Research Article / Özgün Araştırma

DOI: 10.4274/cayd.galenos.2026.77598
J Pediatr Emerg Intensive Care Med 2026;13(2):109-16

A Qualitative Research on the Experiences and Feelings of Pediatric Emergency Service Nurses with Refugee Children and Parents

Çocuk Acil Servisi Hemşirelerinin Mülteci Çocuklar ve Aileleri ile Duygu ve Deneyimleri Üzerine Nitel Bir Araştırma

Mukaddes Demir Acar[1], Gülmelek Yılmaz[2], Selda Yüzer Alsaç[3], Didem Coşkun Şimşek[4]

[1]Tokat Gaziosmanpaşa University Faculty of Health Sciences, Department of Pediatric Nursing, Tokat, Türkiye
[2]Tokat Gaziosmanpaşa University, Institute of Graduate Studies, Department of Nursing, Tokat, Türkiye
[3]Yozgat Bozok University Faculty of Health Sciences, Department of Pediatric Nursing, Yozgat, Türkiye
[4]Fırat University Faculty of Health Sciences, Department of Pediatric Nursing, Elazığ, Türkiye

Abstract

Introduction: This study examined nurses' experiences and feelings when providing care to refugee children and parents in the pediatric emergency service.

Methods: In this phenomenological research design, data were collected using a semi-structured interview form. The study was conducted among 12 nurses working in the pediatric emergency department of a university hospital in Türkiye between September and October 2022.

Results: The average age of the nurses who participated in the study was 34.5 years, and the average duration of employment in the pediatric emergency services was 4 years. Based on content analysis, the themes of the study were identified as follows: (1) problems experienced (increased workload, communication problems, parents' lack of health knowledge), (2) neglected child-related sadness (low socio-economic status, inadequate parental child care), (3) professional responsibility (professional awareness, professional ethics).

Conclusion: Nurses stated that, with the addition of refugees to the country's population, there are problems in the healthcare system and an increased workload. Problems faced by refugees regarding socio-economic status, language and communication, and health literacy are also emphasized. It has been determined that they feel sympathy for these problems, but they endeavor to continue providing care without discrimination due to their professional ethical responsibilities.

Keywords: Pediatric emergency service, nurse, refugee child, refugee parent, qualitative research, experiences, feeling

Öz

Giriş: Bu çalışma, çocuk acil servisinde mülteci çocuklara ve ailelerine bakım veren hemşirelerin duyguları ve deneyimlerini incelemek amacıyla yapıldı.

Yöntemler: Fenomenolojik tasarıma sahip bu araştırmanın verileri yarı yapılandırılmış görüşme formuyla toplanmıştır. Araştırma, Eylül-Ekim 2022 tarihleri arasında Türkiye'deki bir üniversite hastanesinin çocuk acil servisinde çalışan 12 hemşire ile gerçekleştirildi.

Bulgular: Araştırmaya katılan hemşirelerin yaş ortalaması 34,5 olup çocuk acil servisinde ortalama çalışma süresi 4 yıldır. İçerik analizine dayalı olarak çalışmanın temaları şu şekilde belirlenmiştir: (1) yaşanan sorunlar (iş yükünün artması, iletişim sorunu, ebeveynlerin sağlık bilgisi eksikliği), (2) ihmal edilen çocuk kaynaklı üzüntü (sosyo-ekonomik durumun yetersizliği, ebeveynlerin çocuk bakımının yetersizliği), (3) mesleki sorumluluk (mesleki farkındalık, mesleki etik).

Sonuç: Hemşireler, ülke nüfusuna göçmenlerin de eklenmesiyle sağlık sisteminde bazı sorunların yaşandığını ve iş yükünün arttığını belirtmişlerdir. Göçmenlerin sosyo-ekonomik durum, dil-iletişim, sağlık okuryazarlığı gibi konulardaki sorunları da vurgulanmaktadır. Bu sorunlara üzüldükleri ancak mesleki etik sorumlulukları nedeniyle ayrımcılığa uğratmadan bakım vermeye devam etmeye çalıştıkları belirlendi.

