

# EMBRACEMENT WITH RISK CLASSIFICATION: AN INDICATOR OF THE EMERGENCY DEMAND ON A HOSPITAL SERVICE\*

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**ABSTRACT:** This study aimed to characterize and analyze the gateway and possible strategies for organization of the Emergency Service of a University Hospital, considering the embracement with classification of risk, the Emergency Care Network and the Healthcare Network of the Unified Health System. This descriptive, transversal study was undertaken between 9th April and 8th June 2012. A total of 3078 cases of embracement was obtained. The data were collected through participant observation and documental consultation, and were analyzed by thematic and descriptive statistics. The results showed that 63.55% of those embraced access the above-mentioned service due to non-emergency cases. After characterization, some elements were discussed for the organization of the emergency demand regarding the care network. The study showed that in spite of the risk classification being an innovative strategy, on its own it does not resolve the problems of excess nonemergency demand. **DESCRIPTORS:** Nursing; Hospital emergency service; Health services; Unified Health System.

## ACOLHIMENTO COM CLASSIFICAÇÃO DE RISCO: UM INDICADOR DA DEMANDA EMERGENCIAL DE UM SERVIÇO HOSPITALAR

**RESUMO:** Este estudo objetivou caracterizar e analisar a porta de entrada e possíveis estratégias para organização do Serviço de Emergência de um Hospital Universitário, considerando o acolhimento com classificação de risco, a Rede de Atenção às Urgências e a Rede de Atenção à Saúde do Sistema Único de Saúde. Estudo descritivo, transversal, realizado entre nove de abril e oito de junho de 2012. Obteve-se um total de 3.078 casos de acolhimento. Os dados foram coletados por meio de observação participante e de consulta documental, analisados por temática e estatística descritiva. Os resultados mostraram que 63,55% dos acolhidos acessaram o referido serviço devido a casos não emergenciais. Após caracterização, discutiram-se alguns elementos para organização da demanda emergencial na perspectiva de rede de atenção. O estudo mostrou que apesar da classificação de risco ser uma estratégia inovadora, por si só não soluciona os problemas de excesso de demanda não emergencial. **DESCRIPTORIOS:** Enfermagem; Serviço hospitalar de emergência; Serviços de saúde; Sistema Único de Saúde.

## ACOGIDA CON CLASIFICACIÓN DE RIESGO: UN INDICADOR DE LA DEMANDA EMERGEN- CIAL DE UN SERVICIO HOSPITALAR

**RESUMEN:** Este estudio tuvo el objetivo de caracterizar y analizar la puerta de entrada y posibles estrategias para organización del Servicio de Emergencia de un Hospital Universitario, considerando la acogida con clasificación de riesgo, la Red de Atención a las Urgencias y la Red de Atención a la Salud del Sistema Único de Salud. Estudio descriptivo, transversal, realizado entre nueve de abril y ocho de junio de 2012. Se obtuvo un total de 3.078 casos de acogida. Los datos fueron recogidos por medio de observación participante e de consulta documental, analizadas por temática y estadística descriptiva. Los resultados apuntaron que 63,55% de los acogidos accedieron al referido servicio a causa de casos no emergenciales. Después de la caracterización, fueron discutidos algunos elementos para organización de la demanda emergencial en la perspectiva de red de atención. El estudio mostró que a pesar de la clasificación de riesgo ser una estrategia innovadora, sola no resuelve los problemas de exceso de demanda no emergencial. **DESCRIPTORIOS:** Enfermería; Servicio hospitalar de emergencia; Servicios de salud; Sistema Único de Salud.

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## INTRODUCTION

Among the advances which have materialized in the organization of the Unified Health System (SUS) is the implementation of the Healthcare Network (RAS). In the emergency field, there is a set of units which provide health services working and functioning as a gateway to the health system, that is, providing the first assistance to the user of the SUS<sup>(1)</sup>. These units make up the Emergency Care Network (RUE)<sup>(2)</sup> and include the primary healthcare services; emergency care; psychosocial care; and special, open access services, for example, centers which specialize in AIDS, worker's health, and others which attend citizens' specific needs.

The RUE, in spite of being an important component of the health care, still constitutes one of the problematic areas of the SUS. This results from poor structuring of the network, which, added to an increasingly large number of accidents and incidents of urban violence, results in an overload of demand in the hospital ambit<sup>(3)</sup>.

