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ORIGINAL ARTICLE

HUMANIZATION OF CARE: RECEPTION AND SCREENING IN RISK CLASSIFICATION

HUMANIZAÇÃO DA ASSISTÊNCIA: ACOLHIMENTO E TRIAGEM NA CLASSIFICAÇÃO DE RISCO HUMANIZACIÓN DE LA ASISTENCIA: ACOGIDA Y TAMIZAJE EN LA CLASIFICACIÓN DE RIESGO

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ABSTRACT

Objective: to establish relations between the humanization of care and the reception and screening in risk classification by nursing in emergency medical services. **Method:** this is a quantitative, analytical, cross-sectional study. A questionnaire was used and 80 patients who were in nursing consultation were interviewed. Descriptive analysis, means, standard deviation, median, minimum and maximum, frequency and percentage were used. Results were presented in the form of tables. **Results:** it was verified that, of the 64 patients, the majority were female, between the ages of 21 and 40 years and married, and five patients waited longer than the recommended time, and Orthopedics/Traumatology was the specialty with greater number of patients attended. **Conclusion:** it was concluded that the users are satisfied with the Nursing performance in the humanization of care, in the reception and in the classification with risk classification, in emergency medical services. It is inferred that considerations about the theoretical or practical implications of the results and the contribution of the study to the advancement of scientific knowledge are to establish relations between the humanization of care and the reception and sorting with risk classification in emergency medical services. It is hoped to find situations in which there is a lack of humanization and to put them in evidence, proposing changes. **Descriptors:** Humanization of Care; Reception; Screening; Ranking; Risk; Emergency Nursing.

RESUMO

Objetivo: estabelecer relações entre a humanização da assistência e o acolhimento e a triagem na classificação de risco pela enfermagem nos serviços médicos de emergência. **Método:** trata-se de um estudo quantitativo, analítico, transversal. Utilizou-se um questionário e entrevistaram-se 80 pacientes que estavam em consulta de enfermagem. Utilizaram-se a análise descritiva, médias, desvio padrão, mediana, mínimo e máximo, frequência e percentual. Apresentaram-se os resultados em forma de tabelas. **Resultados:** verificou-se que, dos 64 pacientes, a maioria era do sexo feminino, na faixa etária entre 21 a 40 anos e casada, e cinco pacientes esperaram mais que o tempo preconizado, sendo que a Ortopedia/Traumatologia foi a especialidade com maior número de pacientes atendidos. **Conclusão:** chegou-se à conclusão de que os usuários estão satisfeitos com a atuação da Enfermagem na humanização da assistência, no acolhimento e na triagem com classificação de risco, nos serviços médicos de emergência. Infere-se que as considerações sobre as implicações teóricas ou práticas dos resultados e a contribuição do estudo para o avanço do conhecimento científico são estabelecer relações entre a humanização da assistência e o acolhimento e a triagem com classificação de risco nos serviços médicos de emergência. Espera-se encontrar situações em que há falta de humanização e colocá-las em evidência, propondo mudanças. **Descritores:** Humanização da Assistência; Acolhimento; Triagem; Classificação; Risco; Enfermagem de Emergência.

RESUMEN

Objetivo: establecer relaciones entre la humanización de la asistencia y la acogida y el tamizaje en la clasificación de riesgo por la enfermería en los servicios médicos de emergencia. **Método:** se trata de un estudio cuantitativo, analítico, transversal. Se utilizó un cuestionario y se entrevistaron a 80 pacientes que estaban en consulta de enfermería. Se utilizó el análisis descriptivo, promedios, desviación estándar, mediana, mínimo y máximo, frecuencia y porcentual. Se presentaron los resultados en forma de tablas. **Resultados:** se verificó que, de los 64 pacientes, la mayoría era del sexo femenino, en el grupo de edad entre 21 a 40 años y casada, y cinco pacientes esperaron más que el tiempo preconizado, siendo que la Ortopedia / Traumatología fue la especialidad con mayor el número de pacientes atendidos. **Conclusión:** se llegó a la conclusión de que los usuarios están satisfechos con la actuación de la Enfermería en la humanización de la asistencia, en la acogida y en el tamizaje con clasificación de riesgo, en los servicios médicos de emergencia. Se espera encontrar situaciones en que hay falta de humanización y ponerlas en evidencia, proponiendo cambios. **Descriptores:** Humanización de la Atención; Acogimiento; Triagem; Clasificación; Risco; Enfermería de Urgencia.

