Cogitare Enfermagem

ORIGINAL ARTICLE

CHALLENGES IN THE RECEPTION WITH RISK CLASSIFICATION FROM THE PERSPECTIVE OF NURSES

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ABSTRACT

Objective: to understand the challenges perceived by nurses in the process of reception with risk classification. Method: this is a qualitative, analytical research, conducted with nurses working in the reception with risk classification in four Emergency Care Units in the North-Central region of Goiás, Brazil, in the period from October 2019 to February 2020. Results: the following thematic categories emerged, characterized as difficulties faced in the emergency service in view of the perception of the nurse classifier: "Demand issues"; "Informational issues"; "Care issues" and "Organizational issues". Conclusion: we found demand challenges that contribute to overcrowding as an outcome, and informational, care, and organizational challenges understood as basic challenges. This study helps the intervention in a timely manner to modify the reality of the health service.

DESCRIPTORS: User Embracement; Classification; Emergencies; Nursing; Qualitative Research.

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INTRODUCTION

The Urgency and Emergency Care Network articulates and integrates all health services in the territory, aiming to guarantee the expansion and qualification of humanized and integral access to health services for users in urgent and emergency situations, in a fast and timely manner. Urgent care services must provide resolute and quality care to patients with acute or acute chronic conditions, prioritizing the cerebrovascular, cardiovascular, and trauma care lines, defining, in all cases, the need for referral to hospital services of greater density. This study had as its object of interest the Emergency Care Units of the North-Central Macroregion of the state of Goiás. It is a complex intermediate structure between Primary Health Care - PHC and hospitals of high technological density[1].

As for the health indicators of the macro-region of study, ConectaSUS presents, via the Goiás health map, a crude general mortality rate of 5.2/1000 inhabitants. In the table of morbidities linked to hospitalizations in the period from 2016 to 2020, injuries, poisonings and some other consequences of external causes occupy the first place in the ranking with 32,296 cases in the period analyzed. Thus, it points to a high epidemiological picture of hospitalizations for external causes that may initially require the care offered by UPAs within the network[2].

The National Humanization Policy - HumanizaSUS, emerged in Brazil with the proposal to reorganize the health system and humanize the relationships established between professionals, users, and managers[3]. Since then, tools that help organize the service and structure the networks have been introduced, among which is the Reception with Risk Classification (ACCR), a strong trademark of emergency services[4,5]. The ACCR process aims to identify users seeking potentially life-threatening care, besides increasing the resoluteness of severe cases by prioritizing timely and humanized care, thus ensuring effective assistance that is dynamically configured[3,6].

Several difficulties are observed in the emergency room, such as: fragmented work, difficulty in articulating with other points of care in the network, unprepared professionals, increased demand for care and consequent dehumanization in assistance, low-quality ACCR process, and a hostile work and care environment[4]. Overcrowding is accompanied by fast and unresolved care. Without time, qualified listening does not happen and leads to compromising the health of both the patient and the professional[7,8].

A study conducted in 2012, at Santa Casa de Misericórdia de Ourinhos, located in the interior of the state of São Paulo - Brazil, deals with the evaluation of the flow of care in emergency services and addresses some factors considered challenging, such as the high number of users who, although they could be treated in primary health care, continue to seek the emergency service causing overcrowding, which negatively influences the quality of care as a whole[9]. Also, a study carried out in an emergency unit of a university hospital in Londrina-PR, with a sample of 976 patients showed that 60.3% of these patients were classified as green, i.e., a high demand that could be met in PHC[2].

This study is justified by the various challenges pointed out in the literature, thus, it is necessary to understand the perception of nurses regarding these challenges that directly or indirectly influence health care and organization. Thus, understanding this problem makes it possible to intervene in the emergency scenario.

Given the above, the following research question arises: How are the challenges perceived by the nursing professional in view of the experience in the reception with risk classification? In this study, we seek to understand the challenges perceived by nurses in the process of reception with risk classification.

METHOD

This is a qualitative, analytical research, grounded by the investigation of what the individual brings with himself, as perception, through his ideas and suggestions based on experience on a given theme[10]. The study was conducted with nurses working in the reception with risk classification in four Emergency Care Units - UPAs in the North-Central of Goiás, Brazil, in the period from October 2019 to February 2020.

The health macro-region of the state of Goiás is composed of five UPAs; however, for this study, four units were considered, since one UPA was not included in the research because it was not active until the date of data collection. Nurses who were in full professional practice in the mentioned units, who worked directly or who already had experience in ACCR, were included in the study. Exclusion criteria were nurses who never had experience in risk classification, those who were not in full exercise of their functions (only one nurse) and nurses with less than three months without previous experience in ACCR.

