

Nursing process in urgency and emergency: instrument development

Processo de enfermagem na urgência e emergência: desenvolvimento de instrumento

Proceso de enfermería en urgencia y emergencia: desarrollo de instrumentos

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How to cite: Rovere AMD, Gabriel M, Reis EMC, Barbosa CC, Moraes JÁ, Gomes RC, et al. Nursing process in urgency and emergency: instrument development. REVISA. 2024; 13(4): 1041-60. Doi: <https://doi.org/10.36239/revisa.v13.n4.p1040a1060>

REVISA

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Received: 23/07/2024
Accepted: 13/09/2024

RESUMO

Objetivo: realizar a construção de um instrumento específico para o Processo de Enfermagem (PE) destinado aos contextos de urgência e emergência. **Método:** trata-se de revisão integrativa com o intuito de gerar um embasamento sólido para o desenvolvimento do instrumento de Processo de Enfermagem (PE) voltado para o ambiente de urgência e emergência, sendo a etapa do desenvolvimento do instrumento, um estudo metodológico. **Resultados:** 7 artigos foram selecionados para compor a revisão integrativa e utilizados como base para construção do instrumento de Processo de Enfermagem. **Conclusão:** Conclui-se que o instrumento sobre processo de enfermagem na urgência e emergência construído auxilia a lacuna evidenciada da falta de padronização e planejamento da assistência neste contexto.

Descritores: Emergência; Enfermagem; Processo de Enfermagem; Protocolo e Urgência.

ABSTRACT

Objective: to develop a specific tool for the Nursing Process (NP) aimed at urgent and emergency care settings. **Method:** This is an integrative review with the aim of generating a solid basis for the development of the Nursing Process (NP) instrument aimed at the emergency and urgency environment, with the instrument development stage being a methodological study. **Results:** 7 articles were selected to form the integrative review and were used as the basis for the construction of the Nursing Process tool. **Conclusion:** It is concluded that the instrument on the nursing process in urgency and emergency built helps the gap evidenced by the lack of standardization and planning of care in this context.

Descriptors: Emergency; Nursing; Nursing Process; Protocol and Urgency.

RESUMEN

Objetivo: realizar la construcción de una herramienta específica para el Proceso de Enfermería (PE) destinada a contextos de urgencia y emergencia. **Método:** Se trata de una revisión integradora con el objetivo de generar una base sólida para el desarrollo del instrumento Proceso de Enfermería (PE) dirigido al entorno de emergencia y urgencia, siendo la etapa de desarrollo del instrumento un estudio metodológico. **Resultados:** se seleccionaron 7 artículos para componer la revisión integradora y se utilizaron como base para la construcción del instrumento del Proceso de Enfermería. **Conclusión:** Se concluye que el instrumento sobre el proceso de enfermería en urgencia y emergencia construido ayuda a superar la brecha evidenciada por la falta de estandarización y planificación de los cuidados en este contexto.

Descriptores: Emergencia; Enfermería; Proceso de Enfermería; Protocolo y Urgencia.

REVIEW

Introduction

The practice of nursing, as well as other professions, is subject to legal regulations, being outlined by the Law of the Exercise of the Nursing Profession, Law No. 7,498, enacted on June 25, 1986, and regulated by Decree 94,406, of June 8, 1987¹. However, it is important to emphasize that nursing professionals are also subject to specific norms that guide their daily work activities, as established by the legislation, which defines nurses' private actions, giving them responsibilities in the sphere of care and leadership².

Health care is a dynamic process that demands decision-making and professional autonomy. It is crucial that nursing professionals have in-depth knowledge about the current legislation, however, not all of them have a full understanding of the regulations that support their practice. The legislation not only regulates the activities of nurses and their private competences, but also requires the effective application of what is established by the Law of the Exercise of the Profession. The responsibilities, rights and duties of professionals are explained in the Code of Ethics of the nursing profession, and it is imperative that these professionals strictly observe these principles.³⁻⁴

In January 2024, the Federal Nursing Council (COFEN) published Resolution 736/24, which establishes the application of the Nursing Process (NP) in all socio-environmental contexts where care is offered by nurses, technicians, and assistants. This resolution, an update of 358/2009, aligns with the new perspectives of the profession, clearly defining its scope of application and introducing significant modifications. Among the changes, the differentiation between the Systematization of Nursing Care (NCS) and the NP stands out, in addition to adjustments in the phases of the NP, covering evaluation, diagnosis, planning, implementation and evolution⁵.

The standard brings the responsibilities of the Nursing team and modifications related to documentation, care management, teaching and continuous training. The committee responsible for drafting the resolution clarifies that the NCS deals mainly with managerial and organizational aspects, while the NP is emphasized as a fundamental tool in professional practice, highlighting the need for its full adoption⁵.

