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Nurses' perception of risk classification in an emergency care unit in the West Zone of Rio de Janeiro

Percepción de las enfermeras sobre la clasificación de riesgo en una unidad de emergencia de la Zona Oeste de Río de Janeiro

Percepção dos enfermeiros na classificação de risco em uma unidade de pronto atendimento na Zona Oeste do Rio de Janeiro

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Abstract

The aim was to identify the perception of nurses in the classification of risk, in a reception in a UPA, in the West Zone of Rio de Janeiro - RJ. It is a qualitative research through field research with semi-structured interviews, with 10 nurses. Nurses realize that the implementation of the Manchester protocol aims to improve care in urgencies and emergencies, being an indispensable tool for classifying severity and speeding up the process. Respondents do not perceive major difficulties with using the system; some improvements were suggested, such as standardization, implementation throughout the national territory, and attention was drawn to the need to improve the information that reaches the general population, as there is difficulty in understanding the criteria used by the protocol, a fact that generates dissatisfaction in the service on the part of users and even embarrassment to professionals.

Descriptors: Acceptance with Assessment; Risk Classification; AARC; Nursing; Urgency.

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Resumén

El objetivo fue identificar la percepción de enfermeros en la clasificación de riesgo, en una recepción en una UPA, en la Zona Oeste de Rio de Janeiro - RJ. Es una investigación cualitativa a través de investigación de campo con entrevistas semiestructuradas, con 10 enfermeras. Las enfermeras se dan cuenta de que la implementación del protocolo de Manchester tiene como objetivo mejorar la atención en urgencias y emergencias, siendo una herramienta indispensable para clasificar la gravedad y agilizar el proceso. Los encuestados no perciben mayores dificultades con el uso del sistema; Se sugirieron algunas mejoras, como la estandarización, implementación en todo el territorio nacional, y se llamó la atención sobre la necesidad de mejorar la información que llega a la población en general, ya que existe dificultad para entender los criterios utilizados por el protocolo, hecho que genera insatisfacción. en el servicio por parte de los usuarios e incluso en la vergüenza de los profesionales.

Descriptores: Acogida con Evaluación; Clasificación de Riesgo; AACR; Enfermería; UPA.

Resumo

Objetivou-se identificar a percepção dos enfermeiros na classificação de risco, em um acolhimento em uma UPA, na Zona Oeste do Rio de Janeiro – RJ. Trata-se de uma pesquisa qualitativa através de pesquisa de campo com entrevista semiestruturada, com 10 enfermeiros. Os enfermeiros percebem que a implementação do protocolo de Manchester visa melhorar o atendimento nas urgências e emergências sendo ferramenta indispensável para que classificar a gravidade e agilizar o processo. Os entrevistados não percebem maiores dificuldades com a utilização do sistema; foram sugeridas algumas melhorias, como padronização, implantação em todo território nacional, e foi chamada a atenção para a necessidade de melhorar a informação que chega até a população em geral, pois percebe-se dificuldade na compreensão dos critérios utilizados pelo protocolo, fato que gera insatisfação no atendimento por parte dos usuários e até constrangimento aos profissionais.

Descritores: Acolhimento com Avaliação; Classificação de Risco; AACR; Enfermagem; UPA.

Introduction

The situation of emergency services is a matter of concern for the health community and society. The demand for these services has been growing in recent years due to the increase in the number of accidents and urban violence[1].

In addition to this increase, it is observed that many of the services provided in these units are due to low-complexity diseases, referred to these services, due to insufficient structuring of the basic care network, which could be resolved in basic, specialized care services. or in less complex emergency services. There is also doubt on the part of the population as to which unit should go to for each occurrence[1].

The Unified Health System (SUS) is complex and made up of a series of units that complement each other and seek to serve people according to demand and efficiently. Its implementation sought universal health as a guarantee that all people and communities have access to health services without any type of discrimination[3].

Specifically, the emergencies, the construction of federal policy in Brazil involved three main moments: from 1998 to 2003, there was a predominance of regulation; between 2004 and 2008, there was a great expansion of the Mobile Emergency Care Service (SAMU); and from 2009, the implementation of the fixed component of pre-hospital care, the Emergency Care Units - UPAs, predominated[4].

Several ordinances and policies were used to regulate the UPAs for their implementation and/or compliance, for the legal/technical area and to support the implementation of the UPAs. Ordinance 2048/2002, the National Policy for Emergency Care - PNAU and its reissue in 2011, the National Humanization Policy and the National Primary Care Policy are mentioned in all ordinances referring to the UPAs. QualiSUS-urgency is only mentioned in the first Ordinance No. 2.922/2008[5] and the Pact for Health is no longer mentioned in the last Ordinance No. 2846/2011[6].

