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ORIGINAL ARTICLE

EVERYDAY EXPERIENCES OF THE NURSE IN RISK CLASSIFICATION IN AN EMERGENCY UNIT

EXPERIÊNCIAS COTIDIANAS DO ENFERMEIRO NA CLASSIFICAÇÃO DE RISCO EM UNIDADE DE PRONTO ATENDIMENTO

EXPERIENCIAS COTIDIANAS DEL ENFERMERO EN LA CLASIFICACIÓN DE RIESGO EN UNA UNIDAD DE ATENDIMENTO EN SALUD

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ABSTRACT

Objective: to understand the experience of the nurse who acts in the risk classification of an Emergency Care Unit (ECU). ***Method:*** case study, with qualitative approach, based on Comprehensive Sociology of Daily Life, with 12 nurses. The source of evidence was the open individual interview. The thematic content analysis was used. ***Results:*** the daily life in the ECU is expressed in the high demand and in the complaints of the users. It portrays a stressful and conflicting environment for the waiting and suffering of each one that awaits the service. Besides the assistance actions, the managerial and educational ones cause work overload in the routine of the nurse. ***Conclusion:*** changes are necessary for ECU care to be humanized, taking into account the interests of users, who often need attention that goes beyond clinical care, as well as professionals who do not have ideal conditions for professional practice.***Descriptors*:** Classification; Urgency; Emergency; Hospitality; Risk.

RESUMO

Objetivo: compreender a vivência do enfermeiro que atua na classificação de risco de uma Unidade de Pronto Atendimento (UPA). ***Método*:** estudo de caso, de abordagem qualitativa, fundamentado na Sociologia Compreensiva do Cotidiano, com 12 enfermeiros. A fonte de evidência foi a entrevista individual aberta. Foi utilizada a análise de conteúdo temática. ***Resultados*:** o cotidiano na UPA é expresso na elevada demanda e nas reclamações dos usuários. Retrata um ambiente estressante e conflituoso pela espera e pelo sofrimento de cada um que aguarda o atendimento. Além das ações assistenciais, as gerenciais e educacionais acarretam sobrecarga de trabalho no cotidiano do enfermeiro. ***Conclusão*:** mudanças são necessárias para que a assistência na UPA seja humanizada, atendendo tanto os interesses dos usuários que, muitas vezes, precisam de uma atenção que vai além do atendimento clínico, quanto dos profissionais que não possuem condições ideais para o exercício profissional. ***Descritores*:** Classificação; Urgência; Emergência; Acolhimento; Risco.

RESUMEN

Objetivo: comprender la experiencia del enfermero en la clasificación de riesgo de una unidad de atendimiento en salud (UPA). ***Método:*** estudio de caso, de abordaje cualitativo, basado en la sociología comprensiva del cotidiano, con 12 enfermeros. La fuente fue a través de entrevista individual abierta. Dónde se ha usado el análisis de contenido temático. ***Resultados:*** la vida cotidiana en la unidad de salud se expresa en la alta demanda y las quejas de los usuarios. Retrata un ambiente estresante y conflictivo por la espera y por el sufrimiento de cada uno que espera para el servicio. Además de las acciones de asistencia, gerenciales y educativas, se suman en una carga de trabajo muy exhaustiva para los enfermeros. ***Conclusión:*** los cambios son necesarios para asegurarse de que la Unidad de Salud sea humanizada, teniendo en cuenta tanto los intereses de los usuarios que necesitan a menudo una advertencia que va más allá de la atención clínica y los profesionales que no tienen las condiciones ideales para la práctica profesional. ***Descriptores*:** Clasificación; Urgencias Médicas; Acogimiento; Riesgos.

