HUMANIZATION AND PATIENT INTAKE INTERVIEWS IN HOSPITAL EMERGENCY AND URGENT CARE: AN INTEGRATIVE APPROACH

RESUMO

Objetivo: descrever sobre a humanização e o acolhimento nos serviços de urgência e emergência hospitalar. Método: estudo de revisão integrativa usando publicações do período 2001 a mayo de 2011 coletadas na Biblioteca Virtual em Saúde (BVS) e nas bases de dados Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), Literatura Internacional em Ciências da Saúde (MEDLINE) e Eletrcronic Library Online (SCIELO) a partir dos descritores: humanização da assistência, acolhimento e serviços médicos de emergência. O processo de busca na BVS resultou em 17218 referências. Após aplicação dos critérios de inclusão e exclusão foram analisados 46 artigos. Todas as publicações selecionadas foram lidas e categorizadas de acordo com o maior foco em: serviços de urgência e emergência hospitalar, humanização e acolhimento. Resultados: os estudos analisados apontam que no Brasil o fluxo oposto de pacientes entre os serviços de saúde da rede básica e os serviços de maior complexidade acarreta frequentemente situações de superlotação dos pronto-socorros que passaram a ser o principal local de triagem da assistência em saúde, sobrecarregando as equipes dos mesmos. Esta situação vem dificultando o atendimento dado pelos serviços de urgência e emergência hospitalar implicando em um questionamento a respeito dos modelos esperados e a realidade encontrada sobre a humanização e o acolhimento. Conclusão: pode-se verificar que a PNH, criada e difundida pelo Ministério da Saúde, reafirma que os serviços devem receber aos usuários de forma humanizada e acolhedora. Entretanto, ainda existe muita dificuldade na implementação de tal política. Descritores: humanização da assistência; acolhimento; serviços médicos de emergência; padrão de cuidado.

LITERATURE INTEGRATIVE REVIEW

HUMANIZATION AND PATIENT INTAKE INTERVIEWS IN HOSPITAL EMERGENCY AND URGENT CARE: AN INTEGRATIVE APPROACH

ABSTRACT

Objective: to describe humanization and patient intake interviews in hospital emergency and urgent care. Method: an integrative review study of publications from 2001 to May 2011 collected at the Virtual Health Library (BVS) and the databases of Latin American and Caribbean Health Sciences Literature (LILACS), International Health Sciences Literature (MEDLINE) and the Scientific Electronic Library Online (SCIELO). Descriptors used were: humanization of care, intake interview and emergency medical services. The BVS search resulted in 17218 references. Following the application of inclusion and exclusion criteria, 46 articles were analyzed. All selected publications were read and categorized according to greater focus on: hospital emergency and urgent care services, humanization and intake interview. Results: the studies reviewed indicate that in Brazil, the inversion of traditional patient flow between basic healthcare services and more complex facilities often causes overcrowding in emergency rooms, which then become the primary location for healthcare screening, overburdening staff. This hampers the care provided by hospital emergency and urgent care facilities, raising questions regarding expected and actual models of humanization and intake interview. Conclusion: the National Humanization Policy (PNH), created and disseminated by the Ministry of Health (MOH), states that healthcare service users should be received with kindness and humanized care; however, this policy remains difficult to implement. Descriptors: humanization of care; patient intake interviews; emergency medical services; standard of care.

