs, it also lays the groundwork for the development of intolerance towards the group to which he/she does not belong [9-11].

It is likely that nurses, who are the most patient-centered of all health care professionals, may be inadequate in dealing with societies whose language, culture, beliefs, and values they do not know when caring for patients from different cultures. Inadequate education and lack of knowledge about different cultures play a major role in this situation [12,13].

It has been observed that studies on xenophobia in nurses are quite limited throughout the world, and studies on xenophobia in Turkey are mostly conducted with nursing and midwifery students. Furthermore, no study has been conducted to determine the impact of nurses' xenophobia/fear on individualized care. The aim of the present study is to determine the relationship between nurses' perceptions of individualized care and xenophobia risk.

2. Methods

2.1 Aim and Design of the Study

The study was planned and conducted as a descriptive and cross-sectional study to determine the relationship between nurses' perceptions of individualized care and xenophobia risk.

Research questions:

1. What is the level of nurses' perception of individualized care?
2. What is the risk of xenophobia of nurses?
3. Is there a correlation between nurses' perceptions of individualized care and xenophobia?

2.2 Location and Time of the Study

The study was conducted in Sanlıurfa Mehmet Akif İnan Training and Research Hospital between December 2019 and March 2020.

2.3 Population and Sample

The nurses working in the stated hospital constituted the population of the study, and 411 nurses, who were working in the hospital between the specified dates and who agreed to participate in the study, developed the sample of the study.

2.4 Ethical Aspects of the Study

Permission for the study was obtained from Hasan Kalyoncu University Health Sciences Non-Interventional Research Ethics Committee with the decision number 2020/003 dated 04.02.2020, as well as written permission from Sanlurfa Mehmet Akif Inan Training and Research Hospital, where the study will be conducted. The nurses who took part in the study were informed that their information would be kept confidential and would not be shared with anyone else, and their written informed consent was obtained.

2.5 Data Collection Tools

2.5.1 Nurse Descriptive Information Form: The form developed by the researchers as a result of the literature review consisted of questions about age, gender, marital status, education level, professional experience, unit of employment, immigration status in the family, having been in another country before, wanting to live in a different country, receiving transcultural care training and willingness to receive training, frequency of encountering patients from different cultures, difficulties they encounter while caring for these patients, and the issues they pay most attention.

2.5.2 Individualized Care Scale-Nurse Version (ICS-Nurse): It was developed by Suhonen et al. in 2000 and revised in 2005 to assess nurses' opinions on individualized care in health care settings [1,14]. The Turkish validity and reliability study of the scale was conducted by Şendir et al. (2010) (Cronbach alpha 0.77 for ICS-A and 0.88 for ICS-B) [15].

In the first part of the scale consisting of two parts, nurses' perceptions of supporting the ICS-A and in the second part of the scale, nurses' perceptions of ICS-B are ev14aluated. In both sections, there are 17 items and 3 subscales consisting of similar positive statements:

- Clinical picture: It includes care behaviors to support the individuality of patients in terms of their responses to the disease, emotions, feelings, and the meaning of the disease for them (7 items).
- Personal life: It includes nurses' caring behaviors to support the individuality of the patient in areas such as habits, activities, preferences, family relationships, and work and hospital experiences that reflect the patient's beliefs and values (4 items).
- Decision-making control: It consists of the care behaviors of nurses to support the individuality of the individual, reflecting the feelings, thoughts and wishes of the patient individuals and enabling them to have a say in their own care and to participate in decisions about their care (6 items).

The scale is a 5-point Likert scale and is scored as 1=strongly disagree; 2=partly disagree; 3=undecided; 4=partly agree; 5=totally agree. The ICS-A and ICS-B scores are calculated by adding the item scores of the subscales and dividing by the number of items, and they are evaluated separately. The average item scores that can be obtained from each section and its subscales are minimum one and maximum five. High scores indicate that nurses have high perceptions of supporting the individuality of patients and individualizing patient care during the nursing actions performed [1,15].

