

User embracement in pediatric oncological emergency: difficulties and facilitating factors in child care

Acolhimento em emergência oncológica pediátrica: dificuldades e facilidades na assistência à criança

Acogimiento en urgencia oncológica pediátrica: dificultades y facilidades en la asistencia a la infancia

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ABSTRACT

Objective: to identify the difficulties and facilitating factors surrounding the user embracement performed by the nursing team in the pediatric oncological emergency. **Method:** qualitative study, conducted with 12 nursing professionals from the pediatric oncological emergency of a hospital located in Rio de Janeiro. Data were collected through semi-structured interviews conducted between December 2023 and April 2024 and analyzed through thematic content analysis in accordance with Symbolic Interactionism. All ethical aspects were respected. **Results:** two categories were identified: Difficulties and facilitating factors surrounding user embracement in the pediatric oncological emergency; and Perception of user embracement: pointing to possible pathways. **Final considerations:** It was possible to identify as difficulties the lack of an adequate space for user embracement and the reduced team composition; and as facilitating factors, the availability of quality equipment, team cohesion, and good communication with family members.

Descriptors: Nursing; Pediatrics; Medical Oncology; Emergencies; User Embracement.

RESUMO

Objetivo: identificar as dificuldades e as facilidades que permeiam o acolhimento realizado pela equipe de enfermagem na emergência oncológica pediátrica. **Método:** estudo qualitativo, realizado com 12 profissionais de enfermagem da emergência oncológica pediátrica de um hospital localizado no Rio de Janeiro. Os dados foram coletados por meio de entrevistas semiestruturadas, realizadas entre dezembro de 2023 e abril de 2024 e analisadas por meio da análise de conteúdo do tipo temática à luz do Interacionismo Simbólico. Todos os aspectos éticos foram respeitados. **Resultados:** foram delineadas duas categorias: Dificuldades e facilidades que permeiam o acolhimento na emergência oncológica pediátrica; e Percepção do acolhimento: apontando caminhos possíveis. **Considerações finais:** Foi possível identificar como dificuldades, a falta de um lugar adequado para a realização do acolhimento e a composição reduzida da equipe; e como facilidades, a disponibilidade de equipamentos de qualidade, o entrosamento da equipe e a boa comunicação com o familiar.

Descritores: Enfermagem; Pediatria; Oncologia; Emergências; Acolhimento.

RESUMEN

Objetivo: identificar las dificultades y las facilidades que permean el acogimiento realizado por el equipo de enfermería en la urgencia oncológica pediátrica. **Método:** estudio cualitativo, realizado con 12 profesionales de enfermería de la urgencia oncológica pediátrica de un hospital ubicado en Río de Janeiro. Los datos fueron recolectados mediante entrevistas semiestructuradas, realizadas entre diciembre de 2023 y abril de 2024 y analizados por medio del análisis de contenido de tipo temático a la luz del Interaccionismo Simbólico. Todos los aspectos éticos fueron respetados. **Resultados:** se delinearon dos categorías: Dificultades y facilidades que permean el acogimiento en la urgencia oncológica pediátrica; y Percepción del acogimiento: señalando caminos posibles. **Consideraciones finales:** Fue posible identificar como dificultades, la falta de un lugar adecuado para la realización del acogimiento y la composición reducida del equipo; y como facilidades, la disponibilidad de equipos de calidad, el entendimiento del equipo y la buena comunicación con el familiar.

Descriptores: Seguridad del Paciente; Enfermería Pediátrica; Atención de Enfermería; Cateterismo Periférico.

INTRODUCTION

The experience of childhood and adolescent cancer generates physical, emotional, and social impacts from the time of diagnosis, not only in the child but in the entire family and close circle who accompany the stages of illness and treatment, making a relationship of trust with health professionals indispensable¹.

