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RESEARCH

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PERCEPTION OF USERS OF AN EMERGENCY 24 HOUR SERVICE OF RISK CLASSIFICATION

Percepção de usuários de um pronto atendimento 24 horas acerca da classificação de risco

Percepción de usuarios de un listo atención 24 horas acerca de la clasificación de riesgo

Mariana Pellegrini Cesar[1], Silomar Ilha[2], Vagner Costa Pereira[3], Paloma Horbach da Rosa[4], Daniela Buriol[5], Rosiane Filipin Rangel[6]

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ABSTRACT

Objective: to comprehend the viewpoint of users of a 24-hour Emergency Care Unit of risk classification. Method: this is a qualitative research of an exploratory-descriptive character. The investigation was conducted in a 24-hour Emergency Care Unit in the months of June and July 2018, with 12 users of the service. Data were collected through a semi-structured interview, and subsequently they were submitted to content thematic analysis. Results: it has allowed us to identify two categories of analysis: Reasons for the search of emergency care as the first choice and Risk classification: a gap in the knowledge of users. We note that the knowledge that the users have on the emergency care service is scarce and that risk classification is one of knowledge gaps. Conclusion: this issue needs to be analysed further in order to enable us to organize health services.

Keywords: User reception; Triage; Emergencies; Nursing; Health services.

1 Nurse at the Federal University of Santa Maria (UFSM). Specialist in Trauma Urgency from the Franciscan University (UFN). Master student, Graduate Program in Nursing, Federal University of Santa Maria (PPGEnf / UFSM) - CAPES Scholarship.

2 Nurse at the Franciscan University (UFN). PhD in Nursing, Graduate Program in Nursing, Federal University of Rio Grande (PPGEnf / FURG). Specialist in Urgency, Emergency and Trauma from the Faculties of Applied Social Sciences (FACISA / CELER) and Specialist in Gerontology and Mental Health from Candido Mendes University (UCAM). Professor at the Franciscan University (UFN).

3 Nurse at the Integrated College of Santa Maria (FISMA). ICU Specialist from Cândido Mendes University (UCAMPROMINAS). Nurse in charge of the Emergency Care Unit (UPA 24h), Santa Maria and Preceptor of the Emergency / Trauma Residency of the Franciscan University (UFN)

4 Nurse at the Federal University of Santa Maria (UFSM). Specialist in Trauma Urgency from the Franciscan University (UFN). Master student, Graduate Program in Nursing, Federal University of Santa Maria (PPGEnf / UFSM) - CAPES Scholarship.

5 Nurse at the Federal University of Santa Maria (UFSM). Specialist in Trauma Urgency from the Franciscan University (UFN). Master student, Graduate Program in Nursing, Federal University of Santa Maria (PPGEnf / UFSM) - CAPES Scholarship.

6 Nurse at the Franciscan University (UFN). PhD in Nursing, Graduate Program in Nursing, Federal University of Rio Grande (PPGEnf/ FURG). Specialist in Neonatology Nursing at the São Camilo Educational Center. Professor at the Franciscan University (UFN).

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RESUMO

Objetivo: compreender o que os usuários de uma Unidade de Pronto Atendimento 24 horas entendem por classificação de risco. Método: pesquisa de abordagem qualitativa, de caráter exploratório-descritivo. A investigação foi realizada em uma Unidade de Pronto Atendimento 24 horas nos meses de junho e julho de 2018, com 12 usuários do serviço. Os dados foram coletados por meio de uma entrevista semiestruturada e após foram submetidos a análise temática de conteúdo. Resultados: possibilitaram a construção de duas categorias: Motivos para a procura do pronto atendimento como primeira escolha e Classificação de risco: uma lacuna do conhecimento dos usuários. Pode-se perceber que o conhecimento que os usuários possuem sobre o serviço de pronto atendimento é escasso e a classificação de risco se apresenta como uma lacuna no conhecimento. Conclusão: este assunto precisa ser trabalhado para que seja possível a organização dos serviços de saúde.

Descritores: Acolhimento; Triagem; Emergências; Enfermagem; Serviços de saúde.

