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To embrace and be present: The lived experiences of nurse-led consultations in Sweden from the perspective of pediatric nurses

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ABSTRACT

Purpose: This study describes the lived experiences of nurse-led consultations in pediatric emergency departments from the perspective of pediatric nurses.
Design and methods: A descriptive qualitative study with a reflective lifeworld research approach was used to explore nurses' experiences of nurse-led consultations. The study was conducted through meaning-oriented individual interviews with ten pediatric nurses.
Results: The results are grouped into four themes: (a) embracing the encounter and being touched by it; (b) having time to be present and committed; (c) having the ability and trusting in one's intuition; and (d) negotiating between families' wishes and the organization's guidelines.
Conclusions: Our study shows that nurse-led consultations conducted in separate nurse-led reception areas promote a positive experience of the consultations from the perspective of pediatric nurses. In a nurse-led consultation, a nurse's confidence in their ability to provide care is connected to time, broad skills and knowledge, and a supportive organization.
Practice implications: As the rising global population increases the demand for healthcare services, pediatric emergency departments must streamline their services to provide patient-safe, high-quality health care. Nurse-led consultations are an effective means of meeting these growing demands. This study contributes to an understanding of pediatric nurses' experiences at both the individual level and a more structured level, namely that families' wishes and an organization's guidelines do not always coincide.

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Background

Long waiting times for patients seeking care is a common problem in emergency departments worldwide (Boyle et al., 2012; Gonçalves-Bradley et al., 2018; Hing & Bhuiya, 2012; Lindner & Woitok, 2021), especially for children seeking care in pediatric emergency departments (PEDs; Long et al., 2021; Seiler, Furrer, Staubli, & Albisetti, 2021; Swedish National Board of Health and Welfare, 2018). As the population increases, there is a growing need to streamline the process of patient care (Swedish National Board of Health and Welfare, 2018). The United Nations Convention on the Rights of the Child, which became a law in Sweden in January 2020 (Swedish Parliament, 2018), states that every child has the right to receive the best possible health care (United Nations Human Rights Office of the High Commissioner, 1989). One way to achieve this is to shorten waiting times, improve patient safety, and provide high-quality care for children in PEDs. Therefore, it is important to facilitate healthcare professionals' abilities to promote patient health and well-being and improve the satisfaction of the children and parents who visit PEDs (Swedish National Board of Health and Welfare, 2018b). To accomplish this goal, scholars and policy makers must consider the needs of healthcare professionals, as the work environment is a vital part of the care environment. Therefore, this article considers the perspectives of nurses who perform nurse-led consultations in PEDs in Sweden.

Sweden has a well-developed healthcare system, in which healthcare organizations are structured according to the principle that good health and good care are equally important for every citizen (Swedish Codes of Statutes, 2017). In Sweden, children with non-urgent conditions are advised to seek primary care during daytime hours or contact 1177, a healthcare advice line, if they need a consultation regarding basic care (Region Västra Götaland, 2015). Children with urgent conditions should go to PEDs, many of which are open 24 h a day and provide care for children who have suffered severe accidents or sudden serious illnesses. In a PED, children initially undergo triage to assess their care needs; who should receive care first is determined based on the medical

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degree of urgency (Swedish Agency for Health Technology Assessment and Assessment of Social Services [SBU], 2010). Based on the triage, a decision is made whether the child should see a physician or a nurse in a nurse-led consultation (Region Västra Götaland, 2017).

A Scandinavian-developed triage model, the Rapid Emergency Triage and Treatment System for Pediatrics (RETTS-p), is a decision support system that provides recommendations on patients' level of priority. Evaluation of the RETTS-p based on comparisons of different triage nurses' assessments has shown that the model is stable and consistent, and the risk of not identifying seriously ill children is low with the correct use of the RETTS-p (Henning et al., 2016; Westergren et al., 2013). The recommendation is that children who are triaged red or orange should be checked by a physician immediately, while children who are triaged yellow or green should be able to wait for a medical assessment without risk (Predicare, 2018).

