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PROFESSIONAL AND MATERIAL POSSIBILITIES IN EMERGENCY INPATIENT CARE: EXPERIENCE REPORT

POSSIBILIDADES PROFISSIONAIS E MATERIAIS EM SERVIÇO INTRA-HOSPITALAR DE URGÊNCIA E EMERGÊNCIA: RELATO DE EXPERIÊNCIA

POSIBILIDADES PROFESIONALES Y MATERIALES EN SERVICIO INTRA-HOSPITALARIO DE URGENCIA Y EMERGENCIA: RELATO DE EXPERIENCIA

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ABSTRACT

Objective: to identify the professional and material possibilities for health care in emergency inpatient care. **Method:** descriptive study, of experience report type, performed at a first aid service of the Santa Casa de Caridade Hospital located in the Western border of Rio Grande do Sul, and based on the use of participant observation technique. **Results:** professional possibilities included overcrowding of patients, communication difficulties, fragmentation of care, illegibility and lack of signatures of professionals in medical prescriptions and limited number of professionals to provide care. As for material possibilities, they included the financial shortage of the unit and lack of material resources. **Conclusion:** a reciprocal relationship was found between training and the performance of professionals, especially nursing professionals. Such situations were transformed into possibilities performed by creative strategies of nursing professionals, thus demonstrating the benefits of the university-service-community partnership. **Descriptors:** Emergency; Nursing care; Quality of Health Care.

RESUMO

Objetivo: identificar as possibilidades profissionais e materiais para a assistência à saúde em serviço intra-hospitalar de urgência e emergência. **Método:** estudo descritivo, tipo relato de experiência, realizado em um serviço de pronto-socorro do Hospital Santa Casa de Caridade, localizado na fronteira Oeste do Rio Grande do Sul, e desenvolvido pela aplicação da técnica de observação participante. **Resultados:** encontrou-se como possibilidades profissionais a superlotação de pacientes, dificuldades comunicacionais, a fragmentação do cuidado, ilegibilidade e falta de assinaturas dos profissionais em prescrições médicas e limitado número de profissionais para a assistência. Como possibilidades materiais a carência financeira da unidade e falta de recursos materiais. **Conclusão:** percebeu-se uma relação recíproca entre a formação e a atuação de profissionais, especialmente os da enfermagem. Tais situações foram transformadas em possibilidades executadas por estratégias criativas dos profissionais de enfermagem, demonstrando, assim, os benefícios da parceria universidade-serviço-comunidade. **Descritores:** Emergência; Cuidados de Enfermagem; Qualidade da Assistência à Saúde.

RESUMEN

Objetivo: identificar las posibilidades profesionales y materiales para la asistencia a la salud en servicio intra-hospitalario de urgencia y emergencia. **Método:** estudio descriptivo, tipo relato de experiencia, realizado en un servicio de pronto-socorro del Hospital Santa Casa de Caridade, localizado en la frontera Oeste de Rio Grande do Sul, y desarrollado por la aplicación de la técnica de observación participante. **Resultados:** se encontraron como posibilidades profesionales la superlotación de pacientes, dificultades comunicacionales, la fragmentación del cuidado, ilegibilidad y falta de firmas de los profesionales en prescripciones médicas y limitado número de profesionales para la asistencia. Como posibilidades materiales, la carencia financiera de la unidad y falta de recursos materiales. **Conclusión:** se notó una relación recíproca entre la formación y la actuación de profesionales, especialmente los de la enfermería. Tales situaciones fueron transformadas en posibilidades ejecutadas por estrategias creativas de los profesionales de enfermería, demostrando así, los beneficios de la sociedad universidad-servicio-comunidad. **Descriptor:** Emergencia; Cuidados de Enfermería; Calidad de la Atención de la Salud.