The gradual increase in attendance in the emergency services in private and public hospitals has led, on many occasions, the person who needs genuine emergency treatment, who is at imminent risk of death, to wait hours for the care. This partly results from the fact that few people who seek these resources present health problems which are effectively priority in emergency terms, as the majority (65%) of the cases could be attended in another point of care of the health network<sup>(4-7)</sup>. The situation in the emergency services is worsened by problems of the organizational type, such as, for example, the lack of risk triaging, which results in attendance in order of arrival, without any prior assessment of the case; this often results in even greater harm to peoples' health<sup>(2,8)</sup>.

Among the risk triage models, the most advanced – with a systemic design – used by a network of services include the Australian, the Canadian, the American, the Andorran, and the Manchester Triage System<sup>(8)</sup>. The Manchester risk classification protocol was created with the aim of establishing a consensus among physicians and nurses relating to the risk classification tool for the emergency services. As its principal characteristics, it has a scale of five levels by color, based in categories of symptoms, key

discriminants and clinical algorithms, and can be undertaken in below three minutes<sup>(8)</sup>.

In Brazil, the general guidelines for implementing the National Humanization Policy (PNH) propose – in the hospital ambit – embracement with risk assessment, considering this to be one of the potentially decisive actions for the reorganization of the networked health care<sup>(9)</sup>.

In adopting the presuppositions that the emergency hospital services (SEH) are a relevant point of care for the RAS and RUE, and that the implementation of the embracement with risk classification is a rationalizing element in emergency care, it is understood that the identification of weaknesses faced by an emergency adult service (SEA) of a teaching hospital (HU) will make it possible to contribute to a better organization of this service. In this perspective, this study is guided by the following questions: How is the gateway of the SEA/HU characterized? In what way is it possible to contribute in order to better qualify the hospital gateway to the users of the SUS?

Thus, considering the guidelines for embracement with risk classification and the constituent elements of the RAS and the RUE, the aim is to characterize and analyze the gateway, and possible strategies for the organization of the SEA/HU.

## METHOD

This study, of the descriptive transversal type, aimed to characterize the demand for the gateway in emergency hospital treatment, with the SEA/HU of the city of Florianópolis, Santa Catarina (SC).

The data were collected through consulting the formal records of the first contact with the service user, attended and classified according to his/her degree of risk in the SEA/HU, in the period 9th April – 8th June 2012. The data used in the collection instrument included: where the service user was from; whether the service user had sought attendance from another health service, prior to going to the SEA; the principal complaint; the flowchart code used in accordance with the principal complaint, and risk classification. Only the records of those patients with clinical complaints were included in the study, as patients with surgical or gynecological needs do not

pass through the process of risk classification undertaken by the nurse.

A total of 3249 records of embracement were made in the period studied. Of these, 1534 were made in the first 30 days, and 1715 in the following 30 days. However, the following were excluded from the study population: 70 cases referred to the surgical clinic; 05 referred to the gynecology department; and 96 which were not classified, resulting in a total of 3078 cases participating, of which 1451 took place between 9th April and 8th May (corresponding to Month One) and 1627 took place between 9th May and 8th June (corresponding to Month Two). These data were analyzed through descriptive statistics, using an Excel® spreadsheet.

In addition, during the study period, data were collected through participant observation by the researcher responsible, at specific times during the undertaking of the Multi-professional Residency in Health. Through systematic records in a field diary, aspects were observed relating to the first attendance (embracement) of the service user, including: circumstances of the attendance; communication between the professionals; conflictual situation; numbers of staff; demands on the service; occurrence of unforeseeable events. The records of the observation were analyzed according to the technique of thematic analysis<sup>(10)</sup>, following the phases of ordering the data, classification in structures of relevance, summary, and interpretation of the data, with the aim of contributing to the proposal of strategies for the (re) organization of the SEA/HU<sup>(11)</sup>.

This study was approved by the Research Ethics Committee, under Opinion N. 2438/2012, and was in accordance with the recommendations of Resolution 196/96 of the Brazilian National Health Council.

## RESULTS

The SEA/HU, seen as the “nerve center” of the institution, provides emergency attendance 24 hours a day, for a mean of 400 patients/day, who arrive without booking appointments or referred by other centers or services. It is situated in a capital in a coastal region, attendance numbers vary widely by month, being greater or lesser according to the time of year and/or events (holidays/winter, term time/school holidays and scientific-cultural events, among others). The profile of the patients assisted in the SEA/HU is characterized by age over 14 years old, with the most prevalent age range being 45-60 years old. It is, therefore, a center which has a broad range of ages, and which covers widely varying states of seriousness of clinical and surgical health situations, and all the degrees of dependency of nursing care.

