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Original Article

Welcoming with risk classification in urgent and emergency services: applicability in nursing

Acolhimento com classificação de risco nos serviços de urgência e emergência: aplicabilidade na enfermagem

Acogimiento con calificación de riesgo en los servicios de urgencia y emergencia: aplicabilidad en enfermería

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Objective: to identify the knowledge of nurses about the implementation the proposal of Welcoming with Risk Classification in an urgent and emergency service. **Methods:** this is a study with qualitative approach of descriptive and exploratory type. Data collection was conducted through semi-structured interviews, with the participation of seven nurses who work in the unit mentioned. Data analysis followed the steps of thematic analysis. **Results:** they focus on the understanding of participants about welcoming and the facilities and/or difficulties encountered by them due to the implementation of this proposal. **Conclusion:** it was possible to understand the reality experienced by respondents about the theme and notice that in spite of the difficulties, they consider that the proposal contributes to the reorganization of the users' flow and to meet their demands.
Descriptors: User Embracement; Nursing; Emergencies.

Objetivo: identificar o conhecimento de enfermeiros acerca da implementação da proposta de Acolhimento com Classificação de Risco, num serviço de urgência e emergência. **Métodos:** estudo de abordagem qualitativa do tipo descritivo, exploratório. Foi realizada a coleta de dados por meio de entrevista semiestruturada, com a participação de sete enfermeiros que atuam na referida unidade. Análise dos dados seguiu os passos da análise temática. **Resultados:** enfocam a compreensão dos participantes sobre Acolhimento e as facilidades e/ou dificuldades encontradas por eles frente à implementação desta proposta. **Conclusão:** foi possível compreender a realidade vivenciada pelos entrevistados acerca da temática e constatar que, apesar das dificuldades, eles consideram que a proposta contribui para a reorganização do fluxo de atendimento da demanda de usuários.
Descritores: Acolhimento; Enfermagem; Emergências.

Objetivo: identificar el conocimiento de enfermeros sobre la aplicación de la propuesta de Acogimiento con Calificación de Riesgo, en un servicio de urgencia y emergencia. **Métodos:** estudio descriptivo, cualitativo, exploratorio. Recopilación de datos a través de entrevista semiestructurada, con participación de siete enfermeros que trabajaban en esa unidad. Análisis de los datos siguió los pasos del análisis temático. **Resultados**: se centran en la comprensión de los participantes sobre Acogimiento y las facilidades y/o dificultades encontradas por ellos delante de la aplicación de esta propuesta. **Conclusión**: es posible comprender la realidad que viven los encuestados sobre el tema y constatar que, a pesar de las dificultades, consideraban que la propuesta contribuye a la reorganización del flujo de servicio de la demanda del usuario.
Descriptores: Acogimiento; Enfermería; Urgencias Médicas.

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Introduction

The increasing demand for urgent and emergency services is related to several factors, such as increased violence, current disruption of the primary care network, population growth, among others. As a consequence of these factors, one has been noticing a difficulty of access and a lack of humanization in the care provided in the aforementioned services[1]. To minimize this problem, one understands that it is necessary to reorganize the care provided to users in these spaces, taking into account the principles of the Unified Health System, in search of more humanized care.

Welcoming, understood as a relational technology, aims to promote the humanization of care provided to users, being one of the Ministry of Health's proposals to deal with the disability of solvability and quality of health services. Although not mentioned directly among the principles recommended by the Unified Health System, it can be seen as a tool that enables improvements in the offer of care as well as the in reorganization of the Brazilian health system. This technology is anchored to the National Humanization Policy – Humanize SUS *[Política Nacional de Humanização - Humaniza SUS]* which, in urgent and emergency services, proposes that the reception of users should be based on assessment with risk classification[2-3].

The welcoming with risk classification in the Unified Health System, aiming to reorganize the flow of users and provide comfort and listening in a vulnerable situation, replaces the traditional screening. It differs from screening that aims to attend everyone, using as a basis the priority of each user, with organized criteria. The priority is defined by a standard protocol developed by each institution, based on a protocol of the Ministry of Health[2].