The Nursing Process (NP) is recognized as the main tool for the application of this approach, playing a crucial role in the validation of strategies for the elaboration of a personalized care plan. In addition, it is a management instrument of great importance, being used to plan, execute, control and evaluate direct and indirect care actions for clients⁶.

In addition, in the context of urgent and emergency services, where nurses face a tense and stressful environment, the flexibility inherent in the EP is crucial. This dynamic approach allows nurses to progress and revisit their steps as needed, tailoring their intervention plans based on each individual's specific human responses⁷.

This ability to adapt is essential to ensure the effectiveness of care, since health professionals need to act with attention and precision to prioritize the health and integrity of vulnerable patients, highlighting the importance of nursing welcoming actions.⁸

This welcoming not only establishes trust with the patient, but also promotes a meaningful connection with the healthcare professional,

highlighting the relevance of considering not only the technical aspects but also the patient's care needs.⁶

There are universally applicable international protocols for urgent and emergency services, such as the American Heart Association's (AEHLERT) Advanced Cardiac Life Support (ACLS), the American College of Surgeons' (ACS) and Committee on Trauma (COT) Advanced Trauma Life Support (ATLS), and the National Association of Emergency Medical Technicians (NAEMT) Prehospital Trauma Life Support (PHTLS). These protocols aim to standardize patient care, providing a sequence of priorities for the team of urgent and emergency professionals⁹.

In the Brazilian scenario, although there has been an increase in initiatives to speed up the registration of activities related to the Nursing Process (NP), the implementation of recording instruments in professional practice is still recent. Successful experiences are poorly described in the scientific literature, reflecting an incipient visibility of care outcomes¹⁰. Pizzolato et al. (2023) highlight that many records are inconsistent, illegible, and subjective, highlighting the importance of an NP articulated with a Conceptual Model of Nursing as an essential technological tool in professional care.

In this context, it is necessary to develop a specific instrument for the Nursing Process (NP) in urgent and emergency situations, aligned with the problems of the nursing process. This instrument aims to guide the conduct of nurses, ensuring efficiency in care and improving their performance. In addition to providing legal support to the professional, this practice facilitates the communication process through the systematic recording of data and clinical information from the first approach to the patient's destination. Therefore, by considering the data and information recorded, this approach can contribute to the continuity of care¹¹.

The absence or failure of nursing processes in urgent and emergency services is a worrying reality, negatively impacting the quality of care provided and potentially contributing to adverse outcomes, including deaths. This gap highlights the need to develop and implement effective instruments that can facilitate and improve the nursing process in this critical environment.⁹

Resolution 736/24 highlighted the need to implement the Nursing Process (NP) in the urgent and emergency sectors, recognizing the importance of this practice to ensure quality care. However, the finding of the lack of standardization in the instruments related to this process in these sectors reveals a critical gap that deserves attention and intervention. The absence of effective standardization can result in flawed nursing processes, compromising the quality of care and, consequently, the safety and well-being of patients.⁵

In view of this scenario, the justification for this study was based on the need to fill this gap, aiming to develop and implement standardized and effective instruments for the Nursing Process in urgent and emergency services. The lack of uniformity in the instruments can lead to inconsistencies, hindering communication between health professionals, undermining legal support, and potentially resulting in adverse outcomes for patients. Thus, this study seeks to contribute to the improvement of the quality of care in these critical sectors, promoting the effectiveness of the NP and ensuring a safer and more efficient performance of the nursing team in emergency situations.¹¹

Considering the complexity and urgency of health services, especially in emergencies, the implementation of a specific instrument for the Nursing

Process (NP) can significantly improve the quality of care provided. The hypothesis of this work is that the development and application of a standardized instrument for the NP in urgent and emergency contexts will result in a more efficient practice on the part of nurses, leading to clearer communication among health professionals, a more solid legal support and, ultimately, more favorable outcomes for patients. It is believed that this standardization will contribute to improving the safety and well-being of patients treated in these critical situations, providing more effective and quality care.

Thus, the general objective of the present study was to construct a specific instrument for the Nursing Process (NP) for urgent and emergency contexts.

In addition, it is emphasized that to support the development of the instrument, the specific objective was to carry out an integrative review that preceded its construction, aiming to highlight in the literature instruments on the nursing process in urgency and emergency.

Method

An integrative review and a methodological study were carried out to provide a solid basis for the development of the Nursing Process (NP) instrument aimed at the urgency and emergency environment, and the stage of the instrument's development was a methodological study.

Integrative review is a research methodology that allows for a comprehensive and critical analysis of several studies on a specific topic. Unlike other forms of review, such as meta-analysis and systematic review, which have narrower criteria and approaches, integrative review is more flexible and includes both experimental and non-experimental studies. It combines theoretical and empirical evidence to offer a complete view of the phenomenon studied, ranging from conceptual definitions to methodological problem analyses. This approach is especially useful in areas such as nursing, where it is important to consider a wide range of evidence to improve evidence-based care and practice¹³.

