# Implementation of risk-rated host in an emergency care unit

## Implementação do acolhimento com classificação de risco em uma unidade de pronto atendimento

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## RESUMO

**Objetivo:** Analisar o processo de implementação do acolhimento com classificação de risco na unidade de pronto atendimento de uma cidade da região do Recôncavo da Bahia, Brasil. **Método:** Trata-se de um estudo descritivo, qualitativo, realizado com oito enfermeiras, em uma Unidade de Pronto Atendimento 24 horas. Realizou-se entrevista individual em profundidade, analisadas pelo método da análise de conteúdo. **Resultados:** As enfermeiras apresentaram entendimento sobre o sistema de Acolhimento com Classificação de Risco, sendo percebida enquanto ferramenta eficaz de organização dos processos de trabalho, fluxos assistenciais e atendimento aos pacientes. Desvelam ainda, sentidos de humanização, atendimento oportuno e adequado às demandas por nível de priorização, delineamento de fluxos e resolução das demandas. A implementação está entrelaçadas por elementos facilitadores, dificultadores e de desafios, quanto à adesão e à operacionalização. **Conclusão:** o Acolhimento com Classificação de Risco é compreendido satisfatoriamente por enfermeiras, e ainda que hajam presença de elementos dificultadores e desafios, contribuições para atuação em Enfermagem e à atenção à saúde dos pacientes têm sido evidenciadas no cotidiano das práticas, carecendo de maior investigação.

**Descritores:** Acolhimento; Urgências; Serviço de Saúde de Emergência; Tratamento de Emergência.

## ABSTRACT

**Objective:** To assess the implementation process of risk-rated host in the emergency care unit of a city in the Recôncavo da Bahia, Brazil. **Method:** This is a descriptive and qualitative study conducted with eight nurses in a 24-hour Emergency Care Unit. An in-depth individual interview was conducted and they were evaluated by the content analysis method. **Results:** The nurses had an understanding of the Risk Rating Host system, being perceived as an effective tool for the organization of work processes, care flows and patient care. They also reveal senses of humanization, timely and adequate demands attendance by level of prioritization, flow delineation and demands resolution. Implementation is intertwined by facilitating, hindering and challenging elements concerning the adherence and operationalization. **Conclusion:** Risk0rated host is satisfactorily understood by nurses, and although there are presence of hindering elements and challenges, contributions to nursing practice and patient health care have been evidenced in the daily practice, requiring further investigation.

**Descriptors:** User Embracement; Emergencies; Emergency Health Service; Emergency Treatment.

ORIGINAL

## Introduction

Demand for emergency services has been increasing worldwide over the last decades, leading to the need for utilization of the relief organization. Thus, screening systems were developed to identify the clinical priority of each patient waiting for care, allowing easier access.[1]

In this context, screening systems have the objective of organizing the demand of patients who come seeking care in emergency services of hospital and prehospital care, identifying those who need immediate care and recognizing those who can safely wait for care, before there is complete diagnostic and therapeutic evaluation.[1]

With regard to the prehospital component, the Emergency Care Units (UPA) constitute an emergency service intermediate between Primary Care and Hospital Care, where a screening system, called Risk Classified Reception (HSC), is applied. ACCR). This system that operates from the selection of users in priority care, takes into account the universalization, equality and equity of health care.[2]

Within this level of attention, the ACCR is one of the potentially decisive actions in the reorganization and implementation of networked health promotion. The same can be understood as a technology used by the Ministry of Health (MS) to reorient care policy in emergency services, articulating the values of humanization and qualification of care.[3]

In this sense, structured screening now refers to a valid, reproducible classification protocol that allows the classification of patients based on the different levels of urgency and prioritization of care plus the appropriate physical structure and professional and technological organization.[3]

Thus, welcoming refers to the movement of attending to all users, as well as knowing them, giving greater value to listening to their demands, the reasons for seeking health services, as well as means to welcome them, to establish a relationship of trust during healthcare.[4]

The reception, under this logic, is structured from the notion of a techno-assistance action that presupposes the change of the professional / user relationship and its social network through technical, ethical, humanitarian and solidarity parameters, recognizing the user as subject and participant. active in the health production process.[5]

