Perception of nurses about the risk assessment of the low complexity non-referred user

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ABSTRACT. The goal of this study was to assess the perceptions and behaviors of nurses who provide triage with risk assessment to low complexity non-referred patients. The participants of the study were nurses who were performing patients' triage with risk assessment, and the sample consisted of thirteen participants. The instruments used for the interviews were semi-structured questionnaires related to the characterization of the topic under study. Content analysis, i.e., the method proposed by Bardin, was used for data analysis. For data organization, we used MAXQDA Analytics Pro 2018, a software program that favored the identification between the similarities of the elements and ideas, thus making it possible to reach the cores of meanings. The identified categories were: (a) understanding about the healthcare provided by the emergency/urgency care Network; (b) evaluation of patient triage with risk classification; and (c) difficulties/challenges observed at the institution when providing user assessment with risk classification. It is concluded that nurses' perceptions regarding the topic under study were linked to the disarticulation of the healthcare Network, the fragility of the relationship between physicians and nurses, and the lack of use of institutional protocols.

Keywords: emergency nursing; emergency hospital service; user assessment; triage.

Introduction

In Brazil, there were more than nine million intrahospital attendance in emergency services in 2018, with approximately 1.7 million in the state of São Paulo and around 46,639 thousand visits in DRS XI, which comprises the regions of Alta Paulista, Alta Sorocabana, Alto Capivari, Extremo Oeste Paulista and Pontal do Parapanema (*Departamento de Informática do SUS* [DATASUS], 2019).

The Network that underlies the care line of these services is the Urgency and Emergency Network (RUE), which was established by the Ministry of Health Ordinance Nº. 1,600, July 7, 2011, which main objective was to integrate in an articulated manner all health services, aiming to expand and improve the full and humanized access to people in urgent and emergency situations in health services, in an agile and relevant way, throughout the national territory, considering the epidemiological and demographic regional criteria (Moura, Carvalho, & Silva, 2018).

This ordinance also brings the care lines of the Urgency and Emergency Network *(Rede de Urgência e Emergência* - RUE), which meets different conditions (clinical, surgical, traumatological, mental health, among others). The Network consists of the following components: Primary Health Care; Mobile Emergency Care Service *(Serviço de Atendimento Móvel de Urgência* - SAMU 192); Emergency Medical Regulation Center; Stability Room; Emergency Care Units (24-hour UPA – *Unidade de Pronto Atendimento*); Public National Health Force *(Sistema Único de Saúde* - SUS); Hospital; Home Care (Brazil, 2011).

At the beginning of the 21st century, the Ministry of Health invested in the proposal of humanization in health services, and since then, the risk assessment of the user was inserted in urgent and emergency services. This classification system aims to assess the user on their arrival, humanize the service, classify the user according to the severity of the clinical case, decongest the service, reduce the waiting time for medical care and determine the primary care area (Brazil, 2013a).

Carmo and Souza (2018, p. 1082) refer that

[...] the nurse has been the professional responsible for carrying out the risk classification, as its training is focused on assistance in a holistic way, meeting the physical, psychological and social needs, that is, knowing how to see the patient as a whole.

The Resolution nº 423/2012 of the Federal Nursing Council (*Conselho Federal de Enfermagem* [COFEN], 2012), about nursing consultation, states that nurses have legal support for the assignments of risk classification.

The National Policy of Attention to Urgencies (*Política Nacional de Atenção às Urgências* - PNAU) advises that users with acute conditions should be attended in all entry points of SUS health services, in a full and responsible manner, and be referred to services of greater complexity when necessary (Brazil, 2006). However, according to several studies, what happens is the overcrowding of hospital emergency services (*Serviços de Emergência Hospitalar* - SEH) with cases that should be treated at another level of the Network. In this way, the waiting lines are aggravated by problems of organizational origin, and the primary evaluation of users without clinical criteria can generate unnecessary complications in the patient's condition, and even deaths that would be preventable (Carmo & Souza, 2018).

Moreover, some users seek SEH to solve acute cases of low complexity, which are considered as non-emergency. Many times, the users seek this service because they were unable to receive care or because their access was denied elsewhere in the Network. In addition, they might have been attended in an unsatisfactorily, fragmented, and discontinued way in another service. Consequently, the hospital ends up overloaded, which impairs the flow and quality of care.