As a consequence of treatment and the clinical progression of the disease, complications and problems arise that result in oncological emergencies, which will require support or resolution in Oncological Emergency Care services. These services must be adequate and staffed with trained personnel to meet this specific demand, enabling rapid and high-quality identification of higher-risk conditions through the use of care processes involving anamnesis, clinical

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assessment, and triage, thereby preventing or mitigating critical harm². In this context, user embracement emerges as a fundamental step in health promotion and the prevention of complications³.

The word “user embracement” [acolhimento] has multiple meanings. In this study, it is understood as a strategy to expand and enhance user access to health services, promoting the humanization of care⁴. In this context, the literature highlights its potential to build bonds with users and address demands in health services, regardless of the specificities of the context⁴.

User embracement carried out with quality, seriousness, empathy, and *expertise* makes it possible to reduce physical and psychological harm, minimize suffering, and save lives. Therefore, this practice deserves a more sensitive and scientific perspective to highlight, through research, a complex system orchestrated across multiple dimensions and possibilities, in which nurses play a uniquely leading role, managing their team, reconciling clinical practice, the use of protocols, and sensitivity to provide the best possible care to children and their families during such moments of vulnerability⁵.

In the context of Pediatric Emergency Care, user embracement is an important step in the care of the child and family. It develops through attentive listening to the main complaints, passes through clinical assessment and vital signs monitoring, and concludes with the determination of risk classification based on the data collected, guided by an institutional protocol. This step is essential for the continuity of care in an efficient and organized manner⁴. In the pediatric oncological emergency, it becomes necessary, as it favors the early identification of alarming signs and symptoms, while recognition, management, and immediate treatment of oncological emergencies are essential to reduce morbidity and mortality in this population⁶.

Therefore, user embracement as a strategy for health promotion and the prevention of complications in health services is an important technological tool of care that demands from health professionals a complex web of actions involving qualified listening, appreciation of individual particularities, and the understanding and resolution of their health demands⁵. Thus, given the relevance of epidemiological data related to the incidence of childhood and adolescent cancer⁷, as well as the complexity of pediatric oncological care and the challenges of user embracement practice in the emergency context, the need for this study arose.

Furthermore, in a scenario where the child's vulnerability is exacerbated by the severity of the oncological condition, effective user embracement can mitigate the psychological impact of treatment, promoting a less traumatic experience. The scarcity of research in this area signals a critical gap in knowledge, hindering the standardization of practices and the training of specialized professionals^{8,9}. This fact demands from professionals, in addition to ongoing updating and deepening of technical-scientific knowledge, insight and reflection on their practice to navigate the broad universe of pediatrics and prevent cases of morbidity and mortality^{9,10}.

Studies exploring the nuances of user embracement, including its conditioning factors, are indispensable to optimize care and ensure that each child and family receives the comprehensive support needed during pediatric oncological emergencies.

In this context, this study advances by enabling a discussion of the facilitating and hindering factors of user embracement performed by the nursing team in the Pediatric Oncological Emergency, beyond the triage developed during the encounter with the child and family. It is, therefore, an opportunity to understand user embracement as an important humanization strategy in the context of oncological emergencies.

Upon reflecting on this topic, the following question arose: What factors facilitate or hinder user embracement in the Pediatric Oncological Emergency?

Considering the above, the aim of this study was to identify the difficulties and facilitating factors surrounding the user embracement performed by the nursing team in the Pediatric Oncological Emergency.

Theoretical framework

The industrialization and urbanization of the early twentieth century generated social problems that served as a stimulus for scholars of Social Psychology. They felt the need to develop a new theoretical perspective to help understand and analyze the systematic study of human social behavior. Thus emerged the theory known as Symbolic Interactionism¹¹.

Historically, Symbolic Interactionism was inspired by the ideas of Georg Herbert Mead, a philosophy professor, and is directly linked to the founding of the University of Chicago, in 1890, in a context of expansion and consolidation of sociology. Mead understood that people's consciousness is formed through social interactions and processes¹¹.