Linked to the SUS, the Emergency Care Units (UPAs) are part of the National Urgency and Emergency Policy, launched by the Ministry of Health in 2003[7].

These units operate 24 hours a day, seven days a week, can handle most urgencies and emergencies, and help reduce lines in hospital emergency rooms. As the only specialists available: internal medicine, pediatrics, dentistry and social assistance[3].

The places are often overcrowded, making it difficult to serve the entire community present. Thus, there was a need to screen the occurrences, thus prioritizing the most serious cases. Therefore, the Reception with Risk Assessment and Classification (AACR) was implemented as a guideline, which aims to reorganize and carry out health promotion in the network. The implementation of the AACR for care by severity criteria and no longer by order of arrival to the emergency services was the strategy to achieve the principle of the National Humanization Policy (PNH) and was implemented as a pre-established protocol, providing care centered on the level of complexity[8].

This process identifies patients who need immediate treatment, according to the potential risk, health

problems or degree of suffering. The practice is understood as an ethical and professional posture for care by level of complexity.

In this context, Ordinance No. 2048/2002, which regulates urgent and emergency services in Brazil, regulated the implementation in emergency care units for reception and for risk classification screening. This process must be carried out by a health professional, with a higher education level, through specific training and use of pre-established protocols, and aims to assess the degree of urgency of the patients' complaints, placing them in priority order for care[9].

For this reception, the Regional Nursing Council (COREN) of the Federal District, in Opinion No. 005/2010, clarified that the AACR process is an activity that is in accordance with the attributions of the nurse[10].

This process takes place through qualified listening and decision-making based on protocol, combined with the nurse's critical judgment capacity and experience. The order of service is determined as follows: RED ie emergency (will be attended to immediately in the emergency room); ORANGE, that is, very urgent, it is recommended that the patient wait a maximum of ten minutes; YELLOW, that is, urgency (will be seen within 60 minutes, with priority over patients classified as green, in the office or bed in the observation room); GREEN, that is, without immediate risk of death (less urgent, medical evaluation in about 60 minutes); BLUE, that is, chronic condition without acute suffering or social case (should preferably be referred for care at UBS or attended by the Social Service)[11].

Although nurses are considered able to carry out the welcoming and risk classification process in UPAs, some nurses still have doubts about who to prioritize at the time of care[12].

Therefore, the guiding question: What is the perception of nurses in the use of risk classification in Emergency Care Units? And the objective was defined as identifying the perception of nurses in the risk classification, in a reception in a UPA, in the west side of Rio de Janeiro – RJ.

Methodology

This is a qualitative field research with semi-structured interviews with ten nurses in an Emergency Care Unit, located in the West Zone of the Senador Camará district, in Program Area 5.1, Rio de Janeiro.

The choice of the unit was due to the great demand for care and the need for risk classification. The inclusion criterion was defined as: nurses who had been attending care for more than six months in the reception and risk classification, and the exclusion criterion were those who did not fully answer the interviews or were on vacation and leave during the period of data collection. It is important to report that the health unit is in a very conflictual region, with a low socioeconomic level, but with easy access.

The interviews took place in September and October 2019, according to the professionals' availability of time and there was no refusal of professionals to participate. The research was developed in accordance with the recommendations of Resolution No. 466/2012 National Commission for Ethics in Research (CONEP) with the SMSRJ opinion n.º 3.002.717. Participants were informed about the purpose of the study and freely accepting to participate, they signed the Informed Consent Form. In this study, the data were analyzed according to Bardin's content analysis technique.

Results and Discussion

With the collection of data, an analysis of the content obtained was made through the survey of the answers made by the script of questions and the full transcription of the interviews. Then, the most important and relevant ideas were selected from this material, seeking the necessary data to achieve the research objectives.

The data obtained through the interviews were broken down into nuclei or units that were presented by categories. Ten nurses were interviewed, as professionals of an Emergency Care Unit in the West Zone. There is a predominance of female professionals in 90%. According to data from the Federal Nursing Council, in Brazil, 88.02% of nurses are still female. Between the ages of 28 and 60, it is noteworthy that the majority started the profession incredibly young; when comparing age and time in the profession, it is noted that the majority started working as a nurse between 22 and 27 years old (80%). Only two of the interviewees started after the age of 30.

Another trend is qualification, only one of the interviewees does not have any postgraduate course and one of the interviewees has two - Public Health and Family Health, being the most cited courses. The current profile of nurses contributes to a better performance both in carrying out their tasks, as well as in interpersonal relationships and in the development of new goals and health policies. They also state that the profession considers competitiveness in the labor market, the need to acquire knowledge and multiple skills, leading to a constant search for qualification[13].