Thus, it is proposed by the Ministry of Health regarding the welcoming and risk classification in urgent services the division by axes that show users' risks and determine their sequence. Each axis consists of the colors red, yellow, green and blue, the red color indicates users with risk of death and who require immediate care, the yellow color corresponds to users without risk of imminent death but who need intervention soon, green for users without the risk of death or injury in any organs, so they will be attended in order of priority and demand, and finally the blue color that reflects stable users who will receive elective care or according to demand[2].

Choosing welcoming with risk classification as an operational guidance of a health institution requires changes in the relationship professionals/users recognizing them as active subjects in the production of health. It may still be added that welcoming implies the organization of work processes in order to attend, with quality, everyone who seeks the service[2].

A study conducted to analyze the work organization in an urgent and emergency unit from the countryside of Rio Grande do Sul, Brazil, which does not work with the risk classification system, noticed difficulties such as human resources, material resources and disorderly flow of users[4-3]. It also highlighted the dissatisfaction of professionals in relation to the large volume of non-urgent demands for care.

The mischaracterization of care in the Unified Health System and the misuse of this service observed in the large number of elective cases generates stress, overload of professionals and it also impairs the quality of care. In this sense, besides knowing clearly the work process in urgent and emergency units, managers, professionals and users must make agreements with other services and institutions, in order to meet the demand that are really urgent and emergency cases, allowing the improvement of the quality of care and avoiding conflicts and dissatisfactions at work[5].

Due to the difficulties faced by managers and professionals of the Unified Health System, the Ministry of Health presents welcoming with risk classification as a guideline to be deployed in these units with the mission of being an appropriate strategy to ensure better access of citizens to urgent and emergency

services, with resolute and humane care[2].

Given the above, this study aimed to investigate the knowledge of nurses about the implementation of the proposal of welcoming with risk classification, in an urgent and emergency service.

Method

This is a descriptive, exploratory study with qualitative approach, carried out in an urgent and emergency unit located south of the state of Rio Grande do Sul. This unit has triple management of a federal university, a private university and the city's health department and it provides care to the population exclusively by the Unified Health System. It works 24 hours a day, every day of the week, and, according to the unit's records service, it attends on average 252 people per day. It provides care on demand, of urgent and emergency cases, to users from 26 municipalities that make up the southern region of the state, which is a reference. It has its own medical, surgical and nursing staff and it receives every day nursing and medicine students from a federal university and a private university.

Data collection was conducted through semi-structured interviews, from May to July 2011. All 12 nurses who work in the unit were invited to participate in the study, but only seven accepted the invitation. The interviews were recorded and conducted in a private place, previoulsy agreed by the researcher and the participant and it lasted on average 30 minutes. Participants were identified with the letter I, followed by an arabic numeral according to the sequence in which the interviews were conducted. Ex: I1, I2, I3 etc.

One adopted a thematic analysis for data processing, being divided into three stages. First stage, pre-analysis, which consists in choosing the documents to be analyzed and in retaking assumptions and the initial objectives of the research. Second stage, material exploration carried out in a classification operation that aims to reach the core of text comprehension and, to do so, the investigator tries to find categories that are meaningful words or expressions depending on which the content of speeches will be organized. The third step corresponds to the processing of results and their interpretation, and then the results obtained are confronted with the literature[6].

From this analysis emerged the theme: understanding nurses about welcoming with risk classification.

The research ethics committee from the nursing college of the Federal University of Pelotas *[Universidade Federal de Pelotas]*, issued the favorable opinion No. 053/2011.

Results

Regarding the understanding of nurses about welcoming and looking for the meaning of welcoming with risk classification, respondents expressed themselves as follows: *Welcoming is when people look for a doctor or a nurse and they do a risk classification through a protocol. People are classified into green, yellow, red and blue* (I6). *Welcoming is the fastest way to observe what diseases patients actually have and if they need to stay in the emergency sector or to be referred to a basic unit or to another service* (I5). *For me welcoming is giving first attention by a person trained to leave patients more relaxed. It is essential to have patients' vital signs in the first moment to know how to classify them* (I4).

