



USER EMBRACEMENT WITH EVALUATION AND CLASSIFICATION OF RISK: PERCEPTION OF NURSES

O ACOLHIMENTO COM AVALIAÇÃO E CLASSIFICAÇÃO DE RISCO: PERCEPÇÃO DE ENFERMEIROS

ACOGIMIENTO CON EVALUACIÓN Y CLASIFICACIÓN DE RIESGO: PERCEPCIÓN DE ENFERMEROS

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ABSTRACT

Objective: to know the perception of nurses about User Embracement with Risk Classification in urgency and emergency municipal service. **Method:** qualitative research whose data were obtained through interviews recorded on audio in MP3 format and subsequently fully transcribed, conducted with 14 nurses of five hospitals of the Municipal Health Network of Teresina, Piauí, Brazil. The semi-structured interview script was applied to nurses of user embracement and covered issues with data referred to professionals characterization, way of performing the working process, training, and difficulty and easiness of user embracement implementation. The information was subjected to analysis of content, from which three categories emerged: nursing and User Embracement with Risk Classification implementation; difficulties for the completion of User Embracement with Risk Classification; and the space of nurses in User Embracement with Risk Classification. The project of research was approved by the Committee of Ethics in Research of the Federal University of Piauí, under CAAE No. 0245.0.045.000-11. **Results:** the findings showed improvement in medical care, resulting from improved work organization; however, the quality of medical care provided to users was undermined by the inadequacy of reference and counter-reference, inefficiency in multidisciplinary interaction and unpreparedness of professionals for the adoption of this technology. **Conclusion:** it is necessary to expand the spaces for dialogue between professionals and managers and provide a policy of continuing training, so that the health system flow can occur more efficiently. **Descriptors:** user embracement; emergency nursing; classification; humanization of assistance..

RESUMO

Objetivo: conhecer a percepção de enfermeiros sobre o Acolhimento com Classificação de Risco em serviço municipal de urgência e emergência. **Método:** pesquisa qualitativa, com dados obtidos por meio de entrevistas gravadas em áudio, no formato MP3, em seguida, transcritas na íntegra, com 14 enfermeiros de cinco hospitais da Rede Municipal de Saúde de Teresina-PI, Brasil. O roteiro de entrevista semiestruturado foi validado com enfermeiros do acolhimento e contemplou questões com dados referentes à caracterização dos profissionais, modos de operar o processo de trabalho, capacitações, e aspectos dificultadores e facilitadores na implantação do acolhimento. As informações foram submetidas à técnica de Análise de Conteúdo, a partir da qual emergiram três categorias: A enfermagem e a operacionalização do Acolhimento com Classificação de Risco; as dificuldades para a realização do Acolhimento com Classificação de Risco; e O espaço do enfermeiro no Acolhimento com Classificação de Risco. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa da Universidade Federal do Piauí, sob CAAE nº 0245.0.045.000-11. **Resultados:** os achados evidenciaram melhora no atendimento, advinda da maior organização do trabalho; contudo, o atendimento de qualidade ao usuário se mostrou comprometido pela inadequação de referência e contrarreferência, lacunas na interação multiprofissional e o despreparo dos profissionais para a adoção desta tecnologia. **Conclusão:** torna-se necessário ampliar os espaços para diálogo entre profissionais e gestores e instituir uma política de educação permanente, a fim de que o fluxo do sistema de saúde ocorra de forma mais eficiente. **Descritores:** acolhimento; enfermagem em emergência; classificação; humanização da assistência.