Although the significant contribution of the ACCR, an evaluative study conducted in Santa Catarina, Brazil, is acknowledged, it has shown its precariousness, especially regarding the process of operationalization by health professionals.[6] When observing the satisfaction of health service users regarding the ACCR, current evidences indicate that there is a high level of satisfaction, highlighting the welcoming, trust, opportunity, environment, considering comfort, cleanliness and signaling, humanization, considering courtesy, respect and interest, referrals and appointments, and expectations for service.[7] However, this perspective is divergent in the literature, while another study points to weaknesses in the process of disclosing the ACCR objectives, as well as insecurity and dissatisfaction on the part of users regarding the classification process.[8]

Understanding that it is necessary to investigate the process of implementation of the ACCR, in order to encourage existing gaps, as well as potentialities and challenges for the realization of this process, this study aligns

with the objectives proposed in the guidelines of the National Policy for Attention to Urgencies, while allowing to configure a means of evaluating its implementation, also contributing to the improvement of care practices and care management.

In convergence with this justification, this study was permeated by the research question, namely: how is the implementation of Risk Classified Reception configured in a 24-hour Emergency Care Unit? To answer this question, the aim of this article is to analyze the process of implementing risk-classified care in a 24-hour Emergency Care Unit.

## Method

Descriptive and qualitative study that sought to grasp the collective discourse of Nursing professionals who work in a 24-hour Emergency Care Unit (UPA), facing the process of implementing the risk-rated reception system.

The study was conducted in a 24-hour UPA, linked to the public health network, in a city in the Recôncavo da Bahia region. The locus health unit of the study has an average care capacity of 150 to 200 people per day, in which the host with risk classification is applied.

Seven nurses and one nurse who work in the 24-hour UPA participated in the research, including professionals who worked at least one year in the occupation, linked to direct care work to patients and also administrative work of management and coordination of the service and who included in the process of implementing risk-rated care.

These professionals are aged between 25 and 35 years, self-reported black/ brown race/ color, with training time ranging from four to nine years. Regarding training, the participants had lato sensu postgraduate studies in the area of Emergency Nursing, Emergency and Intensive Care Unit (ICU) (06), Health Management (02), Hemotherapy (01), Nephrology (01 ), Obstetrics (01), only one participant reported no postgraduate degree.

Regarding the time of professional training, the study participants are, on average, 6 years of training. Seven of them have a double workday -either as a hospital nurse or as a Nursing course teacher. Regarding the work process of nurses, all have a workload of 36 hours per week, with an average of two years in the job. Only one participant had no other employment relationship.

The study did not include professionals who were away from work, whether on sick leave and / or premium, or on vacation, or any other reason that caused them to be absent from occupational activities, in addition to those who were not in a satisfactory emotional state to attend the interview. During the data collection period, two participants refused to participate in the research, for reasons not mentioned.

As a data collection technique, individual in-depth interviews were conducted, anchored in a semi-structured instrument, previously elaborated, based on the available literature on the subject. The interviews were scheduled and took place at the convenience and authorization of the deponents, by reading and signing the Informed Consent Form (ICF). The events took place in a reserved place in the institution, at times opposite to the work shifts and were recorded and later fully transcribed. Data collection operation was supported by Nursing coordination, as a way of preserving possible impacts on the quality of

care provided during the turn of work shifts, nor the organization of the work dynamics of the teams.

The data organization process occurred through the methodological fulfillment proposed by the theoretical framework of the qualitative approach, meeting the assumptions of content analysis proposed by Minayo.[9] It was supported by NVIVO software to ensure the systematization and coding of data. The analysis is permeated by three dimensions: pre-analysis, in which data are classified and organized, compared to theoretical and objective assumptions, material exploration, coding and aggregation of data, treatment of results obtained and interpretation. That done, the analysis proceeded through a critical reading for the final writing, content organization and writing of the final concepts.[9]

Regarding the ethical dimension of the study, the research project complied with the recommendations proposed by the guidelines, in force, such as Resolution 466 of 2012, of the National Health Council (CNS), ensuring confidentiality, anonymity, confidentiality and autonomy. of the participants. In addition, the was obtained approval by the Research Ethics Committee, under the opinion number: 2,598,581. Participants were identified in the study by codes represented by nurse N and sequence number, example N1, N2 and subsequent.

## Results

The findings are concentrated on the content of the nurses' narratives that unveil the knowledge about risk-classified care and the system implementation process in the UPA.

