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ORIGINAL ARTICLE

Nurses' experiences of emergency care for undocumented migrants who travel by boats

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Abstract

Aim: The aim of our study is to describe and understand the experiences of nurses providing emergency care to undocumented migrants who arrive in Spain in small boats.
Background: Spain receives thousands of undocumented migrants every year who arrive by sea. Provision of appropriate emergency care to undocumented migrants is a public health problem.
Introduction: Nurses, along with other health care providers, such as doctors or cultural mediators, make up the Spanish Red Cross Emergency Response Team. Nurses, in particular, are associated with all phases of emergency care to undocumented migrants who arrive in small boats, offering first aid as well as clinical and humanitarian care.
Methods: Qualitative descriptive study. Seventeen nurses from the Spanish Red Cross Emergency Response Team participated in face-to-face interviews. Thematic analysis was used to analyse the qualitative data.
Findings: Three main themes emerged: (i) guaranteeing comprehensive emergency care, (ii) the nurse, the key member of the multidisciplinary care team for undocumented migrants and (iii) 'making a difference', volunteering as a nurse's role.
Conclusions: Nurses try to guarantee comprehensive care provision for undocumented migrants, even though they face stigma, ethical concerns or an impossibility to prescribe pharmacological treatments. Personalised care, more time and protocols, better training and the incorporation of debriefing are elements that are required to improve the emergency care given to undocumented migrants.
Implications for nursing and health policy: Institutions must develop policies to support provsion of emergency care to undocumented migrants. A public health issue cannot depend upon volunteer healthcare providers. Governments must guarantee funding, training and established care teams. Understanding nurses' experiences could increase awareness of the problem, reduce stigma and improve the comprehensive emergency care provided to undocumented migrants.

KEYWORDS
Emergency care, health policy, nurses, nursing policy, qualitative research, Spain, undocumented migrants, stigma

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INTRODUCTION

The arrival of undocumented migrants (UMs) in the European Union (EU) is a political, social and public health challenge (Puchner et al., 2018). Spain, along with Greece and Italy, receives thousands of UMs, every year, who cross the Mediterranean Sea in small boats (Fotaki, 2019). Since 2002, a formal collaboration between the Spanish Red Cross and the Spanish Government has led to assistance in migrant arrivals (WHO, 2018). After being rescued from sea, the UMs are taken to the port where emergency care is given by the Spanish Red Cross (López-Domene et al., 2019). With the aid of the maritime rescue team, the police or cultural mediators, emergency care is delivered by healthcare providers. Emergency care for UMs includes triage, first aid and diagnosis of pathologies, sexual violence or human trafficking (Jiménez-Lasserrotte et al., 2020). Currently, 25 nurses are part of the Spanish Red Cross Emergency Care Team in Almeria that assists UMs during disembarkation, medical attention at the port, and in ambulances when taken to hospitals or detention centres. Therefore, understanding their experiences related to emergency care provision to UMs, who arrive by small boats, could improve the quality of care given to this risk group.

BACKGROUND

Migration is a global priority, affecting more than 250 million people. In addition to sociopolitical and economic problems, migration is one of the significant determining factors in the health of migrants and host communities (Kassam et al., 2020). It is a political and social challenge that needs a response. The EU receives almost a third of migrants worldwide. In 2020, approximately 125,000 UMs crossed the EU borders, and more than 85,000 did so by sea (EC, 2020). UMs do not possess documents, residency permits or refugee status (De vito et al., 2015; Sesti et al., 2019). Although the United Nations 2030 Agenda for Sustainable Development supports respecting the human rights of migrants and refugees (Chiesa et al., 2019), there continues to be barriers to accessing countries and health systems. In 2020, 41,094 UMs arrived in Spain, 96.2% by sea. They came from various destinations: Algeria (39.5%), Morocco (20.3%), Mali (12.6%), Guinea (7.6%), Ivory Coast (6.6%), Senegal (4.8%) amongst others (8.6%) (UNHCR, 2020). UMs are a high-risk group; despite the majority being men, almost 20% are women and children. UMs risk their lives crossing the Mediterranean Sea in small boats that transport 40–50 people, resulting in more than 2,000 deaths in 2018 and 1,319 in 2019 (Kovras & Robins, 2016; SG, 2020). The Spanish Red Cross Emergency Response Team, made up of doctors, nurses, volunteers and cultural mediators, provides care to migrants. UMs are often affected by chronic diseases, malnutrition, parasitosis, sexual violence and human trafficking (Jiménez-Lasserrotte et al., 2019), as well as dehydration, burns, injuries, myalgias, infectious diseases and urinary retention (Eonomopoulou et al., 2016). After being rescued, the emergency care team provides liquids, food, thermal blankets (De Bono, 2018) and first aid. They also diagnose and treat minor illnesses, and screen for infectious diseases (López-Domene et al., 2019).