2.6 Xenophobia Scale:

It was developed by Veer et al. (2011) to determine xenophobia [9]. Validity, reliability, and the adaptation of the scale to Turkish culture was conducted by Özmete et al. (2018) [11]. In the Turkish version of the Xenophobia Scale, as in the original, a scoring scale from "strongly disagree (1)" to "strongly agree (6)" was used. The lowest score that can be obtained from the scale is "14", while the highest score is "84". A higher score means an increased risk of xenophobia.

2.7 Implementation of the Study:

In the study, data collection forms were used by the researchers by interviewing the nurses face to face. The implementation of the forms took about 15 minutes.

2.8 Data Analysis:

The data obtained from the study were analyzed using SPSS (Statistical Package for Social Sciences) for Windows Version 22.0 (SPSS Inc. Chicago, IL, USA). Number, percentage, mean ± SD, minimum and maximum values were used in descriptive statistics. Normality analysis was conducted by Shapiro-Wilk Test. Independent Groups t-test and Mann-Whitney U test were used for variables consisting of two groups, and One-Way Analysis of Variance (ANOVA) was used for variables consisting of 3 or more groups to examine the effect of demographic and descriptive data on the scales. The relationship between the mean scores of the scales was analyzed by Pearson correlation analysis. Statistical significance value was accepted as <0.05.

3. Results

Table 1 shows the descriptive characteristics of the nurses. The mean age of the nurses was 28.33±5.16 years, 76.6% were between 18 and 30 years old, 56.2% were female, and 78.1% had undergraduate education. Of the nurses, 67.6% had 1-5 years of professional experience. The majority had no family history of immigration (91.7%), 55.2% had never been abroad, and 58.2% stated that they did not want to live abroad.

Properties	No	%
Age (Mean±SD=28.33±5.16)(Min=18, Max=62)		
18-30 years old	315	76.6
31 years old and over	96	23.4
Gender:		
Female	231	56.2
Male	180	43.8
Marital status		
Married	219	53.3
Single	192	46.7
Educational level		
Postgraduate	21	5.1
Bachelor's degree	321	78.1
Associate degree	36	8.8
High School	33	8.0
Occupational Experience		
1-5 years		278

6-10 years	90	21.9
11 years and over	43	10.5
Department		
Internal Medicine service	89	21.7
Surgical service	174	42.3
Medical Intensive care	102	24.8
Surgical intensive care unit	46	11.2
Immigration Status in the Family		
Yes	34	8.3
No	377	91.7
Presence of a previous stay in another country		
No	268	55.2
Being present for education/ internship	90	21.9
Being present for business/ professional development	32	7.8
Being present for travel/ touristic purposes	21	5.1
Desire to live in a different country		
Yes	239	58.2
No	172	41.8

Table 1. Descriptive Characteristics of the Nurses (n=411)

Table 2 shows the opinions and suggestions of nurses about caring for patients from different cultures. Of the nurses, 73.0% reported that they had received no training in transcultural care, and 77.6% reported that they encountered foreign patients from different cultures on a daily basis. Almost all (95.4%) of the nurses reported communication difficulties while caring for these patients, the majority (79.6%) prioritized privacy, 34.3% spent more time caring for these patients, and 58.4% stated that they did not prefer Turkish or foreign patients.

	n	%
Receiving Transcultural Care Training		
No	300	73.0
During undergraduate education	87	21.2
During in-service training	22	5.3
During postgraduate education	2	0.5
Willingness to Receive Transcultural Care Training		
Yes	191	46.5
No	71	17.3
Doesn't matter	149	36.3
Frequency of Encountering Patients from Different Cultures		
Every day	319	77.6
Once a week	37	9.0
Once or several times a month	55	13.4
Challenges in Caring for Patients from Different Cultures*		
Contact	392	95.4
Problems related to patient relatives	175	42.6
Training	**155**	**37.7**