The SEA/HU is divided among three units for attendance: Embracement with risk classification, Internal emergency service (SEI) and Observation Unit. In the embracement with risk classification, flowcharts adapted from the Manchester triage system are used, with a six-color criteria: red (immediate), orange (very urgent), yellow (urgent), green (standard), blue (nonurgent), white (nursing procedures, tests or activities undertaken in nonemergency units).

The characteristics of the gateway of the SEA/HU were identified based in the records of the embracements undertaken using the flowcharts adapted from the Manchester protocol. In the study period, 3078 cases were effectively classified, according to the color criteria (Table 1).

The cases received through internal referral (outpatient centers) or from the emergency ambulance service are not recorded in the embracement with risk classification. Thus, there

Table 1 - Distribution of service users classified in accordance with the adapted Manchester protocol. SEA/HU. Florianópolis, 2012

Classification/color	Month 1	Month 2	Total	%
Red	03	03	06	0,19
Orange	41	64	105	3,41
Yellow	520	491	1011	32,85
Green	843	1012	1855	60,27
Blue	14	41	55	1,79
White	30	16	46	1,49
Total	1451	1627	3078	100

is a possible margin of error – to the lesser - in the data presented here, in relation to the total number of service users attended in the SEA/HU.

The data relating to risk classification in the SEA/HU show that 63.55% of the cases are not emergencies, that is, they are cases which could be resolved at a different level of the RAS/RUE of the SUS. Patients classified with the colors orange and red, which represent serious cases, constitute a minority (3.6%). Added to the cases classified under the color yellow, the total of emergency, highly urgent

and urgent conditions represent little more than a third of the embracements in this service.

Among the complaints recorded as the “principal complaint” of the service user who sought the SEA/HU, emphasis is placed on the first five: abdominal pain, discomfort in adults, headaches; lower back pain; and chest pain, corresponding to more than 50% of the complaints for attendance (Table 02).

Of the total of records with risk classification (3,078), 1,031 (33.49%) stated that they had sought another health service before the HU, returning to

Table 2 - Distribution of the main complaint of service users of the SEA/HU. Florianópolis, 2012

Protocol adapted Flowchart used	N. of attendances month 1	N. of attendances month 2	Total	%
Abdominal pain	236	254	490	15,9
Discomfort in adults	188	230	418	13,6
Headache	137	148	285	9,3
Lower back pain	111	124	235	7,6
Chest pain	108	122	230	7,5
Sore throat	76	104	180	5,9
Dyspnea	85	88	173	5,6
Problems in extremities	64	86	150	4,9
Rashes	67	72	139	4,5
Urinary problems	57	70	127	4,1
Vertigo and dizziness	47	52	99	3,2
Diarrhea	48	40	88	2,8
Vomiting	37	49	86	2,8
Bites and stings	26	36	62	2
Other complaints	164	152	316	10,3
<b>Total</b>	<b>1451</b>	<b>1627</b>	<b>3078</b>	<b>100</b>

this institution on the occasion due to not having been attended (absence of doctor, no space for an emergency consultation); due to having been attended dissatisfactorily (no improvement from the treatment undertaken, weakness of resources for diagnostic support – absence of laboratory, X-ray equipment damaged); or due to having been referred (verbally/letter of referral); among other reasons. On the other hand, 1,965 (63.84%) reported having come direct to the SEA/HU due to closeness (they work in the neighborhood, are students/public servants, live in the region, or are tourists), to preference (the service is a better quality), because they already undergoing treatment in the HU, because it is a center of

excellence, or because it is a teaching hospital and has professionals who are more prepared to undertake the diagnostic investigation.

In relation to the place of origin of the users of the SEA/HU, it was identified that 2,016 service users (65.50%) were from the locale where the service is situated, leaving one to believe that the demand may be related to the service’s geographical proximity. All of these are from the municipality-headquarters, distributed by health district. The other service users came from neighboring municipalities (20.8%) or other municipalities from the state and other states in Brazil (13.10%), or were tourists (0.6%) (Table 3).