The data collection period was from October to November 2019 by means of an online electronic form sent through a link by cell phone messaging application. The invitation to participate in the research was sent to all 57 nurses working in the four units that met the criteria, of which 31 voluntarily adhered (composing convenience sample) and 26 refused to participate. The form was sent in three attempts to be answered by the participants. This form was structured in two parts, the first one characterizing the nurse by means of sociodemographic and graphic professional data, and the second part consisting of the following guiding question: What are the difficulties in ACCR?

The answers were analyzed using the technique of content analysis[10] whose process, in this study, took place in three phases, the first being the pre-analysis with floating reading, formulation of hypotheses and objectives, index referencing, development of indicators and preparation of the material. The second phase was composed of: coding to accurately describe the pertinent characteristics of the content by means of clippings, enumeration, classification, and aggregation into categories. This step was performed with the help of WebQDA Software to count the occurrence and generate the word cloud. Finally, in the third phase, activities for treatment, inference and interpretation were performed.

Este estudo foi aprovado pelo Comitê de Ética em Pesquisa, com parecer 3.499.265. Para resguardar o anonimato dos participantes e instituições, optou-se por identificar as instituições por letras (A, B, C e D) e os indivíduos por números de 01 a 31.

This study was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa), with opinion 3.499.265. To protect the anonymity of the participants and institutions, we chose to identify the institutions by letters (A, B, C, and D) and the individuals by numbers 01 to 31.

RESULTS

Regarding the characterization of the nurses, 87% (n=27) were active in the ACCR activity and 13% (n=4) had already practiced risk classification at some point in their profession. Of the professionals who participated in this research, 45% (n=14) graduated between 2006 and 2010, 39% (n=12) graduated between 2011 and 2015, and 16% graduated between 2016 and 2019. Among the participants, 77% (n=24) had specialization, 13% (n=4) had only a bachelor's degree, and 10% (n=3) had a master's degree.

The results were presented according to the following thematic categories: 1) "Demand issues"; 2) "Informational issues"; 3) "Service issues"; 4) "Organizational issues".

Demand issues

In the results of the first category, nursing professionals highlighted the high demand in emergency services as one of the major obstacles experienced in the ACCR process. When asked about the main difficulties faced in this process, nurses were emphatic:

To attend quickly to many people, to be precise and direct, to attend well and with a smile on the face in such a crowded and stressful environment, to be as fair as possible. (A1)

[...] Overcrowding in the unit, biggest problem faced [...]. (C8)

Overcrowding, people don't look for the ESF overloading the UPAS. (C31)

High patient flow [...] (D17)

Goals to be achieved through the ACCR, such as humanization of care, are compromised because, despite being aimed for, they are not achieved due to overcrowding of the units, as observed in the following statement of the nurse:

High demand of patients, decrease of time for reception! (B6)

Very high patient demand... Overcrowding hindering a humanized care. (D29)

Demand of low complexity patients that overload the emergency service. (D11)

The large number of green and blue patients, overcrowding the unit causing disturbances. (D21)

Informational issues

Regarding the second category, the research participants consider the lack of information - on the part of the user - about the instrument that aims to prioritize severe cases over those that are not severe as a hindering factor in the ACCR process:

Lack of information from the population about the ACCR. (A2)

Patient's understanding. (A18)

Population acceptance. (D20)

Based on daily experience, nurses have the view that users come to the unit with the idea that they have the right to priority care, regardless of their situation. Thus, when they are classified with a color that is not what is expected, the user does not understand and feels dissatisfied with the classification. In this sense, the difficulty evidenced is

[...] dealing with the indignation of patients/companions who think they are more serious than others. (A3)

The patient's non-understanding of his/her priority in relation to the other more severe patients. (B15)

Acceptance of the population. Low complexity patients do not understand or do not accept to prioritize others. (D16)

Lack of knowledge of the assisted population about priorities in ACCR. (C26)

The lack of information of the population, evidenced in the nurses' speeches,

demonstrates that there is a concern and responsibility of nurses as educators of the population to inform them about the RRR. Considerations of the challenging role of educator for those who perform the classification can be observed in the clippings below:

[...] make the patient and companion understand the priorities. (D12)

Make the patient and companion understand that it is not by order of arrival, but by risk classification. (B7)

Still, it was identified in the speeches, the great challenge of awareness that will be treated here as sensitization and education of the population about the priorities of the service, recognizing the crucial action of PHC in the care of less urgent and non-urgent cases, as a strong ally to reduce overcrowding in emergency services.

Many times, the lack of knowledge of the population, the large number of green and blue patients, overcrowding the unit [...] (D21)

Make the population aware of the importance of seeking the BHU (C30)

Care issues

The emergence of the third category made it possible to observe considerable dissatisfaction on the part of the nurses in relation to the intervention of the companion during the ACCR process and the time of medical care, considered a cause of disturbances in risk classification and restlessness of users. Regarding this category, the following difficulties are addressed according to the reports below:

I believe that the companions get in the way a lot, overtaking the patient's speech, which harms and delays the ACCR a little. (C24)

Patience with patients and companions who complain about the delay of care (D10).

