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RESEARCH

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Meanings attributed by the nursing team to pediatric emergencies

Significados atribuídos pela equipe de enfermagem às emergências pediátricas

Significados atribuidos por el equipo de enfermería a las emergencias pediátricas

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Abstract

Objective: to understand the meanings attributed by the nursing team to experiences related to pediatric emergency care. **Method:** a descriptive, exploratory, qualitative study grounded in Symbolic Interactionism, conducted with the nursing team of the emergency department of a public hospital in Paraná, Brazil. Data collection took place between July and October 2022 through semi-structured interviews, analyzed using Thematic Content Analysis, with support from IRaMuTeQ®. **Results:** thirteen professionals participated, including seven nurses and six nursing technicians, and two categories emerged: 1) Meanings attributed to care in pediatric emergencies – addressing the negative meanings related to pediatric emergency care, associated with lack of technical and emotional preparedness. 2) Challenges experienced by the nursing team in pediatric emergencies – in which positive feelings toward dealing with the pediatric reality, continuous training, and the proposal of an exclusive pediatric care room symbolized strategies for safety. **Final considerations and implications for the practice:** nursing professionals attribute a duality of meanings, including challenges and re-significations in the care of children in emergency settings. The need for continuous team qualification, implementation of Standard Operating Procedures, and reorganization of care flows is emphasized to ensure safer care.

Keywords: Emergency Nursing; Pediatric Nursing; Nursing, Team; Qualitative Research; Child Health.

Resumo

Objetivo: compreender os significados atribuídos pela equipe de Enfermagem às experiências vivenciadas no atendimento de emergências pediátricas. **Método:** estudo descritivo, exploratório, qualitativo, fundamentado no Interacionismo Simbólico, conduzido com a equipe de Enfermagem do setor de emergência de um hospital público, do estado do Paraná/Brasil. A coleta de dados ocorreu entre julho e outubro de 2022, por meio de entrevistas semiestruturadas, analisadas por meio da Análise de Conteúdo Temática, com suporte do IRaMuTeQ®. **Resultados:** participaram 13 profissionais, sendo sete enfermeiros e seis técnicos de Enfermagem, e emergiram duas categorias: 1) sentidos atribuídos ao cuidado nas emergências pediátricas - que aborda os significados negativos atribuídos ao cuidado em emergências pediátricas, associados à falta de preparo técnico e emocional; 2) desafios vivenciados pela equipe de Enfermagem frente às emergências pediátricas - em que os sentimentos positivos relacionados ao enfrentamento da realidade pediátrica, as capacitações contínuas e a proposta de uma sala exclusiva para o atendimento infantil simbolizam estratégias para a segurança. **Considerações finais e implicações para a prática:** os profissionais de Enfermagem atribuem uma dualidade de significados, incluindo desafios e ressignificações no cuidado à criança em atendimento emergencial. Ressalta-se a necessidade de qualificação contínua da equipe, da implementação de Protocolos Operacionais Padrão e da reorganização dos fluxos assistenciais, visando à oferta de uma assistência mais segura.

Palavras-chave: Enfermagem em Emergência; Enfermagem Pediátrica; Equipe de Enfermagem; Pesquisa Qualitativa; Saúde da Criança.

Resumen

Objetivo: comprender los significados atribuidos por el equipo de enfermería a las experiencias vividas en la atención de urgencias pediátricas. **Método:** estudio cualitativo, descriptivo y exploratorio, basado en el interaccionismo simbólico, realizado con el equipo de enfermería del servicio de urgencias de un hospital público del estado de Paraná, Brasil. La recolección de datos se llevó a cabo entre julio y octubre de 2022, mediante entrevistas semiestructuradas, analizadas con Análisis Temático de Contenido, con el apoyo de IRaMuTeQ®. **Resultados:** participaron trece profesionales, siete enfermeros y seis técnicos de enfermería, y surgieron dos categorías: 1) significados atribuidos a la atención en urgencias pediátricas, que aborda los significados negativos asociados a la atención en urgencias pediátricas, relacionados con la falta de preparación técnica y emocional; 2) desafíos experimentados por el equipo de enfermería en urgencias pediátricas, donde los sentimientos positivos relacionados con el afrontamiento de la realidad pediátrica, la formación continua y la propuesta de una sala dedicada al cuidado infantil simbolizan estrategias de seguridad. **Consideraciones finales e implicaciones para la práctica:** los profesionales de enfermería atribuyen una dualidad de significados, incluyendo desafíos y resignificaciones, al cuidado de niños en situaciones de emergencia. Se destaca la necesidad de una formación continua del equipo, la implementación de Procedimientos Operativos Estándar y la reorganización de los flujos asistenciales, con el objetivo de brindar una atención más segura.