RESUMEN

Objetivo: conocer la percepción de los enfermeros sobre el Acogimiento con Clasificación de Riesgo en servicio municipal de urgencia y emergencia. **Método:** investigación cualitativa cuyos datos se obtuvieron a través de entrevistas grabadas en audio, en formato MP3 y posteriormente transcritas en su totalidad con 14 enfermeros de cinco hospitales de la Red Municipal de Salud de Teresina, Piauí, Brasil. El guión semiestructurado de la entrevista fue aplicado a enfermeros de acogimiento y abarcó cuestiones con datos referentes a la caracterización de los profesionales, maneras de desarrollar el proceso de trabajo, capacitaciones, y aspectos dificultadores y facilitadores de la implantación del acogimiento. Las informaciones fueron sometidas a análisis de contenido, del cual surgieron tres categorías: enfermería y aplicación del Acogimiento con Clasificación de Riesgo; las dificultades en la realización del Acogimiento con Clasificación de Riesgo; y el espacio del enfermero en el Acogimiento con Clasificación de Riesgo. El proyecto de investigación fue aprobado por el Comité de Ética en la Investigación de la Universidad Federal de Piauí con CAAE Nº 0245.0.045.000-11. **Resultados:** hubo evidencias de mejora en la atención, proveniente de una mayor organización del trabajo; sin embargo, la calidad de la atención al usuario fue comprometida por la insuficiencia de referencia y contrarreferencia, ineficacia en la interacción multidisciplinaria y falta de preparación de los profesionales para la adopción de esta tecnología. **Conclusión:** es necesario ampliar los espacios de diálogo entre los profesionales y administradores e instituir una política de formación continua, para que el flujo del sistema de salud se produzca de forma más eficaz. **Descriptores:** acogimiento; enfermería en emergencia; clasificación

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INTRODUCTION

In the last 20 years the Brazilian public health system showed significant advances with the Unified Health System (UHS) (*Sistema Único de Saúde - SUS*). However, there are challenges in the quest for improvement in quality of care, among which changing the performing in user embracement of users and workers in the health services stands out.

The dynamics of urgency and emergency services has been characterized by overcrowding, fragmented working process, asymmetries of power, exclusion of users at the entrance door, little coordination with the rest of the service network, and its improvement is one of the challenges in health care.¹ In an attempt to reverse this situation, the National Policy for Humanization (NPH) was released in 2004 in order to guarantee the constitutional right to health for all citizens and promote the universality of access, equity in the allocation of resources and completeness in care given. In order to restructure the emergency sectors of Brazilian hospitals, the NPH proposed the User Embracement with Classification of Risk (UECR), aiming to replace the access to the service through queues and order of arrival by the degree of users' needs.²

User embracement, as a way of structuring the processes in health care, aims to provide care to all users, because it goes beyond the classification of risk that determines the sequence of actions in favor of health restoration. It does not take place in the waiting room, nor in the pre-consultation. It is a meeting space where health professionals and users get to know each other. User embracement is a relational technology permeated by dialogue, because it is focused on listening, the valorization of the patient/family's complaints and the identification of their needs.³⁻⁴

UECR is the decisive intervention in the reorganization of the doors of emergency services and the implementation of a health production network that aims to offer health services based on technical, ethical and humanistic criteria from pre-established protocols. However, the classification of risk protocol cannot be considered a panacea for the problems of the urgency services, since its operation needs to be homogeneous and guided both internally and externally.^{1,5}

In this context, nurses are health professionals worldwide recognized as the more enabled professionals to perform the

classification of risk after specific training, considering the peculiarities of the profession, such as: the characteristic of talking and listening to the patients' complaints from a vision of the whole, unlike medical doctors with training based on diagnosis and treatment.⁶⁻⁷

UECR was introduced in emergency hospital services as a pilot project at the Dr. Mario Gatti Municipal Hospital, in the city of Campinas, State of São Paulo, Brazil, at the invitation of the Ministry of Health, in 2000, for later expansion of the humanization program at national level. Subsequently to the good results obtained and the creation of the NPH, this service configured itself as a model for the reorganization of the care flow, which influenced the gradual adhesion process of various Brazilian states.⁸⁻¹⁰

In the State of Piauí, UECR was established in 2009, at the Professor Zenon Rocha Urgency Hospital of Teresina, as a pilot project with own protocol and training of professionals involved. Later, it extended to four medium-sized emergency hospital services.