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INTRODUCTION

It is seen that the commitment of attention to the urgencies by the excess of demand, compared with the available resources, is the definition of overcrowding of the emergency services. It is seen in several countries of the world as a public health problem and,¹ as a consequence, the demand for humanization of care in the Brazilian context is increasing due to the reality that health service users face every day. It is noted that there are several patients' complaints, which deal with maltreatment and lack of adequate care for human needs.²

The National Humanization Policy (HumanizaSUS) was formulated in 2004, formulated by the Ministry of Health, which defined, among its criteria, the restructuring of urgency/emergency services, with the implementation of the Reception with Risk Classification and Assessment (RRCA).³ The importance of the screening service, which is directly linked to the identification and prevention of acute conditions involving red (emergency) colors, is taken into account; yellow (urgency); green (less urgency) and blue (not urgency). The scale of the highest to the lowest risk, according to clinical criteria established by institutionalized protocols.⁴

The main purpose of HumanizaSUS is the initial evaluation, selection and referral of the client to the specialties units appropriate to the service rendered. It is reported that screening is more than classifying patients, it is also guaranteeing the right to citizenship, it is to rescue UHS principles, welcoming and guiding.⁴ It is facilitated by the use of strategies such as protocols for risk classification performed by the nurse, the minimization of problems.¹

It is ratified that, for the acting nurse in the RRCA, it is important that the skills of qualified listening, evaluation and complete recording of the main complaint, teamwork, critical reasoning and agility for decision making, as well as the knowledge of support systems in the care network for the best user referral.⁵ It is shown in studies that the professional working in the urgency and emergency services needs to develop skills that guarantee them technical-scientific success and a warm and humane posture with the users.⁶

It is observed that one of the reasons found for not knowing the relationship between the Humanization of Care and RRCA by Nursing in the emergency medical services is the increase in the demand for these services and the lack of supply to meet the needs that this

system features. It is perceived that these needs that are not supplied generate overcrowding, which result in fast and dehumanized care, not solving the patients' problems. For all this, a hostile environment is created to work, compromising the health of this professional and, consequently, of the patients. All these factors result in a system that works as an endless cycle, deepening every day the limitations, culminating in this strong lack of humanization present in the health systems, more precisely in the emergency medical services, being the proposal of this project to analyze these situations and bring them to the fore, proposing changes.

OBJECTIVE

- To establish relations between the humanization of care and the reception and screening in the classification of risk by Nursing in emergency medical services.

METHOD

This is a quantitative, descriptive, analytical, cross-sectional study with a correlation design among variables performed at an emergency service. Patients who were on RRCA were included and the patients who had the plug were incompletely filled and those classified as orange or red were excluded. Eighty patients were interviewed for this study. Sixty-four patients were selected according to the inclusion criteria treated here as a sample of the population who underwent the Nursing Consultation at the RRCA in the emergency medical services of the Base Hospital of São José do Rio Preto, São Paulo, in the period from February to July 2018. Sixteen patients were excluded because of incomplete information in the interview. The data is analyzed for the interview, considering the following variables: waiting time (in minutes), sex, age, marital status, city of origin, schooling, occupation, race / color, religion, companion, referral, initial care, knowledge about the RRCA, why the RRCA is important, what difficulties are encountered and if you think you have solved the problems. In the questionnaire, "Users are satisfied with the Reception? (Satisfaction questionnaire)", by the patients, the reception and infrastructure of the hospital, in questions one to seven. The questions from one to six were answered in the question "Evaluation of the Reception by the Nurse". Users were also judged by a "General Assessment of RRCA", "User Satisfaction" and "Difficulties Found".

The variables "waiting time" were crossed with "severity of RRCA"; "Medical specialties"

with "waiting time"; "Medical specialties" with "RRCA classification" and "general assessment" with "encountered difficulties".