Palabras Clave: Enfermería de Urgencia; Enfermería Pediátrica; Grupo de Enfermería; Investigación Cualitativa; Salud Infantil.

INTRODUCTION

In child health, emergencies may occur, situations considered severe and life-threatening to the child. In this context, timely and high-quality care determines the success of the outcome.[1] Urgency is defined as an unforeseen occurrence of a health condition, with or without risk of death, in which the individual requires medical care. Emergency, in turn, consists of the identification of health conditions that imply intense suffering and/or represent an imminent risk of death, requiring immediate treatment.[2]

Worldwide, the epidemiological profile of pediatric care has changed over the years. A study conducted in 2020 in Italy identified a significant reduction in hospitalizations, outpatient visits, and specialized consultation activities. However, there was an increase in the severity of diseases admitted to hospital sectors.[3] A study conducted in the city of São Paulo, Brazil, identified that, between 2011 and 2022, there were 98,679 hospitalizations of children under one year of age due to conditions sensitive to Primary Health Care and, among these hospitalizations, 97.4% of cases were treated on an emergency basis.[4]

From this perspective, the nursing team plays an active role in urgent and emergency care settings, whether in risk classification or in care after the child's admission.[1] However, there are several challenges faced by professionals working in the pediatric context, notably the scarcity of training, which generates insecurity and non-specific care.[5]

Thus, the experiences lived in urgent and emergency services are mediated by interactions among children, family members, and professionals. Therefore, the way the nursing team perceives the severity of the clinical condition, technical preparedness, training, and the effectiveness of care is socially constructed, influencing behaviors, decisions, and emotions in the face of pediatric hospitalization.[6,7]

Although there are studies that investigate aspects related to the care pathway for pediatric emergencies, they do not address the subjective aspects inherent to nursing care and the meanings attributed by professionals.[3,7] Understanding the meanings attributed by these professionals in the context of pediatric emergency care may help to understand how the work process occurs, identifying strengths and weaknesses in care. Thus, the following question arises: "What meanings are attributed by the nursing team in the face of pediatric emergencies?"

To answer the research question, this study aimed to understand the meanings attributed by the nursing team to their experiences in providing care for pediatric emergencies.

METHOD

This is a descriptive, exploratory, qualitative study, developed with the nursing team working in pediatric emergency care at a public hospital. Symbolic Interactionism was adopted as the theoretical framework, a sociological theory that emphasizes that human behavior depends on the meanings attributed to things, and that these meanings are shaped through interaction among individuals.[7] This study was conducted in accordance with the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ).[8]

The aforementioned hospital is a tertiary reference within the health care network of the 15th Health Region of the state of Paraná and is located in a municipality in the Northwest region of Paraná, Brazil. It has a mixed-use emergency room with six beds designated for the care of adult and pediatric patients, which implies the simultaneous care of different clinical profiles in the same environment, without specific physical separation, nor an exclusive team for pediatric patients.

The study participants were professionals from the nursing team working in the emergency room of the aforementioned hospital. The eligibility criteria were: being a nurse and/or a nursing technician working in the aforementioned sector, regardless of length of service, experience in child health care, and/or type of employment contract (civil servant, credentialed, resident), allocated to the day and afternoon shifts, from 7 a.m. to 7 p.m., according to the logistics established in the research schedule. Health professionals who were away from their duties for any reason during the study period were not included.

Participants were selected by convenience through contact with health professionals. Among the 25 professionals eligible for the study, 13 agreed to participate, including seven nurses and six nursing technicians. The remaining 12 professionals were not available at the time of the study and/or declined to participate.