User Reception

Changing the practices of welcoming users and citizens in health services is one of the challenges presented by the SUS. Welcoming as a posture and practice in care and management actions in health units, based on the analysis of work processes, favors the construction of a relationship of trust and commitment between teams and services. It also enables advances in the alliance between users, workers, and health managers in defense of the SUS as an essential public policy for the Brazilian population[7].

User embracement is perceived by the nurses interviewed as "an activity capable of evaluating, setting priorities, organizing care for a more humanized and effective care".

It can be seen in the speech of respondents:

> *"Welcoming is to perform a qualified listening with humanization to the patient, listening to their complaints and seeking to guide them in the best way"* (Red).

> *"Promote humanized and qualified service according to the customer's degree of complexity"* (Orange).

> *"Welcoming attentive to the stated and implied needs of the patient. Using active and sensitive listening to the demands involved in the process"* (Black).

It is unanimous among the interviewees that the nurse must be aware of the subjectivities of each user, highlighting the critical look and a globalized and humanized analysis of the patient.

This fact demonstrates that nurses already consider the concept of embracement as part of the health production and promotion process, as something that qualifies the relationship and that, therefore, it is likely to be learned and worked on in all encounters in the health service, as recommended by the Ministry of Health[7].

Welcoming is not a space or a place, but an ethical posture, it does not presuppose a specific time or professional to do it, it implies sharing knowledge, needs, possibilities, anxieties and inventions[8].

Difficulties in Reception

As for the nurses' perception of the difficulties encountered in welcoming users, it is observed that 70%, that is, seven nurses said they exist. And the most cited were overcrowding, which hinders agility in reception; non-compliance with the risk classification; the lack of knowledge of the classification protocol and when the user presents several parameters making the classification difficult.

According to the lines:

> *"Very rude patients, threats suffered by patients and caregivers"* (Blue).

> *"I encounter numerous difficulties, such as service time, we have goals to be achieved, and the aggressiveness of dissatisfied customers with the proposed system"* (Black).

> *"In an emergency unit, with waiting lines, stressed patients and several other situations, it is difficult to hear the patient with quality; and in our unit there is also the blue classification where we refer the patient to Primary Care"* (Red).

> *"When the customer does not agree with the risk classification and wants priority"* (Green).

> *"The patient does not understand how the reception in the emergency care is performed"* (Lilac).

100% claim that in these cases, users and their companions are usually rude, irritated, often aggressive, causing turmoil at the moment of reception and hindering the work of the nursing team.

Urban violence extends to Health units, where nurses and other health professionals are targets of aggression. The Municipal Health Department (SMS) reports aggressions suffered by a doctor, in the Emergency Care Unit of Patience, West Zone of Rio de Janeiro, for refusing to issue medical certificates, highlighting a safety problem faced daily by health professionals and from other areas that deal with the public[14].

The increase in cases of accidents and urban violence in recent years has caused overcrowding in hospital emergencies and emergency rooms, making this area one of the most problematic areas in the health system. For this reason, the Emergency Care Units (UPAs) emerged as one of the strategies of the National Emergency Assistance Program PNAU for better organization of care, articulation of services, and definition of resolute flows and references. This strategy appeared as one of the resolving initiatives for the problem of overcrowding in hospital emergencies[15].

It is observed, however, that the lack of structure in the UPAs in Rio de Janeiro is reported in the media, imposing the difficult task of deciding who will assist the team responsible for welcoming and risk classification in the media. In this sense, there are reports that the red sector, exclusive to severe cases, is often full, with emergencies that keep coming[16].

Risk Rating

Upon arriving at the service, the user is welcomed and received, where his registration is made so that he can be forwarded to the risk classification. Risk Classification is a dynamic process of identifying patients who need medical intervention and nursing care, according to the potential risk, health problems or degree of suffering.

The institutional protocol was built based on the main complaint, guiding the management of the case through the signs and symptoms, which indicate to the health professional a priority level of care.

This assessment process follows the Manchester Protocol and is based on categories of signs and symptoms and contains 52 flowcharts (50 used for routine situations and two for multiple victims) that will be selected based on the situation/complaint presented by the patient[17].

According to the results obtained, 70% are concerned with informing the waiting time for care and this is a facilitator to maintain the quality of care.

When asked how the risk classification is performed, 50% of respondents mentioned the Manchester protocol; 30% referred to interviews and reports of complaints from patients, coming closer to anamnesis than to the protocol itself; one of the interviewees referred to To Life and one referred to "equity".

The Manchester and To Life Protocol methods are similar and may or may not include orange and blue depending on the unit in which it is deployed. As for the nurse who refers to care with equity, it is believed that he refers to the literal meaning of the word: appreciation, fair judgment[18].

The method does not propose to establish a medical diagnosis and, by itself, does not guarantee the proper functioning of the emergency service. This system is intended to ensure that medical care occurs according to the response time determined by the clinical severity of the patient, in addition to being an important tool for the safe management of patient flows when demand exceeds the capacity to respond[19,20].