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INTRODUCTION

Risk classification represents an important process of changes in the practices of prompt care units, by the identification of those who need immediate treatment, according to the potential of risk, health problems or degree of suffering, through protocols that direct this risk classification. However, many emergency services coexisted with overcrowding and large queues, where users disputed service, with no criteria for risk classification, other than the order of arrival. The non-differentiation of the risk, to which each user is exposed, causes some cases to worsen during the waiting period and even death may occur due to lack of care in an adequate time.[1]

Aiming at providing equitable care in the emergency services, host-based strategies with risk classification were implemented in several emergency care units, using protocols to guarantee the standardization of care and provide qualified assistance to users who demand this service. Thus, risk classification is a tool that seeks to guarantee the immediate attention to the most serious user, and that makes it possible to inform the probable waiting time for the user's care at a lower risk.[2]

The dynamic process of classifying risk promotes teamwork through continuous assessment of the user through their need, as well as providing safer working conditions for professionals, which can lead to user satisfaction.[1]

Historically, emergency units have been considered by users as a point of reference for handling any complaints, because they are places of fast and decisive service.3 Thus, urgency and emergency services "are characterized by overcrowding, fragmented work, asymmetries of power, exclusion of users at the door, little articulation with the rest of the service network, and its improvement presents itself as one of the challenges in health care. "[4: 2128]

Thus, "professionals are faced with high spontaneous demand and citizens are welcomed at the doorstep of the health sector", which represents "a challenge, inasmuch as the current reality requires health services to be able to receive a large number of people who seek and demand immediate care. "[5: 774-775]

Given this scenario, the nurse's role is of great acuity, since it is he/she who will listen to the complaint, identify risks and vulnerabilities and, based on their knowledge and backed by a protocol, will judge the need for each user to receive emergency care or not.[3]

The nurse is a professional indicated and qualified to carry out the risk classification, both for their theoretical and practical skills to establish the classification of this risk through the clinical manifestations of the users, as well as the organization of work, the resources necessary for the care and the environment, aiming at the reception and the humanization in care.[6]

Given this context, how does the nurse experience this risk classification process in a care unit in Belo Horizonte, Minas Gerais, Brazil? Due to the limited number of studies on the daily experience of the nurse in the host with risk classification, it is justified to choose this object of study.

OBJECTIVE

- To understand the experience of the nurse who acts in the risk classification of an Emergency Care Unit (ECU).

METHOD

Case study, with a qualitative approach, based on the theoretical framework of Michel Maffesoli's Comprehensive Sociology of Daily Life. As an object of research, qualitative research is endowed with an "analytical and systematic course, therefore, it has the purpose of making the objectification of a type of knowledge possible that has as its raw material opinions, beliefs, values, representations, human relations and actions and from the perspective of actors in intersubjectivity. "[7:626]

A case study "investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomena and context are not clearly defined" [8:32]. In addition, one can rely on the evidence of direct observation of the events to be studied and interviews of the people involved.[8]

Comprehensive sociology is adequate to describe the limits and necessity of situations and constitutive aspects of everyday life, formed by the subject and their interactions, in seeking to present the social forms as they are. Maffesoli defends this methodological resource especially when one intends to give account of the structuring force of the image of a sociality.[9]

The survey was conducted at a Porte III Emergency Care Unit (UPA), [10] in Belo Horizonte, Minas Gerais, which serves the users of the Unified Health System (UHS), as well as the users of the private healthcare

network. The ECU has fifteen nurses who act in the 24-hour risk classification in three shifts: morning, afternoon and night.

The research participants were 12 of these nurses responsible for the classification of risk in the prompt care sector of the Unit. As evidence for the data collection, the individual open interview was used, which was recorded with the prior permission of the informants and transcribed in its entirety. Data collection occurred in the months of July and August of 2012.

The data was analyzed according to the thematic content analysis technique,[11] according to the phases: preparation of the material by transcription of interviews and floating reading of the same; exploration of the material by means of coding, whereby raw data were transformed and aggregated into recording and context units and enabling a description of the characteristics of the content; categorization of the constitutive elements of the text by differentiation and, subsequently, by regrouping according to the semantic character; treatment of results and interpretation, processed according to the established objective and discussion with the existing literature.

The research was developed according to the directives and norms regulating research involving human beings in the Resolution of the National Health Council No. 196, of 1996, as revised by Resolution No. 466 of December 12, 2012.12 Resolution 466/2012 incorporates, from the point of view of The five basic references of bioethics: autonomy, non-maleficence, beneficence, justice and equity, and aims to ensure the rights and duties that concern the scientific community, research participants and the State.[12] The data collection was initiated after the approval of the project by the Ethics Committee of the Pontifical Catholic University of Minas Gerais (CEP PUC-Minas), under Opinion 0410.0.213.0003-11, and authorization of the Ethics Committee of the Research Institution, under the Opinion 009/2012. The anonymity of the research participants was guaranteed through the adoption of pseudonyms chosen by them.