Data collection took place from July to October 2022. Initially, an email was sent to the coordinator of the Continuing Education sector and to the Nursing Directorate at the research site, explaining the study's objectives and how staff members could participate. Following this contact, the researcher personally invited the health professionals. Those who agreed to participate in the study signed the Free and Informed Consent Term (FICT) in two identical copies.

After this stage, a time was scheduled for conducting the interview. Subsequently, the interview was carried out at the workplace itself, in a private setting, through an individual, semi-structured interview, conducted only once with each participant, with an average duration of 30 minutes each. The interviews were conducted by the principal investigator, a nurse and emergency care resident, and by a PhD nurse with experience in the research field.

The interview consisted of questions on sociodemographic and professional characteristics and included the following guiding question: "Tell me about your experience in the emergency room during pediatric care". Other questions were asked to address the proposed objective. The interviews were audio-recorded and fully transcribed. Data collection was concluded when the researchers observed that the data were sufficient to answer the proposed research objective, characterizing theoretical saturation, at which point no new relevant elements emerged in the interviews.[9]

The professionals' characterization data were organized in a spreadsheet using Microsoft Excel 2010® software and analyzed through simple descriptive statistics. The material resulting from the interviews was submitted to the Content Analysis technique, in the Thematic modality, following three stages: pre-analysis, corresponding to reading and organizing the material; material exploration, referring to data coding and classification; and results treatment, inference, and interpretation, in which the results were organized and interpreted according to the proposed theoretical framework.[10]

The data were operationalized using IRaMuTeQ® software - *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*, version 0.7 alpha 2.[11] Based on the initial categories that emerged from the Content Analysis, a textual *corpus* was constructed with excerpts from the interviews that addressed the objective proposed in this study. Similitude Analysis was then applied, which made it possible to identify the occurrence of words and the connections between them, and subsequently, these words were grouped into central and peripheral zones, generating a similitude tree that assisted in identifying the structures.[11] From the convergence between the initial categories obtained from the Content Analysis and the data organization by the software, two final categories emerged.

The study followed the ethical principles contained in Resolutions No. 466/2012 and No. 510/2016 and was approved by the Research Ethics Committee (REC) involving Human Beings of the signatory university under opinion No. 5,594,042/2022 and CAAE No. 60507522.8.0000.0104. To preserve the participants' identity, the following identification was adopted: "NUR" for nurses and "TECH" for nursing technicians, both followed by the order in which the interview was conducted.

RESULTS

A total of 13 health professionals participated in the study, including seven nurses, all female, with a mean age of 30±SD 3.67 years (range: 24 min.; 35 max.), and six nursing technicians, three female and three male, with a mean age of 33±SD 8.67 years (range: 20 min.; 45 max.). The duration of training ranged from one to 19 years; only one participant had a specialization in child health, and only three had experience in child care.

Based on the analysis performed using IRaMuTeQ® software, 208 text segments were obtained, of which 146 were analyzed, corresponding to 70.19% utilization. In the presented similitude tree, connections were identified among the terms: team (n=49), care (n=49), emergency room (n=39), to provide care (n=45), to arrive (n=42), severe (n=42), and adult (n=44) (Figure 1).