RESUMEN

Objetivo: compreender lo que los usuarios de una Unidad de Atención de Emergencia 24 horas entienden por clasificación de riesgo. Método: investigación com enfoque cualitativo, de carácter exploratorio-descriptivo. La investigación se realizó en una Unidad de Atención de Emergencia 24 horas en los meses de junio y julio de 2018, con 12 usuarios del servicio. Los datos se recopilaron mediante una entrevista semiestructurada y después se sometieron al análisis temático de contenido. Resultados: fue posible construirse dos categorías: Razones para la demanda de la atención de emergência como primera opción y Clasificación de riesgo: una laguna del conocimiento de los usuarios. Se puede percibir que el conocimiento que los usuarios poseen sobre el servicio de atención de emergencias exiguo y la clasificación de riesgo se muestra como una laguna en el conocimiento. Conclusión: este assunto necesita ser trabajado para que sea posible la organización de los servicios de salud.

Descriptores: Acogimiento; Triage; Urgencias médicas; Enfermería; Servicios de salud.

INTRODUCTION

Emergency services are an important component of healthcare in Brazil, serving as a point of entry for users in the Unified Health System (SUS) [1]. The reality of overcrowding of emergency services is compounded by organizational problems such as care by order of arrival without establishing clinical criteria. In view of this reality, the Ministry of Health has defined strategies aimed at organizing services, among them, the National Humanization Policy (PNH) [2], created in 2003, aimed at improving users' access to health services. This policy seeks to replace the traditional approach to care, characterized by queues and treatment in order of arrival, with reception that includes risk assessment and classification, as means of improving change in the work of attention and health production, especially in emergency services.

Currently, the emergency services gateway has been mistakenly recognized by users as the first choice of care, even in situations that are not characterized as urgency or emergency.[3-5] This fact generates overcrowding, fragmented care, among other factors that interfere with the quality of care.[5-7]

Risk classification is a fundamental part of clinical risk management in all services when the demand for care exceeds available resources. In emergency services, it is used to define a clinical priority, to signal care flows, to monitor care lines, and to highlight the need for human, administrative, physical, and material adequacy.[8] According to the Manchester Protocol, the priorities Clinics can be classified into five colors that determine the time required for user care: Red (Emerging - 0 minutes); Orange (Very Urgent - up to 10 minutes); Yellow (Urgent - 60 minutes); Green (Little Urgent - up to 120 minutes); Blue (Not Urgent - up to 240 minutes). 9th

According to Ordinance No. 10 of January 3, 2017, 10 which redefines the care model and funding guidelines of the Emergency Care Unit (UPA 24 hours) as a component of the Emergency Care Network, the risk classification is understood as a clinical decision support tool. It has a protocol format, with universal language for clinical and traumatic emergencies, which should be used by qualified higher education professionals (nurses or doctors), in order to identify the severity of the user and allow prompt, timely care. and safe according to risk potential and based on scientific evidence.[7,9]

There are different Risk Rating systems in the country, but the most used is the Manchester (SCRM), created in 1994 in England. In 1998 its use was recommended in hospitals in the United Kingdom, from 1999 it began to be used in Portugal and in 2007 it was introduced in Brazil, in a project of the Minas Gerais Department of Health. Then came the Brazilian Risk Classification Group, responsible for the disclosure, training, implementation, maintenance, audit and assurance of the medical control of the protocol in Brazil.9

Despite the SUS proposal for hierarchical and regionalized care, 1 medium- and high-complexity emergency services are faced with long queues daily to assist users. The UPA 24h has a high demand, sometimes the waiting time for medical care can be long, which generates dissatisfaction and questions by users. Factors of this nature constitute strong barriers to quality because they require high financial investments, great effort of managers and workers and, especially, users' commitment to understand the processes that involve the health care network.[3,6,11]

Given the above, the question is: what do users of a 24-hour Emergency Service understand by risk classification? In the search for answers to the question, the objective of the study was to understand what users of a 24-hour Emergency Care Unit understand as risk classification.

METHOD

Exploratory-descriptive study with a qualitative approach, developed in a 24-hour UPA, located in the central region of the state of Rio Grande do Sul. The study participants were 12 SUS users who sought the referred unit for care. Their choice was made by convenience, with proportionality between the morning, afternoon and evening shifts. These were addressed after the risk classification, during the waiting time for the medical appointment. The number of participants was determined by the need for information and the quality of the data produced, and with 12 participants, recurrence and complementarity of information about the object of study was achieved.[12]

Inclusion criteria were: 18 years or older and classified as green in the Manchester protocol, due to the waiting time criterion (up to 120 min) and the fact that these patients had a clinic of low urgency.

Data collection was performed between June and July 2018, through a semi-structured interview, consisting in the first part of a sociodemographic questionnaire of the participants, in order to trace their profile. And the second part formed by questions about the theme.