RESULTS AND DISCUSSION

♦ The nurses' experience in risk classification in the prompt care unit

Classifying the risk materializes as a daily coping expressed in the experience of nurses working in the ECU.

The nurse "has been the professional indicated to evaluate and classify the risk of patients seeking emergency services, and should be guided by a directing protocol." [13: 03]

Thus, living working in risk classification was approached by the informants with expressions that describe it as an experience of work overload by the high demand, by the restricted time for the screening and the risk classification of the user.

> *The demand, here in the Institution, is very great, we attend at the second largest agreement of the State [besides UHS users]. It is a very high number of calls. I arrive in the heat of everything, noon, the time of the turmoil (Sun Stone).*
>
> *In six hours, which is my shift, ranks at least 150 to 200 patients, sometimes even more. It's very tumultuous! We have little time to sort the patient: up to three minutes. It's really stressful! (Blue Topaz)*

The universal and equitable access established as a doctrinal principle of the UHS implies in the established law of each Brazilian,[14] but also aims to promote resolutiveness and a good prognosis to each one that looks for the service of urgency and emergency. However, the high demand and restricted time for risk classification can determine limits for the care offered by nursing professionals. Thus, the risk classification, by protocol criteria, is present to meet the needs and rights of the users of the prompt service and to normalize the daily life in this work.

> *We get super overloaded, there is no time, sometimes, not even to eat anything. When we're alone here, there are almost 120 patients a day to sort out. Sometimes, it turns out that we do not give a certain attention to each patient, precisely because of this overload, goes unnoticed one thing or another. It's quite exhausting! (Amethyst)*

The uniqueness in attention is suppressed by the short time and the high daily demand. The acceptance in this dynamic process of classifying risk becomes the strategy for the humanization of this service. In this context, classifying the risk should not imply dehumanizing the process, but rather welcoming all of them into a "humanistic focus for the qualification of the processes of meeting users' demands in emergencies and emergencies."[15:1115]

Humanization in health aims to implement UHS principles in the daily practice of care and management, qualifying public health in Brazil and encouraging solidarity exchanges between managers, workers and users.16 But it is necessary to know the challenges between guaranteeing rights, citizenship and work, because there is a space between professional and user, because both hold this

humanization right in this environment of attention to emergencies and emergencies.

Offering health actions, in this context, may imply risks to the health of this professional, since the lack of time for the professional to feed themselves and to meet the body's metabolic needs constitutes a susceptibility, a health that can be impaired due to overworking and many hours without feeding. In addition, the work overload reported by informants implies stress, in a singular attention that is not considered ideal. However, it is justified, by universal access, free entry of users into a door open 24 hours for demands that may or may not be emergencies and emergencies. What emphasizes the possible ignorance of the users of a ECU and a classification of risk, as stated:

> *The question of charging patients, because they do not know and do not understand, they want to be taken care of immediately and it is not that way. It has the classification to eliminate even, to divide the patients who are better and can expect (Crystal).*
>
> *The demand for the less urgent patient here is very large. Many patients that come with return for orthopedic care. We suffer a lot of verbal aggression due to the delay in this service. Exactly why they come in the wrong place. And do not understand what is urgency, what is emergency (Amethyst).*

The lack of understanding of the users about the role and importance of risk classification disorganizes the routine of the service, since the majority of users seek care without needing emergency assistance and, nevertheless, wants quick and resolutive care.

In addition to providing care to patients in need of urgent and/or emergent care, emergency units have symbolized the doorway for patients with chronic and social complaints. This demand overwhelms the team that works there, including, the Nursing team, in seeking to meet the demand that should occur in other levels of health care.17

The everyday is not a concept that one can, more or less, use in the intellectual area. It is a style in the sense [...] of something more comprehensive, of environment, which is the cause and effect, at a given moment, of social relations as a whole.18 In the context of prompt service, we can say that attention to Health begins to act with the everyday in the reality of urgency / emergency, by identifying the problem of alterity, the recognition of the other; and by individuals' ways of acting and thinking. Thus, daily facts are common in work in Emergency Care Units, where professionals and users are found with their knowledge, attitudes and attitudes, in the imbrication of actions and actions in health. However, health actions have their own knowledge, protocols and routines.