Non-urgent use of PEDs is a common problem that has increased over the past decade. Many scholars have investigated why parents choose PEDs instead of seeking primary care for their children's non-urgent conditions (Berry et al., 2008; May et al., 2018; Morrison et al., 2014; Uscher-Pines et al., 2013). Findings show that parents distrust the pediatric knowledge of primary care practitioners and perceive PEDs to be more accessible. Parents worry about their children and want the best possible care for them. At the same time, parents seem unaware of which circumstances are appropriate for seeking care at a PED. Many parents have the attitude that PEDs offer immediate care regardless of the severity of the child's condition (Berry et al., 2008; Ohns et al., 2016; Uscher-Pines et al., 2013). Children and parents who receive advice and information from a nurse before returning home from a PED are less likely to seek emergency care again for non-urgent conditions compared to those who return home from a PED without having had contact with either a physician or a nurse (Gaucher et al., 2011; Sturm et al., 2014).

When primary care resources are insufficient, care at PEDs can be provided using separate nurse-led receptions and then sending children home if they do not require immediate medical attention (Williams et al., 2009). Regardless of their organizational structure, nurse-led consultations have been proven to be effective. Efficient triage combined with a separate nurse-led reception where nurses care for children with non-urgent conditions can significantly improve waiting times, enabling the PED team to focus on children with more acute conditions (Ohns et al., 2016; Rutledge & Merritt, 2017).

Although scholars have described children's and parents' experiences of nurse-led consultations at PEDs to some extent, there is a lack of knowledge in the literature regarding nurses' experiences of these consultations. To develop a patient-safe working model with which to care for children with non-urgent conditions in PEDs, it is essential to consider the experiences of those who perform the care: the nurses. Therefore, the aim of this study is to describe the lived experiences of nurse-led consultations in PEDs from the perspective of pediatric nurses, thereby improving understanding of nurses' experiences of nurse-led consultations, as well as the care that is provided for children at PEDs.

Method

Design

To describe how pediatric nurses experience nurse-led consultations, a qualitative study using descriptive interviews and a reflective lifeworld research (RLR) approach (Dahlberg et al., 2008) was used. RLR aims to describe the essence and meaning of a phenomenon as it appears in a person's existential world. The process of identifying the meanings of a phenomenon requires time and patience. Phenomenological epistemology and Husserl's theory of the lifeworld are the foundations for this approach. A key concept is the understanding of how health, suffering, and well-being are experienced in a person's daily life. This approach is characterized by openness, sensitivity, and bridling: openness refers to allowing a phenomenon, in our case nurse-led consultations, to reveal itself in a new way, which entails sensitivity to the studied phenomenon, while bridling means not being too quick to understand the phenomenon and suspending preconceptions, such as existing understandings of nurse-led consultations. The data for this study were collected via meaning-oriented, individual interviews.

Settings and participants

The study was conducted in two PEDs, one in a university hospital and another in a regional hospital, both located in southwestern Sweden. The working model of nurse-led consultations differed in the two PEDs. The university hospital had a separate nurse-led reception area where the nurses conducted all the nurse-led consultations, attending to children of various ages (from newborn to 16) with medical, surgical, or orthopedic conditions. In the regional hospital, which attended to children with medical conditions from newborn to 18 years old, nurse-led consultations were performed by nurses who were also caring for children with more urgent medical conditions. The RETTS-p was used at both PEDs and supplemented with regional guidelines.

After giving informed consent, ten pediatric nurses participated in the study; three worked at the university hospital and seven at the regional hospital. The inclusion criterion required the nurses to be pediatric nurses who worked in PEDs and performed nurse-led consultations. We chose this sample to include a wide variety of reflections and experiences about the phenomenon under study (Polit & Beck, 2017). Of the ten participants, nine were female and one was male, and their ages ranged from 31 to 61 (average age: 47). All ten nurses were pediatric nurses with a master's degree; they had worked as nurses in pediatric care for between 1 and 37 years (average: 13 years) and in a PED for 2–17 years (average: 8 years).