Thus, this study outlined the following question: What is the perception of the nurse who performs the risk assessment of the low complexity non-referred user in a hospital which is reference in Urgency and Emergency?

This research aimed to investigate the perceptions of nurses who perform risk classification of low complexity non-referred patients.

Methodology

This is a qualitative study, and covers relationships, attitudes, beliefs, habits and representations of socially generated phenomena (Minayo, Deslandes, & Gomes, 2012). From this perspective, the intention was to understand and interpret reality, which are covered with subjectivity.

The data were collected in a public hospital in Oeste Paulista, a tertiary complexity unit that is reference for 45 municipalities in DRS XI region, and it has as its care line the health of women, children, adults, the elderly and mental health. Approximately eight thousand patients are seen per month in the urgency and emergency service, and such treatments are referenced and classified according to the severity.

Data collection was carried out during November 2018, with thirteen nurses who work in the risk assessment service. The thirteen nurses met the inclusion criteria for this study, which were: be a nurse in the urgency and emergency sector; act in the risk assessment field for at least six months; accept to participate in the research; and sign the Informed Consent Form.

The following amount of nurses were excluded from the study: one nurse from another sector who was replacing vacation of another nurse, two nurses who were on a sick leave, 1 nurse who was on vacation, three nurses who had less than 6 months of experience, and three nurses who did come for the interview after at least two scheduling attempts.

The nurses were personally invited in advance, and then the interview was scheduled. The meeting was held in a private room located at the workplace. The research subjects were instructed on the objectives, methodology, guarantee of confidentiality, and freedom to not accept or withdraw from the study at any time.

After obtaining consent, the researcher also requested the authorization to record the interview on audio, using a recorder, with subsequent transcription, to allow the reliability of the collected material.

Five semi-structured questions were asked for interview, which are: what is your understanding about the lines of care of the urgency and emergency network? How does the reception of the non-referred user with acute low complexity condition occurs? What difficulties/weaknesses do you encounter in the service to develop the reception of the non-referred user with acute low complexity condition? What positive points do you find in this reception? What negative aspects do you find in this service? What pertinent strategies do you think would facilitate, expand and organize the user's path in their access to SUS?

In order to test and calibrate the questionnaire, two pilot interviews were applied with nurses who work in the intermediate level and perform the risk classification service using the Manchester protocol. The interview was previously scheduled and individually performed in a quiet and comfortable place.

Aiming to preserve the identity of the interviewees, they were numbered and identified with the letter E (E1, E2, E3 and E4).

For data analysis, we used the Content Analysis technique, a thematic modality proposed by Bardin (2011). The analysis process started with reading the nurses' narratives with the intention of identifying regularities and peculiar experiences through the implicit meanings in the ideas described in the interviews. Then, an interpretative synthesis was elaborated, based on the confrontations, in the expressions, in the experiences and in the points of view of the interviewees. In this synthesis, the authors' interpretations of the content narrated by the nurses were critically incorporated, seeking to bring greater visibility to answer the research question. Finally, in the result's treatment phase, we performed the inferences and interpretation of results, discussing them based on the literature.

For data systematization, the authors used MAXQDA Analitycs Pro 2018 Software, which favored the identification between the similarities of elements and ideas, reaching the nuclei of meanings, which were grouped into significant themes.

The study was approved by the Research Ethics Committee of the institution under CAAE number: 97360118.0.0000.5515.

Results and discussion

Thirteen nurses participated in this study, of which ten (76.92%) were women and three (23%) were men. Regarding training time, at the time of the study, three (23%) had graduated from the college six years ago. About post-graduate studies, eleven (92%) of the interviewees had at least one specialty, with seven of them (58%) in the urgency and emergency field. Only four (30%) of them had a preparatory course to work with patients' risk assessment.

The interviewees' work experience as nurses was from five to seven years (23%), and in relation to their time working risk assessment, four of them were working in this field for four years (30%).

After processing the data, the nuclei of meanings were highlighted and combined in three sections/themes.

Understanding the care lines of the RUE:

The nurses identify the RUE care lines as an instrument that distinguishes the levels of care, which compromises primary, secondary and tertiary care.