It consists of the phases:

- Elaboration of the guiding question: defines the studies to be included, the means of identification and the information to be collected, based on participants, interventions and results.
- Search in literature;
- Data collection;
- Critical analysis of studies;
- Discussion of results;
- Presentation of the review.

Methodological studies focus on the creation, validation, and evaluation of research techniques and approaches. The growing interest in methodological research among nurse researchers is driven by the need to ensure reliable results, test interventions rigorously, and apply advanced data collection methods¹⁴.

To carry out the integrative review, the guiding question was: What are the instruments on the nursing process in urgency and emergency available in the literature?

The data collection period consisted of the months of April and May 2024. During this interval, the search was carried out in the Scientific Electronic Library Online (SciELO) and Virtual Health Library (VHL) databases.

To carry out the integrative review, the following inclusion and exclusion criteria were established. Articles published in the last five years (2019-2024), which met the objectives of the study and were available in Portuguese, English, and Spanish, were included. On the other hand, theses and dissertations were excluded, and the analysis was restricted exclusively to scientific articles.

The Health Sciences Descriptors (DeCS) selected for the search include terms relevant to the theme: Emergency, Nursing, Nursing Process, Protocol and Urgency, combined with each other, in Portuguese, with the help of the Boolean operator and. The careful choice of these descriptors aimed to direct the research to specific sources that address the construction of instruments for the Nursing Process in urgent and emergency scenarios.

To extract the data and analyze the included studies, as well as to facilitate the discussion of the results and present the integrative review, a table was used to synthesize the included studies, adapted from URSI; GALVÃO¹⁵.

The integrative review was conducted in a systematic manner, evaluating scientific articles, protocols, and guidelines, seeking to consolidate information that can contribute to the elaboration of the proposed instrument. The methodological study involved the critical analysis of these sources, identifying essential elements and recommended practices, providing a solid theoretical basis for the construction of the Nursing Process instrument adapted to the context of urgency and emergency.

Results

Integrative review

The integrative review identified a total of 398 articles relevant to the theme studied, of which 7 were selected to compose the basis of this study, as shown in Figure 1.