Data collection

The data were collected via ten meaning-oriented individual interviews (Dahlberg et al., 2008) in February and March 2018 in locations chosen by the participants. Each interview began with a few demographic questions. Then, to direct the participant's intentionality, thoughts, and feelings toward the studied phenomenon, we posed the following question: "What is your experience with conducting nurse-led consultations at the PED?" To obtain richer illustrations, we asked the participants follow-up questions such as "Can you tell me more about that?" or "Can you give me an example?" The first and second authors both attended all interviews except two. One author conducted the interview while the other author observed and took notes. The author who observed the interview had the opportunity to pose additional questions at the end of the interview to deepen the understanding of the phenomenon. Moreover, having two authors attend the interviews enabled shifting between immediacy and distance more easily (Dahlberg et al., 2008). The length of the interviews varied between 21 and 58 min (average: 36 min). All the interviews were digitally recorded and transcribed verbatim, including notation of non-verbal communication, by the author who conducted the interviews.

Data analysis

We analyzed the transcribed data from the interviews using RLR (Dahlberg et al., 2008). The purpose of the descriptive analysis was to determine the meaning of the phenomenon and involved shifting between the whole and the parts and back to the whole again. The entire analysis process were permeated by an open reflective approach, active dialogue with the text, and a bridling attitude. Data analysis began with both authors reading the transcripts of all the interviews to become

familiar with the material. It was important in this stage to maintain an open and reflective approach without starting the analysis process and to pose the following questions: What does the text say about nurse-led consultations? What is the meaning of nurse-led consultations? How can nurse-led consultations be understood in this way? Next, the authors divided the texts into groups to determine the meaning units in the data that related to the phenomenon. These were marked in the text and described with a few words; this process continued until all meaning units had been identified and described. To structure the analysis, meaning units were divided into clusters based on their similarities and differences. The clusters were then placed next to one another, and, similar to the movement between a figure and its background, the clusters were reversed in terms of priority and positioning so the phenomenon could be understood on its own terms. Finally, we reformed the various elements of the analysis into a new whole composed of four themes; these are presented in the Results section together with quotations from the interviews that illustrate the pediatric nurses' experiences of nurse-led consultations.

Ethical considerations

Our study was conducted in accordance with the Declaration of Helsinki (World Medical Association, 2018) and the ethical principles of the Swedish Research Council (2017). As the study was conducted among nurses and according to Swedish law (Swedish Code of Statues, 2003), there was no need for approval from an ethics committee. Nevertheless, we consistently followed rigorous ethical standards. Before data collection began, the unit manager of each PED gave their approval. The first and second authors of this study recruited the nurses. The nurses received written information via email about the study's aim and were informed that their responses to the interview questions would remain confidential. The information clearly stated that participation was voluntary and could be discontinued at any time. The nurses had to respond to the email before further contact was made. During the process of deciding on the time and place for the interview, the participants were asked if they would agree to two researchers being present. When the interviews took place, each nurse was given an opportunity to ask questions, and information about the study was provided again, both orally and in writing. The nurses permitted the interviews to be recorded and signed an informed consent form before the interviews began.

Results

Pediatric nurses' experiences of nurse-led consultations in PEDs can be grouped into four themes: (a) embracing the encounter and being touched by it; (b) having time to be present and committed; (c) having the ability and trusting in one's intuition; and (d) negotiating between families' wishes and the organization's guidelines.

Embracing the encounter and being touched by it

A nurse-led consultation is, first and foremost, about embracing the needs of children and parents and establishing a caring relationship. Many of the nurses stated that a feeling of being affected is common, and that a nurse never seems to leave a nurse-led consultation without being touched emotionally: As one nurse stated, “All encounters give me something, obviously. The day it doesn't affect me any longer, I have to quit my job” (Nurse C). When a nurse has the opportunity to meet the perceived needs of both a child and their parents and provide appropriate care and support, the nurse experiences the encounter as successful, as described by Nurse I: “I think this is fun […] when they are really happy for the time you give them and the advice you give. It is something that can feel very basic […], but for them it is very valuable.”