RESUMEN

Objetivo: describir sobre la humanización y el acogimiento en los servicios de urgencia y emergencia hospitalaria. Método: estudio de revisión integrativa con publicaciones del período de 2001 a mayo de 2011 colectadas en la Biblioteca Virtual en Salud (BVS) y en bases de datos de la Literatura Latino-Americana y del Caribe en Ciencias de la Salud (LILACS), Literatura Internacional en Ciencias de la Salud (MEDLINE) y Electrónica de Biblioteca en Salud (SCIELO) a partir de los descriptores: humanización de la asistencia, acogimiento y servicios médicos de emergencia. El proceso de búsqueda en la BVS resultó en 17218 referencias. Después de aplicar los criterios de inclusión y exclusión se analizaron 46 artículos. Todas las publicaciones seleccionadas fueron leídas y categorizadas según el mayor foco en: servicios de urgencia e emergencia hospitalaria, humanización y acogimiento. Resultados: los estudios analizados indican que en Brasil, el flujo opuesto de pacientes entre los servicios de salud de la red básica y los servicios de mayor complejidad acarrea frecuentemente situaciones de superlotação de los pronto-socorros que pasaron a ser el principal local de triage en salud, sobrecargando a las unidades de los mismos. Esta situación ha dificultado la atención prestada por los servicios de urgencia y emergencia hospitalaria implicando un cuestionamiento acerca de los modelos esperados para la atención y la realidad encontrada sobre la humanización y el acogimiento. Conclusión: se puede verificar que la PNH, creada y difundida por el Ministerio de la Salud, reafirma que los servicios deben recibir a los usuarios de forma humanizada y acogedora. Entretanto, aún existe mucha dificultad en la implementación de tal política. Descriptores: humanización de la asistencia; acogimiento; servicios médicos de emergencia; estándar de cuidado.
The National Humanization Policy (PNH) was established in 2003 by the Ministry of Health (MOH) and states that humanization consists of valuing the different individuals involved in the health production process: users, employees and managers. It is important to underscore PNH guidelines, which serve as general recommendations and are expressed in how users, employees and managers are included in the administration of healthcare services through practices such as: integrated clinical treatment, co-management of services, giving value to work, intake interviews, defending the rights of the user, among others.

The humanization of health care is a growing demand in Brazilian healthcare, arising from a reality in which users complain of mistreatment and a shortage of adequate care, as well as lack of humanization and receptiveness by healthcare professionals. The dynamic of patient care in emergency situations can lead to unwelcoming attitudes, both towards patients and family members, conflicting with proposals for effective humanization recommended by current policy.

This issue promotes much debate and raises questions among those seeking care. The media has highlighted some emergency and urgent care facilities with problems such as delayed and inadequate care by healthcare professionals, insufficient infrastructure and shortages of disposable material, equipment and human resources.

On the other hand, it is important to note the working conditions to which these professionals are exposed. Low wages and double or triple shifts, difficulty balancing work and family life and constant contact with individuals under stress often result in an unfavorable work environment for humanization and intake interviews.

Thus, a social and political dilemma is apparent when considering the broader concept of health according to the World Health Organization (WHO), which states that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The WHO develops and discloses its policies based on this concept; however, are the services provided in line with this broader concept of health?

Intake interviews form part of PNH guidelines and are characterized as a means of serving all those seeking care in a welcoming manner, listening to their requests and offering appropriate responses. They should be used to develop health promotion, care and prevention activities and integrate the user within the healthcare system.

Intake interviews are a component of change in the work process, with the potential to expand care practices involved in the activities of healthcare professionals. These are currently characterized by hegemonic work focusing on procedures, and adapted to the structure of organized healthcare facilities.

Intake interviews as a tool in healthcare involves receiving patients with resolve and accountability, advising the patient and the family regarding other healthcare services, when necessary, for continuity of care and establishing links with these facilities to ensure the effectiveness of the referrals.

Thus, hospital emergency and urgent care, which often forms part of a structured and organized framework in several sectors, requires a policy of conducting intake interviews since they serve as a gateway for receiving individuals seeking care.

Hospital emergency units are replete with complex conditions inherent to the environment itself, caregivers and those receiving care, who experience human relationships through the care process within and organizational system.

Emergency service facilities in Brazil have called for the implementation of a policy that ensures universality, which forms part of the set of principles in the Brazilian National Health System (SUS) that guarantees all citizens access to healthcare services.

Intake interviews emerge as a resource in evaluating and classifying risk, characterized as a mechanism of change in the production of health care. It is a dynamic process that identifies patients requiring immediate treatment based on potential risk, harm to health or level of suffering.