The interviews were recorded by digital recorder and later transcribed. The data were analyzed by thematic content analysis [13], from the three phases that compose it: pre-analysis, when the floating reading of the material was made, taking contact of its structure. Soon the constitution of the Corpus occurred, considering the completeness, representativeness, homogeneity and pertinence. In the second phase of the analysis, the in-depth reading of the analyzed material was performed, with a view to meeting categories for further classification and aggregation of data. And finally, in the third phase, the treatment of the results and interpretation of the data were performed.[13]

The ethical and legal precepts were maintained, according to CNS Resolution No. 466/2012. The project was approved by the Research Ethics Committee of the Franciscan University on May 08, 2018, under opinion 449,662 and CAAE: 88025718.1.0000.5306. Participants signed the Informed Consent Form (FICF) in two ways, one was with the participant and the other with the researchers. To maintain the anonymity of the participants, they were identified by the letter "U" of the user, followed by a number according to the order of interviews U1, U2 ... U12.

RESULTS

Of the 12 participants, nine (75%) were female and three (25%) male. Ages ranged from 18 to 54 years. The level of education was: one (8.3%) incomplete elementary school, four (33.3%) incomplete high school, five (41.6%) complete high school and two (16.6%) complete higher education. After analysis of the results, two categories emerged. Reasons for seeking emergency care as a first choice; and Risk rating: a gap in users' knowledge.

Reasons for seeking prompt care as a first choice

Given the results obtained, the understanding of the majority of users interviewed about the emergency service is presented in the following statements:

> *Ready Service, you get there and will be attended right! On time in case.* (U1)

> *An urgent care. Immediate service.* (U4)

> *A quick service right? A service that should be quick for the people.* (U6)

> *So it's something to be solved now, [...] have some cure for my problem relatively quickly.* (U9)

According to the speeches presented, it is possible to perceive an important knowledge that users have about the operation of an emergency care unit as an immediate service, this knowledge is important because when it comes to an emergency service, time is life. On the other hand, it can be seen as the obligation of agility in care, regardless of the cause or demand presented by the patient. However, it is known that only urgent or emerging cases will have this brevity in care regardless of the flow of the unit. This factor that can lead to user dissatisfaction, when it presents a simpler case or without urgency, its attendance may not be so short, depending on the demand of the service.

There were also speeches of users who referred to the UPA as a "stabilization", or as a quick consultation to be referred to the specialist doctor later, relevant data, since it demonstrates the users' knowledge about the operation of an emergency service.

> *But then I need to make an appointment to know what this pain I really feel is.* (U11)

> *People will make a simple consultation and then depending on the condition are referred to a specialist or something, also to stabilize patients.* (U10)

In addition, the UPA appears as "a place to go when there is no other option", or time to wait for some kind of consultation, presents to the user as the opportunity to have care with a

clinical doctor when primary care is not available. can meet the demands of this patient.

> *When you don't have another place to go and then you come here straight. Because usually we go to the station, but then it has to dawn. I'm not in so much pain, just for me not to wait until tomorrow in case for the post.* (U1)

> *I can't schedule a normal doctor's appointment for a thousand years from now.* (U9)

> *Because it's the only place you have to help others.* (U5)

The statements above show that users sometimes have information that their care could be performed in a primary care service, however, because they are unable to access the doctor of the service or have their problem solved, end up looking for the UPA.

One study participant referred to the UPA as a disease prevention service, a factor that should be associated with primary health care, this demonstrates the gap in popular knowledge about SUS hierarchization.

> *We have something, we have to look for the emergency care, before something more serious happens.* (U3)

It is noticed that the knowledge about the emergency service is sometimes understood by users, but the health system still has weaknesses that make it difficult or impossible for its demand to be met at the destination. In view of this, the risk classification is performed in order to organize care among those patients with urgency or non-urgency, however, this process presents itself as a difficulty for users to understand.

Risk rating: a user knowledge gap

Regarding the understanding of risk classification, users reported as a first assessment to be made, to rate the patient's priority over other users who also have important complaints.

> *To give priority to the service.* (U7)

> *Classification according to the severity of the person's problem.* (U10)

> *Risk classification is a classification that doctors, nurses and technicians have to do, it is an orientation, [...] you have something very serious, you will be attended first.* (U2)

Regarding the data presented above, the findings are important, as the interviewed users recognize the risk classification process performed by nurses and its functionality.

On the other hand, in the following statements, it can be seen that the risk classification is still seen as a "screening", in the sense that there is no scientific knowledge about the patient's complaint and assessment. It is rather an "information gathering" to be passed on to the doctor later.