Mead's written output during his lifetime was relatively limited, concentrated in articles and notes. However, his true influence manifested after his death through the publication of notes and lectures compiled by his students. Furthermore, the interpretation and development of his ideas by sociologists such as Herbert Blumer were fundamental to the dissemination of his thought. Mead's best-known work, "*Mind, Self and Society*", published in 1934, is a compendium of his ideas and represents a landmark in sociology¹¹.

Human action is a process divided into four phases: impulse (the need that drives action), perception (the search for means to satisfy the impulse), manipulation (the use of means to achieve the goal), and consummation (the satisfaction of the impulse). The individual decision, actively made at each stage, is what defines the action. Social norms, in turn, influence these decisions through mechanisms such as negotiations, sanctions, and hierarchies, shaping human behavior¹¹.

Mead's name is linked to the founding of the theory, but it was Herbert Blumer who was the great disseminator of this theoretical perspective, including coining the name by which it became known – Symbolic Interactionism. Blumer believed that human beings understand things through their meanings, and these meanings are elaborated and modified through social interaction¹¹.

The nature of symbolic interactionism is based on three premises¹¹: the first is that human beings orient their actions toward things based on the meaning these things have for them; the second is that the meaning of these things arises as a consequence of the social interaction each person maintains with others; the third is that meanings are manipulated and modified through an interpretive process carried out by the person when confronted with the things encountered along their path.

These premises become more tangible when we understand that Symbolic Interactionism values the meaning that things have for human behavior. And this meaning arises from interaction between people, being constructed and refined in two stages of interpretation. In the first stage, the individual's interaction is with themselves – becoming acquainted with, constructing, and familiarizing themselves with that meaning. In the second, the individual begins to shape the meaning they already know – recreating, selecting, reevaluating, and transforming meanings based on the situations experienced at the moment, thus defining the direction of their action¹¹.

From this perspective, identifying the facilitating factors and difficulties surrounding the user embracement performed by the nursing team in the Pediatric Oncological Emergency entails recognizing that the practice of user embracement results in a continuous interpretive process, in which each interaction with the child, the family, and the nursing team re-signifies the act of embracing. Therefore, user embracement is understood as a symbolic action mediated by experiences, values, and institutional norms, whose interpretation guides how the nursing team perceives and carries out its care.

METHOD

The methodological design of this study was built through exploratory field research using a qualitative approach. The setting was the Pediatric Oncological Emergency unit of a hospital that is a reference for oncological care in the city of Rio de Janeiro. It is important to note that this is an auxiliary institution of the Ministry of Health that is part of the SUS and offers services including medical-hospital care provided directly and free of charge to cancer patients, as well as operating in strategic areas such as prevention and early detection, training of specialized professionals, research development, and generation of epidemiological information¹².

Nursing professionals assigned to this sector from the beginning of 2023 were invited to participate in the study, using the following inclusion criteria: being a nursing professional at the institution and working in the Pediatric Complex. The Pediatric Complex is understood as the set of the following units: Pediatric Outpatient Clinics, Pediatric Wards, Pediatric Intensive Care Unit, and Pediatric Emergency. The exclusion criterion was defined as: nursing professionals who, even though they are part of the Pediatric Complex, do not work in the Pediatric Emergency unit.

Data were collected through semi-structured interviews, conducted with 12 nursing professionals assigned to the emergency unit, and one nursing professional from the ward staff who had worked in the pediatric emergency unit during the study period. Thus, all nursing professionals working in the pediatric emergency were interviewed.

The interviews were conducted on the premises of the hospital under study, in a reserved and private location to promote better interaction between the researcher and the interviewee. They took place between December 2023 and April 2024 and lasted approximately 7 to 30 minutes. Participants were initially asked about the facilitating factors and difficulties encountered in user embracement of the child and family in the Pediatric Oncological Emergency. Subsequently, additional questions related to the study object were asked. Data were subjected to

Bardin's thematic/categorical content analysis, consistent with its respective stages: pre-analysis, material exploration, treatment of results, and interpretation¹³.

