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RESEARCH

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Assessement of the Profile of Assisted Women During the Obstetric Risk Classification Process

Avaliação do Perfil de Mulheres que Receberam Assistência Durante a Classificação de Risco Obstétrica

Evaluación de Perfil de la Mujer que Recibieron Asistencia para la Clasificación de Obstétrico Riesgo

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ABSTRACT

Objective: The study's purpose has been to assess the profile of assisted women in the Welcoming and Risk Classification in a maternity hospital in the rural region of *Alagoas*. **Methods:** Herein, it was chosen a quantitative, retrospective and descriptive approach by going through 1,142 medical records and files registered from January to July 2015. **Results:** The results analyses have shown that the majority of the women attended were concentrated within the age group from 20 to 29 years old (52.4%); attended elementary school (62.4%); began to monitor pregnancy in the first trimester (72.0%); and were classified as a non-urgent risk (30.9%). **Conclusion:** Therefore, the clientele profile shows that the data found might provide subsidies for the health professionals' practice during the prenatal care.

Descriptors: Health Profile, Prenatal Care, Humanization of Assistance, Welcoming, Obstetric Nursing.

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RESUMO

Objetivo: Avaliar o perfil de mulheres assistidas no acolhimento e classificação de Risco em uma maternidade do agreste alagoano. **Método:** Optou-se pela abordagem quantitativa, retrospectiva e do tipo descritiva com 1.142 prontuários e fichas no período de janeiro a julho de 2015. **Resultados:** A análise dos resultados evidenciou que a maioria das mulheres atendidas se concentrou na faixa etária de 20 a 29 anos (52,4%); cursou até o ensino fundamental (62,4%); iniciou o acompanhamento da gravidez no primeiro trimestre (72,0%); e foi classificada como risco pouco urgente (30,9%). **Conclusão:** Portanto, o perfil dessa clientela mostra que os dados encontrados podem fornecer subsídios para a prática assistencial dos profissionais de saúde durante o pré-natal.

Descritores: Perfil de Saúde, Cuidado Pré-Natal, Humanização da Assistência, Acolhimento, Enfermagem Obstétrica.

RESUMEN

Objetivo: Evaluar el perfil de las mujeres asistieron a la recepción y Clasificación de Riesgos en la maternidad Alagoas salvaje. **Metodo:** Optamos por el enfoque cuantitativo, retrospectivo y descriptivo, con 1142 registros y expedientes registrados en el periodo de enero a julio de 2015. **Resultados:** mostraron que la mayoría de las mujeres que asisten se centraron en el grupo de edad de 20-29 años (52,4%); estudiados hasta la escuela primaria (62,4%); iniciado el seguimiento del embarazo en el primer trimestre (72,0%); y se clasificó como poco riesgo de urgencia (30,9%). **Conclusión:** Por lo tanto, el perfil de estos clientes muestra que los datos encontrados pueden proporcionar subsidios para la práctica de la atención de los profesionales sanitarios durante la atención prenatal.

Descriptores: Perfil de salud, Cuidado prenatal, Humanización de la atención, Host. Obstétrica.

INTRODUCTION

The high rates of maternal and neonatal mortality and the increasing rates of cesarean surgery in recent years show the need to deepen the discussions that support the most daring changes in the model of obstetric and neonatal care prevalent in the country. Even with advances in improving prenatal care, childbirth, and birth, reducing maternal and infant deaths still remains a challenge to be overcome.[1]

In Brazil, many emergency and emergency services coexist with extensive queues in which people dispute service without risk criteria, taking into account only the order of arrival. This situation results in low satisfaction of users, since the rationality of the actions prioritized in the attendances, added to the requirements of accelerated pace and intensification of the do due to the overcrowding, have propitiated dehumanized interactions in the service.[2-3]

In an attempt to organize work processes, the Health Ministry, through the National Humanization Policy, proposes the implementation of Welcoming and Risk Classification as the main strategy to regulate the care process, where the nurses are the main players. The work of this professional in Welcoming and Risk Classification has been described as a result of the combination of theoretical and practical knowledge, involvement with public policies and organization of the work environment, associated to the concern with the reception of users and humanization of care.[4-5]

