ABSTRACT

**Objectives:** to identify the conceptions of User embrace with Risk Classification Held by the nursing staff and discuss the factors that contribute to its non-use by the nursing staff in the emergency unit. **Method:** this descriptive qualitative study was conducted with 16 members of the nursing staff working at the emergency care unit of a private hospital in Teresina (PI), Northeast of Brazil. For data collection, we used a semi-structured script and the technique of face-to-face interview. The study project was approved by the Research Ethics Committee of the NOVAFAPI, CAAE 0191.0.043.000-10. **Results:** some of the professionals interviewed are aware of the protocol and the benefits that can be achieved by listening to the patient's complaints. We found that some subjects had difficulties in distinguishing between screening and user embrace with risk classification, which lead us to infer that part of the team is unaware of this device.

**Conclusion:** it is necessary to institutionalize a protocol and develop effective training. Only then humanization and resolvability of emergency care services will be guaranteed. **Descriptors:** User embracement; Emergencies; Nursing.

RESUMO

**Objetivos:** conhecer a concepção da equipe de enfermagem sobre o Acolhimento com Classificação de Risco e discutir os fatores que contribuem para que a equipe de enfermagem não o desenvolva no setor de urgência. **Método:** estudo descritivo com abordagem qualitativa, realizado com 16 profissionais da equipe de enfermagem atuantes na unidade de urgência e emergência de um hospital particular em Teresina/PI/Nordeste do Brasil. Utilizou-se um roteiro semiestruturado para a produção de dados e foi realizada a técnica de entrevista face a face. O projeto foi aprovado pelo Comitê de Ética da NOVAFAPI, CAAE 0191.0.043.000-10. **Resultados:** alguns profissionais possuem conhecimento sobre o referido protocolo e os benefícios que podem ser alcançados por meio da valorização da queixa do paciente. Identificou-se dificuldade em distinguir os termos triagem e acolhimento com classificação de risco, inferindo-se que parte da equipe desconhece este dispositivo.

**Conclusão:** é necessário institucionalizar um protocolo e desenvolver treinamento eficaz, pois só assim será garantida a humanização e resolutividade da assistência de urgência e emergência. **Descritores:** Acolhimento; Emergências; Enfermagem.
INTRODUCTION

The Brazilian Constitution in force establishes that health is a right of all citizens and a duty of the state, which must develop actions for the promotion, protection and restoration of health. Such actions are performed through the National Health System (SUS- Unified Health System), according to the following doctrinal principles: universality, integrity and equity. Emergency services across the country are overcrowded both with patients in need of emergency care and patients who require low complexity care. This hinders visualization and establishment of care priorities.1

This scenario can be identified in most public emergency units in Brazil and have been greatly interfering with the work process and the quality of care provided to the population. For this reason, advances regarding the definition of concepts and the incorporation of new technologies are searched in order to improve the Brazilian emergency care system and organize care. Thus, many municipalities are adopting User embracement with risk classification protocols, in an attempt to improve quality and efficiency of emergency healthcare.2 In this sense, it is important to mention that user embracement is an important tool for the humanization of healthcare. This strategy aims to provide health services according to technical, ethical and humanistic criteria.3

User embracement should be applied to the care of all patients. Health professionals should listen the patient’s voices and requests, be able and willing to give appropriate responses, and use all available resources to solve the existing problems. The aim, thus, is to achieve interested care with accountability. When necessary, patients are referred to other units and links with other services are established for continuity of care. In this manner, the effectiveness of referrals is maximized.4 This strategy was created for the humanization of care provided to users of healthcare services.5