In the pre-analysis stage, the material was prepared for analysis. Initially, the recorded interviews were transcribed and organized, differentiating questions and answers using different colors for ease of understanding. With the transcripts in hand, a first approximation of the interview content was made through a "floating reading" of the raw data obtained during collection, taking the opportunity to correct and improve punctuation and spelling. All elements present in the participants' statements were considered *a priori*¹³.

In the subsequent stage, material exploration was carried out. The raw data (transcripts) were minutely examined line by line. Each significant fragment was identified and coded, resulting in registration units (RU). To organize these codes, a number was assigned to the interview, another to the order of the code within the interview, and a third to the page of the transcript. This numerical structure facilitated the location and reference of specific excerpts. For example, code 9.2.1 indicates the second code from the ninth interview, found on the first page of the transcript. Each participant was identified by a color for better visualization during data analysis.

The third and final stage of analysis consisted of the treatment of results and interpretation. This stage was divided into two parts: in the first, the registration units were subjected to comparative analysis and grouped into thematic axes based on their similarities. In the second phase, the thematic axes were also brought together, giving rise to the categories on which the research was based for the final assessment and interpretation of results¹³.

The association of thematic axes and the consequent creation of categories represented a crucial step in content analysis. This stage made it possible to organize and structure data more efficiently, facilitating the identification of patterns and trends. By grouping similar elements under specific categories, a clearer and more comprehensive view of the analyzed material was obtained, which contributed to building a more solid and well-grounded interpretation.

It is emphasized that the results were discussed in the light of Symbolic Interactionism, a theoretical perspective that works with the idea that people construct their world based on the meanings they attribute to things, a fact that makes it possible to understand how individuals interpret objects and other people with whom they interact, and how the interpretive process guides individual behavior in specific situations¹¹.

In compliance with ethical principles, this study strictly adhered to the guidelines established by Resolutions No. 466/12 and No. 510/16. Accordingly, it was submitted to and approved by the Research Ethics Committees (RECs) of both the proposing institution and the co-participating institution, under opinion No. 6,582,056. To ensure participant anonymity, an alphanumeric coding was adopted, with participants identified as T1, T2 for nursing technicians and E1, E2 for nurses.

Furthermore, all participants received detailed information about the research objectives and methodology, and their participation was formalized through a duly signed Informed Consent Form (ICF).

RESULTS

The characterization of twelve professionals, who participated in the study, reveals a predominantly female profile, with only one male participant. The sample included 8 nursing technicians and 4 nurses, with training periods ranging from 14 to 29 years for nursing technicians and from 17 to 21 years for nurses. Time working at the institution ranged from 8 to 22 years, while experience in the Pediatric Oncological Emergency presented two distinct ranges: two participants with 8 to 9 months of experience and the remaining participants with 8 to 15 years of experience in the unit. Regarding schedule and work shift, the majority of participants (11) worked on-call in 12-hour shifts, 6 during daytime and 5 at night. Only one participant worked a fixed daytime schedule.

From the analysis, two categories emerged: Difficulties and facilitating factors surrounding user embracement in the pediatric oncological emergency; and Perception of user embracement: pointing to possible pathways.

Difficulties and facilitating factors surrounding user embracement in the pediatric oncological emergency

This category is composed of the following thematic axes: describing the context of the pediatric oncological emergency; hindering and facilitating factors for the user embracement process.

This first thematic axis presents the work context of the unit under study in its various aspects, namely: physical characteristics of the environment, team profile, particularities of the care flow, specificities of the type of service provided, as well as the most frequent complaints identified in care relationships.