The main purpose of risk classification is to put an end to the interminable lines in hospital emergency rooms by evaluating the treatment needs of each user.

There is a need to create reception areas that enable interaction between staff and users, which are also welcoming and comfortable, by introducing plants, lighting color and other elements, such as well-placed and comfortable furniture. The positioning of chairs should promote interaction, counters should be low and without barriers so as not to intimidate patients and allow for exchanges while they are seated. This affords a certain
degree of privacy, enabling individuals to describe their problems without being concerned that other individuals waiting in line might overhear.11

Nursing is a fundamental part of the organizational structure of healthcare services and plays an important role in humanization and receptiveness in emergency and urgent care facilities. Head nurses essentially promote contact with others, either through care or in managing teams and resolving conflicts, practicing fairness in their decisions and acting in accordance with ethical and professional guidelines.12

Thus, given the current emphasis surrounding this topic, it is important to develop studies that describe issues inherent to receptiveness and humanization in hospital emergency and urgent care services. There is an overwhelming demand for these services and it is important they be structured so as to comply with current healthcare policies. As such, the present study aims to describe humanization and receptiveness in hospital emergency and urgent care facilities.

**METHOD**

This is a descriptive and exploratory study with a qualitative approach, using integrative bibliographical research which seeks to explain a problem based on published theoretical references.13

Descriptive research aims to identify the characteristics of a specific population, as well as detect possible relationships between variables. In addition to identifying these relationships, some descriptive studies progress further and attempt to determine the nature of this association.14 Exploratory investigations accurately describe the situation and aim to discover the relationships between its comprising elements. Furthermore, they do not require the development of hypotheses to be tested in practice and are restricted to defining objectives and seeking additional information on a given subject. The purpose of this form of research is to elucidate the phenomenon or obtain a fresh perspective of it, as well as discover new ideas.13

The qualitative approach can be characterized as the quest for detailed understanding of the meanings and situational characteristics presented by interviewees rather than producing quantitative measures of characteristics and behaviors.15 It answers very specific questions and deals with a level of reality that may or may not be quantified.16

Data were collected from the Virtual Health Library (BVS) from January to December 2011, using the Health Sciences Descriptors (DECS): humanization of care, intake interviews and emergency medical services. Inclusion criteria were: articles available in full, published from 2001 to May 2011 in Portuguese and Spanish. We excluded publications where only the abstract was available, those written in languages other than Portuguese and Spanish and articles that did not conform to the proposed theme, despite being located using the above descriptors.

The BVS search resulted in 17218 references, 46 of which were analyzed following application of inclusion and exclusion criteria. Of these, 25 are included in the present study and were available in the following databases: Latin American and Caribbean Health Sciences Literature (LILACS), International Health Sciences Literature and the Scientific Electronic Library Online (SCIELO). An additional 5 articles were assessed and included, available for printing on the Ministry of Health website and related to the proposed theme, as well as some documents in the Brazilian legislature.

After analysis, all the articles were read and categorized according to greater focus on: hospital emergency and urgent care services, humanization and receptiveness.

**RESULTS**

- Hospital emergency and urgent care services with respect to ethical, operational and social issues in Brazilian healthcare.

The purpose of a hospital emergency and urgent care facility is to treat patients with or without the risk of death, whose health problems require immediate care. These services function 24 hours a day, seven days a week and contain observational beds for patients that need to remain for longer periods. The facility should be structured to provide adequate assistance in urgent (cases requiring rapid treatment, but without risk of death) and emergency situations (imminent risk of death), offering highly complex and diverse services.1714

Emergency units aim to receive and appropriately treat patients requiring emergency or urgent care. Their goal is to rapidly assess and stabilize patients for admission to the hospital.1825

Although public policies put forward by the Ministry of Health advocate community-based primary healthcare as a form of promoting...
health and preventing disease, the lack of structure in municipal services weakens the provision of care and results in emergency rooms becoming a “gateway” to the healthcare system. These services treat patients in critical situations who perceive their needs as urgent, but do not have access to primary or specialized care.