> *A screening, just for an evaluation to pass to the doctor.* (U8)

> *So I understand it's a screening right?* (U9)

Still, one can notice the lack of knowledge about the care provided. The following users have a poor understanding of the risk classification performed by nurses, the process is understood as a step that has no use in the care of patients in the unit.

> I understand that it is worth nothing there, it is just there, there are people who get there needing much more service and others pass in front, I think that there is worth nothing. (U7)

> *Make a form of the person.* (U5)

Thus, it is understood that although some of the users have important knowledge about the risk classification process, there are still gaps in the knowledge of some of the respondents about the risk classification and its role in the urgency and emergency service. This factor, which can lead to user dissatisfaction with the service, or even unwillingness of them with the team because they do not understand the ordering of waiting time for medical care.

DISCUSSION

Users interviewed referred to the UPA as rapid care, which performs stabilization of patients, which meets the National Emergency Care Policy, 14 which regulates 24-hour UPA and the set of 24-hour non-hospital Emergency Services.

Given the lines presented in the study, it is believed that a determining factor in choosing the user to be attended at 24-hour UPA is the need to want medical care regardless of the waiting time, although they have the knowledge that their clinical condition is not fits this type of service. These data are similar to the results obtained in other similar surveys, in which users who are likely to be served in less complex services seek to solve their problems in emergency services. This may be associated with the possibility of higher resolution compared to primary care, as well as factors related to access, convenience and costs for using these services.[4,11,15]

Another factor is that primary care cannot keep up with demand, with schedules often overcrowded, restricting the medical care of users. It is similar to the results obtained in previous research carried out at 24h PACUs, [5,11,15] which cite the failure of primary care as one of the reasons why urgency and emergency services are increasingly sought. And with this, consequently, there is a growing demand in these places, which generates overcrowding, and thus the precariousness of services.

In addition, the term "risk rating" was associated with "screening" mistakenly. According to the PNH, [2] in the risk classification there is an analysis (evaluation) and an ordering (classification) of the need, moving away from the traditional concept of screening and its exclusion practices, since all will be met.

It is also important to highlight that the accomplishment of this classification is not a simple activity, but it depends on the scientific knowledge of nurses and their professional skills and competences, a subject also discussed in a study that exposes the need for training not only for professionals responsible for nursing care. This process, but for all staff working in urgency and emergency.[7] The Manchester Protocol is a tool that ensures determination and agility in care, from the perspective of pre-established protocols, which will depend on the degree of need of each user, providing attention focused directly on the level of complexity of users.[2]

Thus, it is necessary to train professionals regarding the clarification of the service to users about the risk classification. Users' poor knowledge of the Risk Classification process can have bad consequences, such as interpersonal conflicts between the patient and the staff working on the Risk Classification or service.[15]

The study had limitations regarding its sample size, firstly due to the repeatability of the data obtained and also due to the flow and the demand of the unit. In some busy periods there were no rooms available to preserve the privacy of respondents to collect, while in times of less busy service, users were classified and directly referred for medical consultation, resulting in lack of opportunity to conduct the interview, which should take place immediately after the risk rating process.

CONCLUSION

The study showed that users of the service have important knowledge about urgency and emergency services. Another important factor is that the misuse of this service highlights the fragility in another sphere of care of the health system. Delay for medical attention in primary health care causes users to submit to a classification that has knowledge of the waiting time, but will receive medical care, a factor that contributes to overcrowding and lack of human resources. materials in emergency services.

It was possible to notice that the users have a restricted knowledge about the risk classification, since most of the interviewees had difficulty understanding the concept and the purpose of the reception with risk classification that is recommended by the National Humanization Policy. Sometimes this ignorance can end up generating user discontent and friction with the staff for the delay in care.

The study has limitations because the qualitative approach deals with the subjectivity of the local reality and cannot generalize the results found. Therefore, it is necessary to carry out exploratory research with the population of different realities. In addition, there is a need for actions that include continuing education and training of professionals, especially nurses, as they are responsible for the risk classification process, so that they are qualified to provide adequate guidance on the classification process. risk while performing the same. Thus, educational actions with users on the operation and ordering of care in urgency and emergency services are performed.

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Corresponding author
Mariana Pellegrini Cesar
Address: Rua das Violetas, 56, Patronato
Santa Maria/RS, Brazil
Zip code: 97.020-720
E-mail address: marianapcesar@hotmail.com
Telephone number: +55 (55) 99939-5183

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