Participants described the insufficiency of the physical space designated for the care of children and their families in the pediatric oncological emergency. The environment is described as small, restricted, and improvised, as exemplified by the adaptation of the consultation room as an extension of the bed area. The following statements illustrate these characterizations:

Our emergency unit is very small. We have four beds available. There are four bays, one gurney, one bed we shared with a stretcher, and two chairs for care. (T2)

Since it's a small unit, it's difficult when a patient arrives and the unit is already full. Many times, we have no more beds for them [...] the consultation room, what did it become? An extension of the bed area. It became an extension of the pediatric emergency unit – we have four beds inside and in the consultation room we put two gurneys. So that's six beds – it became an extension. (T3)

If the unit is very full, very full, there's no space inside – it's a small space – so there are some chairs out here. (T8)

The empirical data show that the reduced team composition represents a difficulty for more effective user embracement. The presence of only one nurse, one nursing technician, and one physician per shift is perceived by participants as insufficient to meet the complexity of care demands and to offer humanized, continuous, and individualized care. In this scenario, they also report that user embracement tends to be conditioned by service dynamics and takes place in the same space where patients are attended, negatively compromising listening and dialogue – essential elements of this process.

My team is just me and one technician. That's how the team here works. (E2)

Our team is small here. (T6)

Here in the emergency unit, we're a very small unit – just one technician and one nurse. [...] The very small team also makes our lives difficult; we can't rotate in certain situations [...] We also understand our limitations – the issue of space, the team reduction, the limitations. Unfortunately, we're a large hospital, a general hospital, and there are no specific, purpose-built spaces for children. (T2)

Sometimes, when a child arrives to be attended and welcomed, the team members who are already reduced are providing care to other patients who are admitted or being seen in the emergency unit, [...] So it all takes place within that same environment. This, for me, is something that negatively influences this user embracement process, because many times the family member, the child, or the adolescent refrains from reporting something precisely because they feel embarrassed, because there are other people around. (E3)

This is really a problem – having them arrive in the middle of chaos, the emergency unit full, nowhere to triage the patient, triaging them there in the middle of everyone, and many times the physician is talking to the father, then the mother is asking for something else, another mother who has nothing to do with that situation, and the child: "Auntie, put on a cartoon!" It gets confusing like that. (T3)

I think what makes it difficult is not having an adequate space for it. It happens in the middle of the emergency unit where, at times, we're dealing with a larger patient demand and we have to do both things at the same time. That's tough. (E1)

Although participants reported difficulties regarding physical space and the reduced number of professionals, they explained that, as a closed pediatric oncological emergency unit – meaning it only serves children enrolled at the institution – the care demand tends to be low.

Our emergency is a closed emergency unit, an internal emergency unit. (T3)

In general, our care volume is not very high because we only see enrolled patients [...] Our demand in general is low, compared to external services, because we only see a restricted number of patients – only those who are enrolled at the institution. (E1)

The most prevalent complaints in the service were also mentioned, namely pain and fever.

Unfortunately, pain is one of the complaints that breaks records here. (T3)

Has fever, has a catheter – that's our main demand, generally. (T8)

When asked about the factors that facilitate user embracement, participants highlighted, recurrently, the availability and quality of equipment used in care. The empirical data show that technological resources, especially multiparametric monitors and vital signs carts, are perceived as elements that expedite clinical assessment, favoring intervention with greater safety.

We have multiparametric monitors, a vital signs cart – this helps a great deal in patient assessment when they arrive; we can triage these patients more easily and calmly. (T2)

In clinical terms, our equipment is our facilitator. The multiparametric monitor we have really helps a lot [...] It speeds things up, it gives us safety – while we assess clinically or auscultate, or place a thermometer, there's already a monitor giving you real-time parameters – so it's the facilitator of user embracement [...] High quality, always at hand, everyone uses it. It's the facilitator. (T6)

We have a mobile multiparametric monitor here that greatly facilitates our work in this regard. (E1)

So, we have a portable device, a portable monitor here, and we can quickly measure the child's vital signs, and that greatly facilitates our intervention. (E2)

Also mentioned as facilitating factors was the care record sheet [boletim de atendimento] prepared at the reception desk, highlighted as an instrument that favors the organization of the care flow and the continuity of care, by concentrating relevant initial information about the child. Additionally, team cohesion and good communication with family members were highlighted.