Nurses are in a good position to provide care and satisfy the needs of UMs (ICN, 2015) by performing triage, providing first aid, healing wounds and contributing to their physical and mental wellbeing (Ponce-Blandón et al., 2020). UMs with life-threatening conditions are transferred to the hospital to be cared for by specialists in emergency or critical care (Harrison & Daker-White, 2019). Although there are epidemiological (Eonomopoulou et al., 2016; Ponce-Blandón et al., 2020), demographic (Kadir et al., 2019) and cultural studies focused on UMs (Granero-Molina et al., 2019), little is known about nurses' experiences related to the emergency care provision to UMs who arrive in small boats (López-Domene et al., 2019). Understanding nurses' perspectives could inform health systems with the aim of developing policies to facilitate provision of equitable care to UMs (Kassam et al., 2020).

AIM

The purpose of this study is to explore and describe nurses' experiences relating to emergency care provision to UMs who arrive in Spain via small boats.

METHOD

Study design

A qualitative descriptive study was used. This naturalistic approach enables the direct description of little-known phenomena during a specific time and context. Qualitative descriptive study allowed the nurses' experiences to be explored through a not so theoretical analysis, attached to data and using their own words (Kim et al., 2017). This study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al, 2007).

Sample and recruitment

By contacting the management of the Spanish Red Cross, obtaining permission and using purposive sampling, nurses from the Spanish Red Cross Emergency Response Team were selected (Table 1). The inclusion criteria were: being a nurse with at least one year experience of providing emergency care to UMs, speaking Spanish and providing informed consent. The exclusion criteria were: refusing to participate in the study and having less than one year of experience. Of the 21 nurses who were selected, four refused to participate in the study due to work commitments or lack of time. A total of 17 nurses from the Red Cross Emergency Care Team in Almeria were interviewed (Table 1). The study took place between December 2019 and May 2020, and interviews were conducted in a classroom at the Red Cross.

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TABLE 1 Demographic characteristics of nurses interviewees ($n = 17$)

Participant	Age	Sex	Marital status	Children	Organ	Years' experience
NIDI1	31	Woman	Married	No	Red Cross/AHS	10
NIDI2	29	Woman	Single	No	Red Cross/AHS	8
NIDI3	33	Woman	Married	Yes	Red Cross/AHS	12
NIDI4	35	Woman	Single	Yes	Red Cross/AHS	12
NIDI5	33	Woman	Single	No	Red Cross/CV	7
NIDI6	25	Woman	Single	No	Red Cross	3
NIDI7	27	Woman	Single	No	Red Cross/AHS	6
NIDI8	23	Woman	Single	No	Red Cross/AHS	2
NIDI9	29	Woman	Single	No	Red Cross/AHS	9
NIDI10	38	Man	Married	Yes	Red Cross	16
NIDI11	24	Man	Single	No	Red Cross/AHS	3
NIDI12	36	Woman	Married	Yes	Red Cross	15
NIDI13	35	Woman	Single	No	Red Cross/AHS	12
NIDI14	40	Woman	Single	No	Red Cross	18
NIDI15	39	Woman	Married	Yes	Red Cross	15
NIDI16	32	Man	Single	No	Red Cross/AHS	4
NIDI17	60	Woman	Married	Yes	Red Cross/AHS	11

NIDI = Nurse in-depth interview. AHS = Andalusian Health Service. CV = Civil Protection.