Therefore, it is important to emphasize Welcoming and Risk Classification in the obstetric and neonatal care services, which presents itself as a device that assumes peculiarities specific to the needs and demands related to the pregnancy process, with the main goal of reorganizing the door of entry and all services in deliveries.[1]

Hence, monitoring the trend and profile of obstetric care in Brazilian municipalities and health institutions is fundamental for addressing the main demands of this important sector of parturient and newborn health care, accepting that maternal characteristics such as age, schooling, occupation, marital status; and the neonatal conditions, such as birth weight, length of gestation and type of delivery, influence maternal and child health conditions.[6]

Based on this understanding, the present study aimed to evaluate the profile of women assisted in Welcoming and Risk Classification in a public maternity hospital from the central region of Alagoas State. The interest in this issue came about through the scarcity of scientific studies directed to the perspective of pregnant women as a social subject that must be perceived in a holistic way, according to their peculiarities during the welcoming and the risk classification.

In this sense, the relevance of working with this theme is justified by the fact that this study can subsidize professionals committed to obstetrics, especially nurses during prenatal care, in the planning and implementation of best practices and models of care in order to meet the women's needs.

METHODS

It is a descriptive, retrospective and documental study, which has a quantitative approach. The research was carried out in a public maternity hospital from the central region of *Alagoas* State, which is responsible for providing assiatnce to low and high-risk pregnant women from more than 50 municipalities that compose the central region of *Alagoas* State.

For the composition of the sample, a documented documentary survey was carried out, through medical records, obstetric care records and registration books, used during pregnancy and childbirth in 2013 and part of 2014. In total, 1,142 medical records were analysed from January to July 2015, with an average of 100 medical records per month.

For the data collection, a semi-structured form with identification data to characterize the sample and specific data about the service performed was elaborated. Data were collected after approval of the project by the Ethics and Research Committee from the *Universidade Federal de Alagoas (UFAL)*, under the process No. 22043213.0.0000.5013.

The variables used in the study were as follows: data collection form, age, origin, race/skin color, marital status,

schooling, gestations and parity of the patient, number of prenatal appointments, gestational trimester, previous cesarean section, risk classification and gestational age.

For the organization, tabulation, and analysis of the descriptive statistical data, the Microsoft Excel 2010 program was used. Descriptive analysis occurred from the absolute frequency (n) and percentage (F%) and the results were presented in a descriptive way and using tables to do so.

RESULTS AND DISCUSSION

From the 1,142 (100%) medical records analyzed, 698 (61.1%) were incomplete; 444 (38.9%) were partially filled up with the data, in other words, essential data about the identification of the woman patient, from diagnosis to risk classification were missing.

Table 1 shows the women's socio-demographic data during the study period.

Table 1 –Socio-demographic profile of the women assisted by a maternity from the central region of Alagoas State. Maceió, Alagoas, Brazil, 2015.

Socio-demographic data	n	%
Age group (years)		
20-29	598	52.4
14-19	285	25.0
30-39	221	19.3
40-49	36	3.1
50 or more	1	0.1
Not informed	1	0.1
Marital status		
Common-law marriage	577	50.5
Married	350	30.7
Single	191	16.7
Widow	5	0.4
Divorced	4	0.4
Not informed	15	1.3
Race/skin color		
Brown	1,091	95.5
White	20	1.8
Indian	10	0.9
Black	7	0.6
Yellow	1	0.1
Not informed	13	1.1
Schooling		
Elementary School II (5th - 8th grade)	505	44.2
High School	285	25.0
Elementary School I (1st - 4th grade)	208	18.2
Illiterate	47	4.2
Completed College	36	3.1
Uncompleted College	25	2.2
Not informed	36	3.1
Origin		
Arapiraca city	629	55.1
Another cities in *Alagoas* State	510	44.6
Not informed	3	0.3
TOTAL	1,142	100

Source: Research data.