The delay in medical care that, several times, exceeds that recommended by the protocol. (D13)

Medical care. (D27)

[...] about ACCR, my colleagues end up classifying some non-urgent patients with a higher level of severity in order not to receive complaints about the length of delay in treatment. (C8)

Also, in one of the statements about the delay in medical care, a distorted view of the classification was identified, since the re-evaluation of cases is part of this process: Delay in medical care that makes the initial classification unfeasible, having to reevaluate several patients several times, delaying those who have not yet gone through the classification on a day of high flow. (D19)

In this comment, a research participant refers to dissatisfaction with the waiting time, linked to the lack of knowledge of the classification by users as a weakness.

In relation to the lower risk patient where they are not satisfied with the waiting time, or the elective procedures that are not priorities for care in the emergency room ... (C23)

Many times, the lack of knowledge of the population, the large number of green and blue patients, making the unit tumultuous and causing inconvenience and delay in the care of orange and red patients. (D21)

Organizational issues

In the following excerpts of the nurses' speeches, one notices considerations regarding professional training that manifest themselves to define the difficulties faced in the ACCR, namely:

Lack of structure, lack of training and profile of professionals (lack of academic knowledge). (B14)

[...] lack of training [...] (D17)

They pointed out that another difficulty faced is:

Putting the classification into practice. (D12)

The proper classification being met. (D28)

Some of these aggravating factors are identified in the statements:

Lack of Security. (A4)

[...] stress to the extreme, lack of security. (D17)

Pressure from the community. (A5)

Lack of better working conditions. (C26)

In one of the interviewees' statements, the lack of a referral and counter-referral protocol is identified as a weakness, linked to the cause of overcrowding and difficulties in promoting articulation between levels of care through the organization of patient flow in the Emergency Care Network:

Lack of referral protocol for non-severe patients to primary care units or compatible with their needs, backed by the municipal body, which causes overcrowding in the unit, the biggest problem faced. All this is caused by political and personal issues of the medical class. Moreover, we are not currently having adequate reference by the hospital [...] to forward the cases for hospital admission, overloading all professionals [...] (C8)

DISCUSSION

The high demand for care in emergency services was pointed as a cause of overcrowding in the services surveyed, which in most cases, limits the time of care given to the user, and negatively impacts the quality of the reception, listening, as well as the risk classification process[5]. This, in turn, can result in stress and turmoil for those who provide care and for those who wait for it[11,12].

The demand for non-urgent or less urgent patients ends up increasing the waiting time of all users present in the unit[13]. Although the high demand in emergency units is the major problem evidenced by the literature, this study understands that the root cause and the biggest challenges are related to informational, care, and organizational aspects that will influence the overcrowding of the units.

In general, the user of the Brazilian Unified Health System - SUS, receives little information about the criteria surrounding the protocols used in the institution and established flows[13]. Besides the lack of time, this is also due to the lack of communication between professional and user to present the risk assessment tool used[6,15,16].

The three statements, present in the category "informational issues", lead to the understanding that the lack of information of the population causes a lack of acceptance and understanding by these users. A study showed that when users are not informed about the waiting time, as well as the colors that correspond to the severity of the case, dissatisfaction, insecurity, and anxiety may occur during the ACCR process[11]. Such situation can be managed by the nurse of the service through educational actions that involve the user of the health system in the expanded understanding about prioritization in the emergency service[15].

However, the professional who works in ACCR becomes responsible for informing about the risk classification process, the waiting time according to the clinical picture, and prioritization, generating satisfaction for the user and companion[3,6,12]. This action can make the population aware of the need to use the emergency service when appropriate, considering that the overload of health professionals in this sector sometimes leads them to provide poor quality care to users[15].

It appears that the user, for lack of information, comes to the unit believing that he has the right to priority care, regardless of his health situation. Thus, when they are classified with a color that is not what is expected, the user does not understand and feels dissatisfied with the time that has repercussions in the demand dimension. It is inferred, therefore, that the lack of information addressed in the study category is the cause of dissatisfaction and non-acceptance of risk classification by users, and thus is considered a challenge.

For users without urgent medical conditions to be aware of the need to seek the UPA, it is necessary to clarify how the service works. In this scenario of care to users who do not present severity of their clinical condition and who could be referred to the PHC, the use of the ACCR becomes necessary to organize the flow of users and reduce overcrowding due to high patient demand[3,5,17].