These demands accumulate in emergency units, causing overcrowding and compromising the quality of care provided. This situation is further exacerbated by administrative and organizational problems, such as the failure to classify treatment according to complexity and a shortage of skilled professionals. Patients are seen on a first-come, first-served basis without prior assessment of the case, often severely compromising those seeking care.\textsuperscript{20,21}

Ordinance GM no. 2.048 of November 5, 2002 establishes the guidelines and principles for the consolidation of State Emergency and Urgent Care Systems, improving existing norms, allowing better organization of care, defining patient flow and remedial measures. This decree also contains the Technical Regulation for State Emergency and Urgent Care Systems, to be applied nationally in the Federal District and by state and municipal Health Secretariats when implementing these services.\textsuperscript{20}

In Brazil, urgent care is classified into:\textsuperscript{22}

- Fixed pre-hospital care: consisting of treatment provided in primary care to patients suffering from acute conditions, which are clinical, traumatic or psychiatric in nature and that may lead to suffering, sequelae or even death. It provides adequate care and/or transport to a hierarchized and regulated healthcare facility that forms part of the State Emergency and Urgent Care service. This form of care is provided by a set of basic healthcare units, Family Healthcare Programs (PSF), Community Health Agents (PACS), specialized outpatient facilities, diagnostic and therapeutic services, and non-hospital units known as Emergency Care Units (UPAs), which operate 24 hours and have intermediate complexity.

- Mobile pre-hospital care: this form of treatment aims at early treatment of victims of serious health hazards (clinical, surgical, traumatic or psychiatric) that may cause suffering, sequelae or death and therefore require treatment and/or transport to a healthcare facility integrated into the National Health System (SUS).

- Hospital care: this is formed by hospital complexes that offer emergency and urgent care and must not have infrastructure inferior to that of 24-hour emergency clinics (UPAs). In other words, they must be structurally organized and be capable of resolving all the individual’s needs.

On September 29, 2003 ordinance GM no. 1.863 established the National Urgent Care Policy, composed of state, regional and municipal urgent care systems. This decree stipulates that systems must be organized so as to ensure universality, equality and comprehensiveness when caring for clinical, surgical, gynecological, obstetric, psychiatric and pediatric emergencies, as well as those related to external causes (unintentional injuries, violence and suicides).\textsuperscript{23}

Emergency care units are subject to spontaneous demand, which is often greater than predicted, resulting in work conditions that are not always adequate.\textsuperscript{17,70} This phenomenon is seen worldwide and is characterized by the occupation of all beds, waiting times of more than one hour, high tension levels among staff and significant pressure to address new cases.\textsuperscript{24}

In Brazil, the inversion of traditional patient flow between basic healthcare services and more complex care facilities leads to frequent overcrowding in emergency rooms, which then become the focal point for healthcare screening, overburdening staff. This situation has been a major reason for criticism of national healthcare models, provoking negative impacts for patients and administration difficulties in most states and municipalities.\textsuperscript{25}

The resulting picture is that gradually both public and private facilities become crowded, meaning that patients in real need of emergency care, that is, at imminent risk of death due to heart conditions, hypertension, neurological disorders, trauma, among others, have to wait hours to receive treatment.\textsuperscript{19}

This situation highlights the precariousness of services, often involving corridors crowded with patients on stretchers waiting for treatment, without privacy, comfort or security and vulnerable to cross-infection in a highly stressed and tense environment.\textsuperscript{3}

The increased time spent in these facilities is the primary marker of overcrowding; the shortage of hospital beds is the main cause and delays in diagnosis and treatment are the major consequence, leading to a rise in mortality.\textsuperscript{24}

Although emergency and urgent care services have been widely studied worldwide, it is still difficult to define what constitutes an urgent and non-urgent condition.

