

## WELCOME WITH RISK CLASSIFICATION AND THE CONDITIONS OF ACCESS IN EMERGENCY SERVICE: USERS' EVALUATION

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### ABSTRACT

This case study aims to describe the evaluation of healthcare users about the Welcome with Risk Classification (ACCR) and the conditions for access to the emergency department of a public hospital in Bahia. The data collected through interviews and a semi-structured questionnaire. In the analysis, we used mixed methods of integration of quantitative data, through simple frequencies of responses from users, and qualitative data, while the speech of users analyzed. It observed that most of the participants classified as at green risk (82%); they used car (44%) and buses (41%) as transportation to go to the hospital; and the medical care prioritized to them for green risk and not yellow. The participants showed greater satisfaction with the ACCR in relation to the care provided by nurses and receptionists, while dissatisfaction related to the physical structure and the unit's accommodation. We conclude that the service received all users, but there are complaints about the unit structure, and users classified in green seen primarily, opposing the ACCR guidelines.

**Keywords:** Welcome humanization assistance access health services, emergency medical services, hospital care.

### INTRODUCTION

In recent decades has seen a progressive increase in the use of emergency services in the Brazilian health system <sup>(1, 2 and 3)</sup>. However, to understand the phenomenon of search for urgent and emergency care in the country is required to observe in detail the profile of this complaint, given evidence that about 65% of users who seek emergency services could have their needs met in the basic attention services, such as basic health units, clinics, family health teams and medical offices <sup>(2)</sup>.

The coverage of the basic attention in Brazil has increased since the implementation of the Single Health System (SHS) in 1990, reaching approximately 50% of the total population in 2010, but this percentage is still insufficient to meet the quota of more than 150 million unique users of this system <sup>(4)</sup>. The little availability and low effectiveness of the basic attention services can be considered factors correlated to the demand for emergency services throughout the country <sup>(2)</sup>.

Other factors reported in the literature contributing to the overcrowding of emergency services related to both the demographic and epidemiological profile of the Brazilian

population, with regard to macroeconomic and social conditions. The Brazilian population is aging and life expectancy has increased in recent decades and, in parallel, it has been observed an increase in traffic accidents of urban violence, in addition to the insufficient amount of beds for hospitalization <sup>(5,6)</sup>. From an economic point of view, there is in the low country public investment in health, with percentages of public expenditures similar to health systems that are not universal, the example of the United States of America <sup>(4,6)</sup>. In the social field, the Brazil is considered the most unequal country in Latin America, potentially iniquities generator factor in access to health services <sup>(4)</sup>.

Faced with the problem, the Ministry of Health (MH), in 2006, regulated the strategy with risk classification host, taking as a reference the guidelines of the national policy of humanization - The Humanizes SHS of 2004 <sup>(7)</sup>. The main award of the ACCR is humanizing the care through the promotion of practices and health actions towards the institutionalization of careful users of urgent and emergency services with quality <sup>(8)</sup>.

The host is classified as 'light technology', this means that health practices are permeated by devices related to the establishment of the link between health care professional-user, quality of

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care and resolution of actions<sup>(8, 9,10)</sup>. Welcome means welcome the users, listen to it, understand it, and give voice to individual and collective demands of every citizen. The risk rating integrated with the host consists of a practice of service flow management, prioritizing the most serious cases<sup>(8, 11, and 12,13)</sup>.

The deployment of the ACCR still incipient in public hospitals in the country and the few studies that have analyzed some of its results have focused particular attention on the perception of professionals on the implementation of the protocols and the impacts generated on the management of health services<sup>(3,14)</sup>. There is paucity of studies that address the deployment of ACCR from the perspective of users and this gap of knowledge was motivating for the accomplishment of this case study, which had as its guiding question: what is the evaluation of users regarding the ACCR on a hospital emergency public service?

In this sense, it is expected that the results of this research could contribute useful information to State and municipal managers, healthcare professionals and users of SHS. In addition, to encourage the constant momentum of formulation of public health politics promote improvements in the quality of actions in health and the service hospitals, leaving especially the perspective of the users of such services.

Thus, the objective of this study was to describe the assessment of users regarding the ACCR and conditions for access to the emergency service of a public hospital in the metropolitan region of Salvador/BA.