TABLE 2 Interview protocol

Stage	Subject	Content/possible questions
Introduction	Motives, reasons	Learn about their experiences of emergency care provision to undocumented migrants arriving in small boats.
	Ethical issues	Inform about volunteering, recording, consent, possibility to withdraw, confidentiality.
Beginning	Introductory question	Tell me about your experience of emergency care provision to UMs.
Development	Conversation guide	How has it affected your personal and professional life? ***Explain the gaps in the care for UMs in the different phases of emergency care. ***How can we improve care for UMs?
Closing	Final question	Is there anything else you would like to tell me?
	Appreciation	Thank them for their participation, remind them that their interview will be of great use, and place ourselves at their disposition.

UMs = Undocumented Migrants.

Data collection

Researchers telephoned the participants who fulfilled the inclusion criteria. They explained the objectives and obtained voluntary consent to participate in the study. Two researchers with five years of experience providing emergency care to UMs took part in in-depth interviews following the interview protocol (Table 2). Researchers had a master's degree, qualitative research training and did not require additional training. Each participant participated in one individual and private interview which lasted 63 minutes on average. Prior to the interview, sociodemographic data were collected and participants signed informed consent forms. The interviews were conducted in Almeria, in Spanish, audio recorded, transcribed and analysed by three researchers. Data analysis was carried out using ATLAS.ti.8, a specific software used to organise, analyse and interpret information in qualitative research. Data collection ended when data saturation was reached.

Data analysis

Thematic analysis (Braun & Clarke, 2006), suitable for qualitative description methodology was used following these steps: (1) familiarisation with data: transcription, reading and re-reading of data, and taking note of initial ideas; (2) generation of initial codes: systematic coding of data groups; (3) search for themes: conversion of codes to themes; (4) revision of themes: verify that the codes and themes match; (5) definition/designation of themes: analysing and fine-tuning the details of each theme; (6) elaboration of the report: select examples of themes and subthemes, relate the analysis to the research questions and generate a final report.

Rigour

Strategies based on the criteria of Guba and Lincoln (1994) were used. Credibility: researchers were familiar with the situation and conducted indepth interviews with the participants. The researchers have a long history researching

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TABLE 3 Themes, subthemes and units of meaning

Theme	Subtheme	Units of meaning
1. Guaranteeing comprehensive emergency care	1.1 The nurses' assessment: clinical/humanitarian triage	Triage, communication, nurses' assessment, women/children, time and pathology.
	1.2 Satisfying basic health needs	Teamwork, satisfying needs, sexual violence and psychological problems.
2. The nurse, the key member of the multidisciplinary care team for UMs	2.1 Coordinating action of the multidisciplinary team	Comradery, multidisciplinary team, different priorities, mediators, coordination of the maritime rescue team and police.
	2.2 Guaranteeing continuity of care	Accompanying, administrative problems with hospital transfers, police custody, psychological problems and stigma.
3. 'Making a difference', volunteering as a nurse's role	3.1 A misunderstood social commitment	Difficult experiences, social stigma, security–health clash, professional discrimination and society's rejection.
	3.2 An opportunity for personal and professional growth	Commitment, change in life perspective, feeling useful, professional challenge and moral dilemma.
	3.3 Aspects for improvement in emergency care to UMs	Individualised care, clinical training, languages, time, culture, police training, debriefing, mental health, protocols and gender identity.

UMs = Undocumented Migrants.

UMs. Researcher triangulation was used for decisions regarding coding, analysis and data interpretation. Transferability: detailed descriptions of participants' experiences, contexts and behaviours were provided. To ensure dependability and confirmability, detailed descriptions of each step of the investigation were made, along with an audit trail of transcripts, categories and coding memoranda. An outside researcher with more than five years of experience in UM emergency care reviewed the findings. The authors developed a reflective journal on how their values and preconceptions could affect research decisions in each phase of the study.

Ethical considerations

The Spanish Red Cross Ethics and Research Committee granted approval (grant number: CR-20-01). Before starting the study, written informed consent and permission to record the interviews were obtained. One researcher was a volunteer of the Spanish Red Cross. Researchers declared that there was no conflict of interest.