The proposal of UECR established in the municipal hospital network of Teresina showed the dynamics and the accessibility criteria of users; besides providing guidance for the establishment of the working process centered in the interest of the customers, aiming to improve the performing of the network services. It is worth mentioning that UECR is a relatively recent technology and service and that it can greatly contribute to reorient health practices.

During the implementation of UECR, as a reorganization of the service, concerns arose regarding the nurses' working process, as well as the finding of fragmented care on the part of the health team of UECR. In this sense, filling such gaps in knowledge production can provide subsidies for the creation of measures to generate humanized care and, consequently, for improving the quality of care. With this in mind, this study aimed to know the perception of nurses regarding their working experiences in UECR of urgency and emergency units of municipal hospitals.

METHOD

This is a descriptive study with a qualitative approach, carried out with 14 nurses working in UECR of five emergency hospital services managed by the Municipal Health Foundation of Teresina. In order to obtain data, we used semi-structured

interviews recorded on audio in MP3 format and subsequently fully transcribed. The interview script covered open-ended questions with data regarding professionals characterization, way of performing the working process, training, and difficulty and easiness of UECR implementation. The instrument was applied to UECR nurses that did not take part in the study, and we considered feasibility and ambience. Questions that showed to be difficult to understand were adjusted in order to become clear and understandable.

Data were obtained from September to October, 2011. The interviews were conducted in working places and hours at times chosen by nurses, with random approach, without prior scheduling.

The methodological referential of data analysis was performed through content analysis, focusing on thematic analysis, which consists of unveiling the nuclei of meaning of communication whose presence or frequency has relevance to the object under study.¹¹ In order to preserve the identity of the subjects in the presentation of speeches, we used the code "N" followed by the cardinal number corresponding to the order of the interview.

The interpretation of the data demanded the elaboration of categories by means of their prior ordering through the transcription of interviews, rereading of the material and the organization of reports in a particular order and data into groups with similar themes. This was followed by the classification of data and the creation of categories, after reading the individual speeches and extraction of the key expressions, with selection of themes; grouping of individual speeches related to the themes; grouping of speeches with the same, equivalent, or complementary meanings; extraction of the central idea and listing of categories.

After the analysis of speeches, three categories were identified: nursing and UERC implementation; difficulties for the completion of UERC; and the space of nurses in UERC.

The project was approved by the Committee of Ethics in Research of the Federal University of Piauí (CAAE No. 0245.0.045.000-11), meeting the principles of Resolution No. 196/96 of the National Health Council on research involving human beings.

One of the limitations to the development of this study was the fact that the production of data covered all the emergency hospital

services of the Municipal Health Network of Teresina, since the diversity in the assistance complexity produced some difficulty for grouping of data. Another limitation refers to unequal training of nurses, arising from the replacement of outsourced professionals, who had received training, by nurses hired by public examination (*Most commonly used form in Brazil for hiring public servants*), who did not have the opportunity to participate in this training.

RESULTS AND DISCUSSION

• Research Context and profile of the participants

The age of the participants in the study ranged between 22 and 57 years; 11 were female, who had been working for about 3.2 years in urgency and emergency service and on average had worked in the classification of risk for 11 months; six had participated in training programs provided by the Municipal Health Foundation; and the others had received informal guidelines from a professional who had been working in the service. Nurses with specific training had length of service equivalent to the period of UECR establishment in hospitals; the experience, skill and dexterity had been acquired at the same time of this healthcare implementation.