Thus, one of the advantages of using risk classification is to guide the flow of patients according to their clinical severity. However, what is perceived is that most users do not accept risk classification well and question the nurse's knowledge to judge their complaint as urgent or not.19 As the following report corroborates:

> *If the ranking is yellow up they think great! No need to be dying, only needs to be attended to first of all. If the classification goes from green to down they already question a lot because they associate green with not needing urgent care. So, when you put a green color classification, which means little urgency, they think we're saying they do not need medical attention, so, they can go home and that's not really true, that means they need care from a doctor, but, not a priority, then every patient who is more serious will pass in front (Blue Agate).*

The non-acceptance of the classification received by the user also refers to the respect to the professional that classifies it, as informed by the nurse:

> *It is very important that the patient also respect our profession, respect the function that we are there to exercise, we receive training to do this, then, we have a legal, ethical support to be classifying the patient, always seeking that it be attended and that their complaint is resolved, but often this does not happen (Turqueza).*

Even with so many questions and criticisms from the users, the nurses who participated in the research identify that the recognition of the profession and its importance has increased, as it is stated:

> *Today, the nurse is being accepted, showing his role there. Here, many people respect our work. Most people who do not respect are people who usually have a rating that needs longer time to attend, are people classified as green, such as blue. People who normally need urgent care, they accept very well (Tiger's Eye).*

The use of protocols allows greater security for the professional in the accomplishment of the classification of risk and streamlines the work in the daily life. The constant increase in demand and the overcrowding of emergency services produce the need to deploy patient classification systems to ensure the provision of care according to the severity of the condition that each user presents. The Manchester protocol is not intended to provide the evaluator with a

medical diagnosis, but rather as a clinical priority for patient care, based on the signs and symptoms he presented.19

The Manchester protocol establishes a certain time for the user to be attended to, according to their severity. The risk is stratified into five severity categories represented by a color, a number and a waiting time until the first contact with the emergency room doctor: Level 1 - red (immediate); Level 2 - orange (up to 10 minutes); Level 3 - Yellow (up to 60 minutes); Level 4 - Green (up to 120 minutes); Level 5 - Blue (up to 240 minutes), however, often the deadline may not be obeyed and users remain waiting longer than determined. This implies in bigger complaints that end up being directed to the nurse, who is the professional that stays in greater contact and welcomes first the demand.

> *But in reality, patients at some shifts end up waiting longer, the nurses at the screening being threatened and lowered with slang words (Blue Quartz).*
>
> *The experience that I have [...] all the complaints, whatever aggravating happens during the wait they think it's our fault. One thing that is not always true, because sometimes it happens that the patient is waiting for a longer time than the time it should be, because of even the high demand, of a number of patients that exceed the expected amount, that the shift begins to get tumultuous, so it ends up that the patient waits beyond what he should (Blue Quartz).*

Although the risk classification is based on protocols, there are questions from the users about this practice performed by the nurse:

> *What complicates the life of nurses very much in the classification of risk are the complaints of delay of medical attention. The patient arrives here and he says that you were wrong, that you did the wrong sort. In fact, you followed the protocol right, but because the care is taking, and because you are a nurse, you do not know what he is feeling. But, the good news is that you're backed by the protocol, even though he says we do not know it. Complaints of prompt care from patients will always exist, will not they? (Sapphire)*

The work dynamics of ECU are closely linked to the interdisciplinary work that must be performed by all professionals. However, often, the medical team does not understand the role that nurses play in the classification of risk generating questions, especially, in relation to referrals made:

> *Sometimes, the medical professional who does not know the risk classification, is not accustomed to emergency services and does not know how the protocol that the Institution uses works, he tends to think that in the classification of risk [the nurse] will give a diagnosis . So, if you're a cardiologist, he thinks he's just going to have a tachyarrhythmia or a heart attack and it's not really; All chest pain that has nothing to do with cough and flu goes to him. If it is heart attack, if it is another thing, that will set the diagnosis is it, understand? Because nurse does not make [clinical] diagnosis, nurse makes care diagnosis [nursing] and some confuse (blue agate).*

It is observed that the care process involves both the patient's need to receive a resolution assistance and the nurse's perception of the degree of urgency of this patient in relation to all others who are waiting for care. In addition to meeting the care demands of those seeking the service, the nurse still has to meet other work demands, such as managerial and educational.