Anahtar Kelimeler: Çocuk acil servis, hemşire, mülteci çocuk, mülteci ebeveyn, nitel araştırma, deneyimler, duygu

Address for Correspondence/Yazışma Adresi: Assoc. Prof., Didem Coşkun Şimşek, Fırat University Faculty of Health Sciences, Department of Pediatric Nursing, Elazığ, Türkiye
E-mail: d.coskun@firat.edu.tr **ORCID ID:** orcid.org/0000-0003-0364-5667
Received/Geliş Tarihi: 06.10.2025 **Accepted/Kabul Tarihi:** 02.04.2026 **Publication Date/Yayınlanma Tarihi:** 07.08.2026
Cite this article as: Demir Acar M, Yılmaz G, Yüzer Alsaç S, Coşkun Şimşek D. A qualitative research on the experiences and feelings of pediatric emergency service nurses with refugee children and parents. J Pediatr Emerg Intensive Care Med. 2026;13(2):109-16

Introduction

The United Nations Refugee Agency determined that 79.5 million individuals worldwide were forcibly displaced by the end of 2019.[1] Türkiye hosted the largest number of displaced individuals, nearly 3.9 million, of whom 92% were Syrian refugees. The majority of these individuals are children aged 0-18 (47.4%) and women (46.2%).[2]

The movement of refugee populations has affected the demographic, cultural, and socio-economic structures of all recipient countries, including Türkiye.[3] This vulnerable population, which is increasing in number, particularly along the southern border of Türkiye, poses challenges to the health system and contributes to socio-economic problems.[4] Apart from these problems, refugees face major challenges, and they may shift health service priorities in their host countries.[5] A study was conducted on access to primary health services for refugees: a qualitative study of service user experiences in the United Kingdom by Kang et al.[6] Basic themes included inadequate interpretation of services and language barriers; lack of awareness of the functions and structure of the National Health Service; perception of discrimination relating to religion, race, and refugee status; and problems meeting the costs of dental health, prescription fees, and transport to appointments. Published research articles on child refugees living outside Africa focus on infectious diseases, physical and mental health, food insecurity, neurodevelopmental disorders, psychosocial adjustment, and health promotion strategies.[7] In addition, in emergency services, health literacy, cultural, and language difficulties make it potentially challenging to provide quality care for refugee parents, their children, and health professionals.[8]

Healthcare teams often work in stressful and fast-paced environments while caring for patients with complex and demanding needs. Health professionals often help their patients and families cope with difficult diagnoses, traumatic injuries, and death.[9] Emergency nurses are trained to evaluate and triage patients and to collaboratively treat patients in the early stages of acute illness and trauma. Emergency nurses work in a stressful environment where they routinely witness personal tragedies. Pediatric nurses may experience higher levels of stress than other nurses; often, in addition to caring for the crying child, they also attend to and comfort the child's parents. Pediatric emergency nurses face greater professional challenges.[10-12] Secondary traumatic stress (STS) affects many health professionals.[13] Given that more than a quarter of service providers have moderate to severe STS, anxiety, and depression, future intervention research should address the well-being of both crisis-affected individuals and crisis responders. For this reason, research should build on qualitative findings to better understand both the specific mechanisms of employee mental health and their relationship to perceived organizational or institutional support.[14]

Culturally competent clinical care is a concept often used to describe how health care teams can effectively and appropriately treat culturally and ethnically diverse patients. There is an increased need for health care professionals to be more attuned to the behavioral health needs of racial and ethnic minorities and to the role of the social environment.[15] Given the environmental characteristics of emergency services, a strategy should be developed to support health professionals in communicating effectively with refugee patients and their parents about culturally appropriate care.[16,17]

This study sought to answer the following question: what are the beliefs and feelings of emergency nurses working in pediatric emergency services regarding refugee families? What is the essence of nurses' experiences working in pediatric emergency services with refugee families?

Materials and Methods

Characteristics and Location of the Research

The study examined nurses (participants: P) caring for refugee patients at one university hospital in an urban center of the Middle Black Sea Region of Türkiye between September and October 2022.

Study Design

This research focused on a phenomenological approach, one of the qualitative research methods.[18] Phenomenological research is based on understanding the essence of human experiences and on exploring the meaning people attribute to those experiences.[19] The study was conducted and reported in accordance with the consolidated criteria for reporting qualitative studies.