FINDINGS

All participants identified themselves as nurses; 82.3% were women and 17.8% men, 64.7% were single and 35.3% married. The mean age of the participants was 33.5 years (SD = 4.7). The average amount of experience in providing emergency care to UMs was 10.9 years. Three themes and six subthemes emerged from inductive data analysis (Table 3).

Guaranteeing comprehensive emergency care

This theme describes nurses' experiences related to the provision of emergency care and needs assessment of UMs. Nurses, in addition to their knowledge and abilities, were able to satisfy needs and provide appropriate care. Emergency care provision involved not only clinical services but also an understanding of the UMs' lives.

The nurses' assessment: clinical/humanitarian triage

Nurses' participation in emergency care for UMs is important because it enables the assessment, diagnosis and treatment of health problems. The multidisciplinary team began working the moment UMs were rescued from sea. Nurses were present at disembarkation and prioritised emergencies according to health status. After, UMs were taken to care units where nurses performed triage, first aid and transferred those with serious cases to the hospital in an advanced life support ambulance. One participant described the nursing assessment as follows:

> *The UMs are notably exhausted upon arrival, staggering, hypothermic, and pallid. We have a detailed and accurate triage document, but the first impression is visual.* (NIDI10)

Emergency care teams have care protocols in place. Firstly, three lines of triage were implemented in which UMs were separated depending on whether they had a minor problem or serious disease. Triage was swift for acute conditions, wounds, burns or trauma, followed by chronic pathologies such as diabetes, asthma or tuberculosis and then psychological, humanitarian or social issues. UMs arrived feeling exhausted and disorientated, and did not understand the information given. Nurses needed to gain their trust to be able to perform a valuable assessment, detect problems and find solutions.

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Some of them tell us everything while others hide their age, origin or clinical history. They arrive in an unknown place and are faced with questions from police, nurses… (NIDI4)

Pathologies included skin disease, mycosis or vaginal candidiasis; parasitic diseases such as scabies; trauma, hematomas, cephalgia or burns. Nurses evaluated symptoms including coughing, itching or respiratory difficulties; they recorded their temperature, examined allergies, vomiting, diarrhoea or whether they took medicine. When disease was suspected, they performed a physical examination and recorded vital signs. If the doctor was not present, emergency care was provided by nurses, although they could not prescribe drugs.

Without a doctor's prescription, there's no medicine. If a patient is vomiting you cannot administer Primperan©, you can't prescribe anything and you feel impotent. (NIDI4)

In the case of women, they received a gynaecological assessment related to sexual and reproductive health in which they were asked for their last period and/or a pregnancy test was carried out. Pregnant women were asked about previous pregnancies, miscarriages or their week of pregnancy; if they presented bleeding or trauma, they were taken to the hospital for an ultrasound scan. As for children, they were examined for vaccination coverage, fever or malnutrition. Care for women and children was prioritised due to their vulnerable health, and rape or trafficking victims were identified. As one participant stated, the evaluation was long and they did not have much time.

The team deals with clinical, social and emotional problems…but there's no time. In two hours, you can't assist sixty UMs. You have to prioritise. (NIDI11)

Problems UMs faced varied depending on their place of origin. Sub-Saharan Africans endured a long trip with poor conditions related to hygiene, food provision and health. They were grateful and willing to collaborate as they suffered from unknown chronic diseases (hypertension, heart problems), infectious diseases (tuberculosis) or parasitic diseases (scabies, lice). Algerians and Moroccans arrived with treated chronic conditions (asthma, diabetes). According to nurses, cultural customs could impede emergency care.

Moroccan women are very modest, they don't want to get naked nor be examined by a man, whereas Nigerian women don't mind. (NIDI2)

Satisfying basic health needs

The multidisciplinary team tried to provide comprehensive care to UMs. Whilst a doctor was not always available, a nurse was always present. Each member had their purpose but they all worked together as a team.

It's a team, it doesn't matter if you are a doctor, nurse, or mediator. If you have finished your duties, you help the other by providing dry clothes, handing out sandwiches… (NIDI15).