The dynamics of prompt service is a result of the sum of several factors ranging from the management of the service to the understanding of users about the classification of risk. The work in emergency units is generally intense, considering that this service operates from the open door and with spontaneous demand.17

This great demand for emergency services also leads to stress on the part of users, who charge a decent and quality care, as the professionals who must attend all patients and solve problems that appear and multiply all the time. All this ends up compromising the attention paid to users, decreasing quality as the demand for this sector increases.20 Thus, nurses often have to leave the risk classification to meet other demands:

> *It is not only here that the demand is great, but that we run into some bureaucratic problems, where you have to leave the classification to try to solve, to give a quality of assistance to the patient (Sun Stone).*

Even with all this daily complexity in ECU, the informant refers to similarity with other contexts:

> *No[...] I think that here is not different from other institutions, I think there are even worse things, I have colleagues who work in other places and they say the same thing, have difficulty, patient fighting, patient calls the police, patient thinks That his problem is the biggest and often it is not. It is a conflictive environment, always, does not have a day that does not have a*

conflict, because the patient believes that his problem is the biggest one (Sun Stone).

The nurse is at the forefront of these conflicts. It is he/she who is at the door of the ECU to classify the risk.The risk classification should be "performed by a health professional, at a higher level, through specific training and use of pre-established protocols" .[21: 18]

According to the Regional Nursing Council, [22] the nurse is the professional prepared to perform the risk classification, and is supported by the Brazilian law of professional practice No. 7,498, of June 25, 1986, however, what we observe in the statements of some interviewees is that, even though they are supported by the law of professional practice and are able to carry out risk classification, nurses still feel exposed while performing this practice:

I believe that nurses have a fundamental role, but I also believe that we are very exposed, we still lack legislation to back us up, the classification is still much questioned even by the medical team (Pedra do Sol).

Many of my friends say they do not like the risk rating itself because we take the lead and we end up suffering a lot of threat (Blue Quartz).

In order for the work in the emergency department to be effective, it is necessary that the Nursing staff support the unit's needs. Appropriate Nursing actions should be implemented to meet quality standards in the care performed.23

Aiming at effectiveness and effectiveness in daily work, the nurses' shift schedule determines the location of these professionals in the ECU, as follows:

We are three nurses, one of which is in the classification and two in the assistance, since this demand for assistance is very great (Sun stone).

Even though this division of tasks occurs, the nurses are overwhelmed, as the results show.

The quotidian is the space par excellence of the fragmentations, of the acts that have not materialized according to the tensions,[18] which, in this context are present among users and professionals in the space of urgency and emergency in health. Conflict is manifested by the overload of work and the in (understanding) of the risk classification performed.

Another factor addressed by the interviewees is the difficulty of measuring the pain of users seeking prompt care. Pain assessment is of paramount importance as it can define the severity of the user's complaint. However, because it is a personal experience, it becomes difficult to evaluate:

The patient who comes with a complaint of pain and we cannot measure the pain of a patient, then, we classify the pain of this patient associated with the other signs, the other symptoms that the patient presents us, since each pain is unique (Turquoise).

The measurement of pain is a challenge for the professional, in view that this is a subjective and complex symptom, a personal experience. Pain results in suffering, causing impairment of the quality of life and having considerable repercussions in the psycho-social sphere of the individual.[2,24]

When the logic of pain arises in the daily care of people in cases of urgency and emergency, and when the logic of emotionality emerges, the person arises, because etymologically refers to "the persona, social mask, which are the various roles that the Person acts in the various dimensions of life and in groups of belonging [...] being a character that embodies a little of itself in each space of action, but not its totality."[25:108] For Maffesoli, the human being, as a biological species, "is a single being: the individual is a mode of being of rational historical epochs, and the person of the emotional epochs Bipolarity, individual and person, must be understood as something that will be the cause and effect of a spirit of the specific time ", [26: 310] in the analyzed report, the time of the pain suffered.