In regards to the current gestational age, the survey revealed that at the time the women were attended more than half 773 (67.7%) were in the third trimester (from 28 to 41 weeks and 6 days. Another relevant fact was the lack of records about the Gestational Age (GA), with 190 (16.6%) occurrences, as described in **Table 2**.

Table 2 – Obstetric data of the women assisted by a maternity from the central region of Alagoas State. Maceió, Alagoas, Brazil, 2015.

Obstetric data	n	%
Gestational trimester		
3rd trimester	773	67.7
2nd trimester	97	8.5
1st trimester	82	7.2
Not informed	190	16.6
Parity		
None	447	39.1
First time	303	26.5
Second time	158	13.8
Third time	70	6.1
Multiple times	52	4.6
Not informed	112	9.9
TOTAL	1,142	100
Number of previous abortions		
None	855	74.9
1	139	12.2
2	23	2.0
3 or more	13	1.1
Not informed	112	9.8
Previous cesarean section		
Present	159	13.9
Absent	686	60.1
Not informed	297	26.0
Pregnacy type		
One baby	1,132	99.1
Multiple	10	0.9
Not informed	0	0.0
Number of prenatal appointments		
7 or more	459	40.2
1 to 5	426	37.3
6	204	17.9
Did not have prenatal care	49	4.3
Not informed	4	0.3
Period of the prenatal onset		
1st trimester	822	72.0
2nd trimester	147	12.9
3rd trimester	10	0.8
Not informed	163	14.3
Risk classification		
Green risk (not very urgent)	353	30.9
Blue risk (not urgent)	231	20.2
Yellow risk (urgent)	164	14.4
Orange risk (very urgent)	37	3.2
Red risk (immediate care)	13	1.1
Not informed	344	30.2
TOTAL	1,142	100

Source: Research data.

Another important finding was the expressive quantitative of 344 women (30.2%), with no information about the risk classification. This made it difficult to carry out a more precise analysis of this variable. It is important to highlight the main complaints that were reported by the women during the care services provided (**Table 3**).

Tabela 3 – Obstetric data related to risk classification of the women assisted by a maternity from the central region of *Alagoas* State. *Maceió, Alagoas*, Brazil, 2015.

Obstetric data	n	%
Risk Classification		
Green risk (not very urgent)	353	30.9
Blue risk (not urgent)	231	20.2
Yellow risk (urgent)	164	14.4
Orange risk (very urgent)	37	3.2
Red risk (immediate care)	13	1.1
Not informed	344	30.2
TOTAL	1,142	100

Source: Research data.

Considering that the maternal age of less than 15 and over 35 years old offers a higher gestational risk and allows prenatal care by the primary care team, it has been shown that the profile of the women in the study is defined as a young population with Ideal age group (from 20 to 29 years old) for procreation.[7]

Birth conditions are determinant for a child's health, and these conditions can be strongly influenced by maternal age. It is known that pregnancy occurring both in adolescence and in later ages of the female reproductive period can be considered as worrying and deserving attention due to the possible consequences both on maternal health and health indicators of the infant, in other words, concerning the perinatal conditions.[8]

Therefore, it is understood that reproductive age is a priority issue for public health and that adequate family planning with reduction of unwanted pregnancies and greater promotion of educational activities during prenatal care may significantly interfere with the increase of gestational risks.

Regarding the marital situation, it was shown that the majority of women lived in a consensual union. Nevertheless, it is emphasized that, at the time of the nursing consultation, no document is required that proves the marital status of the woman, and may be omitted from the true marital situation because they consider a stable marital union as a marriage. The safe marital status is considered a factor that reduces the possibility of the appearance of gestational complications, indicating that the presence of the father should be stimulated during the consultation and group activities to prepare the couple for childbirth.[7,9]

When reporting the race/skin color variable, having brown skin color predominated in this study. A relevant data on the racial question is that, in Brazil, from 2000 to 2009, it was observed that 7,064 cases of hypertensive and hemorrhagic diseases were registered in women of color/brown skin color, representing 42.74% of Brazilian maternal deaths.[10]

Based on the place of origin, the study pointed out a larger number of pregnant women from *Arapiraca* city. It is worth emphasizing that there was a significant demand from women from another cities in *Alagoas* State, which can be justified by the fact that the local hospital is a reference for the second macro-region of *Alagoas* State and for the surrounding municipalities, besides providing a range of specialized services that they can supply the clientele' needs.