Patients seeking care can be classified as follows:\textsuperscript{26}
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- Emergency: any acute pathology that compromises the patient’s life, an organ or vital part of the organism by real or potential risk, which requires immediate care. In these cases, primary care will undertake initial therapeutic measures and patients will then be appropriately transported to a secondary-level facility for specialized care;
- Second-level emergency: encompasses pathological problems that, according to their progression, may pose a mid-term threat to the patient’s life;
- Lower or third-level emergency: a pathological problem that, through the course of its evolution, does not represent an immediate or mid-term danger to patients, although complications may threaten their life. These include conditions that require care available only in hospitals, as well as chronic pathologies without acute crises that can remain untreated for 24 to 48 hours and be cared for in outpatient facilities.

Classification criteria are needed to ensure efficient and quality care, although these are still difficult to standardize. “There is still no consensus regarding protocols for medical and nursing procedures and without organization in the sector, achieving better results is difficult or even impossible”. 27

In order for an emergency facility to be truly efficient, rapid and quality care are among the essential variables, in addition to appropriate and rational use of these services. To that end, we must begin with the premise that patients in emergency or critical situations receive adequate assistance in accordance with the level their condition requires. 27 Thus, in emergency or urgent situations, the criterion for access to these services is the level of severity. Patients in emergency situations should therefore be treated first.

- Humanization and intake: a new perspective of emergency and urgent care

To humanize mean to become human, as well as benevolent, agreeable, more sociable, more treatable. 28

Humanization is a subject that is often discussed in public healthcare services, official documents and publications in the field of Collective Health. Although the secular term “humanization” may contain an element of Manichaeanism, its historical use establishes it as that which revitalizes movements to recover forgotten human values or those undermined by periods of ethical laxity. 29-254

In this connection, discussion emerges concerning humanization that seeks to translate, in a practical sense, the paradigmatic revision of healthcare practices where the patients’ comprehensive needs become the focus as opposed to a disease-centered approach. 30

In the area of healthcare, several initiatives have emerged under the term of humanization. It is likely that this term has been used for over two decades in the anti-asylum struggle in mental health care and the feminist movement for the humanization of labor and childbirth in women’s health. Since then, several hospitals, predominantly those in the public sector, have begun to develop “humanizing” actions. 29

The humanization of healthcare is understood as a set of guidelines and principles that advocate the value of different individuals involved in healthcare production (users, employees and managers); foster the autonomy and role of these subjects; increase the level of co-responsibility; establish bonds of solidarity and collective participation in the administration process; identify social health needs of users and employees; and are committed to providing a pleasant environment, with improved work and care conditions. 31

From the perspective of current concepts, humanization can be considered: 29
- A principle of humanist and ethical conduct;
- A movement against structural violence in healthcare;
- A public policy for care and management in the SUS;
- An auxiliary measure for participative administration;
- A technology of care in health services.

In 2003, the National Humanization Policy (PNH) was created in Brazil, establishing principles and operating procedures within the set of relationships that constitute the SUS (National Health System), including different complexity levels of care. Its aim is to spread a new culture of humanization in the public system, in addition to improving the quality and efficiency of the care provided. 32

The PNH is guided by the following principles: 1-9
- Valuing the subjective and social dimension of all care and management practices, as well as strengthening and encouraging integrative processes that promote commitment and accountability.
- Encouraging procedures committed to the production of health
- Strengthening multiprofessional teamwork, encouraging transdisciplinarity and groupality.

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• Operating with cooperation and solidarity in a highly connective network, in accordance with SUS guidelines.
• Using information, communication, continuing education and administrative areas to build autonomy and encourage the protagonism of individuals and groups.