The nurses specified that meeting perceived needs and often high expectations is a prerequisite for a nurse-led consultation, and a nurse's experience is reflected in a family's response to a consultation. A satisfied family makes the performance fun, stimulating, and rewarding: “We had a meeting together; it feels good that they are going home satisfied. It feels good in my heart, it really does” (Nurse A). Meanwhile, a dissatisfied family creates negative feelings about a nurse-led consultation, such as concern, insufficiency, and frustration: “Sometimes […] the parents [get] angry... [...] it feels hard in the moment […] It affects you” (Nurse H).

Embracing can refer to sharing one's knowledge and life experiences; it can also mean being present, affirming, showing empathy, explaining, seeing each child as a unique individual, and understanding each family's needs. Families often want time and attention, as described by one nurse:

> To give them a chance to finish their sentences. To be understanding and listen to them. Allow them to ask questions and give them time. Show a genuine interest; ‘I hear what you say, and I understand what you mean’ (Nurse B).

A nurse-led consultation often involves providing basic advice about how to care for a sick child and informing parents about when it is appropriate to seek healthcare services. Nurse J described how nurses must ensure “that [parents] have received the information they need and that you make sure they know when to seek care again if the condition should deteriorate”. The nurses explained that parents are worried and have a great need for caring support, and that it is essential to understand parents' needs and how to provide caring support:

> Parents are most often focused, but I also have to be focused on their child. Even if I have seen twenty similar children before and I'm not notably worried, I have to see that particular child. I have to mediate my presence to 100% (Nurse D).

To support the parents, it is essential to provide information and caring advice in a calming way that reduces their worries. Moreover, parents must be allowed to express concerns about their children; however, nurses can feel frustrated if there are not enough resources that they can devote sufficient time to the visits and meet the needs of every family: “I feel like that's how the healthcare system treats people nowadays; no one wants to see a patient. [...] I don't want to act like that” (Nurse A).

The nurses stated that emotionally embracing a family when caring for their child during a nurse-led consultation can be difficult when the provided care is not well received: “Not everyone can be reached: some are blocked by stress, anger, and frustration. It is not possible to reach them, but you always try your best for the sake of the child” (Nurse B). Nurses may experience feelings of insufficiency when children or parents are dissatisfied with a nurse-led consultation. Even though the provided care may be appropriate to the child's condition, a parent's criticism can affect the nurse's experience. The nurses stated that this kind of consultation often provokes feelings of failure, regardless of whether the family returns home or stays to see a physician:

> I have talked to [the parents] and explained that the child doesn't need to see the doctor […]. Nevertheless, sometimes they demand seeing a doctor, but when the waiting times get long, they get upset and angry and end up leaving the PED anyway. That doesn't feel good. That's not how the nurse-led visit should end (Nurse A).

Having time to be present and committed

For a nurse-led consultation to be successful, time and commitment are required. The nurses explained that time allows them to be present in an encounter and establish trust with the child and the parents: “It

usually takes quite a long time to perform a nurse-led consultation if you want to feel that the family is leaving actually knowing what to do" (Nurse E). In addition, a trusting relationship facilitates the conditions needed to provide the proper care and support. When they have sufficient time, nurses can experience nurse-led consultations as exciting and positive: "I think this is fun, and it becomes even more fun when [the child and parents] are really happy for the time you give them" (Nurse J). Moreover, giving children and parents time to tell their stories in the early stages of a visit saves time in the long run: "You might spend an extra five minutes making the parents feel calm and safe, then you have won a lot there" (Nurse B). These moments give the nurses an opportunity to confirm their commitment and show their willingness to care for and help both the child and the parents:

> I need to feel that I've got time and that I can give good advice, too. […] I have to be present, and I have to give my time, ten minutes, a quarter hour […] I've got to have time (Nurse C).