**Thematic subcategory 01: Nurses' knowledge of risk-rated care**

The contents of the narratives reveal meanings of the humanization of care, especially when the patient is received, in response to their demands, on arrival at the unit, and their involvement and belonging in the health and disease care process, a fact highlighted in reason of the weaknesses in the process of health care and sensitivity of professionals. The reception with risk classification is recognized by professionals as a tool that makes it possible to classify patients from the logic of the order of risk, as well as the reception of complaints and the clinical history and global assessment in the first moments of care.

> “Reception is the humanized way to treat patients when they arrive at the health facility. Due to a lack of attention, when they seek the health service is because they have a morbidity, but also the attention of professionals. And our training is humanized, and in fact we professionals have to employ what we learn, which should be advocated in practice.”. (N1)

> “With the reception with risk classification, the data collected through the survey of patients' complaints, it is possible to classify them. An outpatient level, for example, rating as low urgent, urgent or at a higher risk, which is classified as red. So, from this data collection we have to classify and from there meet the risk order ”. However, I notice some obstacles, for example, if I identify that the patient is classified as blue, I could refer him to the Family Health Unit, but it is misunderstood, as

> if I was making a medical diagnosis, and my professional advice does not allow, which hinders my performance. (N2)

> "Embracing is to know the patients' complaints first, to know the history, to verify if they present a relationship between the complaint and the history. In general, it is to see the patient's overall state, both physical and psychological". (N3)

The reception with risk classification was aimed at the resolution of health problems demanded by users in the service, which service is seen by nurses, as an open door to the health system.

> "ACCR is a tool that has been used for setting priorities, especially in emergency units. The UPA is an open door here for the municipality and the surrounding region. So, in a way, it's a tool that you work to humanize care, offering more, right away, to those who need it most at that time, so it's an important tool". (N4)

> "Welcoming is resolving, comes from resoluteness. Either you solve it, or the patient's life goes away. It is not listening to the patient and leaving him sitting. I am very practical when I am working, I like to welcome and solve patient problems". (N5)

**Thematic subcategory 02: Implementation process of risk-rated host**

The implementation of reception with risk classification, operationalizing from nurses' performance, is permeated by the presence of facilitating, hindering and challenging elements. Among the facilities stand out, the ability of the ACCR, to organize the demand by prioritizing the cases by severity, all the way, among the difficulties, nurses find the professionals not understanding about the application of ACRR, added to the problems of facilities. physical, structural, regarding the organization of flows, rotation of professionals and absence of materials and equipment.

The challenges are concentrated in overcoming nursing professionals to the difficulties faced in their work process, starting from the assumption of creativity and wisdom, as being the essential components to ensure a qualified and humanitarian care.

**Thematic Subcategory 02 A: Facilitating Elements**

> "The main benefit of the ACCR is to try to organize the dimension of the severity of patients, giving it priority in the care of those who really need it, thus ensuring equity, and this is one of the principles of SUS. By doing so, I will provide more assistance to those who need it most". (N6)

> "For the Emergency Care Unit, ACCR improves flow organization, and for nurses, it provides greater assistance to those who really need it". (N7)

**Thematic Subcategory 02 B: Difficulties**

> "The physical structure of the reception room that we have to work does not have a stretcher. We don't have a children's scale, air

conditioning, and it gets in the way of work. There is a lot of slamming doors, the entry and exit of professionals at all times, and the space is too small to handle the service, there is hardly a wheelchair and also because it is a main passage of people from the city. patients and caregivers have direct access to the unit". (N1)

"Patient access to the room is not good. The same has no privacy because the door is broken. The screening room is in front of a bathroom, poorly structured, and also very small. The reception is already close to the reception rooms, and needed to be more isolated from this area". (N2)

"The user does not understand what the risk rating is. People still don't have enough education to understand. I don't see a patient here at the UPA take more than half an hour to come in and be seen, it's very difficult. There may be longer service on a Monday day, when demand is higher, but here service is fast, however, people complain". (N5)

"For users, there are no benefits with ACCR. For lack of information for lack of publicity, they think that colors represent nothing. The color is seen as a normal color, and has no important meaning". (N7)

**Thematic Subcategory 02 C: Challenges**

"Like every unit, here there are also their difficulties, and as they say: "Nursing is very much on the basis of improvisation", so we always try to improvise, to offer the best quality of care and ensure humanization, which is the fundamental". (N8)