• Nursing and implementation of User Embracement with Classification of Risk

UECR proposes a change in health processes – whose implementation occurs through the use of a protocol to evaluate and classify the user – and is permeated by the humanization that user embracement provides. This way, as part of the healthcare team, nurses need to employ this technology in the perspective of completeness, as evidenced in the following speeches:

Here, we address patients so that they feel comfortable, we investigate the problem, the complaint they make. We classify them according to the colors established by the protocol. (E5)

Patients arrive at the hospital, fill out the admission form, they are referred to the doctor's office, where the nurses perform the classification of risk, with the aid of nursing technicians. (E10)

Patients fill the assistance form at the front desk; they go to the classification room, where they are received by a nurse and a nursing technician. The complaint is evaluated and classified according to the degree of priority: red, yellow, green, or

blue. Then, according to the classification, they are referred to the doctor's office, or when patients are unable to go to the doctor's office, they stay under observation in the emergency medical service and medical evaluation is requested. (E2)

This scenario, in some ways, resembled the reality observed in emergency hospital services that had established UECR, in which nurses classify the risk based on a pre-established protocol that uses colors to identify the priorities of care. In addition, it was found that the proper assistance provided to users by the system has improved the flow of care in emergency hospital services, as called for by the Ministry of Health.^{8,12-3}

This way of working enables agility, better direction of customer flow, with growing service organization. The establishment of UECR brought positive changes to the urgency and emergency services, as shown in the following speeches:

Many patients are being directed to the right flow, so that certain health damages can be referred to a more correct level of assistance. (E3)

The protocol organizes the service, selects and ends up being more organized. (E4)

The following positive factors stood out: humanization of assistance; reorganization of the working process; and the possibility of higher resolution. UECR covers the proper reception of customers, to be held by the entire healthcare team, in any professional-patient relationship. In this sense, it provides recognition and satisfaction of service users, when driven by guidelines for the working process organization.¹⁴⁻⁶

The establishment of UECR brings humanization as immediate response to users of urgency and emergency services through qualified listening and problem resolution: all have access to healthcare, with the replacement of the exclusion or order of arrival by prioritizing the most serious cases.

However, humanization as a consequence of UECR was not entirely expressed in practice, because some nurses reported that there was a tendency to only classify the users:

Because the user embracement is not only to classify and this is what we end up doing [...] (E4)

This is not triage and people confuse it with triage and exclusion. This is a classification, care for priority. (E9)

From the speeches is observed that there is slight perception of what the dimension of

user embracement and humanization is, since these concepts are merely regarded as receiving and listening, and not as a sequence of modes and performances that constitute the process of working in healthcare.

The prioritization of care and users access to the service has user embracement as a previous condition. The occurrence of situations in which the urgent problem reported by users is not expressed physically is common, but just listening allows knowing their needs.¹⁷

However, the performance of user embracement is not always effective, because communication between professionals and users tends to be harmed by work overload, professional unpreparedness and for the time dedicated to care.¹⁸ Certainly, when user embracement is understood and performed, there is a tendency to improve the resolution and humanize the assistance.

The speeches of nurses reported the establishment of UECR regarding the demand, either by guidance and the level of assistance, by the agility of attendance or listening, which is not always qualified. Therefore, it was observed that although the establishment still does not occur in its entirety, the concepts of UECR were understood by the subjects.

• Difficulties for the performing of User Embracement with Classification of Risk

Among the difficulties found regarding the performing of UECR, the following stood out: demand; the unpreparedness of the professionals; and the working process still centered on traditional models.

In accordance with the principles and guidelines of the UHS, the entrance door of the healthcare system is, preferably, basic care. However, the reality in the emergency hospital services differs from what is recommended, according to the following testimonials:

Patients who are classified by blue color must be assisted at the outpatient clinic, but often they do not accept it [...] they say that there are no doctors in the Family Health System and that outpatient clinics are not equipped. (E1)

The reference of patients to outpatient clinics and health centers is a problem and we as health professionals are aware of the failures in these services. The patient, who comes to the emergency medical service just to check blood glucose or blood pressure, takes the chance of those who need more immediate care. (E2)

These speeches regard one of the difficulties that nurses faced in the context of UECR with users used to get ready-service in order to address unresolved health problems in primary care. Users are not always aware of the severity of their problems and are also unaware of institutional rules and policies related to health system hierarchy.¹⁹

In accordance to the care protocol, nurses sought to refocus this flow, but without the necessary co-responsibility:

We just guide people to look for the basic care and they leave angry, [...] they speak a lot about basic care; they say that there is not a correct operation. (E8)

Within this context, users face ambiguous information when they are told to seek assistance in basic care, but without the indication regarding which health unit they may resort to; since there is no agreement between urgency and emergency services and the Family Health Strategy or specialized outpatient clinics.