Each flowchart contains discriminators that guide the collection and analysis of information to define the user's clinical priority. That is, there is no care routine, for example, checking all vital signs of all users who enter the emergency services, on the contrary, for each service, a flow established

in the protocol is followed, according to the symptom presented, which will guide your conduct[12].

The Benefits of the Reception Protocol and Risk Rating

As for the benefits for health professionals and society, 100% were unanimous in recognizing that risk classification is a facilitator for care in emergency care units.

According to the lines:

> *"Speeds up the service"* (Green).
>
> *"Collection of information that can help in a possible diagnosis"* (Yellow).
>
> *"Allows critically ill patients to have faster care"* (Blue).
>
> *"Classifies the customer according to the degree of risk"* (Orange).

It is observed in the speeches that the host is a facilitator for the classification of risk and prioritizes faster care to those who need immediate care.

A study carried out in 2014 found that the correct application of the welcoming protocol and risk classification is essential to identify the fact that there is a large proportion of patients with a lower level of priority in search of urgent and emergency services, which implies in the overcrowding phenomenon in these services. Thus, when considering the beneficial characteristics of the Manchester protocol, the correct application of this system becomes essential in service managements[19].

In addition, by standardizing the behavior of nurses, the use of the protocol minimizes the interference of the subjectivity of the evaluator's gaze, which promotes security in decision-making, the AACR protocol has shown its institutional importance for users to promote a humanized gateway with an agile and safe reception to the clientele, which can reduce negative effects on the prognosis, resulting from delays in care[20].

Improvements in Risk Rating in Reception

As for possible improvements to the functioning of the risk rating, 80% of respondents believe they can be improved.

Reception is not a space or a place, but an ethical posture, it does not presuppose a specific time or professional to do it, it implies sharing knowledge, needs, possibilities, anxieties, and inventions. In this way, it is what differentiates it from triage, as it is not a step in the process, but as an action that must occur in all places and moments of the health service[8].

> *"Public awareness and more information for users about waiting times"* (Yellow).
>
> *"Government, media and professionals raising awareness and informing the population"* (Blue).
>
> *"The same must know which unit to go to according to the symptoms"* (Pink).
>
> *"Patients do not understand why others 'pass' in front of them"* (Red).

Brazilian urgent and emergency services, lately, have been the target of concern among managers, physicians, and administrators; since non-emergency care has continuously and increasing demand, which jeopardizes the treatment of patients in real life-threatening situations. Hospitals and emergency care, as they are freely searchable and enter the health system, promote a disorderly search for care, causing overcrowding, and to improve and ensure that the most serious are treated, the practice of classification is essential. risk within these services[20].

Urgency and emergency services in our country do not have the capacity to attend to the large number of patients who seek services every day, and overcrowding is the result of organizational problems[21].

In this sense, the AACR is a dynamic process and carried out periodically in all patients while they wait for care. Thus, any change in the clinical picture can be identified, changing the priority, if necessary. It is especially important that any further aggravation is identified so that therapy can be started[22].

It is necessary not to restrict the concept of reception to the problem of reception of demand. Welcoming at the gateway only makes sense if it is understood as part of the health production process, as something that qualifies the relationship and, therefore, can be learned and worked on in any meeting in the health service[7].

According to the survey, it was also possible to notice that the communication process between professionals and users also presents weaknesses in the sense of wide dissemination and that respondents recognize the importance of training before incorporating new work processes[23].

Final Considerations

Considering the objectives, it can be said that the technology of Welcoming and Assessment with Risk Classification presupposes the determination of agility in the service based on the analysis, from the perspective of a pre-established protocol, of the degree of need of the user, providing attention focused on the level of complexity rather than the order of arrival.

Nurses realize that the implementation of the Manchester protocol aims to improve care in urgencies and emergencies, being an indispensable tool for classifying the severity and speeding up the process, saving the patient's life in overcrowded services and with little infrastructure.

Nurses do not perceive greater difficulties with the use of the already implemented system, which was considered adequate and beneficial by the interviewees. However, some improvements were suggested, such as standardization, implementation throughout the national territory, and attention was drawn to the need to improve the information that reaches the general population, to further facilitate the procedures in reception and risk classification in the UPAs.

There was a certain difficulty of the population in understanding the criteria used by the protocol, a fact that generates dissatisfaction in the service by users and even

embarrassment to professionals. This fact denotes the need to better inform the general population about AACR.

It is also recalled that the challenges are exposed in the context of classifying the risk in the UPA, as receiving the demand, and classifying it, based only on protocoled practice, does not respond to humanely accepting the needs and demands of people in this service. Safe production of health is necessary but qualified in a relationship of respect for the other as a human being.

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