"We nursing professionals have to have wisdom to be able to work in the face of so many difficulties. I seek to overcome the difficulties that I have been dealing with here UPA, to prevent something that prevents me from doing the work and damaging my shift". (N5)

"The professional autonomy of nursing is respected here, at times it has been questioned by doctors, but it is exercised on a well-founded basis, so there is no final question. Since when I prove because I classified that way and justify the reception, the medical professionals come to respect and then my autonomy as a nurse becomes prevalent". (N4)

"Comparing to other places where I worked, I think the nurse has a lot of autonomy in the development of her work process, even through the partnership established with the medical professionals. I feel comfortable to give my opinion, and doctors are also comfortable saying what they think, so the work here is done together". (N6)

"I have been guided, together with the Nursing team, by the Nursing coordination, and through the meetings and training courses, regarding the classification. The health department has also directed attention on this theme through the meetings, which promotes greater municipal mobilization on the ACCR". (N4)

"The service flowchart works in the unit, me and the other nurses, classify the patients. All the ways we identify most are blue and green patients. In general, during one day, I usually classify three patients yellow and one red, the others would be patients with profiles to be seen at the Family Health Unit". (N6)

> "Due to the deficiency of outpatient care, we provide care to patients with less urgent profiles. This type of care demands on average two hours to be done, being better attended in the outpatient network ". (N7)

## Discussion

The idea of reception already accumulates a wealth of experience in various health services offered by the public health system. This experience is heterogeneous as the SUS itself and carries with it positive and negative aspects of character. Recognizing this long trajectory of welcoming means legitimizing that much of the progress is attributed to practical accumulation.[10] From this point of view, the reception in the health field should be understood as a relational technological tool of intervention in listening, in the building of bonds, in guaranteeing access with responsibility and in the resolution of services.[10]

In this context, the implementation of the ACCR proves to be decisive for the bureaucratic issues existing in the professional-user relationship, in which it is structured, a protocol that governs the functioning of patient screening. With the intention of trying to organize the quality of emergency services, the Ministry of Health adopts the risk classification as a strategy to change the work of care, management and production of health care, in order to meet the different degrees of need of patients.[11]

This study showed that nurses have the understanding that the ACCR is an important device to qualify care within the UPA. Therefore, nurses apply this service, the Manchester System, to classify users in the health service, in order of priority.

The Manchester Risk Classification System (SMCR) has its creation proposed by UK Nursing and Medical professionals, and aims to establish, through strategies, meeting the demands presented by patients in emergencies, based on clinical criteria. , which determine its priority.[12] The Manchester System, in turn, is guided by an emergency care planning guideline, and values opportunities for patients with more complex and risky clinical conditions.[13]

A Brazilian study evaluating the quality of the Manchester System's effectiveness, with regard to the analysis of the preceding time and the time employed in the risk classification, in a given priority for the care and destination of these patients 24 hours after admission to a hospital unit. emergency, revealed that the time involved in activities that the first medical care, remain within the recommended. In addition, the proportion of lower and higher priority ratings 24 hours after.[14]

In this context, the Emergency Classification Risk Rating Reception system aims to establish a work process analysis with the objective of recognizing and organizing care according to the user's needs, replacing the exclusionary screening with a welcoming model.[15] Nurses identify such a contribution to the organization of work processes, emphasizing in particular the organization of care to respond to the severity of the clinical conditions presented, in convergence with the ordering principles of the SUS, as well as the care flows, which when better directed, contributes to the development of nursing practices and the performance of nurses.

Through the ACCR, the nurse formulates clinical and critical judgment of

the case, which is supported by the use of the system. And it is based on the elements of this system, that these professionals are able to make a clinical decision, which is expressed by means of a color, which in turn classifies the priority of user care and organizes the flow of interventions.[2]

The content present in the nurses' narratives shows that there is still a culture of dependence on the service users, especially in emergencies, causing the UPA to be overloaded with disordered emergence of health demands, considered non-urgent. The UPA is the place intended to provide assistance to users with or without risk, whose health problems need immediate care. It aims to improve users' assistance by ensuring care organization, service articulation and defining flows and resolute references.[16] As a result, the UPA shows up as a resolute initiative to address the problems of overcrowding in hospital emergency units.[17]