Table 3 - Distribution of the origins of the users of the SEA/HU. Florianópolis, 2012

Origin	N. of service users	%
Southern Health District	514	16,7
Northern Health District	385	12,5
Continent Health District	159	5,17
Eastern Health District	416	13,5
Central Health District	542	17,6
<b>Subtotal: Municipality-headquarters</b>	<b>2.016</b>	<b>65,5</b>
Neighboring municipalities	640	20,8
Other municipalities (inside and outside the state)	403	13,1
Other locales (tourism)	19	0,6
<b>Subtotal: other localities</b>	<b>1.062</b>	<b>34,5</b>
Total	3.078	100

Based in the data collected during the participant observation, it was possible to identify some aspects which contribute to the excessive demand in the SEA/HU.

One important observation relates to the service users classified with the colors green and blue. These wait a long time (greater than stipulated by the protocol), generally hours, to receive attendance, and often cannot tolerate the wait and give up on the attendance – or even become angry with the team of professionals.

The insufficient number of medical professions for meeting the service’s demands often reflected this delay, in addition to the fact that, depending on the severity of the patients’ conditions, and on the care needs, there were neither human resources, nor physical structure, sufficient for attending all. During the months in which the study was undertaken, the media was present in the SEA/HU, publicizing the issue of overcrowding in the service.

The difficulty of accessing the other health services, and the inefficiency of the attendance, is reported by the service users, both when they seek the Emergency Departments (UPA) and the Primary Healthcare Services (APS), the latter being the more common. The rationale relates to the absence of improvement in the clinical situation. The rationale related exclusively to the APS, on the other hand, would be the lack of medical professionals for undertaking the consultations, and a limited time period for the “emergency”

consultations.

The cultural issue, observed as worsening the excess of demand on the SEA/HU relates to aspects of preference, recommendation by family members, quality of the service, geographical proximity, and to its being a center of excellence for cases of poisoning.

## DISCUSSION

Over the last decades, studies<sup>(6-7)</sup> have revealed an increase in the incorrect use of the SEH (65% of the problems could be resolved in the outpatient services), a demand which exceeds the resources offered and causes long waits for attendance, corroborating the data found in the SEA/HU. The fact that 63.55% of the service users seek the SEH in order to resolve cases which should be resolved at another level of the RAS of the SUS demonstrates an incipient and weak structuring of the RUE. Studies<sup>(4-6)</sup> show that the service users do not differentiate emergency situations in accordance with the technical concept, and that neither do they understand what the services are which make up the RUE. Thus, the SEH continues to function as a principal gateway to the health service.

The demand from service users with complaints classified as nonurgent (green and blue) can be referred by a trained professional to other services of the RUE, as long as access is guaranteed. One study undertaken in a public hospital<sup>(12)</sup>

demonstrated that a large proportion (36%) of service users, embraced with risk classification by nurses, were referred to other services, resulting in a significant reduction of medical attendance. In this regard, immediate treatment was undertaken for people who effectively needed it.

In relation to the number of professionals for attending the emergency service's demand, a study undertaken in the west of Paraná emphasizes that – as well as lack of numbers – there are situations in which the interventions go beyond the multi-professional ambit and include other administrative spheres, inherent to governmental decisions<sup>(13)</sup>. In this same perspective, the mode of organization of the work process of the APS, with the incipient response capacity, and limited time for attending the emergency demand, causes the hospital gateway to be compromised.

In spite of the advances which have occurred in health policies with implementation of guidelines for humanization and embracement of the user at all levels of the system<sup>(1-2,9)</sup>, in popular culture, the idea of expecting resolute capacity from emergency services, or from the hospital Emergency Department, remains. Studies<sup>(13-14)</sup> show that the services which privilege scheduling over spontaneous demand cause the service users to be referred informally to other services, when demand exceeds what has been programmed for or does not correspond to what is offered by the service.

Both the situations cause the service user to resort to the SEH even for those cases which they also believe could be resolved in other points of care. The population perceives greater rapidity or quality in emergency situations through the SEH, and because of this seeks this service; they also note that for the problems which can be resolved at other levels of care, the delay is greater. However, they report difficulty in changing this practice for various reasons, among which one can mention the location of the service, the greater quality or speed in the assistance given, and the positive experiences experienced and/or reported<sup>(14)</sup>.

The excess of demand may be associated with the cultural issue, also recognized by other authors<sup>(15)</sup>, with similar characteristics of people seeking attendance via the emergency service:

as a result of suggestions from family members; a belief that it is a better condition for resolving the problem; and ease of undertaking tests at the time of the consultation.

The fact that this is a public hospital, as well as the inexistence of UPA in three of the five health districts, may explain the demand for the SEA/HU from the local population. However, in two districts which have UPA, it may be suggestive of the lack of diagnostic support, or of the lack of personnel/material for meeting the demand<sup>(1-2,8)</sup>.