Risk Classification is as a dynamic method consisting in identifying the user’s risk/vulnerability. The health professional should take into account the subjective, biological and social dimensions of the process of becoming ill, in order to guide, prioritize and decide about necessary referrals to resolve the problem presented by the individual.6 It is the first point of contact of the user with the emergency unit. Here, a general assessment of the user will be made, which shall not exceed 5 minutes. This assessment involves a combination of the problems presented, the general appearance of the patient, and physiological observations.7 Therefore, this protocol should be used as an instrument based on warning signs/symptoms or usual forms of presentation of disease, in order to allow the classification of patients according to severity levels. Moreover, since it has been validated by the Ministry of Health, it also serves as a reference document for regulatory health agencies and professional boards, and for the control of emergency cases.8

User embracement with Risk Classification should be applied by a multiprofessional team, consisting of: a registered nurse, a nurse technician, a social worker, a physician, concierges and front desk professionals and trainees. However, the first contact with the user should be made by the nurse, who is responsible for classifying the risk level of patients and making referrals. Therefore, the actual application of the Risk Classification protocol is performed by a nurse.

Given this reality, we became interested in finding out what were the nursing staff’s conceptions of User embracement with Risk Classification at the emergency unit of a private hospital in the Teresina (PI). The nursing staff had previously received training on the risk classification system, although this system was not being used by them.

This study aims at:
● Identifying the conceptions of User embracement with Risk classification held by the nursing staff;
● Discussing the factors that contribute to the non-use of the User embracement with Risk classification protocol by the nursing staff in the emergency unit.

METHOD

This descriptive9 qualitative10 study was conducted at a private hospital with an emergency service in Teresina (PI). The hospital comprises a total of 120 beds and has a nursing team consisting of 33 nurses and 203 nursing technicians. From these, 5 nurses and 25 nursing technicians work in the emergency unit, where daily 200-360 care services are provided. Thus, the members of the nursing team who were the subjects of this study were four nurses and twelve nursing technicians.

Data was obtained during an interview conducted as a face-to-face conversation. The interviewee verbally provided all necessary information to the interviewer.11 At this point, we used a semi-structured script, with
questions relating to the subjects’ identification and open questions in order to allow the interviewee to freely develop the content and form of his/her answers. These interviews were fully recorded and transcribed verbatim, given the fact that once recorded, no data can get lost.

In order to maintain the anonymity of the subjects, we decided to describe them with the letter D, from “deponent”, followed by the Arabic numeral corresponding to the interview number. Subsequently, data were analyzed in three steps. First, we carried out a pre-analysis: we selected all the data that were in accordance with the objectives established for this study. We performed a careful reading of the contents in order not to deviate from the topic of this study. The data were then analyzed and compared with the theoretical concepts available and which guided this research. The second step consisted in the exploration of the material. The raw data were arranged in such a way as to allow a better understanding of the topic. Finally, the third step consisted in the treatment and interpretation of the results.

The study project was previously submitted for review by the Research Ethics Committee of the Faculty of Health, Human Sciences and Technology of Piauí - NOVAFAPI. It was approved under protocol CAAE No. 0191.0.043.000-10. The study complied with the “four basic principles of bioethics”: autonomy, non-maleficence, beneficence and justice, in accordance with Resolution No. 196/96 of the Guidelines and Rules for research involving human beings. Thus, the subjects were properly informed about the study objectives and agreed to participate by signing the informed consent form.

RESULTS AND DISCUSSION

Most of the team had received a training on the use of the protocol in question - some six months and others one year before the beginning of this study. Subjects had been working in this unit for 4-8 years. It is noteworthy that seven subjects had been working in this unit for 4-12 months, which shows a high turnover of employees.

During the analysis of the results, two central thematic categories emerged: User embracement with risk classification: nursing staff’s conceptions; and Factors that contribute to the non-use of the User embracement with risk classification protocol in the emergency unit. Due to the unique way in which some of the interviewees see the factors listed in the latter category, we decided to subordinate it into: Difficulties in distinguishing user embracement with risk classification and screening; and Ignorance about user embracement with risk classification.