Nurses handed out food, blankets, took UMs to the bathroom, helped them move around, applied ointment or wrapped sprains. They also evaluated signs of abuse, sexual abuse or female genital mutilation, and took them to the hospital for a gynaecological examination. As one participant said, they sometimes faced problems with the health care providers:

She's just arrived by a small boat, she's pregnant, wanting to know how her baby is. Even if it isn't an emergency, you have to evaluate the mother and fetus. Some gynaecologists at the hospital did not consider the transfer necessary, and arguments arose. (NIDI1)

Given that female UMs felt embarrassed and scared, time and privacy were needed to detect signs of sexual violence or unwanted pregnancies. Newborns' umbilical cords were checked and breastfed babies were given a general assessment that included an evaluation of their skin, respiratory function and vaccination history. On top of colds, hypothermia and dehydration, the children were frightened. '*You see that they draw a boat, a huge fish… representing the fear they felt at sea*' (NIDI9). Nurses explained that some UM mothers took the journey just so that their child's conditions could be treated.

I've seen severe umbilical hernias on girls as well as eye conditions that are not operated on in Africa. Some mothers migrate in search of surgery. (NIDI17)

UMs, especially sub-Saharan Africans, had psychological problems that were hardly assessed in emergency care due to a lack of time. For nurses, it is key to recognise non-verbal signs such as certain looks, perceived sadness or fear as this trauma could result in anxiety or depression later on.

The nurse, the key member of the multidisciplinary care team for UMs

This theme addresses nurses' experiences, their work as emergency care team members for UMs or the coordination with different institutions.

Coordinating action of the multidisciplinary team

Nurses emphasised the work of the Red Cross Team comprising very dedicated volunteers. Although they assist UMs

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who have had difficult experiences (deaths, rape etc.), team members support each other psychologically, giving them the strength to continue.

> *Volunteers come because they want to…and you can tell. There is a real sense of comradery and support. You see doctors collecting material, nurses taking rubbish out…* (NIDI15)

The police and maritime rescue service are not voluntary, they fulfil duties of their job and this is notable. Each part of the team prioritised their objectives (health, social, humanitarian), and it was difficult to combine them. It generated incompatibility between health management and police custody; there are protocols in place, but full coordination was not achieved. For police, the priority was safety, ensuring that UMs were detained and unable to escape or hurt themselves, whereas for nurses, UMs needed to be provided with fluids, food and warmth. Transferring UMs to the hospital required both nurse and police but if the police were unavailable, they could not do so, thus delaying diagnosis and treatment.

> *For nurses, the most important thing is detecting pre-existing health conditions or vulnerability and attending to their basic needs. You cannot delay an emergency because you have to convince the police to transfer them.* (NIDI17)

The role of cultural mediators was key in providing emergency care to UMs. Almost all of them spoke French, English, Arabic and some dialects. For nurses, mediators were essential; as they spoke the language and understood UMs' culture, which facilitated communication and thus the clinical assessment.

> *Without mediators I couldn't work. You need to know how they injured themselves or whether they take medication. It's not just translating but also giving them a warm welcome. The UMs appreciate it.* (NIDI7)

If multidisciplinary meetings were held every 2–3 months, this would help to improve coordination. It would allow nurses to share their views about new problems they face and how to implement solutions.

> *Every institution has a role; we need multidisciplinary team meetings to resolve differences and hierarchical issues… this would enable personal and professional growth, thus resulting in improved care provision.* (NIDI15)

Guaranteeing continuity of care

After receiving emergency care, UMs could be transferred to hospital units for diagnosis or specialised treatment. Later, they were in police custody (72 hours maximum) before being released and sent to humanitarian care centres or migrant detention centres for deportation. The continuity of care is fundamental for pharmacological treatment, wound dressing or monitoring vital signs. Nurses took UMs to the hospital, accompanied them to specialists and police quarters and consolidated the information, which then became available to other entities.

> *We took a UM with cancer to the hospital. I accompanied him to diagnostic tests, painkillers were prescribed. All of this had to be explained to the holding centre later.* (NIDI14)

There can be a language barrier in the hospital (UMs speak Arabic, French, English etc.). The nurse and cultural mediators who attended to UMs since the disembarkation accompanied them to the hospital, identified their problems and could explain it to a healthcare provider: *'They've come for this reason, these are their symptoms, this hurts them…'* (NIDI1). Although hospital doctors may disapprove of transferring UMs because they do not consider their problems urgent, the nurse could explain their reasoning.