At the reception, they prepare a care record sheet, which helps us a great deal. Because it already comes with the patient's main details such as enrollment number and name, and we receive this sheet. [...] So it greatly facilitates our care, because when this sheet reaches us, we fill it in with exactly the data related to the child's current clinical presentation. (T7)

What facilitates it, I think, is that organizational flow – it really helps when the child arrives with the form already pre-filled with their name and time of arrival, I think that makes it much easier for us to enter into the system, into the spreadsheet. (T8)

It's important for us because this care record sheet already has the medical record location, and the professional who fills it out at the reception requests the medical record for us, which helps us access further information about the patient. (E1)

What facilitates it, I think, is team cohesion – both the physicians, the nurses, and the technicians who are there at the time. (T4)

Interestingly, part of the team highlighted that the same factors considered hindering for user embracement can also be perceived as facilitating, depending on the perspective adopted. The reduced physical space and the small team were identified as elements that, while limiting the structure, favor an overall view of the unit and the continuity of care actions toward the child, thereby optimizing the flow of information and decision-making.

We're a small team; with the smaller space, it means we have a better view of the unit, and when the patient walks through the door, we can already get an overview of everything that's happening [...] So it's a situation of great duality. (T2)

I believe that both for information flow, for the safety the patient has in us, and for our own safety in executing the action, it's better because you already have the patient – you welcomed their complaints yourself, so you're already attentive to everything that person told you [...] And you yourself saw the vital signs, you yourself gave that first care to the child and are following up [...] So it facilitates a lot – it facilitates decision-making. (T6)

So the same thing that hinders also facilitates. Because if, for example, the same team that is there attending to the complications, attending to the emergency situations of patients under observation or admitted to the unit, had to break away to another environment, a segregated room, they would stop providing that care. (E3)

Based on the above, regarding hindering and facilitating factors for the user embracement process, it was possible to identify the intervening conditions that influence the user embracement performed by the nursing team in the pediatric oncological emergency.

Perception of user embracement: pointing to possible pathways

This final category was constructed with the aid of two thematic axes: perception of the user embracement process developed by the research participants themselves; and improvement proposals.

When reflecting on user embracement, participants expressed the perception that, even in the face of structural and organizational difficulties in the unit, the service provided is carried out with quality, being performed in the best possible way. The statements reveal a positive assessment of the care provided, offering comfort and active listening to children and their families.

Our patient is very well attended – this is reflected in the statements of the mothers, of our patients here [...] They say that here it's calm, it's a unit where they feel welcomed, they feel well-received here, so we know we provide a good service. (T2)

Look, I feel both from myself and from the other team, a very great commitment, a very strong willingness to make it work – now, the issue of adequacy, what I feel, what it seems to me is lacking, is the flow and the location. So everything I've already told you makes it not seem one hundred percent adequate to me. The intention is good. The professionals are good. What's missing is a roadmap and a location. (T6)

I think people try their best, as I said, to give the child comfort, to have active listening, without judgment. (T8)

As an improvement proposal, participants indicated the need for an adequate and reserved physical space for carrying out user embracement, as well as the presence of a specific team for this process, these aspects being considered fundamental to improving the quality of care provided to the child and their family.

So, there should be a room reserved specifically for this, for us to triage the child. (T1)

If there were a private space, it would be much better. As long as there was also a team to adequately attend to it. (T2)

It would be great to have a little embracement room. (T3)

I think the issue of user embracement, first and foremost, is that it should be a private space that offers comfort to the child. (E2)

DISCUSSION

To describe the context in which user embracement is embedded, the research participants discussed the physical characteristics of the environment: small space, lacking an appropriate place for user embracement, the reduced team composition, the most prevalent complaints in the service (pain and fever), and the low demand associated with the exclusivity of care for children enrolled at the institution.