♦ User embracement with risk classification: conceptions held by the nursing staff

The word “embrace” has many meanings and expresses the idea of “providing shelter, protection, or physical comfort; to support, accept, welcome, listen”. In healthcare, user embracement is a technology created for the reorganization of health services. Its aim is to provide universal access, resolvability and humanized care. It is based on the idea of listening to the patients’ voices in order to provide a positive response to their health problems. Moreover, it aims at decentralizing healthcare - which is classically centralized on the physician - and extending it to the entire team, which increases the supply of services offered to patients.

We found that the nursing staff understand user embracement and risk classification as two separate entities. Thus, many show their conceptions of user embracement as caring for the patient in an attentive manner and believe that, through conversation, the patient will receive quality care. Risk classification, on the other hand, is interpreted as deciding which user should be cared for first. Thus, this reveals that the conceptions held by most of the nursing staff are not directed to using or seeing user embracement with risk classification as a device whose main feature is the organization of emergency services.

We noticed that some of the nursing staff members are aware of the concepts of user embracement and humanization of care delivered to the user at all times of contact with him/her:

User embracement is treating the patient well, making him feel good when arriving at the emergency unit. (D1)
User embracement is providing good care to the patient, is to welcome him with love, with good care. (D16)

[…] All patients who come here are well received by me, I pay attention to them, we do not do our job mechanically, we work with humanization, it is a part of nursing, we advise, give counseling when the patient is tense, is something extra that is part of our job. (D10)

 […] the humanization of nursing, you talk to people, you embrace them, treat them well, becomes a a kind of friend, makes the environment a little more friendly […] (D6)

Some of the subjects seem to be aware of the risk classification protocol, prioritizing
emergency treatments according to the risks and the vulnerability of the user, and also seem to value the benefits that are evidenced by the use of the protocol:

[…] I do not classify my patients according to order of arrival, but rather by the type of care needed […] here patients are classified as priority zero, one, two, three, four, here this has not yet started, but we give priority to whoever needs it most […] (D3)

We will prioritize people, those people who are really high-severity cases, those people who need to go directly to the ER, those who have to be examined in the consultation office, those who can wait for a consultation, so we embrace the patient, and depending on the classification we can improve the emergency care service […] (D8)

We observed that, in this study, one of the interviewees holds the conception of user embracement within the context of health and, especially, within the context of the emergency unit, because he believes that by listening to the complaints of the patient, the nurse will be able to better judge and will be accountable for making the appropriate referral:

 […] user embracement is welcoming the patient, knowing what are his complaints and, with these information, you will classify the risk, decide whether he has priority to be cared for, where he should be referred to first, what are the initial care measures to be taken. […] at the emergency unit we perform direct user embracement in order to know which conduct must be taken, what are the patient’s complaints. (D13)

Risk classification is a dynamic process of identification of patients who require immediate care, according to risk potential, damages to health or degree of suffering. It was created in response to the overcrowding of emergency departments, where the waiting hours and the non-distinction of risks or degrees of suffering result, in some cases, in the worsening of the patient’s condition or even in his death for not being cared for soon enough. This fact is illustrated in the statements below:

In a certain way, it relieves the unit, we refer each patient to the appropriate unit, and so it is easier to evaluate each case […] you know how to do user embracement, talk to the person, tell her how severe her case is, is much better, the patient feels better […] you prioritize the severe cases, cases that can wait. So this way you will “relieve” the ER, the unit will no longer be so crowded and each patient will be directed to the appropriate unit. (D8)

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[…] We do this because not everyone, not every patient can wait, a patient who is still only a case of urgency, if you let him wait too long, it may become an emergency and his clinical picture may increasingly aggravate. (D3)

The reception of health users is a strategic point in emergency care. Therefore, this job should be performed by a trained professional, who is qualified to provide information and make appropriate referrals. Experiments described in the literature cite the nurse as the executor of this process. This reality can be verified in the following statements:

No, no, I don’t do it, because it is not part of my job as a nurse technician. (D12)

 […] here is the nurse who does it, I do not have the autonomy and nor is it part of my job to do that. (D2)