A purposive sampling method was used in this research. Nurses who cared for refugee parents in pediatric emergency services constituted the study sample. In qualitative studies, the data can be obtained from field study observations, written documents, in-depth interviews, and audio recordings.[19]

Demographics of the Qualitative Sample

The number of healthcare professionals working in the pediatric emergency unit is 22 (8 doctors and 14 nurses). Nurses who worked in the pediatric emergency unit for at least one year were included. One nurse had been working for less than one year, and one of them had been on leave. The study included twelve nurses: eight female and four male. Although no rule is specified for sample size in the literature for qualitative studies, failure to obtain additional data and repetition of data are important indicators for terminating data

collection. In-depth interviews aim to reach data saturation.[20] Data saturation was reached when nurses began to use the same or similar expressions and was achieved with twelve nurses. Saturation was reached after the 10th interview, and the last 2 interviews were conducted for completeness.

Inclusion criteria of nurses in the study:

1) Agreeing to participate in the study,

2) Nurses who worked in the pediatric emergency unit for at least one year were included.

Data Collection

The data were collected using a semi-structured interview form. A pilot test was conducted with a nurse to ensure internal validity. The suitability of the questions was determined by consulting two experts with doctoral degrees whose qualitative work on pediatric nursing is indexed in the science citation index.

The questions were finalized in line with their suggestions. To collect data, the researchers prepared four basic, open-ended questions:

1) "Can you tell me about your experience working with pediatric refugee patients?"

2) "Have you ever had difficulties while caring for refugee patients? Can you explain?"

3) "How did working with refugee patients affect your thoughts about your profession?"

4) "What emotions do you experience while caring for refugee patients? Can you explain?"

In-depth interviews were conducted in the nurses' office of the pediatric emergency unit in a quiet environment. The first and second authors (M.D.A. and G.Y.) conducted the interviews. The interviews lasted an average of 20 minutes. Before the in-depth interviews, participants provided permission for voice recordings.

Statistical Analysis

The data were analyzed using the content analysis method. This research method focuses on obtaining reproducible and valid results regarding the content of the data.[21,22]

After the interviews were completed, the researchers transcribed all the audio recordings into text on the computer. Data analysis was carried out in seven stages according to Colaizzi[21]: 1) The written texts were read meticulously and repeatedly by the researchers independently of each other. 2) Expressions suitable for the study were identified. 3) Expressions were grouped. 4) Similar or identical expressions were grouped together, and distinct, noteworthy expressions were identified. 5) The main themes of the study (problems experienced, sadness about the neglected child, professional responsibility) were identified and described in detail. 6) The core structure of the participants' experiences was described. 7) The results of the analysis were presented to the participants. Thus, the accuracy and security of the findings were ensured.

Content analyses were conducted independently by researchers to ensure data consistency. The opinions of two experts not involved in the study were sought to ensure data validity. The experts were required to have experience in qualitative research and at least two articles indexed in the science citation index on the method.

Validity, Reliability, and Rigour

To ensure the reliability of this research, the components of qualitative rigour, namely credibility, transferability, dependability, and confirmability, were considered.[23]

Credibility

Interviews were transcribed separately. An online meeting was held to review the interview records, and similarities and differences were compared with the original language. Thus, validity and reliability were assessed during data analysis. Because the research was planned for publication in international journals, the interview records were translated into English. Thus, the data were translated from Turkish into English by a team of translators, independent of the research team, to ensure the study's credibility. The Turkish and English texts were compared, and the study was finalized.

Transferability

Demographic characteristics of nurses are presented. Readers can evaluate whether it is applicable to their own studies or populations.

Dependability

Expert opinion was obtained regarding the interview questions and their content. A pilot study was conducted to ensure reliability.

Confirmability

For each interview question, follow-up questions were asked to provide clarification. At the end of the interview, a summary was provided to each nurse, and her approval was expected for control purposes. Multiple nurses provided citations to enhance confirmability.