> I understand that we have the first care, which is at the Basic Health Unit (*Unidade de Saúde Básica – UBS*); The second, which is in the emergency room, and the third, of medium complexity, which is in the hospital, which attends other medical specialties and tomography exams. (E3)

> Well, a patient will first enter in the Primary Care, where they will be attended and guided and, if necessary, be referred to Secondary Care. If this patient has an indication of being referred to the Tertiary care, which has the specialties, then they will be referred. (E4)

> Well, about Urgency and Emergency, I believe that urgency is about those patients who can wait 24 hours for medical conduct, and emergency about those who have to be attended immediately. (E8)

The literature shows that in addition to Primary, Secondary and Tertiary Care, the RUE also comprises Promotion and Prevention, Mobile Emergency Care Service (SAMU) - 192, Infirmaries and Intensive Care Units, technological innovations in the priority care lines and home care - Better at Home (*Melhor em casa*) (Brazil, 2011).

The National Hospital Care Policy (PNHOSP) through Ministry of Health Ordinance No. 3,390/2013, within the scope of SUS, states that "[...] hospitals are complex institutions, with specific technological density, of a multi-professional and interdisciplinary character, responsible for assisting users with acute and chronic conditions, which have the potential for instability and complications of their health status." (Brazil, 2013b).

Thus, the reports demonstrate a low understanding of the lines of care, which can interfere in the work process, in the reception, in identifying what is the nurse role within the triage with risk assessment, and in recognizing which interface the hospital will have to establish with the Health Care Network.

The triage nurses need to know where they are in the Network, in order to develop skills that guarantee technical-scientific competence, so they can to assess the patient's needs according to the complexity degree of their clinical condition.

Evaluation of triage with risk assessment

In this theme, the nurse's decision making in the risk assessment is analyzed, in which the evaluation of the complaint presented by the patient is associated with the verification of vital signs. Subsequently, the nurse refers to the physician on duty to discuss the cases that do not have a referral through the Health Offers and Services Regulation Center (*Central de Regulação de Ofertas e Serviços de Saúde* - CROSS). If authorized by the physician, the patient is admitted and has its file open. If not authorized, the nurse guides the patient to look for another health service, closest to their home. The following excerpts exemplify this process:

> First of all, we ask what's going on with the patient, we check vital signs and explain about the referral. Even when we do so, we talk to the physician before dismissing the patient. (E2)

> Evaluation criteria, pertinent questions of why they are looking for the unit, type of pain, the intensity of that pain, vital signs and whether it has changed or not, and the pathological history. (E1)

Nurses are responsible for classifying users who enter emergency services. Most workers are at the triage with risk assessment for more than a year, however, not much is observed about their autonomy (Brazil, 2009a).

Through reports, it is verified that the approach taken by nurses corroborates with literature, in which the triage professional must have an accurate hearing of the patient's complaint, assess the patient's vital signs and classify them according to the severity of their case (Brazil, 2009a). However, these professionals find it difficult to solve the problems of users who enter the Emergency Service.

> [...] if we had a physician with us, as in other protocols, we would have greater support to make a reference guide to the patient come back from here to there. (E13)

> Well, the great difficulty that we have, is that they arrive here without a reference guide and want the service, even though we explain and inform them how it works and where they have to go. Even so, the patient wants to be treated here, and they dosn't understand that here is only for Urgency and Emergency, and many cases that arrive here could be treated in Primary or Secondary Care. (E4)

It is noted that nurses encounter obstacles to develop care, and they refer that many medical professionals do not authorize, evaluate and sign a document justifying why the patient will not be attended. According to the Ministry of Health, and Federal Nursing Council Ordinance N°. 423/2012, nurses have legal support to perform the risk assessment, and can carry out the initial assessment of the patient. They also have the autonomy to determine which classification is necessary for each case. However, it can be observed that the services do not use institutional protocols correctly, which hinders the proper development of reception.

> The negative points are that, most of the time, they dismiss patients who may have a serious condition, and they consider that were not serious, and things that could be avoided happen with the patient, outside. (E5)

> The biggest difficulty is that the hospital is no longer an open entrance for low complexity users, and this patient enters the unit. So, from the moment they enter, and we send them away, turns out to be an omission of help. And we are all advised to send this patient away, we always ask about the records to the physicians, but when their admission is denied, physicians never sign anywhere, which is complicated. (E7)

Therefore, it is possible to say that the relationship between physicians and nurses who work in this service is fragile. The literature shows that the conflicts generated during the work process of these professionals, based on the circulation of knowledge and power, impair professional practice and subsequently the quality of customer care (Mattar e Silva et al., 2018).

