Healthcare staff's evaluation of a walk-in centre at a healthcare centre in an immigrant-dense area.

Rikard Wärdig, Emina Hadziabdic and Katarina Hjelm

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Title: Healthcare staff's evaluation of a walk-in centre at a healthcare centre in an immigrant-dense area

Running title: Evaluation of a walk-in centre

Rikard Wärdig¹ PhD, Emina Hadziabdic² PhD, Associate Professor, Katarina Hjelm³, SRNT, MScN, PhD, Professor.

¹Department of Medical and Health Sciences, Linköping University,

²Department of Health and Caring Sciences, Linnaeus University

³Department of Public Health and Caring Sciences, Uppsala University, Uppsala, Sweden

Corresponding author: rikard.wardig@liu.se +4613286850

Conflict of interest

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Contribution to the paper

The study was designed by all authors, data were collected by RW and analysed by RW and EH. All authors drafted the manuscript. All authors interpreted the results, reviewed and commented on multiple versions of the manuscript and approved the final version.

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Abstract

Aims and objectives. To evaluate a walk-in centre at a healthcare centre in an immigrant-dense area where a high proportion of the patients have limited language ability in Swedish, from the perspective of healthcare personnel.

Background. Increased global migration results in higher vulnerability in migrants, with the risk of increased morbidity and mortality. Migrants' health often deteriorates, which can be attributed to an increased level of stress and adaptation to a new lifestyle. Therefore, immigrants are at higher risk of being affected by, for example, cardiovascular diseases and diabetes. This requires access to good healthcare.

Design. A qualitative exploratory study was conducted, using semi-structured interviews. Content analysis was used in the analysis process.

Methods. Semi-structured interviews were held with 15 purposively sampled doctors and nurses, working at a healthcare centre in Sweden. Data were collected during autumn 2017. The study was performed in accordance with COREQ.

Results. Working at the walk-in centre involved caring for everything from basic to advanced health problems and meant a high pace that required stress-resistant personnel. The walk-in centre was described as both promoting and threatening patient safety. The personnel had several ideas on how to develop the walk-in centre.

Conclusions. A walk-in centre can be seen as a necessity related to issues of ensuring patient safety and delivering care for everyone in an immigrant-dense area. However, it cannot be the only form of care offered, as it seems not to be adapted to certain groups, such as people with disabilities and the elderly.

Relevance to clinical practice. The findings emphasise that a walk-in centre is a way to increase accessibility for the entire population and offer equal care for all, even if it involves challenges that need to be addressed.

Introduction

International migration is increasing, from about 150 million migrants 10 years ago to 244 million in 2018, and migrants' health has become a central public health concern (International Organization of Migration 2018). In 2015 the numbers of migrants were the highest ever, as was the influx of refugees in Sweden (Statistics Sweden 2016). The newcomers mainly originated from Afghanistan, North Africa and Syria and were added to migrants from other Scandinavian countries, from South Europe, Latin America, Asia, the Middle East and Africa, forming a heterogeneous and multilingual group with great dissimilarities in language. Nearly 163,000 individuals sought asylum in Sweden in 2015 (Swedish Migration Agency 2016). The major refugee flows impose demands on the health care system regarding accessibility, quality of care and organisation, as we know that the ability to communicate is essential to promote or regain health (Leininger & McFarland 2006). In addition, migrants have higher mortality and morbidity (Albin *et al.* 2006, Bhopal 2014).

Background

The major international refugee migration has taken place recently, so it is difficult to describe what the consequences will be in the long term. However, it is reasonable to assume that the demand on the healthcare system will be increased as migrants have higher mortality and morbidity (Albin *et al.* 2006, Bhopal 2014). Their health often deteriorates in the new country, which can be attributed to an increased level of stress and adaptation to a new lifestyle and traumas related to the migratory process. Therefore, immigrants are at higher risk of being affected by, for example, cardiovascular diseases, diabetes and asthma (Hemminki 2014, Nielsen *et al.* 2010). This requires providing access to good healthcare and enabling accessibility for immigrants (Rechel *et al.* 2013).