> *If they need an antibiotic/painkiller because they have cavities, infection or pain, I know it isn't urgent but I can't prescribe anything… there's no other solution. If it's a pregnant woman…it could be the only medical examination she'll have.* (NIDI3)

Regarding other professionals, nurses also observed a lack of compassion or administrative obstacles. Their counterparts asked for documents and extensive data relating to UMs that they simply did not have, which considerably delayed the provision of health care.

> *They don't understand that UMs arrive without documents. When admitted to the hospital they ask you for data that we don't have… we do what we can.* (NIDI16)

When UMs needed treatment for various days it was essential to coordinate with the police, who were responsible for attending to them when they were in custody. Nurses affirmed that the continuity of care was not ensured.

> *We give the police the UMs' data and report, the number of their identification tag as well as medical treatment. We explain how to administer it, the frequency, and time… but they are policemen, not nurses!* (NIDI4)

Following police custody, women and children were transferred to humanitarian centres run by the Red Cross or another non-governmental organisation. According to nurses, continuity of care was yet again not guaranteed. Even though

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clinical documentation, treatment paperwork and care plans were handed in, there was a lack of coordination. They sometimes forgot to deliver UMs' health reports when they were released and on other occasions; UMs themselves lost them. Researchers perceived that North Africans were more committed to their health, adhering to the treatment or health education provided, whereas sub-Saharan Africans did not give the same importance to illness. They hid symptoms and did not keep their clinical documentation.

> *We give the UMs their care form, their diagnosis, treatment, and care. The continuity of care is impeded by the UMs themselves as they are not aware of the risk or severity of diseases such as HIV*. (NIDI6)

Making a difference', volunteering as a nurse's role

Although our participants carried out their main professional duties in hospitals or in primary care centres for the National Health System, they also voluntarily attended to UMs (unpaid). Nurses consider volunteering in emergency care teams for UMs as a personal and social commitment, as part of their identity 'being and feeling like a nurse'. Although their choices are often misunderstood, nurses see the opportunity as a chance to grow both personally and professionally.

A misunderstood social commitment

Nurses faced difficulties providing emergency care to UMs, as they attended to people who had left their countries and everything else behind. Nurses endured an emotional burden knowing that acquaintances, friends and family did not understand their volunteer work and asked them: *Are your friends (UMs) coming again?* (NIDI7). UMs face social prejudice as they are accused of depleting health resources, transmitting disease and trafficking drugs. A nurse is, therefore, not recognised in society but instead rejected.

> *I can't tell anyone that I help UMs. They don't understand that you get up at 3 a.m. to help an African that has arrived in a small boat*. (NIDI13)

Nurses worked alongside the police in providing emergency care, but felt as if they had a secondary role. The police controlled security, and nurses felt pressure to finish providing care quickly so that the police could continue their work. As one nurse stated, getting close to UMs was often uncomfortable.

> *If you smile (at UMs), if you try to make them feel better, if you sidestep the protocol… the tension is palpable. Their behaviour (police) is more serious and stricter with UMs*. (NIDI17)

When UMs were transferred to the hospital, other service users made negative comments regarding their care, as if they were prioritised or were transmitting disease. They complained that UMs were favoured and seen first, which created an uncomfortable atmosphere. Nurses had a hard time taking UMs to the hospital because they had to defend them.

> *You can sometimes sense the rejection of UMs in the ER. What's wrong with this one? Why are they being seen first? It can be a case of multiple injuries, burns, it's unpleasant!* (NIDI10)

An opportunity for personal and professional growth

Participants positively valued advances in emergency care for UMs, including the facilities and care protocols for this risk group. Nurses recognised an improvement in team training for comprehensive care and availability of advanced life support ambulances for transferrals. Nurses felt a moral obligation for UMs health and life. Emergency care made them feel useful and aware that there was a difficult experience behind a health condition.

> *Working with UMs is rewarding, the way they look at you, hug you, how they speak to you… There's always a smile, they need that affection*. (NIDI13)

Attending to people who have left everything behind changes your values as a nurse. Volunteering offers emotional balance and understanding your place in your profession and life.