Although well structured, in terms of the organization of the care network, emergency public services are usually overwhelmed, in general, by problems that could be solved at another level of attention, such as Primary Care. This problem is marked by the inadequate use of these services, and this situation decreases the speed of care and negatively affects the quality of the emergency service provided, increasing costs with the health sector and impacting the resolution of the demands presented.[18]

Ratifying the content of the narrative presented by one of the study participants, which emphasizes the decision of the Regional Nursing Council of the State of Bahia, and the Regional Medical Council of that state, is defined by resolutions that every patient who has Access to the Hospital Emergency Service must be attended by a doctor and may not, under any justification, be dismissed or referred to another health unit by a professional other than the doctor. This decision does not imply barriers in the autonomy of nursing practice, but supports them, by rigorously complying with their professional practice, which does not provide, once being in an emergency service, the discharge of a patient without medical evaluation.[19-21]

The benefits of the patient risk classification process, as the focus of this process is to serve the patient more humanely and accurately, acting as a device or means for emergency care units to conduct their work according to their goals.[16] From this perspective, ACCR's central objective is to reduce inequalities. Although all people have the right to services, people are not equal and therefore have different needs. In other words, equity means treating unequally the unequal, investing more where the need is greatest.[22]

For nurses' performance, the ACCR enables the achievement of success in risk classification, and proves to be an essential instrument, capable of guiding the assessment promoted by this professional. The support of the risk classifying process uses subjective and objective parameters, times and flows, which become subject to change in each determined sector, and these are often used by nurses, considering that they have skills for this management, all However, one cannot lose sight of the fact that the success of the ACCR is also related to an effective implementation, with the assistance network (structured and organized).[23]

On the other hand, the understanding for users is not so evident that sometimes they do not know the logic of ACCR. From this point of view, performing the ACCR in isolation does not allow the emergence of

improvements in care quality, giving rise to the need to build agreements, whether internal or external, as a way to enable the operationalization of the processes.[24]

Experiences of implementation of the ACCR, already consolidated in the world, have been evidenced in the Brazilian territory, however they are still little visible, lacking the need for expansion, to know the possible advances, forms of construction, interviews and facilities.[25-26] The nurse operates in this process in a unique way, and is a key part for the proper and efficient functioning of this care production device in urgent and emergency situations. Thus, it should be emphasized that nurses should provide safe and quality care.[27]

## Conclusion

The main objective of this research was to analyze the process of implementation of risk-classified care in a emergency care unit in a city in the Bahia state.

The process of implementation of the ACCR is permeated by the presence of facilities, which are supported by the contributions of ACCR, regarding the improvement of care and management processes for the service, as well as ensuring the resolution, prioritization and quality of care offered. However, there are intrinsic presence of various hindering elements, which start from a desensitization of the community, lack of belonging, weakening of social participation in the Unified Health System, as well as fragility in health education and the empowerment of subjects.

In addition, it is emphasized that the difficulties nurses face in implementing the ACRR are concentrated in structural factors, which express architectural limitations, based on the failures in the organization of the service sectors, as well as the administration of the service and care management offered to patients at medium complexity level. Added to the facilities and difficulties, nurses seek to implement the ACCR, seeking to overcome real and existing challenges in their professional practice. These challenges are raised by living with the difficulties in the work process, which make nurses exercise other skills, such as creativity and critical thinking, in decision-making during care and offering nursing care in the UPA.

Thus, from this study, it was possible to know the nurses' understanding of the ACRR, as well as identify the nuances of the ACCR implementation process, and identify the presence of gaps and challenges in this process.. This knowledge enables nursing professionals and other health professionals, as well as teachers, researchers, health administrators, as well as formulators of public policies, social movements, fiscal councils and public managers, have access to this evidence, as a way of substantiating the actions to be implemented in the context of training and management of services, human resources and costs with the health sector.

The study was limited to investigate the performance of nurses, not being analyzed in the narratives of other professionals of the health team, such as nursing techniques and medical professionals. However, it is understood that nurses develop actions of coordination and supervision of care, and as a result of health services, it was considered relevant to learn the contents of this professional category.

We highlight the essentiality of the nurse in the process of production of

health care, especially in the area of urgencies and emergencies, such as the UPA, for exercising the role of manager of the units. In this sense, this study advances the scientific knowledge, as it highlights the context of the nurse's work in the health care network in the public sphere, unveiling relevant findings for the field of collective health and nursing care.

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