Customs	139	33.8
Infectious disease	125	30.4
Safety	114	27.7
Treatment/care	86	20.9
Nutrition	59	14.4
Religious beliefs	54	13.1
Health policies	36	8.8
Other	5	1.2
Issues Paid Most Attention to When Caring for Patients from Different Cultures*		
Confidentiality	327	79.6
Cleanliness/hygiene	213	51.8
Empathy	186	45.3
Speech-mimics	177	43.1
Body language	173	42.1
Religious beliefs	160	38.9
Individual care	135	32.8
Customs	126	30.7
Nutrition	68	16.5
Entertainment-social activities	18	4.4
Opinions on Accommodation of Patients from Different Cultures in the Same Room		
Can stay	243	59.1
Should not stay	42	10.2
Doesn’t matter	126	30.7
Time Allocated to Care for Patients from Different Cultures		
Spending more time	141	34.3
Spending less time	89	21.7
Doesn’t matter	181	44.0
Preference to Care for Turkish or Foreign Patients		
Preferring Turkish patients	105	25.5
Preferring foreign patients	66	16.1
Doesn’t matter	240	58.4
*= n is multiplied.		

Table 2. Nurses' Opinions and Experiences on Caring for Patients from Different Cultures (n=411)

Table 3 shows the mean scores of nurses on the ICS-Nurse and xenophobia scale. The mean total score of ICS-A was 3.58±0.67, the mean total score of ICS-B was 3.77±0.67, and the mean total score of xenophobia scale was 47.14±10.04.

	Mean±SD (Min-Max)
ICS-A-Nurse (Supporting Individuality)	3,58±0,67 (1-5)
Clinical picture	3,76±0,73 (1-5)
Personal life	3,14±0,97 (1-5)
Decision-making control	3,68±0,74 (1-5)
ICS-B-Nurse (Individualizing Care)	3,77±0,67 (1-5)
Clinical picture	3,88±0,70 (1-5)
Personal life	3,50±0,87 (1-5)
Decision-making control	3,83±0,74 (1-5)
Xenophobia Scale	47,14±10,04 (13-60)

Table3: Mean Scores of Nurses' ICS-Nurse (A-B) and Xenophobia Scale (n=411)

Table 4 shows the comparison of some descriptive characteristics of the nurses with the mean total scores of the ICS-Nurse (A-B) and xenophobia scale.

In the personal life subscale of ICS-A (supporting individuality), the mean scores of male nurses were higher than those of female nurses and the difference between genders was statistically significant ($p<0.05$). According to the educational level of the nurses, associate degree graduates had lower scores in the clinical situation and decision-making subscales of the ICS-A (supporting individuality), and a statistically significant difference was found between associate degree graduates and undergraduate and high school graduates (Post Hoc: LSD $p<0,05$). The mean xenophobia scale score of associate degree graduates was lower, and there was a statistically significant difference between associate degree graduates and undergraduate and graduate graduates (Post Hoc: LSD $p<0,05$).

According to the unit where the nurses work, nurses working in the medical intensive care unit had a higher score in the personal life subscale of ICS-A (supporting individuality) and a statistically significant difference was found between the nurses working in the medical intensive care unit and the surgical service (Post Hoc: LSD $p<0,05$). There was no statistically significant difference between the other variables in Table 4 and the mean scores of ICS-Nurse (A-B) and xenophobia scale ($p>0.05$).