The nurses stated that it is difficult to influence the time allocated for nurse-led consultations, as it depends on both organizational constraints (team, schedule, premises) and patient flow. Nurse-led consultations conducted in separate nurse-led reception areas grant time to each child in a completely different way than when the nurses are responsible for all the children visiting the PED: "In the nurse-led reception, you know that even if there are ten children in the waiting room, they have been looked at by someone else. [...] So when you are in the nurse-led reception […] you have time" (Nurse B).

The nurses explained that having the time to work undisturbed with children is a significant factor in successful nurse-led consultations: "You cannot always hurry with children [...]. You must let them take the time they need" (Nurse B). Eliminating interference, such as phone calls, doorbells, and emergency alarms, results in a calmer work environment, which is vital for positive experiences of nurse-led consultations.

Moreover, the nurses stated that having an insufficient amount of time causes stress, which limits their capacity to show commitment to patients: "If it's stressful and I have lots of children, I feel like…there are so many children, so it spins in my head. [...]. [Focus] is lacking then" (Nurse A). In such situations, a sense of deficiency emerges. Moreover, the nurses explained that when performing nurse-led consultations in conjunction with PED teamwork, time is even more limited. The physician's orders and children in need of more urgent care must be prioritized, which often leads to interrupted or omitted nurse-led consultations.

It is not only the physical encounters with children and their parents that take time; documentation for nurse-led consultations is also time-consuming for the nurse: "[A nurse-led consultation] takes a bit more time, both with premises, energy, and documentation. And the vital parameter checkups that have to be done" (Nurse G).

Having the ability and trusting in one's intuition

A nurse-led consultation requires that nurses have confidence in their ability to care for both healthy and sick children, which involves significant responsibility. The nurses claimed that it is enjoyable and challenging for them when the right professional, personal, and organizational conditions exist: "It is fun to be able to do tasks that are a little more challenging, but […] there should be good conditions for that" (Nurse J).

An essential part of nursing was described by the nurses as "a hunch," "intuition," or "a clinical view." During nurse-led consultations, trusting their intuition is vital for a nurse's sense of ability and security. Through education and work and life experiences, nurses accumulate knowledge that, together with intuition, promotes safe care for each child. The combination of knowledge and intuition was described by the nurses as significant and as strengthening their confidence in their ability to provide good care: "I think it feels good: I trust my assessments, my knowledge, and my experience" (Nurse I). When the proper prerequisites exist for a successful nurse-led consultation, the responsibility is perceived positively, which creates an opportunity for the nurse to grow as a professional.

Nurse-led consultations were described by the nurses as a stimulating and encouraging kind of detective work in which they have to use all of their knowledge to properly care for a child: "It's a bit of detective work, it is fun", said Nurse G, while Nurse H claimed, "Usually, it may not be that difficult, but it's fun to seek around when it is a little unclear". The nurses believed that searching for ways to provide the best care for a child can be empowering at both the professional level and the personal level. Advising children and their families in a way that is unique to the nurse's profession was said to bring a sense of joy and professional confidence:

> Physicians do not give the same kind of advice; they do not give the same time to explain such things. […] Their medical task is, basically, to find a medical problem and fix it or not fix it. However, all this advice we give to the families… That's what we do. That's what we give. (Nurse D).

If the right conditions for a successful encounter are missing, the responsibility can be perceived as scary and stressful. Nurses may be afraid of failing to recognize whether a child is seriously ill or sending a child home who is at risk of severe deterioration: "The biggest fear is that you are afraid of missing something, to send someone home who is really sick […]. That you are going to make a mistake, and that it will hurt the child" (Nurse B).

The nurses claimed that to be able to care for children with non-urgent conditions in a patient-safe way, nurses need knowledge about more severe conditions and illnesses and better awareness of the symptoms that can manifest in such situations. This knowledge is often only available through experience: "Education is always good. [...] It is a confirmation of your knowledge. [...] But it is clear that it is experience that makes you become more confident in your assessment" (Nurse D); "When you have seen ill children, you know what to look for or ask for, and what parameters can be affected. Work experience [is vital]" (Nurse H).