In the process of welcoming, listening and guiding users appropriately, from the point of view of their entrance, one can realize that not always the existing relationship is peaceful, this is because sometimes it is hard for them to understand the team work process. They realize their needs and they demand an immediate resolution, generating often conflicts in this relationship. This conflicted relationship without trust can cause, by intimidation issues, the omission of facts, signs and symptoms which are important for a proper risk classification according to the following speeches: *Nowadays we send them to basic units and this is an inconvenience for users ... when we attend people before them, although we explain, people can't understand it's for a serious situation, a priority* (I3). *In fact I think*

that patients don't say what they feel, perhaps it's dissatisfaction with the service (I7).

When asked if they had taken a training course to act in the area of welcoming with risk classification, most of them claimed to have received some information: *A training course I don't think I could say that, I attended a lecture where people explained what welcoming would be like, it was a superficial explanation about the colors* (I4). *No. Specifically a training course, no. But a doctor gave us some information about the protocol. But a training course we didn't take* (I6). *We received it, but it was a two or three-day training course. It was an initial training course to know what risk classification was like* (I1).

Regarding the difficulties mentioned by the interviewees about the implementation of welcoming with risk classification most respondents mentioned them, representing an obstacle for daily practice because, according to them: *In theory it would work very well if the system (health services network) worked, there is a difficulty of sending patients to a service that welcomed them as we do* (I2). *Another difficulty is the accessibility to other services and we have nowhere to direct them* (I3). *The biggest difficulty is the consultation after classification...* (I4).

When nurses were asked about internal barriers experienced in the urgent and emergency service, they stated that: *Sometimes we classify a patient as yellow, for example, which is the first priority, who should be the next one to be attended, but sometimes the green patients who are waiting there are attended faster* (I1). *It is much more difficult because, unfortunately, it does not depend only on us, we classify them and it depends on the doctor, and sometimes they have a lot of demand or they simply do not want to attend them* (I5). *It hasn't been easy, especially in relation to medical support, we normally don't have medical support, and the waiting time does not follow the protocol* (I4). *One of the difficulties that I have and that I believe my colleagues also have is a delay in the progress of care together with welcoming*(I6).

Despite the difficulties of applicability of welcoming with risk classification it is possible to highlight in the speeches of respondents satisfied with the new work proposal, which allowed a reorganization of the service: *I feel really well, I like to work in the welcoming with risk classification. I find it very important for the city to have this service, I think my participation was very interesting too* (I6). *I love working with welcoming, because I think it is a necessity that the emergency room had* (I7). *I think that the proposal is great, I think that, in a way, it facilitates the flow here inside* (I4).

Another important aspect observed in this study was the participation of nurses in the construction and improvement of the protocol: *In fact the protocol was created by us, nurses* (I3). *It is requested to us in our meetings that if anyone has any suggestions, we should say it to be in the next version of the protocol* (I2).

Besides participating in the construction and improvement of the risk classification instrument, the respondents ensure that their practice is being recognized and valued: *It is a form of professional recognition, that we used to do but that did not have a name and a specific location, so it was valued, because it has at least one more nurse on each shift* (I3). *Here in the emergency room I feel very valued as a nurse. Doctors ask for nurses to do the classification because they trust them and in how they rank patients so I think that nurses' wisdom and knowledge was very valued* (I1). *I think it's an opportunity for nurses to show a new function* (I6).

Discussion

Through the testimonies it is clear that the understanding of welcoming is restricted, it was noticed that the word welcoming reported respondents to situations such as signs verification, colors of classification, the place where the classification is made, and even to the protocol, demonstrating professionals' lack of knowledge in relation to the meaning of the word welcoming. According to the Ministry of Health, welcoming should express an action of approximation, "being with" and "next to" in relation to users, so it is understood as a relationship of someone's inclusion[2].

It is possible to say that not all the professionals from this study and who work in welcoming with risk classification really welcome users who look for the service, but they only classifiy them according to a protocol established by the institution. Corroborating

with what was mentioned by the author[7], what can be observed in the unit of study is care in a fragmented way in which the act of welcoming is restricted to the moment of risk classification, making the professional/user relationship often hostile.