Ethical Consideration

Permission was obtained from the Tokat Gaziosmanpaşa University Social and Humanities Studies Ethics Committee (approval no: 01-29, date: 05.11.2024) and from the relevant hospital. Written informed consent was obtained from nurses

participating in the study. The study data were shared with researchers and two experts. Data were stored on encrypted, password-protected devices. The study was conducted in accordance with the Declaration of Helsinki.

Results

58.3% of the nurses in the study were between 29 and 37 years of age, 66.6% were female, 41.6% had been health professionals for 12 years or more, and 75% had been working in the pediatric emergency services for 1 to 4 years. Of them, 83.3% were married and 75% had children (Table 1). These socio-demographic characteristics of nurses are given for transferability.

As a result of the content analysis, three main themes and six sub-themes were determined: 1) problems experienced, 2) neglected child-related sadness, 3) professional responsibility (Table 2).

Table 1. Distribution of nurses' descriptive characteristics (n=12)

Descriptive characteristic	Number	%
Age (year)		
20-28	2	16.6
29-37	7	58.3
38 and over	3	25
Average age	34.5	-
Gender		
Female	8	66.6
Male	4	33.3
Total years as a nurse		
1-4	1	8.3
5-8	3	25
9-12	3	25
12 and over	5	41.6
The years worked in the pediatric emergency services		
1-4	9	75
5-8	2	16.6
9-12	1	8.3
The average working year in the pediatric emergency service	4.0	-
Level of education		
Associate degree	2	16.6
Undergraduate degree	8	66.6
Graduate degree	2	16.6
Marital status of nurses		
Married	10	83.3
Single	2	16.6
Number of nurses who have children		
Has a child	9	75.0
None	3	25.0

Problems Experienced

Nurses stated that the addition of refugees to the country's population has led to insufficiencies in the health care system and to an increased workload. Problems faced by refugees regarding socio-economic status, language and communication, and health literacy were also emphasized. Nurses do not blame the refugees for these problems and seek to understand them empathetically.

The sub-themes of this section are increased workload, communication problems, and parents' lack of health knowledge.

Increase in Workload

Nurses stated that when refugee families and children come to the hospital, the polyclinic, and the emergency service, their workload increases. It was also noted that this situation could lead to problems, such as epidemics and increased waiting times for their patients' examinations.

I mean, I think there is a backlog, especially epidemics, births, and frankly, I think that all of them are an extra burden on our health system (P-12).

In my opinion, the intensity of polyclinic and emergency services creates excessive costs for the state and makes it difficult for our citizens to access health services (P-10).

Communication Problem

Nurses reported that language and communication deficiencies are significant factors affecting nursing care practices for children brought to the emergency unit.

Since we do not fully understand the patient's complaint due to the language barrier, we cannot adopt an appropriate approach to his illness. How will he administer the treatment we recommend at home? We cannot be certain that it is applied correctly and adequately at home (P-10).

When a person speaking a language we do not know arrives, we raise our tone of voice. We believe he understands what I am saying when I shout. When I shout, the other person does not want to express himself to me because he thinks I'm shouting in anger. This indicates a breakdown in

Table 2. Summary of qualitative analysis

Theme	Sub-themes
Problems experienced	Increase in workload
	Communication problem
	Parents' lack of health knowledge
Neglected child-related sadness	Insufficiency of socio-economic status
	Insufficiency of child care of parents
Professional responsibility	Professional awareness
	Professional ethic

communication. The words in my language have different meanings in his language, leading to a communication breakdown. Did the patient urinate? I ask her mother whether she perceives her stool, and she says she does not. I also think that was no urine output; for example, we experienced this. This is a simple example; similar examples can be generated (P-4).

It is possible that the baby has an allergic condition; the family knows about it, but because they couldn't tell us, we may have administered an allergenic drug (P-12).

Parents' Lack of Health Knowledge

They stated that parents lack healthcare information, which is why the disease processes in their children are also affected. Nurses stated that they applied appropriate care, such as nutrition, hydration, and hygiene, for preventable infectious diseases.

I think they do not know how to care for the child; that is why most of them become ill. A nutritional deficiency is present, likely because their immune resistance is low, and they nevertheless become ill. Care is lacking. Most of the parents have low educational attainment, and there is a considerable lack of knowledge (P-3).