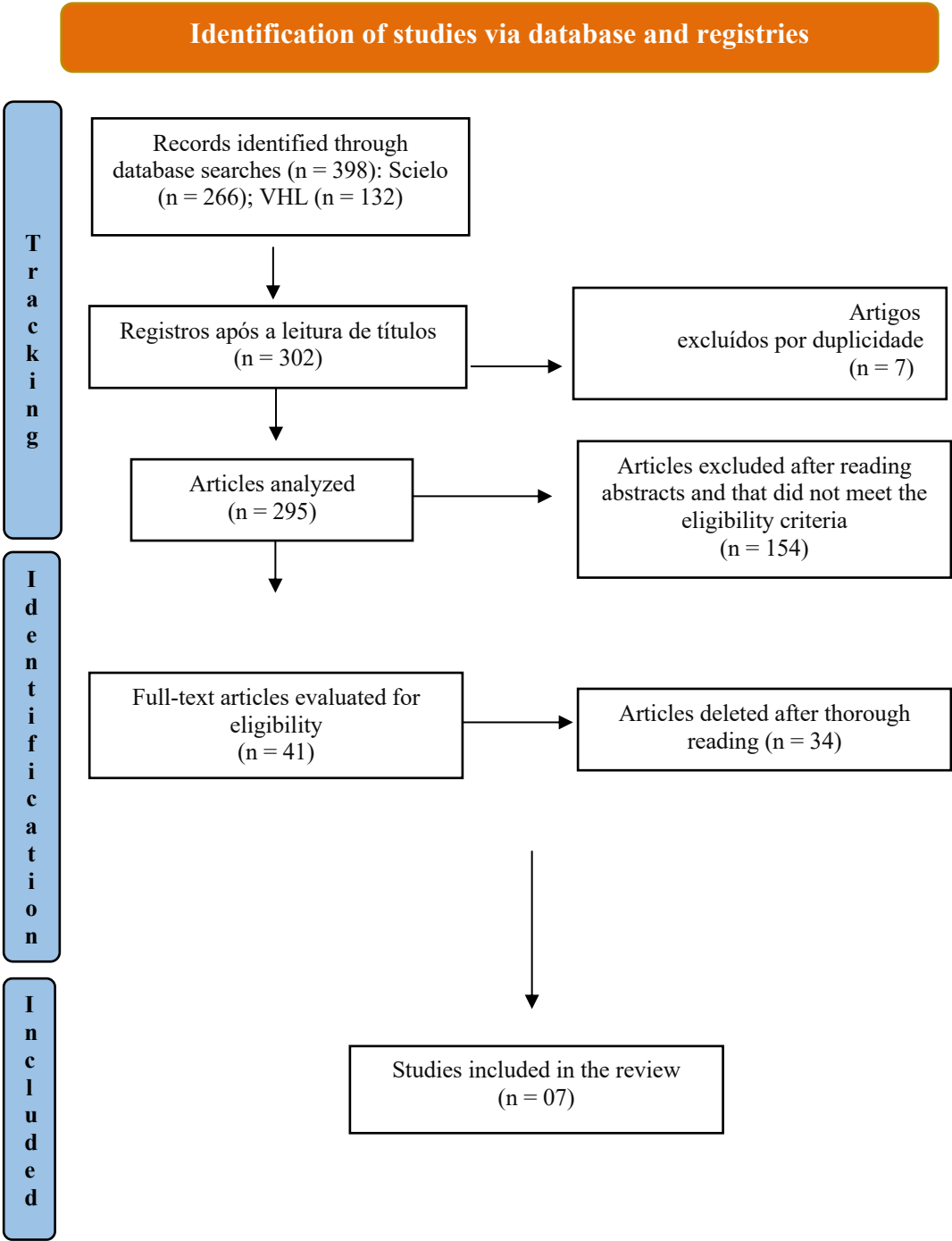


Figure 1 - PRISMA flowchart (adapted) of the study selection process.

The articles chosen are mostly recent, with 4 published in 2023, 1 in 2022, 1 in 2021 and 1 in 2020. In terms of language, 2 were published in English and 5 in Portuguese. Regarding the themes addressed, three articles focused on the elaboration of a registration pattern that includes nursing diagnoses, results and interventions for the shift change of nurses in the emergency room, using a severity scale. Two articles described the nurses' perceptions about the implementation of a Nursing Process instrument in an emergency room, evidencing the challenges and benefits of this implementation. One article aimed to validate the appearance and content of a specific instrument for the Nursing Process Record in the Mobile Emergency Care Service (SAMU).

Finally, one article addressed the instruments used by nurses to manage care in response to the demands of the emergency hospital service (Chart 1). These articles provide a solid foundation for understanding nursing practices in emergency settings, highlighting the importance of standardized and validated tools to improve quality of care and patient safety.

Table 1: Selected articles in the databases.

Article and Authors	Year of publication	Language	Main theme
1 Barbosa et al. ¹⁶	2023	Portuguese	Development and validation of a prototype of a mobile application to assist in the shift change of nurses in emergency units, using the severity scale NEWS
2 Farias et al. ¹⁷	2023	Portuguese	Development of a registration standard for nursing diagnoses, outcomes and interventions in an Emergency Care Unit (UPA) based on the International Classification for Nursing Practice (ICNP).
3 Matzembacher et al. ¹⁸	2023	Portuguese	Nurses' perceptions about the implementation of the Nursing Process in an emergency room, identifying challenges and opportunities for improvement.
4 Pizzolato et al. ¹⁹	2023	Portuguese	Validation of an instrument for the registration of the Nursing Process in the Mobile Emergency Care Service (SAMU), focused on the usability and adequacy of the content.
5 Nascimento et al. ²⁰	2022	Portuguese	Construction and validation of a checklist to ensure secure communication during the transition of patient care between out-of-hospital services and hospital emergency units.
6 Rabelo et al. ²¹	2021	Portuguese	Description of the instruments used by nurses to manage care in an emergency hospital service, with emphasis on strategies to deal with the high demand and complexity of the environment.
7 Rabelo et al. ²²	2021	Portuguese	Analysis of the work process of nurses in an emergency hospital service, highlighting aspects of direct care and care management in a highly complex scenario.

Construction of the Nursing Process Instrument

The Nursing Process Instrument is a tool developed to systematize and standardize the collection, recording and analysis of data in the nursing process. It is composed of different sections that aim to ensure comprehensiveness and accuracy in obtaining the information necessary for patient care. The instrument includes specific fields for patient identification, initial assessment, intervention planning, execution and evaluation of results.

This instrument is essential to ensure the consistency and quality of nursing care, allowing an effective follow-up of each case, in addition to minimizing errors and facilitating communication between professionals.

The full model of the Nursing Process Instrument is available in APPENDIX A.

Discussion

Horta's theory of Basic Human Needs (1979) establishes a model for nursing practice, which encompasses philosophy, propositions, concepts, definitions and principles. The veracity of these theories is validated or challenged through detailed testing of their components. A principle is a central premise or assumption essential to the construction or explanation of a theory. Concepts are described as abstract and general, while propositions, which arise from these concepts, express fundamental truths to be followed. Principles are statements that, although provisionally accepted as certain, are susceptible to testing and experimentation¹⁶.