The nurses also said that nurses and parents do not always agree about a child's condition. Parents who express their concerns through anger, frustration, and, sometimes, violence are challenging:

> The children who are not that ill usually have to wait a little longer. […] we have had quite a few angry parents, and it's also hard. [I] hope they do not strike me. There have been some of these, you know (Nurse A).

In such situations, a nurse's trust in their own ability is essential. To reach parents in spite of all these feelings and remain calm and convey a sense of security, nurses need to have a special kind of understanding and patience, which was described by one nurse: "I usually ask, '[…] What are you worried about? Or what made you come here today?' […] And then you can reach the core of the problem" (Nurse B).

Cultural and linguistic differences are often major challenges, and cultural competence is also required to understand and meet the needs of children and their families: "I've heard many stories about children dying of, for example, fever and pneumonia in their home countries. Despite this, we get confused, thinking, 'It is just a common cold, what are you doing here at the PED?'" (Nurse F).

Thus, a nurse's trust in their ability and/or intuition is essential in encounters with children and parents and contributes to a positive experience in a nurse-led consultation.

Negotiating between families' wishes and the organization's guidelines

A nurse-led consultation involves negotiating between a family's wishes and an organization's guidelines. Nurses assert that an internal conflict may occur for a nurse who is trying to respond to the needs of every child and every parent while also meeting the external requirements of their organization, as these needs and requirements do not always coincide: “It doesn't feel right when children that are well and not in need of medical care attend the PED; these [are the] children you have to reject […] when the workload is overwhelming. It doesn't feel right at all” (Nurse A).

Nurses aim to care for every child and parent. However, insufficient time and limited resources while working under pressure can prevent nurses from meeting every family's needs and wishes:

> So, my job is just to send them home…then you feel a little split: you want to help both children and their parents, but we do not have that mission [to care for children with non-urgent conditions] at the PED; this is not the right place to be (Nurse B).

The nurses explained that both internal and external negotiations may occur when a nurse wants to be available and help all the children seeking care at the PED but is unable to do so due to organizational guidelines:

> You want the parents to be satisfied because they might expect a doctor to see them, [to] feel safe when they go home and have received the information they need. You want to make sure that they know [what to do] if the condition should deteriorate (Nurse J).

When parents expect to meet a physician, it can be challenging to convince them to listen to a nurse and accept care therefrom. Nurses often feel frustration when parents do not accept the offered care: “Then there are those whom you do not really reach, the ones who get upset. However, you cannot...you cannot help everyone” (Nurse B). Sometimes, nurses give in to parents' wishes and let them see a physician even though there is no medical need:

> Then there are these parents who come to see a physician even though, in my opinion, it's not necessary. Sometimes I feel like there's no point in trying to send them home, so I'll let them wait for their turn. But they do have to be prepared for long waiting times (Nurse C).

Sometimes parents agree to go home and seek primary care unless their child's condition deteriorates, in which case they should revisit the PED.

The nurses specified that high patient flow combined with inadequate working conditions may lead to feelings of stress and insufficiency. Such conditions can also increase the demand for nurse-led consultations to lighten the workload for others on the PED team and decrease patient waiting times. These demands seem to come from both organizations and nurses' colleagues in PEDs: “I feel that there has been too much of this ‘send them home’... I sometimes feel that it's not just about the patient and how the patient feels, it's about relieving the doctors, and I don't like that” (Nurse A).

The nurses do not want the children or their parents to feel unwelcome. However, the nurses also stated that while all children are entitled to good and equal care, proper care can often be given at a primary care center or at home, depending on the child's medical condition.

Discussion

This study has indicated that nurse-led consultations are one way of meeting the increasing patient demands in PEDs and are best conducted in a separate nurse-led reception area. When the healthcare goal is to improve waiting times, a team of flourishing healthcare professionals may be the key to success. Such a nurse-focused working model promotes positive experiences of nurse-led consultations from the perspective of pediatric nurses.