Critical care environments can interfere with the professional behavior. Such services require concentration, attention, technical and relational skills, knowledge and agility of all professionals on the team. However, the relationships in the work environments assume amplitude and complexity that go beyond the formally established limits, showing tensions that emerge in the daily practice (Mattar e Silva et al., 2018).

Thus, it is necessary for professional nurses to put their autonomy into practice, in order to improve care and direct each case to their respective point of assistance. For this, the approach and guidance on how this will be done should occur in the least harmful way to the patient.

It is also observed that communication among the health team is flawed, although it is fundamental for a good work development, since the union and interaction strength the bond between the team and the patient. Effective communication is crucial for the quality and safety of clients, as it aims to improve the efficiency of communication between care providers, ensuring that both verbal and recorded information are accurate and complete (Olino et al., 2019).

Difficulties/challenges presented in the institution, during the triage with risk assessment:

In addition to the absence of a physician to continue the work of triage of the nurse who assesses the need for treatment, the interviewees also revealed, as a challenge, the poor understanding of the population about the referral of health services. They also mentioned the need of a protocol to develop the triage with risk classification that has national validity, considering the difficulties of the service.

> What I think would help in the organization in this issue of patients and the people who come here, would be a orientation, a better education wherever they go, like at the UPA or UBS, so when they arrive here, there would be no such constraint of having a problem, like being in pain or even being with an elderly person, and having to go back to where they have to go back in order to be admitted and treated. (E5)

> The patient's lack of knowledge about the health service, they don't understand that there is a hierarchy. The patient needs to be educated and they need to understand that there is a Primary Care, an Emergency Service, and afterwards, the Hospital. (E8)

The Health Care Network is defined as health actions and services, with different technological densities that are interconnected by technical, logistical and management support systems, prioritizing the integrality of health care (Brazil, 2010).

The need for both population and institutional education is perceived, since the elaboration of an Information and Guidance Manual on the Urgency and Emergency Network, systematically updated, could support professionals who guide users on the paths between different services.

Regarding the protocol, the necessity of elaborating a document with national validity was raised. Most of the interviewees emphasized that a national protocol would assist the user's risk classification process and would facilitate the service.

> I think it would be much better for the user if a protocol with national validity was installed, instead of an institutional one. Because they would not be referred, they could have more time of care, and it would benefit the physician's organization, in order to treat acute cases, and then the chronic ones, because not everyone is able to keep coming and going to the units that are not close to them. (E7)

From the interviewees' statements, it is observed that there is an institutional protocol, however, it is not being properly used. The literature shows that the protocols aim to help assess the patient's severity and risk of worsening, that is, the protocol acts as an inclusion tool and does not have the purpose of referring anyone without assistance, but rather to organize and guarantee service to all users. The recommendation is that the protocol presents at least four levels of risk classification, as it helps the accuracy, validity and reliability of the clinical evaluation (Brazil, 2009b).

The protocol is also intended to ensure patient safety in relation to the medical care time, as the main purpose of colors is to classify the severity of the clinical condition, and the maximum time they will wait to be seen. If this is not being properly respected, the protocol is not reaching its reliable purpose and, mainly, it harms the patient (Brazil 2009b).

As limitation, this study has the fact of not being developed in all components of the RUE. However, the results are relevant as they point to the need for health education on triage, specialized courses in this field, and the formulation of a protocol that maximizes the autonomy and resolution of the experienced problems at the time of classifying and proceeding with the user's care.

Conclusion

The perception of nurses in relation to the care of the low complexity non-referred user is linked to the disarticulation of the Network, the fragility between physician and nurse relationship, and the lack of use of a protocol.

Therefore, to strategically seek to reverse this flow, and in order to overcome the fragmentation of the Care Network, it is recommended a union between the managers of Hospital Service (Emergency Room), Basic Health Units (UBS) and Emergency Care Units (UPA), as well as the education of the population about which path to take in the face of an acute scenario of low complexity, aiming to guarantee access to the system and health care integrality.

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