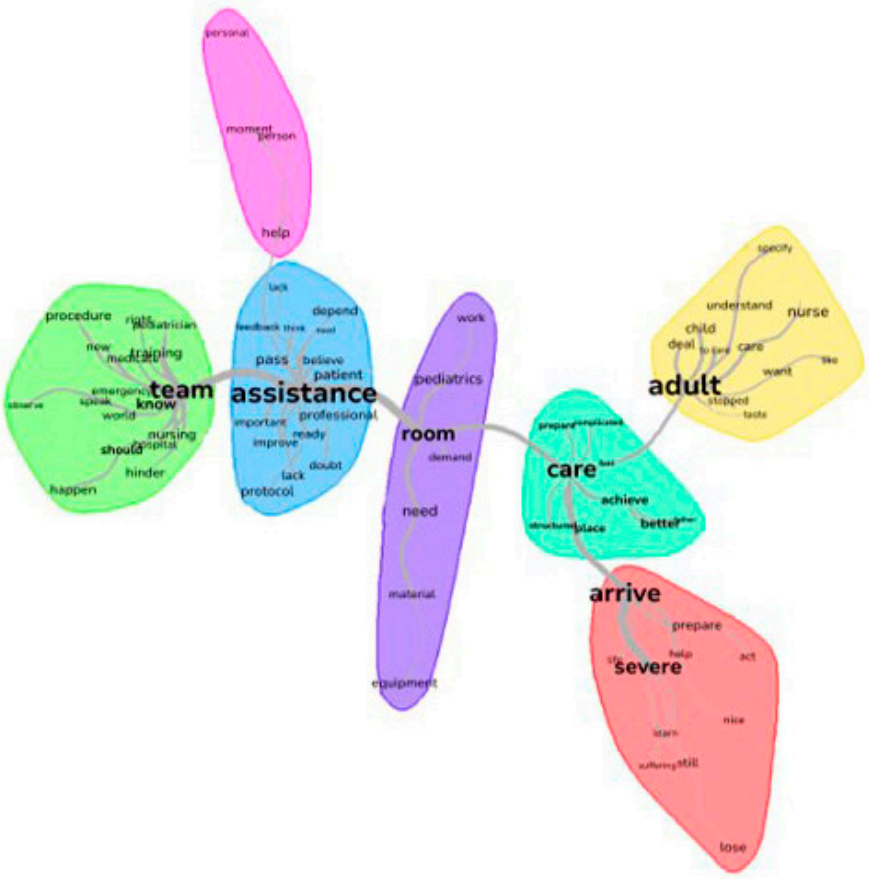

Figure 1. Similitude tree generated in IRaMuTeQ®, based on the interviews.

From the Thematic Analysis and the indicated words, two categories emerged: Category 1 - Meanings attributed to care in pediatric emergencies; and Category 2 - Challenges faced by the nursing team in pediatric emergencies.

Meanings attributed to care in pediatric emergencies

Care in pediatric emergencies was associated by the nursing team with a practice of high emotional tension and responsibility. Words such as "improve", "manage", and "help" indicate the professionals' commitment to the child's recovery.

At the same time, expressions such as "arrive", "severe", "suffering," and "lose" reflect the intense emotional burden to which these professionals are exposed, especially in critical situations involving imminent risk of death. Such experiences give rise to feelings of fear, apprehension, insecurity, and sadness.

The words presented in the similitude tree show that care in pediatric urgent and emergency contexts imposes on nursing professionals a set of challenges that go beyond the technical dimension of care. The prominence of terms such as "care", "team", "professional", and "need" reveals the meaning of the demands faced, which require not only knowledge and skills but also rapid decision-making and coordination with the multidisciplinary team. In this sense, the following terms stood out: fear (n=5), apprehension (n=1), insecurity (n=3), and sadness (n=3).

The nursing team professionals attributed to care in pediatric emergencies meanings associated with feelings of fear, apprehension, and insecurity, which occurred, in part, due to the insecurity caused by a lack of knowledge and experience in pediatric urgent care.

> *What I feel when facing a pediatric emergency is insecurity […]. I get quite confused regarding medications, dosage, procedures, even intubation. I have difficulties in several aspects. I can manage an adult patient emergency well, but not a pediatric one* (NUR 7).
>
> *I feel a little scared, apprehensive, afraid of doing something wrong* (NUR 3).
>
> *I think a professional needs to have a bit of fear to avoid overconfidence. A professional who has lost fear can even become dangerous, right? So, we are always afraid of the new. The child, the child's clinical condition, the care itself, for me, was very new. So, the fear came every time a critically ill child arrived* (TECH 5).

In the participants' statements, feelings of incapacity and sadness emerged, as well as expressions such as "heart in one's hands", symbolically linked to the inability, in emergency situations, to cope with the severity of the clinical cases treated in the service.