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INTRODUCTION

Emergency inpatient service must have a physical structure defined by the number of people who seek it, that is, according to the patients' demand. This type of care requires professionals to maintain health care supported in patient safety. This support is not restricted to working environment conditions, but it also covers the availability of professional/human resources and materials.¹

Search for such service has shown a considerable increase, especially in the first aid units. Several situations have triggered this growing and disorderly search, such as the growth of urban violence, socioeconomic issues and lack of resolute actions in primary health care services.²

First aid units represent 24-hour access to clinical, pediatric, obstetric, surgical and/or traumatological specialties for patients, since the purpose of the work developed in this environment is the clinical stabilization of the patient with a guarantee of comprehensiveness of care. This guarantee results in the referral of the patient to another specific unit for appropriate treatment of their health conditions and/or their reintegration into society.³

The nurse is the professional responsible for the organization of work and for providing comprehensive care in first aid units. This responsibility is permeated by the complexity of interpersonal and professional relations, often increased by unhealthy, ambiguous and paradoxical working conditions, mainly in relation to the maintenance of workers' health.⁴

Emergency nurses must produce a dynamic and resolute care in the face of the high number of daily attendances, which, in most cases, are superior to the capacity of their resources.⁵ They are responsible for coordinating the work actions of many professionals with different opinions, personalities and thoughts.⁶ In this reality, it becomes relevant to study the possibilities, because these can contribute and even interfere in the way the work process is conducted. Therefore, the present study was elaborated to answer the following question: what are the professional strategies that allow the execution of health care in the first aid service?

OBJECTIVE

- To identify the professional and material possibilities for health care in emergency inpatient care.

METHOD

This is a descriptive study, an experience report, carried out in an First Aid service of Santa Casa de Caridade Hospital, in the Western border of Rio Grande do Sul, whose object of research is the professional/patient interaction for the purpose of developing health care in an emergency situation.

The present study was developed by applying the participant observation technique, from August to December 2016, which was made possible by the orientation and supervision of professors in the curricular training and by the registration of activities in weekly portfolios. The presented results are approached qualitatively through a narrative. This research is in accordance with the Resolution of the National Health Council, number 466/2012, with the research project approved by the Ethics Committee in Research, under Certificate of Presentation for Ethical Appreciation: 38090414.5.0000.5323.

RESULTS

♦ Professional Possibilities

The present study, through systematized observation of reality, enabled to prove the existence of *daily overcrowding of the emergency service*, which was mostly caused by the permanence of patients whose needs should be target of direct action of professionals inserted in primary care.

This reality of care was clearly elucidated from the risk classification, which evidenced the predominance of patients categorized with blue and green colors. This represents a service gap to the extent that interprofessional and intersectoral communication advocates the use of reference and counter-reference, which in fact exists only when there is personal motivation by the professional.

As a strategy to reduce daily overcrowding of the emergency service, the use of risk classification through the Ministry of Health protocol was materialized. This instrument is based on the nursing screening of patient's signs and symptoms to define waiting time for medical care. Such screening results in the classification of the degree of risk to life and is indicated by color.

Thus, the red color refers to immediate emergency care; the yellow color denotes the emergency care in medical consultation with a maximum wait of 60 minutes; the green color indicates cases not framed as emergency, which may receive care in up to two hours; and finally, the blue color indicates situations that can be seen in primary care, which can wait 4 hours without complications of the clinical picture.

Despite this effort to reduce overcrowding of the First Aid Department, some situations go in the opposite direction and end up worsening the progress of the service. In this sense, *communicational difficulties* favor the fragmentation of care in different ways. These include: illegibility and absence of dosages and the professional's signature in the medical prescription; denial, by the professional of the consecutive shift, to perform medical evaluation.

With regard to medical illegible prescriptions or without stamp/dosages/signatures, the professional was sought to solve the event at the time. In due course, these events were discussed during the change of shifts, thus promoting the importance of checking the medical prescription and guiding the professional, whatever they may be, regarding compliance with the presence of the signature/professional registry and dosages for dispensing materials/medications by the pharmacy.

Sequentially, First Aid Department coordinators, physicians and nursing professionals were reported, albeit verbally, about the denial in performing medical evaluation of the patient in after the change of shift. This type of event expresses discontinuity of assistance, of evaluation and of care on an ongoing basis.