Inappropriate or non-existent reference and counter-reference, non-implementation of the national Policy of Urgencies Assistance in its fullness, population's unawareness of the provision of health services, or its improper use, determine gaps in the establishment of UECR and weaken the assistance to users classified as less serious.¹⁰

This circumstantial framework meets Article 198 of the Federal Constitution and Ordinance GM No. 2048 of the Ministry of Health, which stipulate that public actions and health services must integrate a regionalized and hierarchical network with the purpose to provide a single system that allows to improve the organization of assistance, articulation of services, and define flows and references. Therefore, the reference and counter-reference system is indispensable to promote the universality and completeness of assistance and becomes an important element in the involvement of the entire network.²⁰⁻²¹

To reverse the scenario of emergency services overcrowding and overcome the current model, the reordering of demand from users in the network is imperative. The assistance must have a systemic level, with a focus on users, in order to reset, integrate and organize fluxes, and readjust the working processes.²²

On the other hand, the lack of a reference system that integrates users of emergency medical services to the basic

network, to ensure follow-up after the episode which led them to the service, favors the recurrent search for emergency services.²³ As a strategy to minimize this problem, the specific training of health workers stood out regarding the operation of the public assistance network and its relationship with health policies:

Some professionals have been inserted within the classification of risk; professionals who have had no training. (E13)

What actually has to happen is training, capacity building of professionals in neighborhood and rural hospital; so that they understand that not all has to come here, neighborhood hospitals can assist [...] This is why overcrowding occurs. (E7)

Parallel to this, there was a medical perspective, with assistance still centered on the biomedical model and unlinked to the multidisciplinary team, regarded as an obstruction to the resolution of users' problems. The working process centered on traditional models has a logic hard to be torn, because while other professionals engage dynamically and accompany the result of their work, doctors tend to stay apart, with a limited view of reality.²⁴ The following speeches are a good illustration:

The resolution would be much better if the multidisciplinary work actually took place, but it is not our case. (E6)

In the classification of risk, nurses and nursing technicians perform together, from here they go to the general practitioner, who is also part of the team, but there is difficulty with doctors who do not follow the protocol, even those who know it. (E10)

UECR limited to a professional category, with specific time and physical space, diverge from the operational way of healthcare working processes proposed by the UHS.² This way, it is possible to notice the heterogeneity of actions in the scenario where each professional category and each sector work in a unique way, without the obligation to embrace users while assisted in the health system and sometimes limiting the embracement to triage.

Facing this reality, the challenge in the service includes restructuring the flow of assistance and seeking proposals that include the appropriate direction of users classified as green and blue, implying improved organization of the working process, management of overcrowding and consequent suitability of demand.

• The space of nurses at User Embracement with Classification of Risk

By the characteristics of the profession, nurses are enabled to provide care to patients in urgency and emergency situations, given the scientific knowledge they have and the legal support provided by the Law of Professional Practice No. 7.498/86.²⁵ In the role of classifier, nurses assess signs and symptoms. They do not diagnose, but directs the flow of care and reduces the waiting time for more severe patients, on the grounds that all users will be assisted.