It is important to highlight that, for the implementation of the User embracement with risk classification protocol, some prerequisites are required, such as: establishing flows; care protocols and classification of risk; training teams to use such protocol; obtaining information system for scheduling appointments; performing quantification of the daily care and establishing users’ profiles and peak hours; making the physical structure suitable for providing emergency care and emergency care. These prerequisites are valued by the following speech:

It is valid when you have equipment and professionals who are trained to do this, and it is very important in order to be able to prevent “swelling”(overcrowding) inside the hospital and demands from patients who do not need to be in the emergency unit. (D10)

• Factors that contribute to the non-use of the User embracement with risk classification protocol in the emergency unit

• Difficulties in distinguishing between user embracement with risk classification and screening

It is important to stress that some subjects had difficulties in distinguishing between screening and user embracement with risk classification. Such an occurrence was attributed to the fact that emergency services used to perform screenings, whose process was based on the exclusion of those patients who were not at risk of death.

Risk classification is like separating, right? These are specific cases, let’s say that there is an urgent case, a more urgent case, a case of extreme urgency. We have to do a sort of screening, right? (D14)
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set of practices and technical activities with social and environmental concerns that are carried out in order to know and control the risks that work can cause to the environment and to life. 

My knowledge of the dangers, the risks that we run, right? In the emergency room, for example. (D4)

The risk is always there, however, since we have support, all the adequate equipment to protect ourselves, it is easier for us to avoid being contaminated or contaminating others. (D9)

I’m not sure about this risk classification here. I think it’s about caring for the patient in a correct manner, like not using gloves, not washing the hands, I think that it contributes to it, it welcomes this risk classification. (D12)

No, I do everything in my power to perform this user embracement, I try to wash my hands every time I administer a medication, I try to keep this risk classification away. (D12)

Doing this user embracement with risk classification, first of all, is the risk of danger that the professional is running, of contamination, it poses a great risk to the professional. (D15)

My view is that we who work at the emergency unit and at a hospital must be on guard, to prevent the risk, right? Doing so we will not be contaminated and won’t contaminate the patient. (D7)

Thus we do not have enough information to make distinctions. (D5)

These answers are attributed to the high turnover of the nursing staff and to the ineffectiveness of the training received by them. Only a meaningful learning experience would be able to effectively achieve the suitability of staff to the processes of change in the daily routine. Thus, continuing health education is a good strategy for the institution, because it is fundamental to help the staff deal with the constant changes that take place in this unit. Its goal is to transform the workplace into a site for a critical, conscious, committed and technically competent performance. Such skills are also required for applying the user embracement with risk classification protocol.

CONCLUSION

This study helped us understand the conceptions of user embracement with risk classification held by the nursing staff. We found that some of the interviewees are aware of the concept of user embracement directed to health services and of the concept of risk classification as a process that identifies those patients who require priority care. It is known that such a device was
created by the Ministry of Health in order to organize the flow of care services, giving priority to the most urgent cases and following pre-established protocols in accordance with the reality of the institution. For its implementation, it is important to listen to the patient, take into consideration their complaints and anxieties, in order to provide correct guidance and make the appropriate referrals.

However, when questioned about the factors that contribute to the nursing staff not applying this protocol, some of the interviewees showed difficulties in distinguishing between user embracement with risk classification and screening. Furthermore, we found that some respondents were unaware of the care protocol, since they attributed the non-use of the protocol to the high demands for emergency services. This is contradictory to the logic of the process, which has as one of its objectives to relieve the flow of care services at emergency care units.

It became evident that, even though most interviewees had received training on the device, there was no satisfactory assimilation of the contents and concepts. We observed that the emergency care unit in question has the adequate physical structure to direct patients according to the risks they present. However, there is no institutionalized protocol, which is also a factor that contributes to the team not applying the user embracement with risk classification protocol in that unit.

REFERENCES


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