> *There is a feeling of incapacity. We suffer so much that we end up calling the pediatric ICU team asking for help, we feel our hearts in our hands. When a critically ill child arrives, we wonder whether we will be able to do our best for them* (NUR 5).
>
> *I, personally, do not like caring for children. I do not feel prepared to provide care. I was prepared to care for adults. When all those children started to arrive [due to COVID-19], I became desperate. I was not ready! There was a child who died there, went into cardiac arrest, a physician started chest compressions as if it were an adult, and then the child died, a completely stressful situation. The feelings at that moment were anger for having lost the child and sadness. The other technician who was with me remained composed at the time, the nurse knew how to handle the situation, but I broke down. I thought it was better to step aside* (TECH 2).
>
> *I think my main feeling during pediatric emergency care is sadness, seeing that little child full of life going through that situation. It is something that marks me. Of course, at the moment, we try to set that aside and do our best to save the child, to help them* (NUR 1).

Although the terms "fulfillment" and "happiness" appear with low frequency in the similitude tree, they emerge in the statements with strong symbolic meaning, representing positive feelings. These terms were related to experiences of belonging and professional success in pediatric care. Such emotions not only symbolize the overcoming of insecurities but also reinforce the construction of the professional identity of the nursing team, especially when the care provided results in favorable clinical outcomes.

> *When a child arrives in poor condition, we provide care and stabilize them, then later see [the child] calm, peaceful with their mother, eating. Helping in that person's life, seeing that each one did their part. It is a feeling of belonging, of being part of a team that is helping in that individual's life, and also of fulfillment* (TECH 6).
>
> *A feeling that could describe what I experience during pediatric care would be happiness for being there, doing good for that child in such a difficult moment* (TECH 3).
>
> *I like it, I have always liked working with children! I always wanted to, I like it and identify with dealing with children. Theoretically, I prefer pediatrics more than adults. There are many more details, there is the mother's side, the child's side, there is that whole aspect, but I like it a lot. The feeling that comes is fulfillment* (NUR 2).

From the perspective of Symbolic Interactionism, nursing professionals attribute multiple and ambivalent meanings to care in pediatric emergencies. While they experience fear and insecurity when providing care to children, they also experience feelings of fulfillment, happiness, and belonging in their role as nursing professionals.

Challenges faced by the nursing team in pediatric emergencies

The nursing team experiences complex challenges when dealing with pediatric emergencies. Inexperience (n=12), lack of protocols (n=9), lack of training (n=8), lack of equipment (n=6), and difficulty (n=5) refer to the main challenges faced by the nursing team.

The professionals highlighted the lack of protocols, especially those related to medication, the scarcity of specific material resources for pediatric care, and the lack of trained professionals to handle pediatric emergencies. These difficulties were considered barriers to providing care to children in emergency situations. The development of protocols was identified as a necessary document, as it guides safe nursing care for pediatric patients.

> *There are still some protocols needed to care for these children. Care varies according to the pediatrician, so sometimes we feel a bit lost for not having this protocol, a routine, but nothing that causes a deficit in care* (NUR 1).
>
> *A child needed to be intubated due to the team's delay in providing care. Intervention in an emergency should be immediate. Everything is improvised. We do not have protocols. We have access to materials and equipment, that is not lacking, but in terms of care, there is nothing that actually works. Protocols help provide direction* (NUR 3).
>
> *The greatest difficulty was not knowing how to deal with the child. I do not know how to calculate medication dosages, I do not know, it is not something from my daily routine. If there were protocols there in the [emergency] room, routines to be followed, it would be much easier for the team to care for the child. This lack of protocols weighs on daily practice* (TECH 2).

Furthermore, delays in care and distress among health professionals were associated with the scarcity of material resources and infrastructure specific to pediatric emergency care, considering that, in this context, every minute is essential to save a life.

> *There should be a specific place to care for these critically ill children, because everything is mixed there [emergency room], it becomes disorganized. Sometimes, a three-day-old baby arrives and stays in the same environment as a patient with a multidrug-resistant bacterium, which is not appropriate* (TECH 1).
>
> *The room was not equipped with the necessary devices. Sometimes, we had to borrow medical equipment from other sectors to be able to support the child. It is not easy not having the appropriate equipment at the time of an emergency* (TECH 2).
>
> *Sometimes, there is no specific material for children in the room during care, and we need to go after it, either in pediatrics or in the pediatric ICU, and that takes time. Losing time during emergency care is dangerous, every second matters* (NUR 4).