There are arguments to indicate that the migrants who come here are those from the population of origin who have good health because they are able to migrate. However, comparisons in health between native-born persons and immigrants usually favour the natives (Hemminki 2014). Health can be challenged by both somatic diseases and diseases of a psychiatric nature. A review study (Kirmayer *et al.* 2011) describes factors that affect the mental health conditions for people who migrated. The study concludes that most people manage the transition to life in the new country, but that difficulties arise. Mental health can be affected by the person's uncertainty about the status as a refugee and opportunities to stay. Unemployment and loss of former family members and roles are other aspects, together with difficulties in learning the new language and adapting to the new culture.

Migrants represent a heterogeneous group. With different ethnic and historical roots, various cultures and different ways of taking care of their health, it is difficult to generalise the group's needs. In the same way, the migration in itself implies different impressions of different individuals, the reasons they had to migrate and their perceptions of their past lives, which affects health conditions in the new country (Toselli *et al.* 2014).

Even though escape from war, terror and persecution is not a new phenomenon, the high number of migrants poses a high level of demands on primary care in Sweden. Previous studies, (Eckstein 2011, O'Donnell *et al.* 2016) have focused on how primary care works for migrants and have examined the phenomenon from different perspectives. Cheng *et al.* (2015) describe in a review how the group of refugees and asylum seekers find it difficult to get in touch with and use primary care. Migrants may difficulty navigating in the often complex and interchangeable systems of the healthcare models. In addition to language problems, there is often also lower knowledge about health and lack of social

support and other socioeconomic factors that make it difficult to seek care (O'Donnell *et al.* 2016, Cheng *et al.* 2015).

Walk-in centres have previously been evaluated mainly in North American and British studies (Salisbury & Monro 2003). Consequently, the results of these studies are not directly transferable to the Swedish context since these walk-in centres are independent of a healthcare centre. In the North American and British context, the incentive for walk-in centre has been to create increased accessibility, which is in agreement with the Swedish context. Salisbury and Monro (2003) found that a heterogeneous patient group visited walk-in centres. Often it was banal injuries and disorders that patients presented with and patient satisfaction was high. The authors of the review study ask whether increased accessibility is motivated by real needs or if it increases the need for care that is not really needed.

This study can emphasise suitable working methods to meet the needs of immigrants and provide suggestions on how primary healthcare can be organised for these groups. In the particular county council where the study took place, a special initiative was implemented by starting a walk-in centre to meet the needs of the large refugee group that became particularly evident in 2015, the peak year of influx of refugees. Therefore, it provided a unique opportunity to study a healthcare centre and a way to organise the care that has been delivered in order to meet the needs of the migrants. There are no previous studies that have evaluated a walk-in centre at a healthcare centre, in a context of many foreign-born care seekers from the perspective of healthcare personnel. The main purpose of the project is to evaluate the walk-in centre's activities at the healthcare centre and whether it meets the needs of users or if there are alternative ways of organising care.

AIM

To evaluate a walk-in centre at a healthcare centre in an immigrant-dense area where a high proportion of the patients have limited language ability in Swedish, from the perspective of healthcare personnel.

METHODS

Design

A qualitative, explorative study design was chosen, as it provides new insights and increases the researcher's understanding of a particular phenomenon that has not previously been investigated (Patton 2015). Qualitative semi-structured interviews were considered useful as they gave the participants the opportunity to respond in their own words and to express their own personal experiences but within a given frame. The research process and the presentation has followed the COREQ guidelines, see supplementary file (Tong, Sainsbury & Craig 2007).

Sample and Setting

Swedish healthcare is divided into three levels with varying degrees of specialisation: primary level with primary healthcare (PHC), county level with county hospitals and district county hospitals, and regional level with regional/university hospitals. PHC forms the cornerstone of the healthcare system and is responsible for public health and treatment of diseases and injuries that do not require hospital or specialist care. PHC is provided by healthcare centres, with outpatient clinics staffed by GPs, nurses and assistant nurses. Each PHC area serves a defined population based on locality and access criteria. Patients needing specialised care are referred to hospitals, with the most highly specialised care provided by university hospitals where research and teaching of staff also takes place (The Swedish National Board of Health and Welfare 2016). According to the Swedish legislation, the Health and Medical Services Act (2017:30), primary healthcare, without limitation in respect of illnesses, age or patient group, is responsible for the needs for basic medical treatment, nursing, preventive work and rehabilitation, which do not require the medical or technical resources of a hospital or other special skills (Ministry of Health and Social Affairs 2017).