As for the presence of the companion, mentioned as a hindrance to the reception with risk classification in the category on care issues, the HumanizaSUS policy is emphatic in proposing the reception of the user and companion through an environment and professionals prepared to receive them[4,7]. The listening and bonding established with the patient and companion during care can help in relation to the best way to act in therapeutic actions, since it can be evidenced what they bring of real health needs.

Also, regarding the care, there is a dynamism in risk classification, considering the need for periodic evaluation of users, as well as those who were not seen, or even those whose time exceeds what was established by the classification protocol[4]. In this category, the nurse expresses the indignation at having to re-evaluate the patient who is waiting for care, ascertaining the team's lack of knowledge about the ACCR process. Constant re-evaluation is mentioned as fundamental and must be performed until the patient is attended to and the problem is solved[18]. This corroborates a study that points out patient monitoring while waiting as an essential action due to a possible worsening of the patient's clinical status[4].

It is a fact that the waiting time, mentioned in the issues of care in the 24h UPA (Emergency Care Unit) health service and linked to the process of classification or slowness of medical care is an aspect that generates considerable dissatisfaction on the part of users and, therefore, the service, starting with the classification, which does not always occur smoothly[11]. This fact can be seen in the news that show the overcrowding in emergency units.

The discipline of the team, pointed out in the category about organizational issues, is an essential differential to deal with users. This point was raised by the participants of a research, when they stated that the category must be prepared to perform health functions, as well as deal with patients and the whole context that involves them in risk classification[11,19].

In this perspective, interdisciplinarity, based on the dialogue established among the professionals of the sector, facilitates teamwork in the search for effective solutions for synchronous work, and the user, in turn, will be the greatest beneficiary. However, when actions are fragmented, assistance is compromised[13,15].

Knowledge about risk classification is inherent to the work process of health professionals and characteristic of the emergency room[6,19]. It is understood that there is a fragility in terms of professional training and lack of knowledge of behaviors, standards and criteria established for the implementation of assistance.

Therefore, the training of the professional who works in the emergency room is fundamental, as well as the development of expertise to handle the cases in the best way, ability to work with the pressure that the service exerts, psychological preparation to face daily challenges, critical sense to make decisions, and affinity with the service performed [14,18,20].

The analysis of the Donabedian dimensions (structure, process, and result), applied to some studies, showed precarious classification for the dimensions or part of them. In view of the evidence, the need for investment in team training, infrastructure, and correct use of the ACCR protocol was verified[7].

There are some aggravating factors in the ACCR scenario in emergency units identified in this study, such as the lack of referral protocol, lack of safety, pressure from users, and working conditions that generate an organizational disorder that is harmful to the professional and user.

Studies have shown that the justifications for seeking the unit for those classified as non-urgent were the delay in care and the absence of a physician in the primary care unit, which suggests fragility in the network of primary care services[6,13]. Since primary care is the gateway to other services, emergency care may be impaired by this organizational disorder.

It is observed that there is a cascading relationship between the aspects of weakness perceived by the nurses. The delay in care and the lack of information for the population are linked to the crowdedness of the service, which prevents nurses from playing the role of educator of the population. The lack of professional training can be an aggravating factor for overcrowding, considering that prepared professionals can manage the service in the best way, helping to create and adopt and use protocols and flows.

Finally, it is worth noting that the nurses in the study work in different units with organizations, protocols, and flows adopted by different managements, which may represent limiting factors of this study, but which also indicate an individual observation for future interventions.

This study helps to elucidate the difficulties pointed out here from the point of view of nurses who work with the reception with risk classification, so that by understanding the weaknesses, they can intervene, in a timely manner, to modify the reality of the demand, care, information, and organization of the health service. This study also contributes to further investigations on the theme that can leverage even more nursing research.

CONCLUSION

It can be concluded that the study made it possible to understand the main challenges perceived by nurses in the experience of the process of embracement with risk classification in the investigated UPAS. Here, the informational, care and organizational challenges are understood as basic challenges, while the challenge of demand is presented as the outcome.

The research participants considered as a challenge the lack of information about the instrument that aims to prioritize the severe cases over those that are not serious, thus considering it a complicating factor in the process of welcoming and classifying. Information is an indispensable factor in the relationship between professional and user, which requires the formulation of strategies to improve the transfer of information to users and family members/companions and thus qualify the care provided. Considering these facts, it is up to the nursing professional to develop educational activities based on dialogue and user participation according to the specific reality.

Since this study presented the difficulties of the ACCR process in the perception of nurses, it also signals margins for investigation from the user's perspective through further research, to be subsequently carried out interventions based on two analyses.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - Sampaio RA, Rodrigues AM, Nunes FC, Naghettini AV; Drafting the work or revising it critically for important intellectual content - Sampaio RA, Rodrigues AM, Nunes FC, Naghettini AV; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - Sampaio RA, Rodrigues AM, Nunes FC, Naghettini AV. All authors approved the final version of the text.

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