As I said, a lack of care can lead to many illnesses, such as fever, cough, diarrhea, and vomiting. For example, they give milk to a patient with diarrhea. Why do you administer it? She says the child wanted milk; the child may want it, but she does not know that in such a case, milk should not be given (P-2).

They mainly present with infectious diseases characterized by fever, cough, and respiratory distress. Sometimes, diarrhea may predominate. Diarrhea can be severe. Our own citizens are a little more sensitive, a little more accustomed; they catch up with the slightest diarrhea, but refugees come when the work gets a little harder (P-10).

Neglected Child-related Sadness

Healthcare professionals who participated in the research reported feeling sadness and compassion because many children and families had to leave their countries and become refugees due to wars, and because, in their professional roles, they frequently encountered neglected parents and children.

The sub-theme of this section is the neglected child.

Insufficiency of Socio-economic Status

Nurses stated that child neglect occurs because of socio-economic inadequacies of refugee parents who have to change countries. Thus, they stated that they were very sad and trying to understand their traumatic experience.

Changing the state or the country is a situation that can occur only out of necessity. That's why I feel so sorry for these helpless people (P-7).

They must establish order in a country with which they are unfamiliar, both for themselves and for their children. I feel very sad and hurt, so I don't want to hurt any child as much as I can (P-6).

They originated from a specific war-affected environment. They entered illegally and did not come of their own accord; I do not think they were particularly pleased. I am compassionate, especially toward the little ones (P-12).

I contend that many of them are in disarray. When you see it, you cannot forget the condition of the children; most of them are in need of care (P-3).

Their hair is markedly unkempt, and they demonstrate inadequate personal care. Probably because they have many children, because their living conditions are poor, or, I don't know, it could be their family structure (P-1).

Insufficiency of Child Care of Parents

Nurses generally observed that families were inadequate in providing care for their children. They stated that children may develop diseases due to a lack of care. Thus, they are a highly vulnerable population who have been through an immense amount of trauma as a family; the nurse's quotes corroborate the trauma experienced by the children.

I consider this a difficult situation for people. I feel very sad, financially, morally, and psychologically, especially for the children. It is a great loss for people to lose their homes and jobs (P-9).

In general, their socio-economic status is lower; the ones I've encountered exhibit this pattern. They have very poor hygiene and suffer from associated infectious diseases; they lack adequate heating and nutrition, and their children are very weak. I think that children are also ill because of their low immunity (P-5).

Children with low body resistance are brought in for care because they are more severely malnourished. We observe that some people walk barefoot in the winter months. They experience a marked deterioration in health and subsequently develop pneumonia. Their prognosis is worse, so their recovery is delayed. Many patients present with pneumonia due to inadequate care (P-8).

Professional Responsibility

All nurses who participated in the research stated that they try to provide care for refugee families and children who come to the pediatric emergency unit as part of their professional responsibilities, without discriminating against them compared with other patients.

The sub-theme of this section is professional awareness and ethics.

Professional Awareness

It can be seen that pediatric emergency nurses fight on the front line in the struggle with such a problem and do their best in accordance with their professional awareness.

I take care of the patient; after all, he is the child. It's neither his nor the family's fault. I take care of the child when he comes here; I do everything for his health and solve the problem (P-1).

Professional Ethics

It has been stated that nurses strive, as far as possible, to fulfill their professional roles for patients in accordance with professional ethical principles.

Being a foreign national or being Turkish does not mean anything to me; I look at patients as patients and do my best (P-11).

When a child presents in an emergency, we do not discriminate among patients. We do not think of them as a Turkish citizen or the citizen of another country (P-6).

Discussion

The aim of this study was to examine the essence of the experiences, observations, and feelings of pediatric emergency nurses providing emergency care to refugee children and parents. This study also aimed to evaluate refugee children and families from nurses' perspectives. The subject was discussed in-depth with respect to the themes identified in our research. Health literacy, socio-economic status, language and communication deficiencies among refugees have been discussed in numerous studies.[24-27] The findings of our study are consistent with the literature (theme: problems experienced).