> *We see women and children who've suffered sexual violence, genital mutilation, forced marriage…we're lucky to have been born on this side of the sea*. (NIDI15)

Volunteering for many nurses is 'making a difference', finding the time to help others. It is a step forward in life, a commitment to care with an emotional reward. It means you want to participate in life, be close to suffering, that other people's health is important to you and that you need to make decisions.

> *I remember small boats with critical or deceased UMs. Who attends to them first? Who takes them to the hospital? They are difficult times*. (NIDI14)

Participants ran the risk of getting personally involved in UMs' problems; despite trying to separate personal and professional life, it is not easy. As one nurse said, they found themselves in certain situations that affected them more, which made them get more involved, and as a result felt even more affected.

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It happens to me with the children, I think of mine and they play on my heart strings. Dead, dehydrated, hypothermic…you go home with a lump in your throat. (NIDI10)

Aspects for improvement in emergency care to UMs

Finding a balance between an individual's and a group's needs is complicated. When many UMs arrive on small boats, they lose their sense of individuality: '*It's as if you don't recognise faces, you can't differentiate them*' (NIDI6). The lack of time hindered a more complete assessment and diagnosis. They were exhausted and we were unknown and you cannot question it. '*If there are 100, you cannot stop, you have to see to the next one. It's impossible!*' (NIDI9). The nurses' station is well-equipped; there are human and material resources, but there is a lack of time and training. Nurses revealed the need for training in emergency care and healing wounds, burns or tropical diseases. Although the Spanish Red Cross offers specific courses, more training is needed in languages and culturally adapted care as this aspect is a challenge for the nurses' assessment.

Thanks to French classes, I talk to UMs directly and I can help them better. More clinical and cultural training is needed in emergency care. (NIDI16)

They also deemed necessary an improvement in care provided to children. During this phase, children (who are often separated from their parents), their mothers and other pregnant women are detained in cells. Nurses request that these spaces become more humane.

We have tried to get them to improve children's cells, make sure that they have a good mattress, toys, but they're detained…we can't do anything. (NIDI12)

UMs move around in groups under police custody. Although some people see them as criminals, they are looking for a better life. '*You go here! You go over there! It can't be like that, you have to explain things to them*' (NIDI4). An end to stereotypes is also necessary; not all UMs lie or yell. It is therefore essential to train security forces in emergency care or public health. This can be a significant development for nurses.

The police and Civil Guard are not healthcare professionals. Nurses could train them in infectious disease and protection to calm them down and reduce fear (NIDI15).

The participants requested an improvement in emergency care team coordination. There is a need to revise protocols, identify mistakes and discuss problems. As one nurse stated, debriefing sessions would be beneficial: '*We need to discuss how we feel, what mistakes we've made and how we can improve*' (NIDI14). Continuity of care and health education can be improved. For example, if a UM is constipated in one centre, they should be given a diet rich in fibre in another centre. Another aspect to consider is that mental health, sexual orientation and gender identity should be included in the nurses' assessment.

Our assessment is more based on physical health…we don't ask ourselves how they are emotionally, if they're sad, if they want to talk… (NIDI11)

Lastly, nurses highlighted a lack of care for dental health, gynaecological examinations and vaccine provision, but most of all, the need for care protocols for the most prevalent health conditions which includes administering medication.

We need algorithms and protocols that include administering medication. This would permit nurses who attend to UMs to have legal protection. (NIDI13)