According to our participants, pediatric nurses' experiences of nurse-led consultations are reflected in families' responses to the encounters. To facilitate successful encounters, it is important to embrace both the child and the parents. Research has shown the importance of the parents' role in nurse-led consultations: to support and help the child and to give the nurse valuable information about the child (Alavi et al., 2015a; Grahn et al., 2016). When a nurse listens, encourages, and provides information, parents feel both supported and safe. Their trust in the nurse is then conveyed to the child, who may feel safer in the unknown situation (Grahn et al., 2016). It is the nurse's responsibility to create a caring and empowering encounter in which both children and parents can cope with potentially unfamiliar situations (Hemingway & Redsell, 2011; Moe et al., 2017; Wigert et al., 2014).

Interestingly, the experiences of the nurses in our study were defined by the children's and parents' perceptions of the care provided during nurse-led consultations. In a relatively short time, a nurse must emotionally embrace an entire family and attempt to provide what is requested. Thus, establishing a trusting relationship not only creates a good experience for the family but also affects the nurse's experience. Being present and listening are essential to developing good, caring relationships. Harder et al. (2018) described the nurse's, child's, and parents' participation in healthcare situations as a movement between mutuality and alienation: mutuality is characterized by mutual respect and understanding, while alienation describes a situation in which individuals play a passive role. How this movement occurs depends on each person's actions; meanwhile, understanding participation as a process requires nurses to be aware that there may be differences in how a nurse, a child, and a parent understand a situation. Golsäter et al. (2014) highlighted the complexity and challenge of promoting children's participation in these encounters and providing them with their own space while also fulfilling healthcare responsibilities. Studies have confirmed that nurses, based on the prerequisites associated with specialist competences, can create a positive encounter in which a child feels safe (Grahn et al., 2016; Harder et al., 2018). It is vital for children to experience security and control in unfamiliar situations (Karlsson et al., 2016). Our experience is that distraction, such as singing familiar songs, blowing bubbles, wearing colorful scrubs, or playing with toys can help a nurse capture a child's attention and trust, which is crucial to ensuring a positive experience for the nurse, the child, and the parents (c.f. Drape & Greenshields, 2020; Tran Thi et al., 2022). Indeed, Longobardi et al. (2019) noted that blowing bubbles is a useful distraction that can minimize a child's perception of fear and pain during an examination in a PED.

This study has shown that a nurse's performance during a nurse-led consultation can evoke feelings of happiness and pride in the nurse, as well as feelings of failure and frustration. Even if a nurse has the skills and knowledge to successfully perform a nurse-led consultation, a sense of insufficiency in terms of available resources can lead to uncertainty and an unwillingness to continue with the encounter. Awareness of how families can affect nurses' experiences, both positively and negatively, is essential. We consider this insight to reflect a significant aspect of nurse-led consultations.

This study has also shown that nurses' trust in their own ability to perform nurse-led consultations is essential to ensuring a positive experience for everyone involved. Professional, personal, and organizational prerequisites to successful nurse-led consultations are important. For a nurse to maintain confidence in their own ability, having enough time to perform nurse-led consultations is as important as having a wide range of caring skills and knowledge. Alavi et al. (2015c) described individual and organizational barriers as threats to pediatric nurses' perceptions of their caring abilities. In addition, not having a caring attitude or an interest in children can be a barrier to a pediatric nurse's abilities.

Organizational barriers include inefficient educational systems, failure to develop professionals' capabilities, and inappropriate managerial policies. Making clinical decisions is a crucial part of nurse-led consultations. Accordingly, clinical decision-making abilities are necessary for pediatric nurses, and studies have shown that both nursing professionalism and trust in their own ability impact nurses' decision-making patterns (Choi & Kim, 2015). A nurse's professional experience is important in ensuring high-quality health care; professional experience helps when structuring work and makes external demands more manageable. Experience and knowledge provide nurses with greater self-esteem and can also reduce their experiences of stress (De Almeida Vicente et al., 2016; Grahn et al., 2016). Nurses need to trust their abilities to provide high-quality health care. Professional knowledge, experience, caring, motivation, and efficient education systems all impact nurses' perceptions of their own abilities (Alavi et al., 2015a; Alavi et al., 2015b).