		Gender:	Age	Marital status	Level of Education	Occupational Experience	Department
ICS-A-Nurse (Supporting Individuality)	t / F	0.909	0.835	0.984	1.124	0.873	1.156
	p	0.660	0.793	0.512	0.263	0.728	0.220
Clinical picture	t / F	1.423	0.718	0.500	2.794	2.993	2.629
	p	0.155	0.488	0.618	0.040	0.051	0.050
Personal life	t / F	-3.036	0.054	-0.348	2.284	0.315	3.539
	p	0.003	0.947	0.728	0.078	0.730	0.015
Decision-making	t / F	0.020	0.501	0.108	3.030	0.367	1.435
	p	0.994	0.606	0.914	0.029	0.693	0.232
ICS-B-Nurse (Individualizing Care)	t / F	0.884	0.815	1.101	1.017	0.810	1.059
	p	0.697	0.810	0.306	0.447	0.818	0.373
Clinical picture	t / F	1.376	0.514	0.018	1.854	0.563	0.583
	p	0.170	0.598	0.986	0.137	0.570	0.626
Personal life	t / F	-1.436	1.257	0.138	0.967	0.753	0.579
	p	0.152	0.286	0.890	0.408	0.472	0.629
Decision-making	t / F	1.627	2.038	0.885	2.005	1.161	1.881
	p	0.105	0.132	0.377	0.113	0.314	0.132
Xenophobia Scale	t / F	1.840	1.600	1.777	2.644	2.227	1.685
	p	0.066	0.203	0.066	0.049	0.109	0.170

Table 4. Comparison of Some Descriptive Characteristics of Nurses and ICS-Nurse (A-B) Xenophobia Scale Total Scores (n=411)

In Table 5, nurses' opinions/experiences about caring for patients from different cultures and the mean total scores of the ICS-Nurse (A-B) and xenophobia scale were compared.

Nurses who received transcultural nursing training during their undergraduate education had higher mean scores on the ICS-A (supporting individuality) clinical status subscale and the xenophobia scale total score than those who received postgraduate education (in-service or postgraduate), and the difference between the groups was found to be statistically significant (Post Hoc: LSD p<0,05). The total and personal life subscale mean scores of the ICS-A (supporting individuality) of the nurses who wanted to receive transcultural care training were lower than the nurses who did not prefer to receive training and there was a statistically significant difference between the groups (p<0.05).

Nurses who preferred to care for Turkish patients had lower mean scores in the total and subscale scores of the ICS-A (promoting individuality) and lower mean scores in the ICS-B (individualizing care) subscale. The mean total score of the xenophobia scale was higher in the same group of nurses. There was a statistically significant difference (p<0.05) between the groups regarding the preference for Turkish or foreign patients.

The mean scores of the ICS-A and ICS-B personal life sub-scale scores of the nurses who stated that the time they allocated in caring for patients from different cultures was not different were higher and the difference between the groups in terms of the duration of care was statistically significant (p<0.05).

		Immigration status in the family	Presence of a previous stay in another country	Receiving transcultural care training	Desire to live in a different country	Frequency of encountering patients from different cultures	Preference to care for Turkish or foreign patients	Time allocated to care for patients from different cultures	Receiving transcultural care training
ICS-A-Nurse (Supporting Individuality)	t / F	1.008	0.679	0.920	0.900	0.999	1.517	1.051	1.663
	p	0.464	0.961	0.640	0.678	0.481	0.014	0.384	0.003
Clinical picture	t / F	0.472	1.420	2.112	0.966	1.058	7.461	0.590	1.827
	p	0.637	0.236	0.045	0.335	0.367	0.001	0.555	0.162
Personal life	t / F	0.766	1.409	0.367	2.187	0.689	9.810	3.386	3.249
	p	0.444	0.209	0.777	0.029	0.559	0.000	0.035	0.040
Decision-making	t / F	0.933	1.044	1.995	1.967	0.661	4.578	0.085	2.088
	p	0.351	0.373	0.114	0.050	0.577	0.011	0.918	0.125
ICS-B-Nurse (Individualizing Care)	t / F	1.129	0.631	1.104	1.101	1.016	1.214	0.877	1.063
	p	0.264	0.976	0.300	0.305	0.450	0.163	0.709	0.366
Clinical picture	t / F	0.522	0.869	1.183	0.259	0.765	3.296	0.212	2.005
	p	0.602	0.457	0.316	0.136	0.514	0.038	0.809	0.136
Personal life	t / F	1.063	0.386	2.117	0.376	1.356	9.834	3.911	2.564
	p	0.289	0.763	0.097	0.172	0.256	0.000	0.021	0.078
Decision-making	t / F	0.503	1.672	1.470	1.770	0.648	6.856	0.781	1.318
	p	0.615	0.172	0.222	0.078	0.585	0.001	0.459	0.269
Xenophobia Scale	t / F	-0.103	0.957	2.872	1.985	0.901	7.182	3.008	0.412
	p	0.918	0.413	0.036	0.048	0.441	0.001	0.051	0.659