In emergency and urgent care services, the patient intake interview is one of the specific guidelines of the PNH and is characterized as evaluating needs using risk assessment criteria, ensuring access to other levels of care. It is considered a technique for reorganizing services, aiming to guarantee universal access, resolvability and humanization of care.1,33

The intake interview is a technical care procedure that implies a change in the existing relationship between professionals, users and other social components through technical, ethical and humanitarian parameters, including the user as an active participant in the production of health.7

It is considered more than a communicative phenomenon, includes verbal discourse and should translate into actions intended to assess the health needs expressed by the user, promoting a response.34

This patient assessment can be understood as an act that initiates before users arrive at the healthcare facility and should be defined as a means of addressing the requirements outlined by the patient. Some authors consider it to be a warm reception of the individual at the beginning of the encounter, transmitting receptiveness and interest so that patients feel valued.33

It is an act of approximation, a means of relating to individuals seeking healthcare services. It is not restricted solely to the act of receiving, but consists of a sequence of actions that comprise the methodologies applied in healthcare work processes at any level of care. To that end, it is recommended that humanization form an integral part of encounters between staff and users, based on a relationship of accountability and receptiveness in which the patient is a bearer and creator of rights.35,12

Intake interviewing aims at listening to and valuing complaints by the patient/family, identify their needs and respect differences. It is a relationship-based technique permeated by dialogue and defined as a conversation between two or more people that consists of involvement, listening and mutual perception. It is characterized by an ethical attitude that does not require a specific professional or time for its execution and implies the sharing of knowledge, necessities, possibilities, anxieties and interventions.7,36

Through intake interviews, we promote the meeting, presence, relationship, and establishment of a link between the family/patient (users) and health workers. These interviews generate humanizes relationships between cared and cared for, since it is an indispensable technological tool in healthcare.36

When patients are received and referred for care on a first-come, first-served basis without establishing clinical criteria, it can exacerbate overcrowding and aggravate the current state of health and disease. To that end, intake interviews are conducted with risk classification, which consists of a dynamic process that identifies patients needing immediate treatment in accordance with the clinical severity of their case.7

The objectives of risk classification are to guarantee immediate care for users presenting with a high level of risk; advise patients who are not at imminent risk as to probable waiting times; promote teamwork by continuous assessment of the process; provide better work conditions for healthcare professionals by discussing the environment and implementing horizontal equity; increasing user satisfaction and, primarily, enabling and instigating co-responsibility and the construction of internal and external care networks.38

In addition to being dynamic, the risk classification process should be continuous and include actions that offer guidance to users and their family members through emotional support and security. Clear information should be provided on the destination of each patient.37

Nurses are the professionals recommended to classify patients according to clinical status for emergency and urgent care services, following specific training for this role. They should be guided by protocols standardized by the institution.39

In order to carry out risk classification, most hospitals apply international principles, namely the Canadian Triage and Acuity Scale (CTAS3), Australian Triage Scale (ATS3), Emergency Severity Index (ESI3) and Manchester Triage System (MTS3).40

The institution should have an appropriate Risk Classification for the entire critical care team: nurses, nursing technicians, doctors, psychologists, social workers and administrative staff.38

Staff should listen to the patient’s health complaint, fears and expectations and identify
risks and vulnerabilities. They should also consider the assessment of users themselves and be accountable for providing a suitable response to the problem, combining the immediate needs of users with available services. This will result irresponsible and decisive referral in cases where patient needs require treatment by a different facility.7

It is important to underscore that nursing activities are not restricted to merely classifying patient risk. These professionals accompany patients for extended periods and provide care that can subjectively be considered humanized or not.

As healthcare professionals, nurses guide new behavior, seeking the participation of their peers in developing plans and projects and serve as inspiration for others willing to follow in their path. Thus, they are considered leaders and are required to work alongside members of their team with professional satisfaction, instigating humanized care by welcoming individuals seeking care.12

CONCLUSION

The present study establishes that the PNH, created and disseminated by the Ministry of Health, states that health services should receive users in a humanized and welcoming manner. However, there is still significant difficulty in implementing this policy, since many facilities do not provide the conditions needed for its execution in addition to lacking skilled professionals.

Humanization and receptiveness should not only permeate the reception of those seeking care, but also continue until the individual leaves the healthcare unit. In this respect, there are still a number of challenges to overcome, requiring continuous expansion and enhancement of current policies involving managers, staff and users in order for consolidation and improvement to be achieved in accordance with recommendations.

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