The evaluation of pain should be part of the daily activities of the Nursing team, since it is these professionals that accompany the users most of the time, and must be effectively qualified to carry out this evaluation. This practice becomes important because it makes care more humanized when caring for the person with pain, considering it integral, a unique being.20

It is also observed in the results, that experience and knowledge help to measure the pain::

So, you have to have the critical sense very sharp, we know the patient when he is in pain [...] we can not be, let's put it that way, underestimating the patient's complaint, taking into account everything he tells you, But there is something that we [...] He tells you one thing and you know it's different, especially, after some time working with the risk classification. At first, not so much! And I see that it's something that happens every day, let's talk like this, more experienced (Sapphire).

Thus, it is observed that the nurse and the whole team should be prepared to evaluate the pain, that is considered the fifth vital sign

and is a determining factor for the conduct to be taken with the user.

Through pain or other symptoms and signs, the nurses who act in the classification of risk coexist daily with the responsibility of deciding who will be attended first. However, some informants comment on the fear of misclassifying a patient who may need immediate care and, for some reason, be misclassified:

> *I've never had a problem with the rating, it's never happened that I screened a very serious patient in the wrong way and that brings me some problem, thank God. But, every day I sit here in this chair to screen patients, I'm afraid that's going to happen. So we have to have some knowledge (Sapphire).*

The permanent qualification of the professionals who work at the entrance to the service is necessary, since they act at the threshold of the decisions aiming at correct answers, but they can be subject to errors that, often, can lead to serious damages to the users or even to the death of a serious patient. Thus, it is fundamental to aim at the permanent education of professionals, structured according to the profile of the institution and professionals who participate in the activity in loco, to also provide a higher quality and safety assistance to the user.[27]

The search for new knowledge must also be the responsibility of the professional that acts in the risk classification, which must always be updated to meet the demand of users seeking care, with quality:

> *The nurse, has to be always studying, always seeking knowledge because it is part, it is no use to think that it formed that it will not learn, that it will only do what it knows. Each patient is one, it's different, it's a new case, you have to be studying, you have to be updating yourself (Tiger's Eye).*

Despite the use of the protocol, the results show that professionals need to increase their knowledge in the course of their professional practice. The nurse's qualification enables the provision of care that focuses on the user's safety, effectively attending to their needs and ensuring fewer possibilities of injuries during the waiting time in the classification of risk.

When considering the nurses' experience in the ECU, the daily life is expressed contextualizing the high demand and the complaints of the users. It portrays a stressful environment for the waiting and the suffering of each one that awaits the attendance. In addition, nurses are responsible for the unit's management actions and other concerns are present in the daily life of these professionals..

CONCLUSION

The daily experience of the nurse in the classification of risk extrapolates his assistance. It is a practice marked by overcrowding, with a high demand for patients who do not need emergency care, complaints from users and questions from the multidisciplinary team. Besides all this, the nurse lives the conflict of the managerial and educational demands in its action in the risk assistance classified for a safe and quality care.

The informants emphasize the importance of continuing education in their training and of the permanent education for all the staff that works in the emergency care units, aiming at conscious and safe practices and improving the quality of care provided to the users at risk.

The results show the need for changes so that the assistance in the prompt care is humanized, attending both the unique interests of the users, who often need an attention that goes beyond the clinical care, as well as the professionals who perform their work without ideal conditions for its exercise.

The study showed the importance of users being advised when to go to emergency and emergency units. As well as the need to divulge the purpose of a risk classification, since it is noticed that many users do not know it.

The high daily demand for non-urgent services in the UPA also deserves special attention. However, it is understood that, for emergency services, to function effectively, it is necessary that the referral and counter-referral system be effective and that primary health care be resolute in order to reduce users' demand for the service Urgently, making this service no longer the first choice for cases not classified as urgent or emerging.

The nurse, faced with the complexity of the risk classification and the theoretical-practical and attitudinal responsibility to humanly serve the user in the ECU, makes explicit the need for their professional recognition to comply with the norms of protocol for the risk. Also, the respect of the users and the work team for the role it performs in the ECU, which becomes complex and challenging in its daily experience to mediate the immediate treatment, according to the potential of risk, health problems or degree of guaranteeing the universal right to health in an equitable, integral and

humanized way. These aspects indicate the contributions of this study to nursing.

It is worth emphasizing the limitation of this study, because it is characterized as a local. However, it portrays the reality of urgency and emergency in a large hospital, with high daily demand and may have an external generalization capacity, from this case study, in similarities realities..

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