Horta (2011) establishes the following principles: nursing values and maintains the uniqueness, authenticity and individuality of the human being; nursing practice focuses on the human being and not only on the disease or imbalance; all nursing care aims at prevention, cure and rehabilitation; nursing recognizes the human being as a member of a family and community; and nursing sees the human being as an active participant in their own self-care.

As can be seen, the selected studies reflect a diversity of approaches to improve nursing practice in emergency services. Barbosa et al. (2023) and Farias et al. (2023) focused on the development of tools to optimize nursing practice. While Barbosa et al. (2023) validated a mobile app for shift change, Farias et al. (2023) created a registration standard for diagnoses and interventions. Both studies presented tools that were well evaluated by the experts and considered useful for clinical practice.

Pizzolato et al. (2023) and Nascimento et al. (2022) validated instruments to improve documentation and communication in the emergency context. Pizzolato et al. (2023) validated an instrument for SAMU, with high validity, except for ease of reading, while Nascimento et al. (2022) created an effective checklist for communication during the transition of care, with an excellent validity index.

It is noted that validated tools enable and organize the nursing service, making care structured.¹²

Matzembacher et al. (2023) and Rabelo et al. (2020) explored nurses' perceptions and the work process. Matzembacher et al. (2023) identified difficulties and opportunities in the implementation of the Nursing Process,

while Rabelo et al. (2020) analyzed the dimensions of nurses' work and the characteristics of the work environment. Both studies highlighted the importance of overcoming challenges to improve quality and safety in care.

A study that aimed to carry out an integrative review on the nurses' perception of the difficulties of patients in the oncology service identified that a work environment that does not perform the NP in its entirety, through the use of validated tools, makes the actions become mechanistic, without qualifying the nursing care, making it susceptible to the occurrence of adverse events²³.

Rabelo et al. (2021) identified that nurses' skills and attitudes are essential to manage care in an intense and complex environment. This aligns with the findings of Rabelo et al. (2020), who highlighted the crucial role of care management and the need for effective strategies to cope with the challenging environment.

In summary, the studies show significant progress in the development and validation of tools and practices for nursing in emergency services, with an emphasis on improving communication, documentation, and care management, in addition to addressing the challenges faced by professionals in the workplace.

Conclusion

It is concluded that the instrument on the nursing process in urgency and emergency built helps the gap evidenced by the lack of standardization and planning of care in this context, which requires objectivity and agility in the decisions made in order to equip nurses for effective, agile and safe care. In addition, the integrative review carried out supported and reinforced the need for wide dissemination of this instrument.

It is suggested that further research be carried out on the subject, such as validation studies and implementation of the instrument, in order to refine it and make it an important tool for nurses, aiming at the well-being and quality of care provided to patients who go through the urgent and emergency service.

Acknowledgment

This study was funded by the authors themselves.

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APPENDIX A

Construction of the Instrument for the Nursing Process (NP) for Urgency and Emergency

Patient Identification

Name	Age	Date of birth ____/____/____
Sex <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No Etilist <input type="checkbox"/> Yes <input type="checkbox"/> No	
Evaluation date ____/____/____	AP:____mmHg T:____ RF:____CF__	
Bed	HGT:____CF__SAT:____	
Allergy		
Medication in Use		
Type of occurrence	<input type="checkbox"/> Traffic Accident <input type="checkbox"/> Drowning <input type="checkbox"/> Fall <input type="checkbox"/> Burn <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> <input type="checkbox"/> FAB <input type="checkbox"/> FAF <input type="checkbox"/> Clinical: <input type="checkbox"/> Other:	
Risk Classification Protocol	<div><div>VERMELHO</div><div>EMERGÊNCIA ATENDIMENTO IMEDIATO</div></div> <div><div>AMARELO</div><div>URGENTE ATENDIMENTO EM ATÉ 60 MIN</div></div> <div><div>VERDE</div><div>POUCO URGENTE ATENDIMENTO EM ATÉ 2 HORAS</div></div> <div><div>AZUL</div><div>NÃO URGENTE ATENDIMENTO EM ATÉ 4 HORAS</div></div> <div><input type="checkbox"/>Emergency <input type="checkbox"/>Urgency <input type="checkbox"/>Not Urgent <input type="checkbox"/>Not Urgent</div>	

Visual Analogue Scale


Pain	<div><div>LEVE</div><div>MODERADA</div><div>INTENSA</div></div> <div><div>0</div><div>1</div><div>2</div><div>3</div><div>4</div><div>5</div><div>6</div><div>7</div><div>8</div><div>9</div><div>10</div></div> <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>
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Anamnesis