## METHODOLOGY

This is a case study, descriptive, quantitative, and qualitative in nature, which developed in the emergency service of a public hospital in the metropolitan region of Salvador, Bahia. The case study has great value for this type of research by providing in-depth knowledge of a reality bounded and allows the apprehension of many aspects related to the object of study<sup>(15)</sup>.

The hospital studied is a benchmark for medium and high complexity in the region under direct management of the Secretariat of Health of the State of Bahia (SHSB). With 159 inpatient beds, performs elective surgeries and

emergency, ambulatory care in various specialties, has bioimagem service, high-risk nursery and an adult intensive care unit with eight beds.

The emergency service composed of the waiting room for risk classification, police station, 2 bathrooms for users and 2 clinics (medical and dental), 2 beds for patients in critical condition, joint observation unit with 25 beds (2 semi-intensive), nursing station, orthopedic rooms, minor surgery, suturing, fogging, pharmacy deposit material - clean and purge, 2 bathrooms for professionals and 2 for inpatients.

The ACCR deployed on emergency for adults in January 2011. The Protocol for the risk classification follows the international guidelines triage system priorities of Manchester<sup>(16)</sup>, with an adaptation of system colors. Thus, to protocol the service determines that all users have to take care of and there are four colors representing the classification of risk: red, yellow, green, and blue.

Red rating corresponds individuals in critical situation clinical picture unstable risk of death; yellow to those in clinical situation semi-critical, being stable or without risk of death; green classifies patients in clinical situation is not critical, but can evolve into risk conditions, yellow and blue are representative service-sensitive patients, strictly, outpatient welcomed guided to seek care in basic health unit of neighborhood or region.

The emergency team is comprised of 15 nurses, 36 nursing technicians, seven physiotherapists, 95 doctors (33 on specialty clinic, 19 in orthopedics and 43 in general surgery), seven social workers, a nutritionist, and support staff (porters, hand sanitizers, receptionists, among others). Two nurses perform risk classification, from Monday to Friday, from 07:00 to 7:00 pm. The average attendance has been 100 patients per day at this time and, in the 12:00 am, gets to be greater than 250 patients per day are.

A hundred users who participated in the study met the inclusion criteria: have stable medical condition; be conscious and oriented in time and space; be over 18 years; and have the risk classified by nurses of the ACCR. Users sorted in the color red did not participate in this study

because they did not fulfill all the criteria defined and in the days of data collection, there was no user classified in blue attended by nurses of the ACCR.

All study participants were invited and accepted participates voluntarily, after signing an informed consent. The Research Ethics Committee of SHSB (opinion No. 097/2011) approved this study. The data collected between the months of January to April 2012 with application of a questionnaire. The researcher himself made the questions users in a reserved area in the waiting area and recorded the answers on the questionnaire.

The questionnaire consisted of closed and open issues that have led to, respectively, the quantitative and qualitative data. The first, represented absolute numbers and simple frequencies correspond following variables: sociodemographic characteristics; means transport used to get to hospital; type risk classified; time call in credit rating and doctor. Privacy attendance with nurse; assignment grade 0 (totally unsatisfied); 1 to 5 (not happy), 6 to 9 (satisfied), and 10 (completely satisfied) the waiting room, risk classification, the nurse cozy and receptionist, room hygiene, physical structure and organization care.

The qualitative variables, formed by the expressions that most in the speeches of the participants emerged, print the perception of users on the service and the care received in ACCR, as well as the facilities and difficulties regarding the geographical accessibility and organizational. All the data of the questionnaire tabulated in Excel for Windows® program and each participant identified under an alphanumeric code (p01, p02, p03 until p100).

In the analysis, using mixed methods of integration of quantitative data, by means of simple frequencies of responses from users, and qualitative data, which considered the speeches on access and host the service studied. In this sense, emerged two categories of analysis: 1) facilities and difficulties in organizational and geographical accessibility to emergency service, and 2) evaluation of users about the strategy of ACCR.

## RESULTS AND DISCUSSION

In the section we present the results of the study and discussions about the characterization of users by demographic variables selected in table 1, the type of risk classified to the same and equivalences between the other qualitative and quantitative variables with two categories of analysis.

Considering the data in table 1, most users are female (63%), which converges with studies also reported an increased demand for hospital emergency services by persons of the female gender<sup>(17,18)</sup>. The age group between 20 and 49 years, (51%) obtained higher percentage, corresponding result with the information of the Department of Informatics of the SHS<sup>(19)</sup> with regard to the demographic profile of the population of the municipality studied. Regarding characteristics of users, the highest percentage studied until incomplete elementary school (41%) most proceeded the actual municipality (90%) showing same as another study<sup>(16)</sup> pointed out the shorter distance from the house to emergency service, greater the use of this service; more than half was married (52%) with family income between one and four minimum wages (62%).