After the data tabulation, two functions of statistical analysis were performed: descriptive and inferential. The profile of the studied sample was studied in a descriptive way, considering the analyzed variables and their unfolding. The data were replicated in an absolute and relative way in this first part. The analysis of comparison between the means of satisfaction of the color classification groups was performed as a statistical objective. The results were obtained by means of analysis between the values of P (significance). Finally, all analyzes were performed using SPSS Statistics software, version 23, linked to the features of the Excel tool (version 2016). Descriptive and inferential methods were used, analyzing the probabilities of a population based on the sample data. In some cases, given the need

for a better understanding, the following methods were used: average; median; fashion; standard deviation; maximum value; minimum value; Kruskal Wallis test; Spearman correlation; Shapiro-Wilk test; standard error and significance.

Hypothesis tests were conducted using the Multivariate Linear Regression, which analyzed the behavior of the R² value, the correlations between the variables analyzed and the degree of explanation of the dependent variable in relation to the independent variables of the sample.

RESULTS

A convenience sample was considered with 64 patients, that is, the patients were included in the Nursing consultation at the reception and screening in the classification of risk in the emergency medical services of the Base Hospital of São José do Rio Preto, São Paulo (Table 1).

Table 1. Sociodemographic analysis of patients. São José do Rio Preto (SP), Brazil. 2018.

Variable	Color - Yellow		Colour - Green		Colour - Blue		Total	
	n	%	n	%	n	%	n	%
Sex								
Female	9	52.94	26	60.47	2	50.00	37	57.81
Male	8	47.06	17	39.53	2	50.00	27	42.19
Age								
Up to 20 years	1	5.88	5	11.63	0	0.00	6	9.38
21 to 40 years	4	23.53	15	34.88	2	50.00	21	32.81
41 to 60 years	4	23.53	11	25.58	1	25.00	16	25.00
61 to 80 years	6	35.29	10	23.26	1	25.00	17	26.56
> 80 years	2	11.76	2	4.65	0	0.00	4	6.25
Marital status								
Married	10	58.82	21	48.84	2	50.00	33	51.56
Widow	2	11.76	2	4.65	0	0.00	4	6.25
Consensual union	0	0.00	2	4.65	0	0.00	2	3.13
Single	2	11.76	11	25.58	2	50.00	15	23.44
Separated	2	11.76	4	9.30	0	0.00	6	9.38
Divorced	1	5.88	3	6.98	0	0.00	4	6.25
City								
São José do Rio Preto	5	29.41	13	30.23	1	25.00	19	29.69
Other Municipalities	12	70.59	30	69.77	3	75.00	45	70.31
Schooling								
Without schooling	3	17.65	2	4.65	0	0.00	5	7.81
Incomplete elementary school	5	29.41	14	32.56	1	25.00	20	31.25
Complete elementary school	3	17.65	4	9.30	1	25.00	8	12.50
Incomplete highschool	1	5.88	5	11.63	0	0.00	6	9.38
Complete highschool	5	29.41	14	32.56	0	0.00	19	29.69
Incomplete higher education	0	0.00	1	2.33	1	25.00	2	3.13
Complete higher education	0	0.00	3	6.98	1	25.00	4	6.25
Occupation								
Autonomous	3	17.65	9	20.93	0	0.00	12	18.75
Retired	3	17.65	10	23.26	1	25.00	14	21.88
Student	0	0.00	3	6.98	1	25.00	4	6.25
Employer	0	0.00	2	4.65	0	0.00	2	3.13
Housewife	3	17.65	4	9.30	1	25.00	8	12.50
Unemployed	1	5.88	1	2.33	0	0.00	2	3.13
CLT	4	23.53	11	25.58	1	25.00	16	25.00
Employed without bond	2	11.76	3	6.98	0	0.00	5	7.81
INSS	1	5.88	0	0.00	0	0.00	1	1.56
Race/Colour								

White	6	35.29	25	58.14	3	75.00	34	53.13
Brown	6	35.29	14	32.56	1	25.00	21	32.81
Black	3	17.65	4	9.30	0	0.00	7	10.94
Yellow	2	11.76	0	0.00	0	0.00	2	3.13
Religion								
Catholic	7	41.18	17	39.53	2	50.00	26	40.63
Evangelical	8	47.06	14	32.56	1	25.00	23	35.94
Spiritist	0	0.00	4	9.30	1	25.00	5	7.81
None	2	11.76	6	13.95	0	0.00	8	12.50
Outra	0	0.00	2	4.65	0	0.00	2	3.13
Total	17	100.00	43	100.00	4	100.00	64	100.00

Table 2 shows the total average of the satisfaction of users with respect to the host with risk classification.