In our study, it was determined that nurses had difficulties in communication due to the different languages spoken and different cultures while caring for refugee children; they could not fully evaluate the complaints of the patients, and therefore, they were insufficient in their treatment and care practices. These system-related problems were not caused by refugees and their children. Many studies have drawn attention to the problems caused by speaking different languages in health services.[28,29] In emergency and other services, cultural, language, and health literacy problems make it potentially challenging to provide quality care for many parents.[8] Poor access to health services is considered to have detrimental consequences for the health outcomes of refugees and host populations, and may impose greater costs on the health care system in the long run. The main problems in accessing health care are linked to poor health literacy and a lack of awareness of one's right to health care; cultural and linguistic differences; protection issues due to lack of legal status; and inability to afford health services due to inadequate socio-economic status.[30] Limited health literacy disproportionately affects people of lower socio-economic status, members of minority or refugee groups, and those with limited linguistic proficiency. Insufficient health literacy was associated with higher rates of emergency room visits for non-emergency care, hospitalization and rehospitalization, and poorer health and care among children.[8,31]

Emergency room nurses provide the first line of health care communication when they perform pediatric triage on the patient. The nurses have many opportunities to engage with and support children and parents, including providing discharge and home care.[32] Ideal discharge information can maintain quality of care for a child after discharge, minimize confusion for parents, and reduce readmissions and associated family and financial barriers.[33] However, in our study we observed that health workers could not adequately fulfil their educational roles due to language barriers. Similarly, in our study, health professionals stated that, in terms of numbers, refugees strained the health care system, and these statements were presented under the relevant theme (theme: problems experienced). It has been stated that the increase in the refugee population increases hospital workload and creates organizational difficulties. Although health professionals have difficulty performing their educational roles due to language barriers and patient density, they nevertheless attempt to provide equal care to every patient according to universal/professional ethical principles, as reported in the results/themes (theme: professional responsibility and ethics).

The pediatric healthcare climate involves challenges for direct care providers who are continually exposed to both critically ill children who may be living in unhealthy circumstances and possibly facing death, and their families, who are also suffering. For other care providers, especially nurses, compassion fatigue may result in STS symptoms, decreased productivity, decreased patient satisfaction scores, job turnover, job dissatisfaction, and safety issues.[34,35] Newly arriving refugees in any location face heightened health needs related to their journey and to unhealthy environments.[36] Similarly, in our study, inadequacies among refugees in our country were identified under the theme "neglected child-related sadness". For this reason, it has been determined that they are particularly regretful about the neglect of refugee children and the difficult climate in the pediatric emergency service. These feelings are reflected in compassion fatigue, burnout, and stress among nurses related to their observations of refugees.

Study Limitations

To our knowledge, this is the first qualitative study to investigate the essence of pediatric emergency service nurses' experiences with refugee parents in Türkiye. The findings of this research provide novel and useful insights to inform practical initiatives in policy, cultural care, and interventions aimed at addressing the healthcare needs of the refugee population. Thus, mixed-methods, quantitative, or qualitative studies are needed to better understand the mechanisms underlying these conclusions. Although the results are encouraging, they cannot be generalized to other disciplines or nations.

Conclusion

We found that nurses in pediatric emergency services had significant self-reported experience in the management of pediatric emergency patients. Although there have been internal and external refugees in the past, studies examining the effect of refugees from abroad on child health remain insufficient, and more such studies are needed. Including refugees in future research should be considered.

Ethics

Ethics Committee Approval: Permission was obtained from the Tokat Gaziosmanpaşa University Social and Humanities Studies Ethics Committee (approval no: 01-29, date: 05.11.2024) and from the relevant hospital.

Informed Consent: Written informed consent was obtained from nurses participating in the study.

Footnotes

This article was presented as an oral presentation at the 3. International Congress on Biological and Health Sciences (14-16 April 2023).

Authorship Contributions

Surgical and Medical Practices: M.D.A., S.Y.A., Concept: M.D.A., S.Y.A., Design: M.D.A., G.Y., S.Y.A., D.C.Ş., Data Collection or Processing: M.D.A., G.Y., S.Y.A., D.C.Ş., Analysis or Interpretation: M.D.A., G.Y., S.Y.A., D.C.Ş., Literature Search: M.D.A., G.Y., S.Y.A., D.C.Ş., Writing: M.D.A.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study received no financial support.

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