Although the SEA/HU has a risk classification system implanted, and this is considered to be a potentially decisive strategy in the reorganization and implementation of networked healthcare<sup>(8)</sup>, it is necessary to go further. In this regard, the techniques for collection and analysis of data made it possible to produce some indicators regarding the organization of the gateway of the SEH and also, in relation to the other points of care of the RAS/RUE.

One first indicator relates to the creation, in a partnership between the team of the SEA/HU and the Municipal Health Department and its local departments, of protocols for referring service users classified as green (standard), blue (nonurgent) and white (nursing procedures, tests or activities undertaken in nonemergency units). In accordance with the RUE guidelines, it is necessary for there to be articulation and integration of the various health services and equipment, such that it may be possible to constitute health networks with connectivity between the points of care<sup>(1-2)</sup>. The establishment of partnerships between professionals who are part of RAS/RUE could lead to the clarification of the service user for access to the health service preferentially based on the APS. Furthermore, the partnerships motivated by the continuity of the care reflect the actions directed towards compliance with the principles of the SUS.

The sensitization of the team working in the SEA/HU, through techniques of integration which explore each actor's knowledge regarding the RAS/RUE, constitutes a differentiated condition for organization of the service. The teamwork and the interprofessional relationships in the context of the health care practices remain desired but not yet achieved. It is necessary,

therefore, to encourage the protagonism of the subjects involved in the care, in a perspective of management which makes them co-responsible for the care given<sup>(16)</sup>. In parallel, the institution of care protocols for undertaking procedures which are already prescribed, negotiated between the team members, makes it possible to appropriately systematize the care. The resulting benefits correspond to a better quality of the service given, and also to safety for the professional who undertakes the action<sup>(17)</sup>.

Although the data have not been systematized, a greater demand for the SEA/HU was observed on Mondays, as opposed to what was observed on the weekends. This is an important point for reflection, given that the overburden of work can occur due to the volume of the demand at specific periods. Studies which demonstrate the relevance of redistribution of work shifts, with the addition of professionals on shifts/days with greater demand, are necessary, not only as technology for the management of people in the hospital environment, but also in quality of care and reduction of the overburdening of the team. On the other hand, the issues which surround the relationship between the human resources and the quality of the services are complex<sup>(18)</sup>. In general, professional dissatisfaction is generated by the excess of work and, often, by lack of preparation in the attendance of the cases in the emergency services, which require governmental action for sufficiency and for confrontation of professional links' weak points<sup>(18)</sup>.

In relation to the other points of care of the RAS/RUE, the identification of weak points, both in the APS and in the UPAs, in the attendance of emergencies, can support operative interventions in this field of work. The emergency services have become an escape valve for the health services<sup>(19)</sup> and, in this regard, the broadening of access in the APS for undertaking the embracement of lower complexity acute cases already constitutes a driver for change in the RUE<sup>(1-2)</sup>. In other words, the embracement of acute cases, with risk classification, in all the RUE points of care, will better define the appropriate practices and interventions in the different health problems which place demands on these services. To this end, the importance is emphasized of the

necessary training of all professionals of the RUE for the first attendance to the SUS service user<sup>(2)</sup>.

## FINAL CONSIDERATIONS

This study demonstrated that the demand for the SEA/HU is high, although it does not correspond to its specific attribution. The majority of service users resort to this service in order to resolve nonemergency cases. This can be explained by different reasons, among which is the nonrecognition of the flow of the RAS/RUE; the incipient diffusion of information regarding these networks; the ease for the service user, in being attended immediately, due to this being the service closest to her house, work or school; the characteristic of the attendance to emergency demand; the recent implementation of the embracement of acute cases in the other points of care, in particular, in the APS and UPA; and the necessary training of professionals.

The resolution and organization of the gateway of the RUE, with access to the other health services, and sufficiency of diagnostic support, can contribute to changing the profile of the SEA/HU and, generalizing, of the SEH. The communication between the points of care constitutes a decisive factor for clarifying citizens, especially in relation to the continuous care and monitoring in the primary healthcare service, with appropriate diagnosis and treatment.

The integrality of the services, taking into account the qualification of the system of referral and counter-referral, contributes to the process of advising the service users in their seeking the service indicated for the complexity of their health problem. However, further studies with this perspective, with broader data collection, could not only corroborate the results found here, or present other aspects not evidenced in this study, but broaden indicators of new technologies for organizing networked healthcare.

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