As for this, the importance of the continuity of care based on clinical evaluation and on the transmission of information about the patient from one shift to the next was emphasized. Such information corresponding to nursing and medical conducts is opportune for the maintenance or recovery of the clinical picture of the patient. In addition, there has been a disharmonious relation between the physical structure and the number of professionals, since the aforementioned emergency service is divided into three basic areas: reception, waiting room and screening room; yellow area, comprising a doctor's office, a nursing room, a medication room, a room with four beds for patient observation, a dressing room and a clinical isolation room. The red area has a

nursing room, dressing room, lavabo, storage and purge room and a room with eight beds plus the nursing room, of these four with support for continuous monitoring and mechanical ventilation, plus a clinical isolation bed.

For this physical structure, three nurses are available per shift, one for each area; two physicians: a clinician and an emergency doctor; six nursing technicians, two per area. These insufficient human resources include unforeseen events, such as compensatory rest days, varied absences that are not notified in advance and medical leaves, a fact evidenced during the period for observation of practical activities and specifically during the formulation of internal communications. All this results in a scenario in which other professionals feel overwhelmed, and these factors, added to overcrowding, favor job function deviations and occupational stress.

During the work routine of the sector, the absence of nurses in one of the sectors occurs once or twice a week, the absence of nursing technicians occurs more than once a week and of the absence of physicians occurs at least every 15 days and at the maximum frequency of once a week.

The strategy to solve the problem of limited number of professionals for providing care was mostly adopted in an immediate manner, not in the long term. For example, in the absence of a physician to assist in the yellow area during a shift, the physician in charge of the red area, after a conversation between team and coordinator, attended patients classified as red and yellow.

In the same sense, in the absence of a nurse in the yellow area or in screening, a single nursing professional was responsible for these two sectors, using, whenever possible, supervised nursing academics and multidisciplinary internship staff to assist their functions.

In the case of absence of nursing technicians in the yellow area or observation sector, the technician of the sector that was less overcrowded. Also, nursing students in supervised practical activities were called by their teachers to provide assistance and patient care.

♦ Material Possibilities

The huge financial crisis that hits the hospital often causes shortage of essential materials for the continuity and quality of care. In the midst of this scarcity of material resources, firstly, the absence of syringes and needles for drug administration was noticed. Subsequently, the lack of antiseptic solution,

urethral catheter, some Folley probes, sterile gloves, sterile occlusive material for peripheral accesses and some antipyretic, analgesic and benzodiazepine drugs were noticed.

Such absences, besides exposing the quality of health care, also impact on workload and stress. Nursing professionals need to consult the pharmacy to replace the prescribed medications and then request a new medical prescription.

This set of facts reveals institutional deficiency in relation to financial resources, which goes against the payment of professional. This also corroborates occupational stress and fragmentation of care, already strengthened by overcrowding.

With regard to the shortage of material resources, professionals have used the strategy of substituting these inputs by similar ones with the same purpose and they have constantly searched for the optimization of available material. As an example, in the absence of a urethral catheter, an aspiration probe was used.

DISCUSSION

Interestingly, patients have sought emergency care as the first choice for the solution of their problems, which has resulted in overcrowding. This reveals the existence of difficulties in the primary care level for disseminating and propagating the purposes of the health network services and corroborates the disarticulation of this network with regard to reference and counter-reference, intersectoriality.⁷

The reduction in the search for emergency services involves a multidisciplinary and continued primary care, that is, the development of follow-up actions and clinical and informational/educational monitoring.⁸⁻⁹ Otherwise, there have been several adversities in the care at first aid units, such as poor quality of care, professional overload and health service overload, among others.¹⁰

Care fragmented indicates gaps in nursing planning that affect the execution of actions. Consequently, communication noises and conflicts are perceived among the members of the multiprofessional team, limiting the continuity of care. Thus, the common objective of work in emergency care is not clear to all professionals.