Table 2. Total averages of the Satisfaction of the Users with Relation to the Reception. São José do Rio Preto (SP), Brazil, 2018.

Users are satisfied with the Hosting? (Satisfaction Questionnaire)		
Hospital Reception and Infrastructure Evaluation		
Total Average	Evaluations	
Regular	2	3.13
Good	9	14.06
Great	53	82.81
Nurse Reception Evaluation		
Totala average	Evaluations	
Regular	2	3.13
Good	14	21.88
Great	48	75.00
Nurse Reception Evaluation:		
General evaluation	Evaluations	
Bad	1	1.56
Regular	2	3.13
Good	18	28.13
Great	43	67.19
Total	64	100.00

Table 3 shows the analysis of waiting time versus color classification (severity).

Table 3. Waiting Time versus Severity (Colour) - Protocol Efficiency Analysis. São José do Rio Preto (SP), Brazil, 2018.

	Colour - Yellow		Colour - Green		Colour - Blue		Total	
	n	%	n	%	n	%	n	%
Time								
Up to 60 minutes	4	23.53	17	39.53	1	25.00	22	34.38
61 to 120 minutes	8	47.06	15	34.88	1	25.00	24	37.50
121 to 240 minutes	4	23.53	8	18.60	1	25.00	13	20.31
> 240 minutes	1	5.88	3	6.98	1	25.00	5	7.81
Total	17	100.00	43	100.00	4	100.00	64	100.00

In table 4, it was observed that, when the medical specialties are related versus the waiting time for the care.

Table 4. Medical Specialties versus Waiting Time. São José do Rio Preto (SP), Brazil, 2018.

	Up to 60 Min		61 to 120 Min		121 to 240 Min		> 240 Min		Total	
	n	%	n	%	n	%	n	%	n	%
Specialties										
Orthopedics / Traumatology	14	63.64	6	25.00	3	23.08	0	0.00	23	35.94
Cardiology	0	0.00	1	4.17	0	0.00	2	40.00	3	4.69
General surgery	3	13.64	6	25.00	2	15.38	1	20.00	12	18.75
Vascular surgery	0	0.00	0	0.00	1	7.69	1	20.00	2	3.13
General clinic	4	18.18	6	25.00	2	15.38	0	0.00	12	18.75
Hematology	1	4.55	0	0.00	0	0.00	0	0.00	1	1.56
Neurosurgery	0	0.00	0	0.00	2	15.38	1	20.00	3	4.69
Neurology	0	0.00	1	4.17	0	0.00	0	0.00	1	1.56
Clinical oncology	0	0.00	1	4.17	0	0.00	0	0.00	1	1.56
Otolaryngologist	0	0.00	0	0.00	3	23.08	0	0.00	3	4.69
Urology	0	0.00	3	12.50	0	0.00	0	0.00	3	4.69
Total	22	100.00	24	100.00	13	100.00	5	100.00	64	100.00

In Table 5, the medical specialties were correlated with the classification of RRCA.

Table 5. Crossing of Medical Specialties versus Classification of RRCA. São José do Rio Preto (SP), Brazil, 2018.

	Colour - Yellow		Colour - Green		Colour - Blue		Total	
	n	%	n	%	n	%	n	%
Specialties								
Orthopedics / Traumatology	1	25.00	15	34.88	7	41.18	23	35.94
Cardiology	1	25.00	1	2.33	1	5.88	3	4.69
General surgery	0	0.00	9	20.93	3	17.65	12	18.75
Vascular surgery	1	25.00	1	2.33	0	0.00	2	3.13
General clinic	0	0.00	8	18.60	4	23.53	12	18.75
Hematology	0	0.00	1	2.33	0	0.00	1	1.56
Neurosurgery	0	0.00	3	6.98	0	0.00	3	4.69
Neurology	0	0.00	1	2.33	0	0.00	1	1.56
Clinical oncology	0	0.00	1	2.33	0	0.00	1	1.56
Otolaryngologist	1	25.00	1	2.33	1	5.88	3	4.69
Urology	0	0.00	2	4.65	1	5.88	3	4.69
Total	4	100.00	43	100.00	17	100.00	64	100.00

Table 6 shows the general evaluation of the users with the difficulties encountered.