The primary healthcare tasks are mainly shared in the Swedish context, although they may differ at the level of detail between the different county councils. In the Swedish primary healthcare system, healthcare centres are central. The primary task of healthcare centres is to receive people seeking planned and unplanned healthcare within general medical competence. The mission also includes rehabilitation, psychosocial activities and health promotion as well as disease prevention efforts (The Swedish National Board of Health and Welfare 2016).

The studied healthcare centre is located in a medium-sized city in the southeast of Sweden. The district belongs to an area with a high proportion of foreign-born persons, with more than 51 percent born abroad (Official Statistics of Sweden 2017). As the healthcare centre has a high proportion of foreign-born patients and many with limited knowledge of the Swedish language, they face special challenges based on the multicultural population. Language difficulties among many refugees and asylum seekers led to the opening of the walk-in centre. The walk-in centre has been running since 2012 and receives 45 patients daily, it is open on weekdays 8.00–13.00. These patients first meet a nurse and are sometimes referred further to a doctor at the healthcare centre who is available for consultation. Interpreters in Arabic and Somali have been available since 2016. A large majority of Swedish healthcare centres do not have walk-in centres. Instead, the patient can call and the nurse makes the assessment whether the patient should visit the healthcare centre, refer to self-care or another healthcare provider.

Inclusion criteria for participants in this study were: healthcare personnel working in the walk-in centre, with at least six months' experience. The sample was purposeful (Patton 2015) and consisted of 15 participants, 3 doctors, 8 nurses and 4 district nurses, working at the same healthcare centre with a walk-in centre. They were aged between 26 and 62 years, with a median age of 45. Twelve were women. The staff had worked at the healthcare centre between 1 and 25 years, median 6 years.

Data Collection

The head of the department gave the research team written permission to conduct the study. An interview guide was developed on the basis of previous studies and literature in the field and was discussed with researchers experienced in migration and health (KH, EH). The guide was tested on two individuals working within the same context as the other informants. No changes were made to the interview guide, so these data were analysed and used in the study. The first author participated in a workplace meeting and informed about the study. At the same time, written information was also provided about the study. The healthcare personnel, doctors, nurses and district nurses who wanted to participate informed the research team by email. Those willing to participate chose the time and place for the interviews in order to create a safe interview environment.

The interviews took place in the healthcare centre facilities in secluded rooms. The interviews were conducted in autumn 2017 and were led by a nurse and researcher in nursing (first author). Before the interviews, there was time to establish contact, take part in informal conversation, and create an opportunity for the informants to ask questions. In this connection, written informed consent was obtained. Interviews were conducted by the first author, following a semi-structured interview guide focusing on the central question: Can you describe your perceptions of the walk-in centre?

In order to deepen, clarify, and develop the informants' answers (Patton 2015), probing questions such as "Can you tell me more?" and questions based on informants' previous statements were asked. The interviews lasted 15–45 minutes, on average 30 minutes. They were digitally recorded. After the interviews, there was time for reflection if required by the participants. The interviews were transcribed verbatim using a transcription guide (McLellan, Macqueen, & Neidig 2003), by a professional secretary employed by the project.

Data Analysis

Content analysis according to Patton (2015) was used. Content analysis focuses on the characteristics of language as communication, particularly the content or contextual meaning of the text. Conventional content analysis is useful when the aim is to describe a phenomenon in an area where existing theory or literature is limited (Hsieh & Shannon 2005). The analysis started with the researchers (EH, RW) reading all data repeatedly in order to obtain a sense of the whole. To find and highlight exact words in the text that captured key thoughts or concepts related to the aim, the transcripts were read word-by-word by EH and RW. Codes were marked and labelled as close to the original text as possible. All authors agreed on how to categorise the different codes based on how they were related and linked. The content within each category was sorted into subcategories in order to capture its complexity. Finally, definitions for each subcategory and category were developed (Patton 2015). The categories and their names were derived from data and not from preconceived categories, a procedure known as inductive category development (Kondracki & Wellman 2002). Quotations for each category were identified from the 15 interview transcripts in order to report the findings and maximise their diversity. As a final step, the last author (KH) read excerpts of the raw data to validate the content of the categories (Patton 2015).