The distribution of participants by risk classified by the nurses, presented asymmetrically, 18% had the risk defined in yellow color and 82% in green, which demonstrates that the participants were in clinical conditions that certainly not demanded urgent or emergency services. Studies indicate that most users will met in hospital emergency services could have been accommodated in the health services network of primary health care, by not addressing needs or health problems of urgency or emergency<sup>(2,5)</sup>.

### 1) Facilities and difficulties organizational geographical accessibility the emergency service.

With respect to geographical accessibility, 67% evaluated the hospital as being distant from the housing site. It was found that the most widely used means of transport for participants to go to the hospital residence was the car itself or rented (44%), followed by those who reported that they were on a bus (41%), a fact that may be related with the socioeconomic conditions of the participants.

**Table 1.** Demographic Characterization of users served on hospital emergency service studied, Jan.-Apr. 2012.

Variables	(n)	(%)
<b>Age</b>		
18-19 years	6	6
20-49 years	51	51
50-69 years	36	36
More than 70 years	7	7
<b>Sex</b>		
Male	37	37
Female	63	63
<b>Level of education</b>		
1st grade incomplete	41	41
To the 1st degree and the 2nd incomplete	22	22
2nd degree to 3rd degree full	37	37
<b>Origin</b>		
City X *	90	90
Salvador	2	2
The metropolitan region of Salvador and the State	8	8
<b>Marital Status</b>		
Married	52	52
Single	35	35
Stable Union	5	5
Widowed and separated	8	8
<b>Monthly Household Income</b>		
Less than or equal to 1 SM **	33	33
More than 1 and up to 4 SM	62	62
More than 4 SM	5	5

City where study conducted. \*\*Minimum wage.

There are reports of users that highlight the use of the automobile and bus as facilitator and difficult for the offset to the hospital, respectively:

I came by car, facilitates the transport (p08),

[...] having a car helps a lot, but we will not always be with him available (p20); and

So long, buses as means of transport so that you do not have a car (p51),

The location of hospital at entrance of the city is very difficult getting here (p59).

The answers related to organizational accessibility, 63% were satisfied once reached the emergency service and 37% reported delay attended at the reception. In relation to the organization of the service flow (reception – risk classification – medical care), the average number of points awarded by the interviewees was 5.8 points, this score translates into satisfied users, even with 50% of users saying that it took

so long for medical care is a negative factor for the flow. The average rating assigned to the attendance of the reception was 6.4 points; it believed that satisfaction with the reception could be associated with very good breakfast choice by the receptionists.

Organizational accessibility evaluation revealed good agility in meeting emergency hospital service, mainly to users sorted in green color. It observed that all users met, regardless of risk classified.

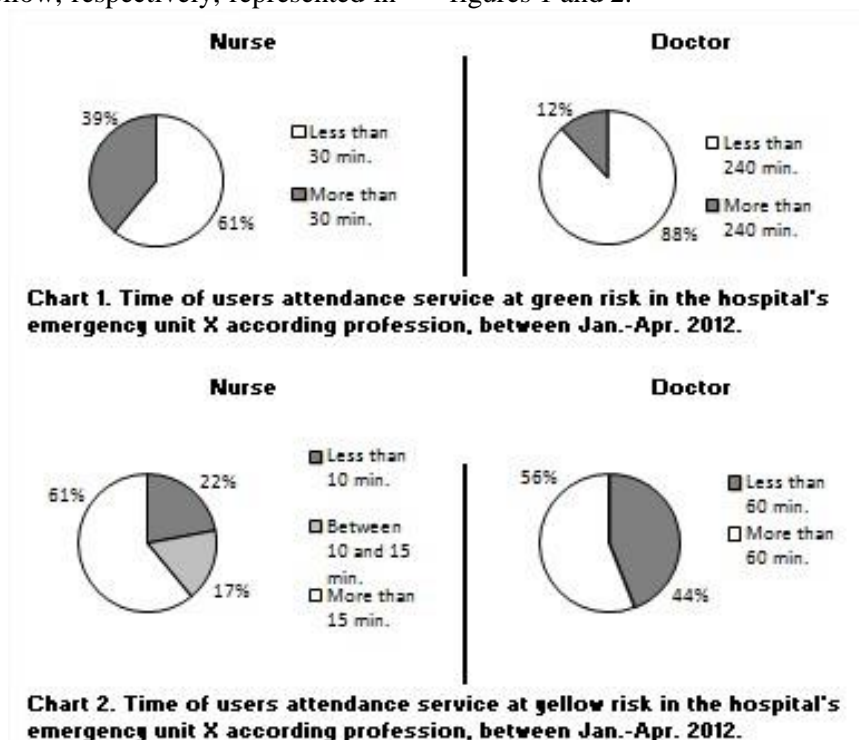
With respect to accessibility, the organizational difficulty higher frequency of complaints from users was about the delay for medical care:

Need faster medical care (p18); and

Delay in medical attention, need to be faster, there is only one serving (this).

The time for service of the nurse and physician varied according to the risk classified

in green and yellow, respectively, represented in figures 1 and 2.



It should note that, among the results of this study, calling attention late in attendance for classifying risk and medical care of users sorted in yellow color. The literature points out that users need to have the risk classified into 15 minutes even<sup>(20)</sup>, considered by hospital protocol studied 30 minutes just for the sorted in green. In addition, patients at yellow risk can develop into red, depending on the syndromic conditions.

For medical care, the time varies in accordance with the color assigned by the nurse. For those classified in green, the maximum wait time is 240 minutes and for the yellow color is 60 minutes<sup>(20)</sup>. It was observed that, to prioritize the green color, the emergency service studied followed the reverse logic of priority in attendance, opposing what recommends the ACCR protocol adopted in that service. This entails in low resolution of urgent and emergency medical service in relation to the time factor for people who are at risk to aggravate the condition.

## 2) Evaluation of users about the strategy of ACCR

The assessment as to the infrastructure involved the waiting room and the room of risk classification. At first, 90% of users felt uncomfortable with the second, 51% say are

comfortable. The assessment by assigning points, cleaning of the room credit rating received 5.1; the air conditioning of the room he obtained 3.3 and to the structure of the room gained 4.6 points. As for the reception service, 80% claimed to have well attended and the evaluation demonstrates averaged 6.4 points.

The replies from users for the attendance in the emergency with pre-assessment for ACCR, 82% said they were satisfied with this form of meet by chance. This satisfaction reinforced with the speeches presented, which seems to be associated with, especially, the role of nurses at the reception and the Concierge:

The service was good; the nurse was very polite (p21);

I met with the nurse and she answered me well (p45); and

The girl at reception was very polite and made up my file (p55).

The ACCR protocol unit, the Manchester, and the literature advocate that users informed about the approximate time for medical attention<sup>(16,20)</sup>. The results showed that 73% of users did not receive information about this time. Supplant this information can lead to dissatisfaction about waiting for care as the risks of ACCR protocol,

following the example of green and blue, which can take more than 4:0 for the doctor meet.

Regarding appearing times at the hospital (between Jan. 2011 and Apr. 2012) not having risk classified by nurse of ACCR, 43% said they assisted doctor without having passed risk rating at 30% said they had risk classified before medical attention and for 27% the questionnaire was not applicable, they sought care in the emergency before deployment of the ACCR. This denotes that many users met outside the time when risk classification is performed (7 am to 7 pm), with a stream of care that it not known if gravity sets the priority.

The attendance of the nurse with ACCR obtained 7.9 points in the evaluation of users and 62% say she kept the privacy, leaving the door closed at the time of service. When asked if they called by name during the service with the nurse, 96% say yes. With this, it evidenced that the service's risk classifiers studied followed some of the guidelines of humanization with respect to the individuality and the right to privacy during attendance.

## FINAL CONSIDERATIONS

It found that the assessment of the users about the conditions of access to the service studied was unsatisfactory. This is because, in terms of geographical accessibility to distance from the hospital to the urban center was considered the main obstacle to access to the emergency unit. With respect to organizational accessibility complaints about physical structure were prevalent, as well as the discomfort of the waiting room and risk classification, even after the unit have gone through a recent reform in the physical structure. Such structural aspects consist of great challenge for managers of emergency hospital units, especially by balancing the quality of reforms in welfare units with the real needs of users and services.