Concerning the educational level, there was a greater predominance of women who reached an average of studies less than nine years. Nonetheless, the Health Ministry classifies the period less than five years as a gestational risk factor.[7]

Moreover, the predominance of women with more study time tends to reduce the probability of developing serious morbidities and maternal death due to preventable causes, since the higher the maternal level of education the greater the number of prenatal appointments performed, which is a factor that increases the chance of early detection and treatment of morbidities.[7] It is therefore relevant that nursing analyze the level of education of these pregnant women since it can influence the understanding of the information provided during the consultation, including the life habits.[11]

In relation to the profession, the study revealed that the vast majority of women were farmers. During pregnancy, the heavy workload and tiring physical activities performed by pregnant women may be related to the emergence of restricted intrauterine growth and premature delivery.[12]

By the time they were seen at the Welcoming and Risk Classification, most women were pregnant for the first time. This finding reflects the importance of nursing consultations for this group since it is through them that women will know all aspects of gestation, following the growth and development of the fetus, and experiencing the preparation for the process of the first childbirth. Knowledge about the number of pregnancies is essential since women with a high number (five or more) have a higher risk of maternal morbidity and mortality.[13-14]

When parity was analyzed, a greater prevalence of nulliparity was obtained, being characterized by the Health Ministry as a gestational risk factor for women. The incidence of pre-eclampsia is influenced by parity, in other words, nulliparas are at higher risk (7 to 10%) compared to multiparous ones.[7,15]

Gestation is a special event in a woman's life and often the feeling of being a mother is permeated by uncertainties and insecurities. The transformations experienced in the gestational period are novelties, especially for nulliparous pregnant women, and doubts related to the types of births usually become a dilemma. With the evolution of full-term pregnancy, the fear of the unknown associated with the lack of correct information often precipitates the choice for a surgical delivery.[16] It is worth mentioning that the large multiparity is also a condition that increases the chances of damages during gestation. Multiparous women either do not

carry on or do not attend all prenatal visits because they feel safe and supported by previous experiences.[17-18]

In regards to the existence of previous abortions, the study showed that a higher percentage of women did not have antecedents for such. This data is similar to a cross-sectional study carried out in São Paulo on the prevalence and characteristics of women with abortion who have a history of gestation. It was shown that among the 555 women who became pregnant, 380 (68.5%) reported never having had any type of abortion. The existence of previous abortion is pointed out, though in another study, as a risk factor for low birth weight.[19-20]

Observing the previous delivery type, it was observed that most of the women did not present obstetric history of a previous cesarean section. In order for women to be able to choose the best type of delivery appropriately, according to their health condition, beliefs, and personal values, it is essential that they feel fully informed.[16]

It is important to emphasize that by disregarding the indicative clinical situations for a cesarean section, mothers undergo unnecessary risks, and result in a slower recovery, increase spending on hospitalizations and medications, conditions that are not present when childbirth happens by vaginal delivery.[16]

Concerning the type of gestation, the study showed that single pregnancy had a higher prevalence among women. One important fact that called attention was the complete filling of information in the risk classification card, which contributed to a differential analysis of the variable under examination.

The occurrence of preterm birth is the major impact factor in perinatal mortality and short- and long-term morbidity in multiple pregnancies. Up to 48% of newborn infants born to twin pregnancies are born before 34 weeks, compared to 9.7% of those born from single pregnancies.[7]

Considering the number of prenatal appointments, it was shown that most of the women managed to reach a significant amount, which implies lower maternal risks. However, although early prenatal initiation is essential for adequate perinatal care, the ideal number of consultations remains controversial.[8]

A study published in 2013 showed an increase in perinatal mortality in prenatal care with a reduced number of appointments, indicating the importance of end-of-pregnancy surveillance (32 to 36 weeks) to identify risk situations and guarantee specific interventions.[21]