Pathological history	<input type="checkbox"/> HAS <input type="checkbox"/> DM <input type="checkbox"/> ANGER <input type="checkbox"/> IRC <input type="checkbox"/> Cardiopathy <input type="checkbox"/> Others: Yes () No ()Accepts transfusion of blood and blood components as indicated by medical
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Physical examinations

Neurological System	<input type="checkbox"/> Awareness <input type="checkbox"/> Oriented <input type="checkbox"/> confused <input type="checkbox"/> Disoriented <input type="checkbox"/> Sedated <input type="checkbox"/> comatose <input type="checkbox"/> Torpor
Pupillary Assessment	<input type="checkbox"/> Isochoric <input type="checkbox"/> Myotic <input type="checkbox"/> Anisochoric <input type="checkbox"/> Photoagents <input type="checkbox"/> Non-reagents
Speech	<input type="checkbox"/> Aphasia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Dyslalia <input type="checkbox"/> Aphonia <input type="checkbox"/> Dysphasia
Motor Response	<input type="checkbox"/> Hemiplegia <input type="checkbox"/> Plegia <input type="checkbox"/> Plegia <input type="checkbox"/> Paresis <input type="checkbox"/> Paresthesia
Glasgow Coma Scale Eye opening: Better motor response:	<input type="checkbox"/> 4. Spontaneous <input type="checkbox"/> 3. To the verbal command <input type="checkbox"/> 2. The pain <input type="checkbox"/> 1. Absent <input type="checkbox"/> 6. Obeys commands <input type="checkbox"/> 5. Localizes pain <input type="checkbox"/> 4. Unexpected bending <input type="checkbox"/> 3. Hypertonic flexion <input type="checkbox"/> 2. Hypertonic extension <input type="checkbox"/> 1. No response
Better verbal response	<input type="checkbox"/> 5. Oriented <input type="checkbox"/> 4. Disoriented and preserved <input type="checkbox"/> 3. Inappropriate words <input type="checkbox"/> 2. Incomprehensible sounds <input type="checkbox"/> 1. No response

	<p>Interpretation</p> <p><input type="checkbox"/>13 to 15 Mild Trauma</p> <p><input type="checkbox"/>9 to 12 Moderate trauma</p> <p><input type="checkbox"/>3 to 8 Severe Trauma</p>
Respiratory system	<p><input type="checkbox"/> Eupneic <input type="checkbox"/> Bradipneic</p> <p><input type="checkbox"/> Tachypneic <input type="checkbox"/> Dyspneic</p> <p><input type="checkbox"/> AR Ambient <input type="checkbox"/> IOT</p> <p><input type="checkbox"/> Venturi <input type="checkbox"/> Mask TQT</p> <p><input type="checkbox"/> Catheter 02 <input type="checkbox"/> Oxygen Mask</p>
Skin Coloring	<p><input type="checkbox"/> Normochorated</p> <p><input type="checkbox"/> Pale</p> <p><input type="checkbox"/> Acyanotic</p> <p><input type="checkbox"/> Cyanotic</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Anicterica</p> <p><input type="checkbox"/> Afebrile</p>
Cardiovascular system	<p><input type="checkbox"/> Bradycardic <input type="checkbox"/> chychycardic normocardial</p> <p><input type="checkbox"/> Filiform Full Pulse</p> <p><input type="checkbox"/> Rhythmic <input type="checkbox"/> Arrhythmic <input type="checkbox"/> Normotensive</p> <p><input type="checkbox"/> Hypertensive <input type="checkbox"/> Hypotensive</p>
Gastrointestinal System	<p><input type="checkbox"/> SNG <input type="checkbox"/> SNE <input type="checkbox"/> VO</p> <p><input type="checkbox"/> Gavage. <input type="checkbox"/> Open <input type="checkbox"/> Closed</p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> melena</p> <p><input type="checkbox"/> Vomiting</p>
<p>Abdomen</p>  <p>Regiões do abdome</p> <p>1. Hipocôndrio direito</p> <p>2. Epigástrico</p> <p>3. Hipocôndrio esquerdo</p> <p>4. Flanco direito</p> <p>5. Mesogástrico</p> <p>6. Flanco esquerdo</p> <p>7. Fossa Iliaca direita</p> <p>8. Hipogástrico</p> <p>9. Fossa Iliaca esquerda</p>	<p><input type="checkbox"/> Normal <input type="checkbox"/> RHA Distended</p> <p><input type="checkbox"/> Increased <input type="checkbox"/> RHA Pain on palpation</p> <p><input type="checkbox"/> Decreased <input type="checkbox"/> RHA Flabby</p> <p><input type="checkbox"/> Globoso <input type="checkbox"/> Flat</p>
Urinary elimination	<p><input type="checkbox"/> Anuria <input type="checkbox"/> SVA Spontaneous</p> <p><input type="checkbox"/> Choluria</p> <p><input type="checkbox"/> Dysuria <input type="checkbox"/> SVD <input type="checkbox"/> diaper.</p> <p><input type="checkbox"/> Haematuria</p> <p><input type="checkbox"/> Oliguria. <input type="checkbox"/> Colostomy <input type="checkbox"/> Uropen</p> <p><input type="checkbox"/> Piuria</p> <p><input type="checkbox"/> Polyuria. <input type="checkbox"/> Ileostomy</p>
Laboratory Changes	<p>Na:</p> <p>K:</p> <p>Cl:</p> <p>Ca:</p> <p>Mg:</p> <p>U:</p>