Ethical Considerations

The study was approved by the Regional Ethical Review Board in Linköping, Sweden, Dnr 2017/223-31 and was performed in accordance with the Declaration of Helsinki (World Medical Association Declaration of Helsinki 2013). Principles of written informed consent were followed. Before the interviews, the informants received the information that participation was voluntary and that they could, at any time, withdraw from the study without any explanation.

Results

Three categories emerged from the data: (1) Caring for everything from basic to advanced health problems, with the three subcategories: large variation among visitors; the main purpose being to solve simple health problems; and a professional challenge. Category (2), Perspectives of the workload and the work environment, has the subcategories: Stimulating but challenging work; and Patient safety – promoted or threatened? The last category (3), Suggestions on how to develop the walk-in centre, contains the subcategories: Teaching patients about the service of the walk-in centre and the Swedish healthcare system; More opportunities to meet the doctor and the nurse; and The need for better premises.

Caring for everything from basic to advanced health problems

This category describes how the walk-in centre is organised and its functions, the healthcare it provides. In other words, what it is and what it is not. The category also refers to who the patient is and common reasons for visiting or reasons for visits that are actually beyond the scope of the walk-in centre. The centre is appreciated by most of the staff, but there are challenges.

Large variation among visitors

The staff say that the “typical” patient does not actually exist at the walk-in centre. The staff meet lots of different people of different origin and with different reasons for the visit. Although they say it is hard to generalise, there are some issues that are described more commonly, even though the answers differ slightly between the staff. Common patients are those with mild infections, with pain problems or skin rashes. Throat or stomach pain, headache and dizziness are other common phenomena described as the reason for the visit. Although uncommon, there are patients with acute chest pain or similar acute symptoms that should seek emergency care, who turn up at the walk-in centre.

“They may have been in pain for a very long time, a lot of psychiatry, anxiety, sleeping problems, stomach ache. They may be tired or they cannot work. Yes, very much so. It is recurring... and those who have pain in the throat with difficulties swallowing.”

The staff report that slightly more women than men come to the centre. Often the patients are unemployed because those who have work cannot wait as long as assumed. Many of the patients were born abroad, but one of the nurses said that Somali men rarely visit the walk-in centre. Persons with various disabilities and older persons are also not so common visitors. This is believed to have to do with the difficulty of waiting for a long time and the difficulty of getting to the walk-in centre.

The main purpose being to solve simple health problems

The staff described how the main purpose of the walk-in centre is to address simple types of health problems. If the matter is too complicated or the problems too many, the idea of the walk-in centre

fails. These patients do not belong at the walk-in centre, but should be booked at a scheduled time. Patients receive information about prioritising among their symptoms and that only one problem is handled within the framework of the consultation.

“It should be a simple, well-defined problem that they are seeking care for, but it does not look like that in reality. Some come with a piece of paper where there are ten different things noted that they seek care for, and the doctor has a quarter of an hour to handle the problems.”

In order to create the best conditions for solving these cases of simple health problems, there are some important aspects that the staff bring up. First of all, visits should not be too long. One way to keep visits short is to explain the time frames to the patient and to avoid social chat. On the other hand, some said that it may be worth taking extra time to teach the patient about self-care, otherwise they will come back soon. Even if the ambition is to deal with these simple health problems, it is impossible to influence who is in the waiting room. However, the nurses avoid booking complicated cases with the doctors. These cases may involve long-term chronic problems or psychiatric disorders, and these patients are instead offered help in other ways.

A professional challenge

The advantages and disadvantages of the walk-in centre were described from a patient as well as an employee perspective. The benefits, for example, are varied work content that challenges and develops the nurses' skills. Meeting the patient physically is described as a necessity as regards the language barriers and creating opportunities for equal care for all. When words are not enough, it is possible to point, gesticulate or use body language to understand each other. The walk-in centre creates opportunities for helping many people, and the staff say that it is good to have a form of care where it is always possible to welcome the patient for a visit. The use of the walk-in centre is maximised almost every day.

“It requires a lot of those who work there. It puts our knowledge on trial. You can see almost everything at the walk-in centre.”