Hindering factors for the practice of user embracement were identified as the absence of an appropriate place for its performance, respecting the privacy of the child and their family member, as well as the reduced number of professionals working in the emergency unit.

In this regard, attention is drawn to RDC N^o50, which addresses the technical regulation for planning, programming, drafting, and evaluating physical projects for health care establishments. Although it does not dedicate an exclusive chapter to pediatric emergencies, it establishes general guidelines that significantly influence child care in these establishments¹⁴. The regulation addresses aspects such as infrastructure, hospital organization, and the structuring of the urgency and emergency area, directly impacting the quality of pediatric care.

In accordance with RDC N^o50, facilities intended for pediatric care in emergency settings must be specifically designed and equipped to meet the needs of children, including appropriate furniture for caregivers and safety measures that ensure patient privacy.

In this context, it is highlighted that the privacy of the child and their family member constitutes an ethical and legal obligation that must be respected not only in interactions between the patient and the nursing team, but also in verbal or written communications with other workers involved in care, as well as with family members. It is the duty of every nursing team professional to advocate for the patient in all circumstances during care, ensuring their privacy and safeguarding their autonomy.

Using the lens of Symbolic Interactionism¹¹, it is possible to understand how the physical context, professional norms, and social interactions dynamically condition the meanings of user embracement, trust, and the quality of care. These meanings are not static but are continuously negotiated, influenced by physical conditions, interpersonal relationships, and the social and ethical norms that permeate the hospital environment.

Pain and fever are among the most common symptoms experienced by children with cancer^{15,16}. The literature shows that the most common oncological emergencies in the pediatric context are associated with metabolic, hematological, cardiovascular, respiratory, and neurological alterations, infections, as well as hematopoietic stem cell transplantation. In this context, early recognition and immediate treatment of these oncological emergencies can reduce the chances of potential complications and improve clinical outcomes¹⁷.

Regarding the reduced number of professionals working in the pediatric oncological emergency, the literature¹⁸ highlights that providing comprehensive care with positive impacts requires an available, accessible, and trained workforce to respond to the complex demands of the setting. Therefore, capacity development strategies are fundamental for operating in resource-limited settings, given that the performance of nurses in pediatric oncology is influenced by subjective, educational, and organizational factors^{19,20}.

From the perspective of Symbolic Interactionism¹¹, the reduced number of professionals constitutes a symbolic element that shapes the meaning of user embracement for the nursing team. By experiencing this situation daily, the team builds meanings about user embracement as a process that is hindered, fragmented, and permeated by tensions between the ideal of humanized care and institutional reality.

Participants identified as facilitating elements for user embracement the availability of quality equipment, team cohesion, and good communication with family members, given that the latter favors the establishment of bonds of trust and safety.

The availability of adequate materials constitutes a facilitating tool not only for the work process, but also for interpersonal relationships between the user and the team. The literature²¹ highlights that the lack or deficit of human and material resources can generate obstacles that extend the time needed for the implementation of essential care in the context of pediatric oncology.

Communication in the pediatric oncological context plays an important role in care relationships and is challenging for health professionals, especially when it comes to the clinical condition of high-risk children, as it requires language adaptation for both the child and their family²². Good communication with family members is necessary not only to prepare them for potential late effects involving oncological treatment that pose risks to the child²³, but also to obtain assistance from family members in the care relationship with the child.

Good and efficient communication between teams, and between teams and users, was highlighted by the participants in this study. However, there are institutions in which it is argued that, in work environments, teams with low integration, ineffective communication, and lack of collaboration among members are common, and that, to optimize the performance of these teams, the manager must direct their attention to both individual professionals and the dynamics of interpersonal relationships. After all, the concept of “team” is intrinsically linked to the performance of joint tasks, where different individuals share activities and knowledge to achieve a common goal²⁴.

In contrast, the lack of integration and communication between teams – a common challenge today in workplace interactions²⁴, analyzed through the lens of Symbolic Interactionism¹¹, suggest that the lack of collaboration may be the result of conflicting interpretations and meanings that team members attribute to their roles and their position in the care dynamic. The lack of effective communication can create symbolic barriers among professionals, hindering the formation of a cohesive team and the achievement of the common goal of providing quality care.