The nursing team also attributed a negative meaning to the lack of qualified professionals for pediatric care and to the insufficient number of training opportunities focused on pediatric emergencies.

> *There should be more people trained to care for children, because there are many people who are trained to care for adults. It is not that they do not know how to do it, but those who care for children need to have a different response, to identify an emergency, because it is different* (NUR 2).
>
> *As this is a teaching hospital, we have to learn all the time, the entire team, it is a demanding, continuous job. Something that hinders the learning and training of professionals is staff rotation. Many do not like pediatrics, have never had training, and this complicates things, because the flow of critically ill children has started to increase in the institution* (NUR 5).
>
> *The greatest challenge here at the hospital, for quality care in pediatric emergencies, is having a prepared team, both medical and nursing, with experience in child care to guide the care and support the team. The nursing team needs to improve its qualifications, nurses, technicians, residents, after all, it is a teaching hospital* (TECH 4).

Although training is identified as a relevant strategy for re-signifying care, the statements also revealed fragility in the face of team turnover and work overload, which generate situations of insecurity experienced in clinical practice. These elements reinforce the need for continuous, structured institutional investments adapted to the reality of the services.

> *In the short term, I think training. Some team members have a certain level of knowledge, others not so much. Team turnover is very high. So sometimes you think you have trained the team, and suddenly everyone has changed. So, this is something that makes care more difficult. Because, whether we like it or not, teamwork changes. Knowledge and organization, everything we had well-structured, you lose. I have to start all over again* (NUR 6).
>
> *The hospital provided some members of the nursing team working in the emergency room with training in the pediatric ICU, and I thought it was very valuable, so we could see the correct ways to care for these children, to even understand procedures like CBG [capillary blood glucose test], which we had been doing incorrectly. The training was very valuable, and I believe this is the path to improving care, more training* (NUR 5).
>
> *I think training would be necessary, the creation of protocols, continuing the feedback we already provide, ongoing training, professional updating, and the creation of protocols. In the pediatric ICU, there were many protocols. For venous access, we had a protocol that was always performed by two [professionals], never alone; tube replacement, always by two* (TECH 3).

The participants suggested the need to create an emergency room exclusively for pediatric care, conducted by qualified professionals, which was symbolically understood as an attempt to re-signify care practice. This reflects the redefinition of the care situation, attributing meanings of organization and safety to the interactions established in the context of pediatric emergencies.

> *To improve patient flow in the hospital, I think there should be a pediatric urgent care unit and a semi-intensive unit, with a flow from lower to higher severity, in addition to fixed and trained professionals, not staff rotation as happens here. Sometimes, professionals without experience are assigned to the sector, and at the time of the emergency, there is no time to teach, it is not the moment* (TECH 4).
>
> *Regarding structure, what would be interesting is really having a pediatric emergency department, with staff trained to provide care and with the appropriate materials to handle all of this. Then it would be a different story, it would certainly be a different reality and a different type of care* (TECH 5).
>
> *There should be a larger structure: television, bathroom, even a specific emergency department for children* (NUR 2).

The challenges experienced by the nursing team are related to structural limitations, lack of protocols, professional turnover, and lack of training. However, the proposal of a dedicated room for pediatric care symbolizes strategies to achieve greater safety. Thus, care becomes a dynamic field for the construction of meanings based on practical experience.

DISCUSSION

This study's results revealed that care in pediatric emergencies imposes emotional and structural challenges on nursing professionals. Feelings of fear and insecurity emerge especially in contexts of high clinical complexity, such as cases with imminent risk of death. In light of Symbolic Interactionism, it is possible to understand that these feelings are constructed through social and institutional interactions: among professionals, with children, and with the service. The reported insecurity, for example, is not only individual, but symbolic of a work context that lacks preparation, organization, and support.[7]