The disadvantages described include the high pace that creates stress for the staff. This is partly explained by short visiting times and the fact that many of the patients are hard to handle in a short time. Persons with frequent care-seeking behaviour who often return, along with long waiting times, are other factors that are considered negative by the staff. Several staff members wished that the walk-in centre could be open all day and felt that a limited number of patients and times to consult doctors is unfortunate.

Perspectives of the workload and the work environment

In this category it was found that working at the walk-in centre meant a high pace that required stress-resistant personnel. The working environment was influenced by patients who were often described as happy to receive help on the same day, but could at the same time be adversely affected by patients who were annoyed due to long waiting times. The walk-in centre was described as both promoting and threatening patient safety. The benefits of the patient visiting the centre instead of consulting via the telephone were described as promoting patient safety, especially when

the patient had language problems. At the same time, there were descriptions of overcrowded waiting rooms that easily become a place for the spread of infection, which threatens patient safety.

Stimulating but challenging work

Many among the staff found it stimulating to work in the walk-in centre, but at the same time noted that it would be too strenuous to do it on a daily basis. The work requires a lot of energy and concentration but is also described as exciting and challenging as you do not know what problems you will face. However, having the patient in front of you instead of on the phone is described as being less stressful.

“Once there was a patient who said he had a Swedish ant in his blood. It turned out to be a tick. It’s so good to be able to check what they mean at the walk-in centre.”

Meeting many people who cannot speak Swedish is described as a stressor, as the visits are expected to take 15 minutes each. The interpreters become a necessity because they can translate, but they also explain that this kind of care should not take too long and that it is important to prioritise among their symptoms. Another source of irritation is recurring patients who do not rely on the self-care advice they have previously received. Some patients expect medication and antibiotics and when they do not get it, conflicts can occur. Therefore, it is important that experienced, competent and robust nurses and doctors with professional integrity work at the walk-in centre.

“Since we get the interpreters, they really have a lot to do. And it’s great that we can solve the problems in a different way now than we might have done before.”

Often patients are happy to receive help on the same day, which affects the working environment for the better. However, long waiting times can create irritated patients, so the nurse may start by managing the patient’s annoyance and dissatisfaction before it is possible to address the actual reason for the visit. There are also a few descriptions of threatening patients, although this is not an everyday occurrence at the walk-in centre.

Patient safety – promoted or threatened?

The staff said that the walk-in centre usually promotes patient safety. Some even declared it to be a necessity on account of language difficulties. Being able to make accurate assessments in a short time when speaking different languages is facilitated by seeing and touching the patient. The use of interpreters can facilitate, but at the same time interpreters are in place for only a few languages. One nurse described a patient who told her by telephone that she had been bitten by very small birds. She saw no alternative but to invite the patient to the health centre for an assessment. When the patient was in place, it turned out to be harmless mosquito bites.

“They want to show things that may be perceived differently in their homelands. Vomiting, diarrhoea that can be fatal and they want to visit us directly, while we think they should stay at home and use self-care.”

What is also described as promoting patient safety is the fact that colleagues can consult each other at the walk-in centre and that nurses can get a second opinion from the doctor. In that way, they will never have to be alone with difficult decisions. On the other hand, two other aspects emerged,

which were considered to threaten patient safety. Firstly, the lack of triangulation, which allows a severely ill patient to wait their turn if he or she does not raise an alarm. Secondly, because infections can easily spread in overcrowded waiting rooms. A low level of knowledge among some visitors has caused parents to sit in the waiting room with children who have, for example, gastroenteritis or chickenpox.

“The risk is if the wrong person visits the walk-in centre. Someone may have a stroke and be sitting with queue number 30 in his hand, that’s not good, I think.”

Suggestions on how to develop the walk-in centre

This category is about the ideas the healthcare staff had about how the walk-in centre could be developed to better meet the needs of the patients. These ideas included teaching patients about the service of the walk-in centre and the Swedish healthcare system, more opportunities to meet the doctor and the nurse and better local facilities. Even though a majority were in favour of developing the walk-in centre, there were also calls to discontinue it and return to more conventional methods.