Welcoming should be part of a process that aims to promote quality of life through sensitivity, subtlety and subjectivity in health professionals' practice[8]. It is therefore specifically a process of human relations, and it should be played by the whole health team and in all sectors of care, it should not merely receive and send users in a fragmented way, but it should constitute a sequence of actions[2]. This is considered a relational technology that can provide significant changes in the way of working in the health area, one also adds that this technology is permeated by dialogue and that it aims at listening and valuing of users' and their families' demands besides respecting differences[9].

Welcoming is present in human beings' daily relationships, however, when it refers to health services, in particular the urgency and emergency ones, it is necessary to take into account the difficulties set by its flow and routine of demand at the health unit and also the difficulties in detecting, through a simple classification instrument, the needs that are in users' subjective world[10].

In this context, welcoming starts to be understood from the base document of the National Humanization Policy as an ethical behavior, a way of developing health working processes in order to reach all the users who look for health care, listening to their complaints and adopting at work a behavior that is able of welcoming, listening, and giving more appropriate responses to users[11].

The dissatisfaction reported translates the idea that when users look for an urgent and emergency service, they look for a resolution or immediate referral for their health problem, not found in the primary care network, or in basic health units, even if their demand is not classified as urgent or emergency by the adopted protocol. Such a situation can sometimes make users dissatisfied and even aggressive with professionals, agreeing with a study in which users and carers were dissatisfied with the service and resolution they received in emergency services, a fact also reported in the media about the negative aspects of care received in these spaces[12-13].

This fact demonstrates the need for these professionals to reflect about the relationship they have established with users, especially when that relationship can become tenser, such as in the entrance door of health units. Because the imposition of administrative boundaries, such as the distribution of numbers of sequence, for example, can cause a distancing in the user/professional relationship.

It is understood that, when a new proposal is implemented in a health service, training courses are necessary among those involved in the process, this is because team learning requires individual and group efforts, that is, learning and involvement provide a sense of belonging that can create value at work and a bigger probability of success of the proposal[14]. These authors claim that, for an adequate training to occur, it is necessary for the institution to provide human, material and physical resources that enable the proposed activity. However, it is known that the lack of economic and financial resources, found in health institutions, which depend on resources provided by the Unified Health System, resulting from a faulty health policy in whick the transfer of funds by federal, state and municipal authorities is precarious and slow to happen, it is, in most cases, the cause of the little investment in improvements related to human resources. The socioeconomic context in which Brazil is inserted, shown by different types of media, limits the actions of investment in the health sector, since the funds destined to institutions and services generally do not reflect the care that individuals receive for purposes of diagnosis or treatment.

Factors involving human resources, which have economic and financial difficulties, are related to the shortage of staff, more than one job, lack of incentive and motivation, leading to little commitment with

themselves and with the institution, low self-esteem, lack of recognition and professional value, job dissatisfaction, as well as working hours (during or outside working time) of conduction of potential activities involving the practice of training at work[14].

Regarding the understanding of welcoming with risk classification and as a synonym of welcoming, it can be inferred that the training course received was insufficient, did not include the National Policy of Humanization, because it is focused only on the risk classification. The welcoming and the implementation of protocols based on users' risk classification should consider other aspects that constitute the context of this unit.

The partial knowledge that nurses have about the topic can be associated with little financial investment and in vocational training, by managers of urgent and emergency services, and thus by not considering the context as a whole, humanizing policies and welcoming implemented with the risk classification tool fails to achieve its true meaning, based on the policy[2].

The National Humanization Policy of health services, through its legal provisions offers comprehensive training that involves the meaning of welcoming users and not simply classifying them as objects[1].

The implementation of risk classification protocols enables one to offer care according to different levels of necessity and not in order of users' arrival. Welcoming made through this nursing protocol becomes a support for systematized nursing interventions, providing emergency assistance to victims in a safer, fast and complete way[15]. However, nursing cannot stop taking care of users in their welcoming in order to do a simple risk classification.