However, this can be a situation of not very defined outlines for all professionals who perform UECR, as shown in the following speech:

User embracement came to give priority, but it does not occur in 100% of the cases, because we come up against the cooperativeness existing among doctors. We cannot refer level green a/b and blue patients, precisely because of this question: we do not have support from the medical class. (E6)

Another difficulty in the establishment of UECR that stood out was the low importance that doctors attribute to the protocol. This contingency generated dissatisfaction in nurses who realized the existence of distrust in the assumptions of UECR by both the population, and doctors. Furthermore, the fragile interdisciplinary relationship and the non-systematization of care dispensed to users can have important implications for patient safety.²⁶

The following interviewees' speeches corroborate the resistance to practice based on the protocol for classification of patients:

We classify; we explain to patients that they belong to the blue group and that this means outpatient care. But patients go to the doctor's office door and knocks, they want to be assisted and the doctor assists them. So our work is lost. (E12)

Patients enter the institution; they are classified according to the protocol, in accordance with their main complaint. There is a protocol and we follow it to classify patients. It is not by chance, it has scientific basis, but sometimes we are little valued, doctors are unaware of this protocol and think that we classify in vain. [...] (E7)

The nurses were aware that they were performing their own job safely with regard to proper referencing of classified users. However, they were not sure as to the legal support offered by resolutions and opinions issued by competent bodies for the

performance in UECR:

Legal support? No, I don't know it (laughs). (E14)

We only have the Foundation Protocol, this is the only document that I know. (E8)

Conversely, there was no mention of the profession legal provisions such as nursing consultation, private activity of nurses, who use components of the scientific method to identify health/illness conditions and implement nursing measures which contribute to the promotion, prevention and protection of individuals' health. Added to this perspective is the Nursing Federal Council's Resolution No. 423/2012, which regulates the classification of risk and prioritization of care in emergency services by nurses, holders of knowledge, skills and abilities to ensure scientific rigor to the procedure. It is essential to reiterate that the classification of risk, according to the resolution mentioned, should be executed within the context of the nursing process and meeting the principles of NPH.²⁷⁻²⁸

Only one interviewee mentioned the Nursing Code of Ethics:

Our legal support is the Code of Ethics, which we have to follow [...]. We follow the Foundation Protocol that is also supported by the Nursing Code of Ethics. (E9)

Despite this disagreement, some nurses expressed a feeling of protection regarding the autonomy that the protocol and training provided them:

It is a project that has resolution, which supports the nurse of urgency and emergency service and guides on the resolution of issues that arise. (E3).

I think that the support is the professional preparedness, the training, knowing the Ministry of Health manual. (E7)

The speeches, on the one hand, showed the space occupied by nurses in the context of UECR and, on the other hand, highlighted the fragility in this service management, since the protocol was not equally used by all professionals, confirming the need for continuing training focused on adhesion to the NPH.

CONCLUSION

UECR was established to make care more human in emergency medical services, for both users and health professionals, since the triage did not satisfy those who sought this service. It had prerequisites for the introduction of a protocol and the training of professionals, which seek to guide the performance, without getting rid of a

watchful eye oriented toward the needs of users who seek this service.

Nurses realized changes arising from the establishment of UECR, with emphasis on agility in assistance to users with acute health disorders that require immediate intervention. Among the difficulties, the following emerged: fragility of the reference and counter-reference system, generator of agglomeration of users in the service; lack of training of some professionals, affecting the quality of care; and the uneven multidisciplinary engagement.

UECR ratified the relevant role of nurses in the emergency hospital service, because it has instruments to rearrange the flow, considering the intrinsic characteristics of the profession, such as greater permanence of time next to users/families, conflicts resolution, qualified listening, and care from a holistic perspective. However, studies focusing on the multidisciplinary team in UECR are unquestionable in order to unfold new perspectives.

UECR must be disclosed within and outside the framework of the urgency and emergency services in order to direct the flow of UHS users. It is imperative that managers and employees make space to rethink and redirect the performance, considering the perception and criticism of the subject of this research, who emphasized the sensitiveness of the interpersonal relationship between professionals and the later with users. It is expected that the healthcare team manage to establish goals that encompass the humanization and promote discussions on how to improve the service provided to UHS users who seek urgency and emergency services, to prevent their persistence as the more accessible door of entrance.

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