Teaching patients about the service of the walk-in centre and the Swedish healthcare system

In the interviews there is clearly a need for staff to clarify both the mission and the limitations of the walk-in centre and how the Swedish healthcare system is structured. The staff spend a lot of time meeting and explaining to patients what the mission is. Most visitors are described as being in the right place, but it is relatively frequent that patients are consulting for beauty operations on their nose or chest or that some recurring visitor mostly seems to be there for social reasons. It can be dangerous when someone with acute myocardial infarction is in the waiting room. The latter leads to the suggestion to have some kind of triage instead of taking patients in the order in which they arrive. The need for further in-depth information is therefore clear and could be solved with additional interpreters and information texts in different languages.

“We have also made some rules about how patients should behave ... We have rules of procedure in Arabic, Somali, English and Swedish. So sometimes it’s a bit of an education centre.”

The staff say that many of their patients come from cultures where healthcare is not tax-financed, so you can come to a specialist directly once you have paid. Therefore, a cultural clash and dissatisfaction can arise when a patient who expected a doctor meets a nurse instead, a nurse that is often a woman. Here it becomes necessary for the nurse to explain how the system is structured and it is often described as taking some time before the nurse has the patient’s confidence.

More opportunities to meet the doctor and the nurse

A large majority of the staff felt that the walk-in centre should be expanded further and stay open all day. The staff considered that the possibility of more and longer doctor appointments could make the walk-in centre better. One way to expand this opportunity is to have more doctors and nurses connected to the walk-in centre. It is perceived to be a tough job to be the first healthcare provider

to meet the patient, and therefore doctors on-site could facilitate and contribute credibility. Having the doctors available in the same place also has other advantages. This is to get quick confirmation of assessments and consult the physician to handle the patient smoothly. However, this is something that some of the doctors are hesitant about as they see a risk that all cases will then go through a doctor.

"I tend to think we should be open all day to handle more patients and reduce the pressure, because stress and pressure are difficult when we work there."

The need for better premises

Many among the staff highlighted that the premises were not so well designed for the purpose. Among the suggestions were larger waiting rooms, to reduce the risk of infections spreading and to offer a seat to everyone who needs and wants one. A larger and better waiting room is expected to reduce irritation among visitors. There were also other proposals from the staff to increase well-being. Someone suggested the opportunity to patients to wait for their turn outdoors and that the digital number sign could be visible there too. Other suggestions were a children's corner, a coffee machine or a television – everything in order to make the wait more bearable.

"it is not appropriate that patients with infectious diseases are in close vicinity of other patients in the waiting room especially when we have old and fragile patients"

Discussion

This study is unique as it evaluated a walk-in centre at a healthcare centre, in a context of many migrant care seekers from the perspective of healthcare personnel. As the literature review did not reveal any previous studies on this, only partial comparisons to other studies will be possible to make. The main results showed that there was large variation in patient characteristics and health problems at the walk-in centre. Patients were mostly unemployed and immigrants, aged from newborn to middle age, with health problems that varied from basic, such as colds, to advanced health problems e.g. myocardial infarctions. Although the patients and their problems were described as varying, the elderly and disabled were missing. The staff described how the long waiting times were difficult for them, which should be considered. The walk-in centre was appreciated by most of the staff, but there were challenges such as that many of the patients were hard to handle in a short time, which caused stress for the staff. The walk-in centre was related to patient safety and equal care for everyone, with the importance of working in a multiprofessional team and training patients about the service of the walk-in centre and the Swedish healthcare system.

An interesting finding in this study was the main purpose of the walk-in centre, which was to inform about self-care and to solve simple health problems. On the other hand, most of the migrant patients had other expectations of the care, and traditional preferences were highly relevant for migrant patients. Many migrants in Sweden come from countries where there few or no nurses but only doctors, and therefore they want and expect to meet doctors. Furthermore, they want results and action-oriented care instead of process-oriented care with long periods for investigations (Sachsl

1983). Our findings also highlighted the importance of patients' expectations of healthcare needing to be considered in order to develop equal person-centred care plans for migrants.