Table 6. Cross-Cutting the Overall Assessment versus the Difficulties Found in the Nursing Consultation in the Classification of RRCA. São José do Rio Preto (SP), Brazil, 2018.

	Delayed Medical Care		Lack of orientation		Does not Report Difficulties		Total	
	N	%	N	%	N	%	N	%
Evaluation								
Terrible	0	0.00	0	0.00	0	0.00	0	0.00
Bad	1	6.25	0	0.00	0	0.00	1	1.56
Regular	0	0.00	1	25.00	1	2.27	2	3.13
Good	7	43.75	1	25.00	10	22.73	18	28.13
Great	8	50.00	2	50.00	33	75.00	43	67.19
Total	16	100.00	4	100.00	44	100.00	64	100.00

Inferential statistics were used to analyze statistical crosses, applying the Kruskal-Wallis test. The Kolmogorov-Smirnov normality test was chosen for the analysis of the variation of the results between the analyzed groups, since the data was non-parametric. The results were obtained in all analyzes by $p < 0.05$, characterizing the difference between the groups studied, and all tests included alpha error of 5% and reliability of 95%.

The variables "medical specialties" and "waiting time" were analyzed and found a value of $p = 0.002$. It is concluded that, according to the analysis of the p value, using the Kruskal-Wallis method, with 95% confidence, the level of satisfaction is statistically different among the risk groups, exemplified by yellow, green, blue, and in all other crosses performed, the level of satisfaction remained statistically equal between the RRCA.

It was verified that the dependent variable "color classification" by the Kolmogorov-Smirnov normality test, with a value of ($p = 0.000$), behaves non-parametrically, that is, the data are not distributed normally. It was concluded that, by the Kruskal-Wallis method, with 95% reliability, the level of satisfaction remained statistically equal among the risk groups, exemplified by yellow, green and blue.

At the intersection of the variables "color classification" versus "race/colour", and "colour classification" versus "routing", a value of $p = 0.003$ and $p = 0.039$, respectively, were considered, as the correlation was significantly correlated. According to Spearman's correlation, these variables present a low correlation level of 0.272 and 0.259, respectively. It is noted that other crosses of the variable "color classification" and other variables did not present levels of significance, being $p > 0.05$.

DISCUSSION

It was verified that, among the 64 interviewed users, 57.81% and 42.19% were female and male, respectively. The predominant female age group was predominant, ranging from 29 to 41 years, representing 32.81%. In a similar study, the majority of patients attending emergency services (53.7%), with a mean age of 20-29 years, were represented in a similar study.⁷ It has been confirmed in another study that men seek health institutions more because they are more vulnerable to severe and chronic conditions compared to women. A predominance of young adults, ranging from 25 to 34 years of age, was presented in the study of the age group.⁸ This fact is emphasized by an international study that affirms, in this sector, that men are evidenced with greater proportions of care.⁹

It was shown that 31.25% of the users had incomplete Elementary School, followed by 29.69% with complete High School, and the majority of the users of this study had incomplete Elementary School. It is shown, in another study, the High School as the predominant schooling.¹⁰ Results similar to those of this study were found in a survey¹¹ showing that the majority of users interviewed (41%) studied until incomplete Elementary School.

It was found that 25.0% were employed and 21.88% were retired, and 70.31% of the interviewed users were residents of other municipalities. These results disagree with a study showing that 90% of the patients live in the municipality, and a survey shows that the

closer the emergency service is to the user, the greater the frequency.¹²

There were high ratings of "very good" and "great", in the variables investigated with the users, and the majority of these were of low schooling. It was found in another study, carried out in a tertiary hospital and reference in the region, that the majority of the users were adults and had low educational level, presenting high satisfaction rates with care.¹³ It is concluded, therefore, that since the Base Hospital is a model institution, the users have a greater guarantee of receiving a greater resolution of their health problems.