	Cr: Hb: HT: Leukocytes: Platelets: Capillary Blood Glucose:
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Diagnostics	Nursing Interventions
Ineffective breathing pattern	<input type="checkbox"/> Monitor frequency, rhythm, depth, and effort in breaths <input type="checkbox"/> Record thoracic movements observing the existence of symmetry, use of accessory muscles, and retractions of intercostal supraclavicular muscles. <input type="checkbox"/> Auscultate the breath sounds, observing the areas of reduced/absent ventilation and the presence of adventitious noises. <input type="checkbox"/> Remove secretions by stimulating coughing or aspirating. <input type="checkbox"/> Administer supplemental oxygen when needed.
Ineffective airway clearance	<input type="checkbox"/> Open the airway using the chin lift technique or jaw lift maneuver, as appropriate. <input type="checkbox"/> Determine the need for upper or lower airway aspiration <input type="checkbox"/> Listen to the breath sounds before and after aspiration. <input type="checkbox"/> Identify patient who requires actual/potential insertion of artificial airway <input type="checkbox"/> Position the patient to relieve dyspnea. (Semi-fowler)
Decreased cardiac output	<input type="checkbox"/> Assess vital signs regularly (BP, HR, RR) <input type="checkbox"/> Monitor (ECG) to detect arrhythmias <input type="checkbox"/> Administer supplemental oxygen when needed <input type="checkbox"/> Evaluate tissue perfusion and capillary filling <input type="checkbox"/> Monitor the efficacy of oxygen therapy (eg, pulse oximetry, arterial blood gases), as appropriate. <input type="checkbox"/> Administering medications as prescribed by the doctor
Risk of infection	<input type="checkbox"/> Properly clean (fomites) the environment after each patient's use. <input type="checkbox"/> Change the equipment for patient care according to the institution's protocol. <input type="checkbox"/> Teach proper handwashing to health professionals.

	<input type="checkbox"/> Wash hands before and after each patient care activity. <input type="checkbox"/> Wear gloves as required by universal precaution protocols.
Excessive liquid volume	<input type="checkbox"/> Passing urinary catheter as appropriate <input type="checkbox"/> Monitor the patient's hydration status <input type="checkbox"/> Assess the location and extent of edema, if present Administer diuretics as prescribed by your doctor
Risk of ineffective cerebral tissue perfusion	<input type="checkbox"/> Monitor cerebral perfusion pressure <input type="checkbox"/> Monitor neurological status <input type="checkbox"/> Monitor the Glasgow Coma Scale trend <input type="checkbox"/> Monitor pupil size <input type="checkbox"/> Write down headache complaints
Risk of suicidal behavior	<input type="checkbox"/> Determine the presence and degree of suicide risk <input type="checkbox"/> Administer medications to reduce anxiety, agitation, or psychosis and stabilize mood, as appropriate. <input type="checkbox"/> Refer the patient to a mental health care provider (e.g., psychiatrist or psychiatry/mental health advanced practice nurse) for evaluation and treatment of suicidal ideation and behaviors if necessary.
Anxiety	<input type="checkbox"/> Use a calm and reassuring approach Listen to the patient carefully. <input type="checkbox"/> Explain all procedures, including sensations that the patient may have during the procedure. <input type="checkbox"/> Administer medication to reduce anxiety, as appropriate
Mobilidade física prejudicada	<input type="checkbox"/> Determinar a capacidade atual do paciente para transferir-se (p. ex., nível de mobilidade, limitações aos movimentos, resistência, capacidade para ficar de pé e suportar o peso, instabilidade médica ou ortopédica, nível de consciência, capacidade de cooperar, capacidade para compreender instruções) <input type="checkbox"/> Selecionar a técnica de transferência adequada ao paciente. <input type="checkbox"/> Auxiliar o paciente no recebimento de todo o atendimento necessário (p. ex., higiene pessoal, coleta dos pertences) antes de realizar a transferência, conforme apropriado.
Risco de queda	<input type="checkbox"/> Identificar déficits cognitivos ou físicos do paciente, capazes de aumentar o potencial de quedas em determinado <input type="checkbox"/> Identificar comportamentos e fatores que