DISCUSSION

The objective of our study was to explore and describe nurses' experiences of providing emergency care to UMs who arrive in Spain by small boats. The increase of migration to the EU comes with caring for UMs (Fotaki, 2019; Sesti et al., 2019), and the need to understand how healthcare providers' experiences can improve care provision (Harrison & Daker-White, 2019; Sevinç et al., 2016). After UMs disembark the small boats, nurses carry out a clinical, humanitarian and social assessment (Kelly, 2019; WHO, 2018). As highlighted in other studies, there is a lack of time to carry out protocols for detecting health conditions or victims of violence or trafficking (Jiménez-Lasserrotte et al., 2019; Olukotun et al., 2020). Whilst nurses develop a comprehensive approach to emergency care for UMs, we concur with Ponce-Blandón et al. (2020) that there should be more interventions related to this risk group, which could mean including social workers in order to detect problems (Gibbons & Stoklosa, 2016; Samra et al., 2019). UMs require psychological support for fear or trauma suffered, although this differs depending on the culture or country of origin (Granero-Molina et al., 2019; Jiménez-Lasserrotte et al., 2020). Nurses confirmed that there continue to be problems in coordinating police and healthcare providers (Chiesa et al., 2019); continuity of care implies separating emergency care from the legal status of UMs (De Bono, 2018). As with other studies, participants face administrative obstacles, communication issues and social and professional stigma (Drewniak et al., 2017; Puchner et al., 2018). Our study highlights the ethical challenges for nurses. Nursing care is not easy in a complex environment, when time, trust and care

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continuity are lacking. According to Kalengayi et al. (2015) conflicts, clash of expectations and moral dilemmas arise that affect healthcare providers. Nurses also have affirmed the need for an institutional response that goes beyond volunteering (Linke et al., 2019), where they would be recruited to carry out a vital role (Gobeyn, 2018; Hughes, 2016). Although approximately 60% of nurses spoke English and 10% French, none spoke Arabic, while UMs usually speak French or Arabic. Our findings corroborate the need for interpreters and cultural mediators (Chiarenza et al., 2019), alongside a systematic assessment of mental health (Kallakorpi et al., 2019). Nurses demand training in compassion, cultural competencies, and human trafficking (Albright et al., 2020; Dumit & Honein-AbouHaidar, 2019). This would also be useful for students learning about UM care (Evgin & Muz, 2020). As other studies demonstrate (Harrison & Daker-White, 2019), participants propose having more time to provide care, promoting clinical autonomy, exploring stigma, defending patients (UMs) and safeguarding the care history of UMs as ways to improve the issue (Chiarenza et al., 2019).

LIMITATIONS

This study has several practical limitations. All participants were Spanish nurses. Nurses were volunteers who received training in humanitarian attention or basic and advanced support. If they were specialist nurses in emergency care, our results could be different.

CONCLUSIONS

Nurses try to guarantee comprehensive care for UMs that arrive by small boats. As members of a multidisciplinary team, they assist in first aid, basic needs and continuity of care. Emergency care to UMs is an opportunity for personal and professional growth; nurses endure difficult experiences and moral dilemmas that can alter their perspective on their profession and life. The problems detected include pharmacological prescription and referral in the custody phase or hospital centre. In order to improve emergency care provided to UMs, nurses suggest increasing time for care provision, adapting care to consider cultural aspects, addressing mental health and sexual diversity, and improving specific training.

IMPLICATIONS FOR NURSING AND HEALTH POLICY

The Spanish government is responsible for funding and regulating provision of emergency care to UMs that arrive in small boats. The Spanish Red Cross provides emergency care on the coast, and the National Health System attends to UMs in health centres. Nurses are key in care provision and coordination of healthcare providers, cultural mediators, police or maritime rescue service during the emergency care for UMs. The government should guarantee constant material and equipment for emergency care for UMs without depending on their influx or the availability of volunteer doctors and nurses. Attention for UMs is a health and social issue. Training programmes for healthcare providers and security forces can improve care and reduce ethical dilemmas. Along with emergency care, UMs need medical attention for basic health needs. This competence requires specific legislation to increase the legal security of nurses and their actions. Working on the front lines puts nurses in a position to fight against social stereotypes and stigmas of UMs. Nurses can raise awareness of their work with UMs through media and scientific journals. In addition, nurses can participate in the development of specific training programmes on providing caring for UMs in health science degrees.

AUTHOR CONTRIBUTIONS

Study design: JGM, MMJL and CFS. Data collection: MMJL and IMFM. Data analysis: JMHP, IMFM and CFS. Study supervision: JGM, MMJL and MDRF. Manuscript writing: MMJL, MDRF and CFS. Critical revisions for important intellectual content: JGM, CFS, JMPH, MMJL, MDRF and IMFM.

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CONFLICTS OF INTEREST

No conflict of interest has been declared by the author(s).

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