It has been reported in similar surveys that schooling is a factor that influences the evaluation of user satisfaction. It can be inferred, therefore, that an influential factor in the research was the high prevalence of users with low schooling.¹⁴⁻¹⁶ It was concluded that the higher the level of education, the more critical the user will be about the services they attend and, therefore, will require a higher quality of this service, resulting in a probability of dissatisfaction on the part of these patients.¹⁷⁻⁸

There was confirmation that the user satisfaction with the services rendered may be due to the fear of being deprived of quality assistance when reporting negative aspects of the service and, thus, creating a conflict between them and the professionals.¹⁹

It was verified that when the "general evaluation of users" was crossed with the "difficulties found" that, in general, 67.19% of the users classified the variables, in the passage through the Nursing consultation in the RRCA, with an "Excellent". It is reported in surveys that trust is essential to establish a therapeutic relationship, having a strong impact on the patient's adherence to treatment, since a service that shows beneficial actions, safety and quality of care reflects the confidence transmitted.²⁰⁻²² These authors concluded that trust in the service, evaluated positively by the patients interviewed, helps in the adherence and recovery of the individual's health.

It was noted that the users were consistent with the literature when asked about education and respect of professionals. The majority of respondents were satisfied with the behavior of the team during the service, however, when users were asked about the knowledge of the RRCA, 64.06% answered that they did not know. In addition, 90.63% of the users reported that the RRCA solved the problems in the emergency room. Data were collected from another survey that reported that more than 50% of respondents do not

know about the RRCA,¹¹ and this shows that the majority of users using emergency services do not know how RRCA works, causing conflicts to be generated between the professional and the patient.

It was identified that 76.47% of the patients with yellow classification were above the waiting time and 74.42% of the patients with green classification were within the expected waiting time, as well as 75% of the patients with the blue classification. It is known that this fact goes against the recommendation of the protocol, which recommends shorter-term care for more severe patients. It is verified, through the data of another survey with 172 users, performed in a hospital of high complexity, that, in medical care, the average waiting time did not exceed the time recommended by the protocol of the unit in none of the classification colors.¹¹ It can be noticed that in other studies, in which the waiting time of the users until the medical attention was also evaluated, all the results were within the recommended time for the colors blue, green and yellow.²³

It was verified, when relating the medical specialties with the waiting time, that only five patients waited more than the recommended time, that is, they were attended with a time superior to 240 minutes. Among the specialties were two patients in the Cardiology, one in General Surgery, one in Vascular Surgery and one in Neurosurgery. In another study, it was shown that the greatest complaints from users were related to delayed medical care.¹¹

When correlating the "medical specialties" with the "RRCA" classification, it was demonstrated that Orthopedics/Traumatology was the specialty with the highest number of patients attended, or 23 patients, corresponding to 35.94% of the sample, followed by General Surgery and General Clinic, both with 12 patients, corresponding to 18.75% of the sample, respectively. Based on these data, another research that demonstrated a higher percentage of users served in the specialties of Clinical Medical, Surgical and Orthopedics. The present process of epidemiological transition in which Brazil is located is based on this data, placing an alert regarding the substitution of cases of diseases transmissible by noncommunicable diseases and external causes, transferring the morbimortality of the younger groups to the groups the elderly, with a predominance of morbidity.²⁴

It was seen that, in addition to the optimized time to attend those who presented

more severe clinical conditions, the RRCA device should serve as a subsidy for professionals, through the classification and monitoring of each user's risk, to provide information about the expected time for care that, according to the classification, present less serious clinical.¹⁸ In this way, the RRCA should be used as a potentiator so that professionals, through this classification, can monitor the users according to the risk, alerting about the expected waiting time for care for those who were classified in color with less severe clinical conditions because all of this information is important and helps users and family members feel safer and less anxious.²⁵

CONCLUSION

It was concluded that the level of satisfaction in all the strata surveyed remained statistically equal among risk groups, exemplified by yellow, green and blue. It was found that, although many users did not know the host system, many classified it as a functional system and evaluated it with high acceptance rates. It is understood that, in the colors yellow, green and blue, individuals were in the recommended time, with a small portion of them above the standard waiting time. In terms of waiting time and medical specialties, five patients exceed the recommended time, there being a statistical difference between the means obtained by the groups and, in the medical specialties versus the classification colors, Orthopedics/Traumatology and General Surgery and General Clinic, in this order, were those that had the majority of users classified in green and blue colors.

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