Work actions are included in planning as part of institutional organization. In the emergency inpatient service, the nurse was identified as responsible for managing these actions. Such management is enabled by the

dialogue between professionals for the purpose of equity of care.¹

The better the relationship between professionals, the greater the chances of success to minimize singularities and differences. Thus, the work process is made of interpersonal relationships and these directly influence on the daily routine. Unfavorable and tense relations generate difficulties of development and effectiveness of actions in health care. Preserving healthy relationships with the team is indispensable to develop and promote a quality therapeutic care for patients.¹¹

Illegibility and absence of dosages and professionals' signatures in medical prescriptions demonstrate disregard and negligence in relation to their professional competencies and duties. It also generates a greater time and an accumulation of work for the nursing team, since this search seeks to solve problems that limit patient care.

Medical prescriptions must be signed and stamped, allowing identifying the professional in case of need; it must not contain erasures and amendments. Also, illegible and/or misleading recipes or those that may cause error when dispensing medicinal products or those containing codes or acronyms may not be released.¹²

Investment in health information and communication technologies qualifies the work process. Infrastructure, equipment and software contribute to productive efficiency and cost control and quality of services, which promotes a better provision of services.¹³ Constant professional updating of knowledge is a facilitator of professional practice and should be an institutional policy and responsibility, as advocated by the National Policy of Permanent Education, since it collaborates to individual and organizational development.¹⁴

In addition, the limited number of professionals increases the workload and can lead to stress. In this sense, caring for oneself as a professional is an institutional responsibility, rather than a possibility, legally supported by the Consolidation of Labor Laws.

Since nursing is the category with the largest amount of health services either in emergency care or not, it should point out the best indicators for staffing. More than talking to those responsible for the institution, nurses need to provide themselves with data and information about their exposure and the consequences for patients.¹⁵

Excesses cause wear and tear that among health professionals, especially among nursing

professionals, have been manifested by the burnout syndrome. On the other hand, the impediment or the improvisation for the execution of work actions, by different limits, can cause moral suffering.¹⁶

The presence of high psychological demands is one of the peculiarities of the work in the First Aid Department and plays a significant role for occupational stress. It also causes harm to the health of professionals and becomes harmful when added to the lack of control over work actions and low perception of social support. Occupational stress should be considered by the hospital institution as a challenge that requires strategic actions. Among these actions, authors suggest permanent or continuing education and health promotion actions.¹⁷

Scarcity of material is one of the main problems that affect nursing managers, who need to give up planning and reduce the lack of materials needed for care. This event goes against the development of quality care¹⁸. Nursing is responsible for providing care to users and, for this purpose, it needs to have qualified human resources and in a quantity that enable it to meet institutional expectations.

The present study evidences more than the reality of nursing work in emergency service, it indicates that this work is not restricted to aspects of the teaching-learning process. The study shows that the quality health care goes through contributions of different orders and that access to working conditions, besides reflecting in the quality of care, determines the viability of work and the worker's health or the rates of absenteeism.

CONCLUSION

Among the possibilities observed in the emergency inpatient service, there was a reciprocal relationship between training and the performance of professionals, especially among nursing professionals, which demonstrates the benefits of university-service-community partnership.

The insertion of nursing professionals under training in the aforementioned service, besides capacitating them for health care in emergency situations, makes them more committed to the community needs, in addition to enabling the capture and construction of new creative strategies to deal with communicational, interpersonal and even managerial problems.

Health care in the emergency hospital service, while strengthening the multiprofessional training of nursing, provides

qualification by updating the professional to the extent that students, academics, interns and professors dialogue with professionals and promote the updating of knowledge of clinical and assistencial practice and contribute with initiatives and creativity to solve problems.

The mentioned strengthening of the service also reflects in the availability of more professional and material resources to meet the needs of the population. This availability may assist in ensuring universality in access, equity and comprehensiveness of care, since professionals will not care about the time spent in attending each patient, but with the best solution for the problem, as it is a moment for learning. Also, professional activity is not exclusively an exercise in which nothing is learned, since institutions should promote lifelong education.

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Rubim MM, Cardoso LS, Silva JJS da et al.

Professional and material possibilities...

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