Despite the challenges described, nursing professionals assess the care provided to the child and family during user embracement as adequate and identified as a possible improvement the availability of a room in the pediatric oncological emergency for user embracement, in order to offer comfort and privacy to the child and their family.

The availability of an adequate physical structure, quality materials and equipment, combined with the presence of qualified and motivated professionals, are essential elements for health promotion and for optimizing work, and directly impact the quality of care provided to patients. Thus, when favorable working conditions are available, professionals are able to transform available resources into positive outcomes, providing excellent care and, consequently, better quality of life for patients²⁴.

It is acknowledged that the results found regarding participants’ perceptions of user embracement showed an awareness that, despite the limiting physical conditions for its performance, the team demonstrates the capacity and commitment to offer quality care to patients and families.

The assumptions of Symbolic Interactionism¹¹ help us understand that the professional's critical perception of their own activity derives from the meanings constructed in the full relationship with the work environment, in interaction with patients and with colleagues. By attributing positive meaning to their work, the professional carries out their actions in the best possible way. Armed with their technical expertise and human sensitivity, they are called to go beyond the protocol, to unravel the nuances of each case, to interpret the signs and silences, and to build bridges of trust that enable comprehensive and personalized care.

Regarding professional discomfort about the lack of an adequate space with privacy for the patient, the ideas of Symbolic Interactionism¹¹ demonstrate that the experience of this context has constructed this meaning in virtually all professional participants in the research. And this compels them to act in ways that preserve the intimacy and privacy of the child and their family member as much as possible, promoting an environment of comfort, respect, and empathy.

Study limitations

The main limitation of this study is associated with the fact that its development took place at a single institution, which does not favor the generalization of results, nor the ability to predict behaviors and actions. However, the results of this study may be applicable to similar contexts, making them valuable for user embracement in the pediatric oncological emergency.

FINAL CONSIDERATIONS

It was possible to identify the factors that permeate the user embracement process in the context of the Pediatric Oncological Emergency, highlighting as hindering factors the lack of an adequate space for carrying out the activity and the reduced team composition; and as facilitating factors, the availability of quality equipment, team cohesion, and good communication with family members.

The results innovate by showing that in the complex landscape of health, where science meets humanity, user embracement emerges as a fundamental pillar – not reduced to mere triage, but as an important humanization tool in pediatric oncological care. More than a simple strategy or work process, it reveals itself as an act of deep interaction, permeated by meanings that are constructed and transformed in the flow of the professional-patient relationship.

The conduct of future studies, with theoretical foundations capable of fostering the importance of ideal user embracement, is essential, given the scarcity of research that delves into the theme of user embracement in the context of pediatric oncological emergencies – a setting marked by unpredictability, in which care activities require agility and wisdom.

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Conceptualization, A.S.L.P. and T.P.S.; methodology, A.S.L.P. and T.P.S.; validation, A.S.L.P., T.P.S., IR.S., L.J.S, S.C.M. and J.R.B.D.; formal analysis, A.S.L.P., T.P.S., IR.S., L.J.S, S.C.M. and J.R.B.D.; investigation, A.S.L.P. and T.P.S.; resources, A.S.L.P. and T.P.S.; data curation, A.S.L.P. and T.P.S.; manuscript writing, A.S.L.P. and T.P.S.; review and editing, A.S.L.P., T.P.S., IR.S., L.J.S, S.C.M. and J.R.B.D., visualization, A.S.L.P., T.P.S., IR.S., L.J.S, S.C.M. and J.R.B.D.; supervision, A.S.L.P. and T.P.S.; project administration, A.S.L.P. and T.P.S. All authors read and agreed with the published version of the manuscript.

Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*User embracement in pediatric oncological emergency: difficulties and facilitating factors in child care*".