It is worth emphasizing that, in the South, Southeast and Center-West regions of Brazil, in the period from February 2011 to October 2012, 75.6% of the pregnant women with the highest age and schooling were attended by a medical professional. On the other hand, in the North and Northeast regions, half of the women with three or more pregnancies and previous negative outcomes were attended to a greater extent by nurses, when compared to those with fewer gestations and with no negative outcomes.[22]

Furthermore, it was verified that the majority of the consultations were carried out in public establishments, being the prenatal accomplishment in these services more frequent in residents in the North and Northeast regions, in women of smaller age and schooling, black or indigenous race/skin color, with no partner, with more pregnancies and with previous negative outcomes.[22]

It was shown that most of the women in the study started prenatal care in the first trimester. This finding becomes relevant for obstetric care, considering that the Health Ministry recommends the early intake of women in the prenatal period, so that appropriate interventions during the gestational period can be performed, whether preventive or therapeutic.

According to the Manchester protocol, a large part of the female population presented a less urgent risk. Considering that the study was carried out in a hospital specialized in the care of high-risk pregnancies, this result reflected an inadequate demand for the complexity level of the hospital institution.[9,20]

In Brazil, the reference and the counter-referral system is still in deficit and there is much to be done in relation to access to referral services in obstetric complications. Achieving this ideal condition is a determining factor for the significant difference in the containment of high maternal mortality rates due to direct causes and, consequently, the reduction of vital indicators in the country. Therefore, it is necessary to reorganize the women's care network in the puerperal pregnancy cycle and its attachment to maternity, with the purpose of adjusting the service profile of these clients and ensuring a decisive and responsible assistance.[20,23]

In this perception, the welcoming, in its various dimensions, triggers a series of transformations in the work process, in the relationships established in care spaces and in the organization of health services that provide care to the population.[24]

In the organization of the care services flow, according to the severity or aggravation of the complaint presented by the patient, the role played by the nurse who, exercising her leadership, emerges as the protagonist at the door of the emergency services becomes notorious. It is considered that this role is pertinent to him since his professional training covers not only technical and biological questions, but also social and emotional aspects, that allow a practice that is welcoming and responsive to the needs of the people.[25]

The humanized care performed by the nursing professional, respecting the time of each woman, facilitates the clarification of doubts and the learning in relation to the process of gestating and giving birth. The differential in the care of the obstetrician nurse is in welcoming women respecting the rights of the pregnant woman as a citizen and assisting in the process of health education, valuing attentive listening. It is worth emphasizing that the use of the obstetrical records during the consultation facilitates the quick access to the main information about the pregnant woman, then speeding up

during the attendance and even beyond the scheduled time the identification of problems for the decision making.[26-27]

CONCLUSIONS

Based on the results analysed, the profile of women assisted by a maternity from the central region of Alagoas State showed that the female population, in its majority, has shown the following characteristics: major concentration within the age group from 20 to 29 years old; living in consensual union; presenting brown skin color; having low schooling levels; being in the third trimester of pregnancy; being primiparous and nulliparous; having no abortion and cesarean history; having a pregnancy type of one baby; performing seven or more prenatal appointments with early onset in the first trimester; and they were classified as not very urgent.

It should be noted that this study made possible a more critical and singular look at the socio-demographic and obstetric characteristics of the female population. In this context, the implementation of the Welcoming and Risk Classification appears as a new care model that inserts the health professional as the main protagonist in the clinical decision-making process, and also allows providing important information for the primary health care of the pregnant woman.

Furthermore, it is relevant to emphasize the importance of having a reliable record of the information about the women obtained during the Welcoming and Risk Classification, in order to make it possible to know the particularities of the assisted clientele, as well as their individual needs and risk factors that deserve attention in the pregnancy period.

According to the aforementioned, the obtained profile demonstrated that these findings from the Welcoming and Risk Classification corroborate with those of the scientific literature and can provide subsidies for the practice of health professionals during the prenatal care. This amis to increase educational actions that take into account the peculiarities and specific needs of women, then providing not only the prevention of future problems, but also a better quality of both gestational and parturitive periods.

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