	<p>afetem o risco de quedas.</p> <p>Revisar o histórico de quedas com o paciente e a família.</p> <p><input type="checkbox"/> Identificar características ambientais capazes de aumentar o potencial de quedas (p. ex., chão escorregadio e escadas sem proteção)</p> <p><input type="checkbox"/> Monitorar o modo de andar, o equilíbrio e o nível de fadiga com a deambulação.</p>
Risk of unstable blood glucose	<p><input type="checkbox"/> Monitor blood glucose levels as indicated</p> <p><input type="checkbox"/> Monitor for signs of hyperglycemia (polyuria, polydipsia, polyphagia, weakness)</p> <p><input type="checkbox"/> Monitor for signs of hypoglycemia (sweating, brain fog)</p> <p><input type="checkbox"/> Administer insulin as prescribed</p> <p><input type="checkbox"/> Maintain IV access, as appropriate</p>
Urinary retention	<p><input type="checkbox"/> Monitor urinary clearance, including frequency, consistency, odor, volume, and color, as appropriate.</p> <p><input type="checkbox"/> Monitor for signs and symptoms of urinary retention</p> <p><input type="checkbox"/> Educate the patient about signs and symptoms of urinary tract infection</p> <p><input type="checkbox"/> Instruct the patient to drink fluids</p> <p><input type="checkbox"/> Identify the factors that contribute to incontinence episodes.</p>
Urinary retention	<p><input type="checkbox"/> Provide privacy for disposal.</p> <p><input type="checkbox"/> Stimulate the reflex bladder by applying cold to the abdomen, massaging the inner thigh, or letting water flow.</p> <p><input type="checkbox"/> Insert bladder tube as appropriate.</p>
Diarrhoea	<p><input type="checkbox"/> Evaluate for signs of dehydration, such as skin turgor and dry mucous membranes.</p> <p><input type="checkbox"/> Administer fluids and electrolytes to prevent dehydration, as prescribed by a doctor</p>
Acute pain	<p><input type="checkbox"/> Perform comprehensive pain assessment, including location onset, duration, frequency, and intensity of pain, as well as improvement and triggering factors</p> <p><input type="checkbox"/> Monitor pain using a valid and reliable rating instrument for age and communication ability</p> <p><input type="checkbox"/> Administer analgesics in a daytime schedule in the first 24 to 48 hours after trauma or injury.</p>
Hyperthermia	<p><input type="checkbox"/> Monitor body temperature regularly.</p> <p><input type="checkbox"/> Administer antipyretics as prescribed by the doctor.</p> <p><input type="checkbox"/> Encourage fluid intake and keep the environment ventilated.</p>

	<input type="checkbox"/> Apply cold compresses to the forehead or armpits if necessary. <input type="checkbox"/> Monitor for signs of dehydration or complications associated with fever.
Hipertension	<input type="checkbox"/> Obtain a detailed history of the patient's health to determine risk level, including medications in use <input type="checkbox"/> Measure blood pressure <input type="checkbox"/> Identify possible causes of hypertension

Evolution of the Nurse

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AVE	Stroke	
AVEH	Hemorrhagic stroke	
AVCI	Ischemic stroke	
RFM	Reflex photo motor	
MID	Mydriasis: pupil dilation	
MIO	Miosis pupil contraction	
AP	Anisochorias pupils	
DFA	Dysphasia, difficulty speaking	
RMD	Motor response pain	
FR	Respiratory rate	
MV	Breath sounds	
MV+	Vesicular murmurs present	
Spo2	Oxygen Saturation	
CPAP	Continuous positive airway pressure	
BIPAP	Positive pressure continues on two levels	
VNI	Non-invasive ventilation	
VM	Mechanical Ventilation	
TO	Oxygen Therapy	
DPOC	Chronic obstructive pulmonary disease	
IRA	Acute respiratory failure	
IRP	Progressive respiratory failure	
CTP	Transient peripheral cyanosis	
CP	Peripheral cyanosis	
CC	Central Cyanosis	
IC	Jaundice	
PC	Skin pallor	
ER	Erythema	

PA	Blood pressure	
FC	Heart rate	
ECG	Cardiogram	
IAM	Acute myocardial infarction	
IC	Heart failure	
DVC	Congenital vascular disease	
FA	Atrial fibrillation	
BAV	Ventricular atrial block	
TGI	Gastrointestinal tract	
DRGE	Gastroesophageal flow disease	
HDA	Upper GI bleeding	
HDB	Lower GI bleeding	
GE	Erosive gastritis	
SSVV	Vital signs	
HAS	Systemic Arterial Hypertension	
DM	Diabetes mellitus	
MSD	Right upper limb	
MSE	Upper left limb	
MID	Right lower limb	
MIE	Right lower limb	
MMII	Lower limbs	
MMSS	Upper limbs	