The expertise of the nurses and receptionists was evaluated by users as satisfactory, being reported for them just the agility and education of these professionals in attendance. Whereas the proposal of ACCR goes beyond speed and education, it becomes necessary to understand other variables to analyze nursing practices in caring for people in a situation of urgency and emergency. That these practices are sensitive to the needs and problems of health users, the service flow by gravity with a positive impact in assisting managing services.

The majority of respondents classified in green, however, according to unit protocol patients in this color not are in clinical situations of urgency or emergency. These points to the need to conduct studies to carefully evaluate the coverage and quality of basic attention of this municipality, in order to identify potential causes of such pent-up demand that has sought care clinics in emergency services.

In front of a model attention predominance of hospitals, one that prioritizes actions curative and not preventive will be a big challenge to reorganize the urgency and emergency hospital services. The change to a health promotion model requires reorganization of practices and services in the health sector. In the field of hospital service of urgency it is necessary to develop policies that cause positive impacts in host, in establishing links between patient-professional, reliable, in the humanization and minimization of asymmetry of information between professionals and users.

It is understandable how major this research limits the sample size and the fact that their results are restricted to the health service studied, not allowing to be extrapolated to other services of this municipality. However, expected that this initiative would inspire the realization of other studies, with more factors to analyze and that may stimulate more investments in public health and, therefore, contribute to the improvement of the quality of the population.

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## ACOLHIMENTO COM CLASSIFICAÇÃO DE RISCO E ACESSO EM SERVIÇO DE EMERGÊNCIA: AVALIAÇÃO DE USUÁRIOS

### RESUMO

Estudo de caso que teve como objetivo descrever a avaliação de usuários quanto ao Acolhimento com Classificação de Risco (ACCR) e às condições de acesso ao serviço de emergência de um hospital público na Bahia. Os dados foram coletados mediante aplicação de um questionário com perguntas abertas e fechadas. Na análise, utilizaram-se métodos mistos de integração dos dados quantitativos, por meio das frequências simples das respostas dos usuários, e dados qualitativos, considerados os discursos sobre o acesso e

acolhimento dos usuários. Observou-se que a maioria dos participantes foi classificada com o risco na cor verde (82%); utilizou carro (44%) e ônibus (41%) como meio de transporte para ir ao hospital; e o atendimento médico foi priorizado para a cor verde e não a amarela. Os participantes demonstraram maior satisfação quanto ao ACCR em relação ao atendimento prestado por enfermeiras e recepcionistas, enquanto que a insatisfação foi quanto à estrutura física e às acomodações da unidade. Conclui-se que o serviço acolheu todos os usuários, porém há queixas acerca da estrutura da unidade, e usuários classificados na cor verde foram atendidos prioritariamente, contrapondo as diretrizes do ACCR.

**Palavras-chave:** Acolhimento, humanização da assistência, acesso aos serviços de saúde, serviços médicos de emergência, Assistência hospitalar.

## ACOGER CON CLASIFICACIÓN DE RIESGO Y ACCESO EN SERVICIO DE EMERGENCIA: EVALUACIÓN DE LOS USUARIOS

### RESUMEN

Estudio de caso con el objetivo de describir la evaluación de usuarios en relación al Acogimiento con Clasificación de Riesgo (ACCR) y las condiciones de acceso a los servicios de urgencia de un hospital público en Bahía. Los datos fueron recolectados a través de cuestionario con preguntas abiertas y cerradas. Para el análisis fue utilizada métodos mistos de integración de datos cuantitativos, por medio de las frecuencias simples de las respuestas de los usuarios. Se observó que la mayoría de los participantes fue clasificada con el color verde de riesgo (82%); utilizo carro (44%) e autobús (41%) como medio de transporte para ir al hospital; y la atención fue priorizada para el color verde y no amarillo. Los participantes demostraron mayor satisfacción con el ACCR en relación a las atenciones prestadas por enfermeras y recepcionistas, y la insatisfacción estuvo relacionada con la estructura física y las acomodaciones de la unidad. Se concluye que el servicio recibió todos los usuarios. Se presentaron quejas acerca de la estructura de la unidad, y los usuarios clasificados en el color verde fueron atendidos prioritariamente contrariando las directrices del ACCR.

**Palabras clave:** Acogimiento, humanización de la atención Acceso a los servicios de salud, servicios médicos de urgencia, atención hospitalaria.

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**Submitted:** 17/02/14

**Accepted:** 02/03/15