This study has indicated that it is not a nurse's commitment that limits a successful encounter; rather, specific skills and organizational resources (time, guidelines, and location) promote or limit the quality of nurse-led consultations. To achieve patient-safe nurse-led consultations, such consultations should be organized in a way that minimizes the risk of stress. Deficiencies in clinical activities have a negative effect on both patient safety and nurses' work environments. Workload, time shortages, professional issues, shift work, and a lack of employer support all have significant impacts on nurses' abilities to provide good care (Von Thiele Schwarz et al., 2016). Trust in their ability to care for children with non-urgent conditions combined with proper organizational prerequisites enable nurses to experience the nurse-led consultation as a stimulating and challenging assignment.

Methodological reflections

When a study aims to describe the meaning of a phenomenon, descriptions are often more useful than numbers (Arman et al., 2015). Based on an RLR and phenomenon-oriented analysis (Dahlberg et al., 2008), the present study's results provide an in-depth understanding of the phenomenon of the nurse-led consultation. Our intention has been to openly and transparently describe the entire research process, i.e., selection, data collection, and data analysis, which is essential for the study's credibility. Furthermore, Dahlberg et al.'s (2008) research states that it is essential to bridle the authors' preconceptions of the studied phenomenon to ensure that the result is not based on these preconceptions. Thus, in this study, different techniques were used to identify and bridle our preconceptions, such as writing down our thoughts about the phenomenon and repeatedly discussing and reflecting on our pre-understandings of nurse-led consultations, as we have our own experiences of working as pediatric nurses in PEDs. While we are aware that our preconceptions may have affected the results of the study, we believe that we have reached a deeper understanding of nurse-led consultations and that our results describe the experience of nurse-led consultations in a new, broader way.

Our findings are restricted to the PEDs of two different hospitals in Sweden. The participants in the study were pediatric nurses, many of whom had many years of professional experience working with children. Including participants with less professional experience could result in more nuanced data. Similarly, including participants from several PEDs could enrich the data and increase the generalizability of the study's results. However, limitations notwithstanding, our findings are valid within the described context and may be applicable in other care settings as well.

Conclusions

In conclusion, nurses' lived experiences of nurse-led consultations largely depend on how children and parents receive the provided care. Sufficient time for the consultations, broad skills and knowledge, and a well-organized workplace all improve nurses' performance. The well-being of the child-patient is of primary importance to nurses. Under the right conditions, a nurse-led consultation can be perceived as stimulating and challenging by the nurse. In contrast, inadequate conditions can result in feelings of the assignment being demanding and overwhelming. Moreover, it is important to understand that the negotiation between a family's wishes and an organization's guidelines can have an emotional impact on the nurse.

Practice implications

As the rising global population increases the demand for healthcare services, PEDs must streamline their services to provide patient-safe, high-quality health care. Nurse-led consultations are an effective means of meeting these growing demands. Thus, this study presents knowledge regarding pediatric nurses' experiences of conducting nurse-led consultations, highlighting their experiences at both an individual level and a more structural level within the healthcare organization, namely that the requirements from families often do not correspond to the organization's guidelines. This knowledge is important for supporting the needs of nurses, children, and parents, but it is also important for decision-makers, as the results revealed organizational factors that may obstruct a functioning nurse-led consultation. Furthermore, educational endeavors should be enhanced for teaching healthcare professionals about nurse-led consultations from pediatric nurses' own experiences.

Further research is needed to establish the lived experiences of nurse-led consultations from the perspectives of children and parents. All this together could contribute to the literature on improving nurse-led consultations and supporting the needs of nurses, children, and parents.

Author statement

The three authors have been involved in the conception and design of the study, drafted and critically revised the manuscript and approved the final article.

Authors' contributions

Study Design: VN, MN, KK.
Data collection: VN, MN.
Analysis: VN, MN.
Manuscript preparation: VN, MN, KK.
Supervision: KK
Writing, reviewing and editing: VN, MN, KK

Declaration of Competing Interest

None.

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