Table 5. Comparison of Nurses' Opinions/Experiences Regarding Providing Care to Patients from Different Cultures and Mean Total Scores of ICS-Nurse (A-B) and Xenophobia Scale (n=411)

Table 6 shows the relationship between the mean scores of ICS-Nurse (A-B) and xenophobia scale. A weak positive correlation was found between the mean scores of the ICS-Nurse (A-B) total score and sub-scales (except ICS-A Personal life sub-scale) and the mean total score of the xenophobia scale (p<0.001).

	Xenophobia Scale	
	R	**p**
ICS-A-Nurse (Supporting Individuality)	0.177	0.000
Clinical picture	0.190	0.000
Personal life	0.068	0.167
Decision-making	0.177	0.000
ICS-B-Nurse (Individualizing Care)	0.210	0.000
Clinical picture	0.258	0.000
Personal life	0.144	0.003
Decision-making	0.138	0.005
No	109	(87.2)

Table 6. The Relationship Between the Mean Scores of ICS-Nurse (A-B) and Xenophobia Scale

4. Discussion

The findings obtained from the present study, which was conducted to determine the correlation between nurses' perceptions of individualized care and the risk of xenophobia, are discussed in this section in the light of the literature. According to the findings of the study, nurses' perceptions of individualized care were moderate, and their perceptions of individualizing the patient care (ICS-B) (3.770.67) were higher than their perceptions of supporting the patient's individuality (ICS-A) (3.580.67). In Turkey, Karayurt et al. found that the level of nurses' perception of individualized care and Can and Acaroğlu found that nurses' perceptions of supporting the individuality of the patient (ICS-A) were similar to the results of our study [6,16]. In the study conducted by Charalambous et al. and Suhonen et al. in Finland, it was observed that the mean scores of nurses' individualized care perception were higher than in the present study [17,18]. Suhonen et al. in a study conducted to determine the level of individualized care perceptions of nurses working in different countries and to compare the differences between them, it was observed that nurses' perceptions of individualized care were at a good level, but there were differences between countries. Perceptions of individualized care were found to be lower among nurses working in Turkey, Cyprus, and Portugal than among nurses working in the United States and Greece [19]. It is estimated that differences between countries are influenced by many factors, such as individual and professional characteristics of nurses, working conditions, workload, and differences in the health care systems of the countries.

Idvall et al. evaluated the relationship between sociodemographic characteristics of nurses and individualized care giving and found that educational level and professional experience were important factors [20]. In our study, the scores of nurses with associate degree were found to be significantly lower than those of nurses with bachelor's degree in the clinical situation and decision-making sub-scales of supporting individuality (ICS-A). As a different result, in the current study, it was observed that the duration of professional experience was not a factor affecting nurses' perceptions of individualized care.

In the study of Suhonen et al. it was stated that the department where nurses work is a factor affecting the perception of individualized care. In their study, they found that nurses working in long-term care units had lower perceptions of individualized care [18]. In our study, nurses working in internal intensive care services had a significantly higher personal life sub-scale score of supporting individuality in care (ICS-A) than nurses working in surgical services.It can be said that ICU nurses internalize nursing behaviors to support patients' individuality in terms of beliefs and values, habits, activities, preferences, family ties, and hospital experiences.