This study found that healthcare professionals worked in a multiprofessional team where they treated the patient independently and only shared information with each other (Kvarnström *et al.* 2013). However, this research acknowledged the importance of a transprofessional team with increased involvement of doctors, such as more and longer doctor appointments and having the doctors on-site. Team-based care is about structurally gathering staff from different professions around a patient in order to contribute their unique skills, competence and resources in patient care (Kvarnström *et al.* 2013). Striving for transprofessional teamwork has been recommended because it is considered effective; on the other hand, it is time-consuming (Thylefors *et al.* 2005). The manager's duty is to make the division of responsibilities clear and to bridge professional and organisational boundaries in the team-based care (Kvarnström *et al.* 2017). Thus, successful patient-centred care requires healthcare staff to work together with the focus on the patient and his/her right to be involved in his/her own care.

The findings emphasised the need for health literacy that includes knowledge about the services of the walk-in centre and the Swedish healthcare system, with a certain ability to understand, assess and communicate selected information about the care obtained in order to attain health and well-being (Vissandjée *et al.* 2017). Existing research (O'Donnell *et al.* 2016, Cheng *et al.* 2015) has shown that migrants are mostly underprivileged in health literacy, such as the ability to interpret and use health information, due to lack of awareness of resources, communication barriers, and inadequate social and institutional networks. In this study, health literacy at a walk-in centre was described as both promoting and threatening patient safety. Promoting patient safety included the fact that the patients with language barriers had the opportunity to have consultations at the centre instead of consulting by telephone. At the same time, a low level of ability to interpret and use healthcare information among some visitors has caused the spread of infections while visiting the waiting room, which threatened patient safety. However, health literacy is not just about individual traits; it is important to ensure that governments and health systems present clear, correct, suitable and accessible information to the migrant population (Rudd 2015). This is in order to enable migrants to have better access to appropriate and safe healthcare, which in turn encourages social justice by increasing migrants' social engagement, inclusion and full citizenship.

When conducting a content analysis, there is a risk that authors do not understand the context in full and therefore fail to identify key categories (Hsieh & Shannon 2005). In order to understand the context in which this study was performed, close cooperation between the authors was maintained in order to use the extensive experience of refugees' health available within the research team. All authors are nurses in their basic profession and have a good knowledge of what nursing at a healthcare centre means, as well as experience of both mental and somatic care. In the analysis process, internal validity was ensured via peer debriefing (Hsieh & Shannon 2005), which involved all authors agreeing on the development of categories in order to strengthen the trustworthiness of the results.

One potential limitation is that those who agreed to participate might be more positive about working at a walk-in centre than their colleagues who chose not to participate. This is certainly not unique to this study, but it does raise questions about the sample. On the other hand, the sample can be seen as a strength based on the healthcare personnel's extensive experience of both the walk-in centre and earlier conventional work at the healthcare centre, and can further be seen as particularly information-rich cases, thus strengthening the trustworthiness of the data (Patton 2015).

It might be seen as a limitation that only one healthcare centre was studied. However, as there are no other similar healthcare centres we had a unique opportunity to study a new organisational initiative designed to meet the new challenges with all newly arrived migrants in an immigrant-dense area. This must be seen as a strength.

Conclusion

A walk-in centre is an appreciated way of working among the staff at a healthcare centre in an immigrant-dense area. A walk-in centre can even be seen as a necessity related to issues of ensuring patient safety and delivering equal care for all. At the same time, the study shows that it cannot be the only form of care offered, as it seems not to be adapted to certain groups, such as people with disabilities and the elderly. The work is usually described as functioning well at the walk-in centre, but challenges arise when patients do not understand the conditions for the visit and the context of the care on offer. Therefore, it is important for all patients to understand how the walk-in centre is structured and organised and how the Swedish healthcare system works.

Relevance to clinical practice

Increased globalisation and migration make demands on how primary healthcare should be arranged to meet the needs of patients. As refugees have an increased need for care, deriving from both somatic and psychiatric ill health, we need to develop and evaluate forms of care that meet users' needs, while at the same time offering accessible and high-quality care for the native population as well. The study showed that a walk-in centre is a way to increase accessibility for the entire population. This study provides a contribution from the perspective of healthcare personnel. Who, if any, can evaluate it better?

What does this paper contribute to the wider global clinical community?

- No study has been revealed in previous research evaluating a walk-in centre at a healthcare centre in an immigrant-dense area from the perspective of healthcare personnel.
- The findings emphasise that a walk-in centre is a way to increase accessibility for the entire population and offer equal care for all, even if it involves challenges that need to be addressed.

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