Furthermore, the fact that care takes place in a physical space shared between adult and pediatric patients may constitute a relevant element for understanding these findings. The need to care for patients under different care logics, whether clinical, communicational, or technical, may require adaptations in professional conduct and favor the occurrence of errors.[12,13] In specialized contexts, such as pediatric hospitalization, studies have indicated that nursing professionals often perceive themselves as unprepared to face critical situations, especially those related to the child's death, the family's grieving process, and the multiple demands involved in this type of experience.[14,15]

In this scenario, the complexity of care provided to patients, combined with the high workload, may contribute to the physical and emotional exhaustion of professionals, who deal daily with situations that generate suffering. Frequent exposure to emergencies requiring rapid responses, intense tasks, long working hours, and exhausting shifts may trigger, among nursing workers, the development of Burnout Syndrome, an emotional disorder marked by intense physical and mental exhaustion, associated with highly stressful work environments.[16,17]

A study conducted in hospitals in Spain showed that many nursing professionals working in pediatrics presented high levels of Burnout, with low personal accomplishment being the most recurrent aspect among participants.[18] This finding converges with the statements presented, such as "feeling of incapacity" and "heart in one's hands" when facing a critically ill child, demonstrating that suffering is not limited to technical aspects, but deeply affects the symbolic and emotional field of practice.

Similarly, a study conducted in Turkey with nurses from pediatric emergency units identified high emotional exhaustion levels, depersonalization, low personal accomplishment, and moderate compassion fatigue levels.[19] In the Middle East, another study with pediatric nurses indicated that individual characteristics, perception of inadequate remuneration, and limitations in hospital or care unit capacity were factors that intensified Burnout, negatively affected professionals' quality of life, and contributed to poorer assessments of patient safety.[20] These findings are consistent with this study's results, in which professionals reported feelings of deep sadness, helplessness, and overload when facing emergency situations involving children.

On the one hand, pediatric emergency care imposes intense emotional challenges; on the other hand, it can also provide experiences of professional satisfaction and meaning-making at work. This aspect was highlighted in Category 1, which revealed feelings of belonging, fulfillment, and happiness in response to successful clinical care. Such feelings symbolically re-signify suffering and reinforce the identity of nursing professionals as a fundamental part of the care team.

A study conducted in a hospital in the Southern Region of Brazil showed that experiences of pleasure in the workplace tend to occur when professionals find favorable conditions to apply their technical and personal competencies, promoting full autonomy in the performance of their duties.[21]

The findings therefore indicated that improving the quality of care in pediatric emergencies does not depend solely on the individual efforts of professionals, but requires institutional policies that ensure stability, adequate physical structure, well-defined protocols, and continuing education. This understanding expands the notion of individual preparedness and shifts responsibility toward a collective approach.

In this sense, the results pointed to the need to strengthen public policies aimed at organizing the network of pediatric urgent and emergency care, as well as improving hospital management, especially in the implementation of care protocols. The fragility of these elements, as evidenced in the participants' statements, reveals gaps that compromise the quality of care, patient safety, and the well-being of professionals.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR THE PRACTICE

The findings made it possible to identify that nursing professionals symbolically attribute a duality of meanings, including challenges and re-significations in the care of children in emergency settings. Pediatric emergencies result in a set of heterogeneous feelings, due to the complexity of the situation. It is up to the nursing team to have the necessary preparation to care for this population in an assertive, safe, and humanized manner, which requires, at the institutional level, the implementation of Standard Operating Procedures, the strengthening of continuing education strategies, and the reorganization of care flows, especially given the need to review care provided in environments shared between adults and children.

Further studies on this topic are relevant, both to consolidate existing knowledge and to minimize possible controversies inherent between pediatric emergency practice and research. New studies are suggested, such as intervention studies with the team itself, to assess the need, adaptability, and adequacy of practice during pediatric care in emergency services.

As a limitation of the study, it is highlighted that participants were interviewed within the health service itself, during situations in which they were experiencing emergency care, without having sufficient time to reflect on the situation experienced. Considering that the study was conducted based on recruitment from a single public health service in the Southern Region of Brazil, the findings cannot be generalized to other health services or geographical contexts.

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DATA AVAILABILITY RESEARCH

The data underlying the research text are contained within the article.

CONFLICT OF INTEREST

No conflict of interest.

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