In the study, it was determined that the mean total score of the xenophobia scale was 47.14±10.04 and the risk of xenophobia was above the medium level. In Turkey, studies on xenophobia were mostly conducted with nursing and midwifery students, and no studies on xenophobia in nurses were found. In the study of Durat and Tarsuslu's investigating the relationship between cultural sensitivities of nursing and midwifery students and xenophobia, xenophobia scores were in parallel with the results of the current study (median=47 in nursing students and median=45 in midwifery students) [14]. Kahraman et al. used a different measurement tool to assess xenophobia in midwifery students and found similar results [21]. Güngör et al. investigated the relationship between intercultural effectiveness and awareness of nursing and health vocational school students and xenophobia and showed that the increase in the number of immigrants in the country and the prolongation of their stay increased the tendency of xenophobia caused by future anxiety, especially in young university students [22]. It is clear that studies on xenophobia in nurses around the world are quite limited, with most being conducted in African countries, and qualitative and review studies predominating. There is a need for studies that assess the risk of xenophobia in nurses using valid and reliable measures and that demonstrate the effectiveness of interventions to reduce the risk.

It is likely that nurses, who are the health professionals who have the most contact with patients in health institutions, may

be inadequate against individuals and families whose language, culture, beliefs, and values they do not know while caring for patients from different cultures. Lack of adequate training and lack of knowledge about different cultures have a high share in this regard [10-12]. In the current study, the majority of nurses (73%) stated that they did not receive transcultural training, while about half (46.5%) stated that they would like to receive training. Şanlıurfa province, where the study was conducted, ranks fourth in Turkey in terms of the number of Syrian immigrants [14]. As a natural consequence, the number of immigrants receiving health services is high. In our study, the fact that the majority of nurses (77.6%) encountered patients from different cultures every day was effective in their desire to receive training in transcultural nursing. As a result, nurses who received transcultural care training during their undergraduate education had a significantly higher risk of xenophobia than nurses who received this training after graduation (in-service or postgraduate education). This indicates that transcultural nursing education should continue with postgraduate training. The significantly higher risk of xenophobia in nurses who prefer to care for Turkish patients may be due to their lack of education and feeling inadequate when caring for patients from different cultures.

In the present study, nurses reported that they had the most difficulty in communication (95.4%) while caring for foreign patients. In our study, despite frequent encounters with patients from different cultures, communication difficulties, and lack of transcultural training, nurses' paying attention to patient privacy while caring for foreign patients (79.6%), not discriminating between Turkish and foreign patients (58.4%) and allocating equal and/or more time for care (78.3%) indicate that they are committed to professional values and sensitive to cultural differences.

In the study, the mean scores of nurses who received transcultural care training during their undergraduate education were found to be significantly lower than nurses who received postgraduate education. These results support the need for postgraduate transcultural nursing education to enhance the individual nursing perceptions of nurses caring for patients from different cultures. It was found that the individualized care (A-B) perceptions of nurses who did not discriminate between Turkish and foreign patients in their care giving preferences and who stated that the time they allocated to care for patients from different cultures was not different were significantly higher.

As the main result of our study, a weak positive correlation was found between the mean scores of nurses' perception of individualized care and the mean total score of xenophobia scale ($p<0.001$). The higher the nurses' perception of individualized care, the higher the risk of xenophobia. In other words, as the risk of xenophobia increases, the perception of individualized care increases. There is no study in the literature examining the relationship between nurses' perceptions of individualized care and xenophobia risk. As a partially related result, Charalambous et al. reported that nurses' cultural sensitivity was an effective factor in individualized care [17]. It is considered that there is a need for further studies on this issue.

Conclusion

The current study found nurses' perceptions of individualized care to be moderate and the risk of xenophobic attitudes to be above moderate. A weak positive correlation was found between the mean scores of nurses' perception of individualized care and the mean total score of xenophobia scale. According to the results of the study, it is recommended to

- Provide transcultural care and individualized care trainings to nurses before and after graduation,
- Conduct studies that assess the risk of xenophobia in nurses using valid and reliable measurement tools and reveal the effectiveness of interventions to reduce the risk,
- Conduct studies examining the relationship between nurses' perceptions of individualized care and xenophobia risk.

Lıst of Abbreviations

• ICS-A : Individualized Care Scale- Patient's perceptions of supporting their individuality.
• ICS-B : Individualized Care Scale- Perceptions of individualizing the care of patients.

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