Putting into action the welcoming with risk classification requires an attitude that implies analysis and daily review of practices in the units. The Ministry of Health, when it suggest steps for the implementation of a welcoming system with risk classification gives the manager the responsibility for the "Implementation of qualified hearing systems for users and workers, with guarantee of analysis and referrals based on the problems presented"[16:42].

The implementation of welcoming with risk classification becomes relevant when it generates benefits to care, such as decrease in professionals' and users' anxiety, improvement of interpersonal relationships of the healthcare team, standardization of data for studies, research and planning, and increase in users' satisfaction, since they will be attended faster and more effectively, changing the focus of the disease to the patient in individuals' holistic approach[17].

In daily work, one can easily find overcrowded services and professional overload, and it seems to make more difficult to exercise what is recommended in the humanization policy to users. It is necessary to find strategies to minimize these aspects to make welcoming more humanized and thus achieve the purpose of implementing risk classification in urgent and emergency services.

It is necessary to identify the difficulties found by nurses when they work at welcoming with risk classification, both in relation to the care network and reference and counter-reference systems, as to the internal problems of the service itself, which allows a situational diagnosis and an alternative proposition for a better match between the proposal of the Ministry of Health and the reality of the professional context[17-18].

One of the parameters provided by the Ministry of Health to implement the host with risk classification is "access criteria: identified publicly, included in the care network, with the use of reference and counter-reference protocols", and this question, among others, is a responsibility of managers of health services[19:44].

For the appropriate use of different levels of complexity one must establish flows in an organized way. Non-existent flows and easier access to more complex levels create distortions that harm the principles of comprehensiveness, universality and

equity, proposed by the Unified Health System[11].

Regarding the various difficulties reported, it can be said that they hinder the implementation of the proposal as one assures that it is necessary to know the structure of services and to establish the care network of emergency rooms, with reference and counter-reference protocols effectively agreed, with the definition of co-responsibilities in order to address the remaining distortions in the entrance doors of the Unified Health System[5]. However, these difficulties that exist in the Unified Health System do not correspond only to the entry process, but they involve it as a whole, the flow must have flexibility, cooperation and commitment of everyone involved.

According to the National Health Facilities Registry the city where the unit under study is located has a network of 46 basic health units, which might be able to absorb the demand for appointments, laboratory tests and procedures that are less complex[19]. However, it is understood that this does not occur due to mistakes in reference and counter-reference, little investment to adapt material conditions and human resources with the service demand, which was also mentioned by another study[13].

Regarding the conflicts between team members who worked in the service under investigation, it can be inferred that the appropriate conduction of the protocol developed by the team itself did not have support of all its members, because if there is disagreement it is because there are gaps on the instrument. Moreover, it shows managers the need to review the flow of attendance and conduct training of all the staff, including especially doctors trying to enable them to work as a team and to assume their function according to programmed collective agreements. Collective agreements must be built by all the staff in order to standardize the actions/procedures agreeing with the medical team, respecting the waiting time recommended for each of the classifications, in order to avoid injuries on users' health.

The protocol adopted by the unit under study is in accordance with the standards suggested by the Ministry of Health, following other studies with similar protocols that adopt the suggestions of the Ministry of Health, in which care was classified by levels and colors, namely red, necessity of immediate care, with priority zero; yellow, priority 1 involving urgency, that is, care as soon as possible; green for non-urgent cases, with priority 2 and blue with care according to the user's arrival, and priority 3[20].

Therefore one highlights again the responsibility of managers of units and services to ensure care in agreed periods as well the accountability of professionals about their absences at the time previously set.

Studies show that health workers, managers, users and the community who are linked to the service, start to have responsibility for recognizing and accommodating the actual needs and for the achievement of a gradual system of assistance to primary care and for the construction of new knowledge through the intercession of participants[11].

The valuation and professional recognition of nurses can be reached through their autonomy, motivation and job satisfaction. People are motivated by interesting jobs, by new challenges, by increased accountability and this motivation makes employees to perform their tasks with dedication and satisfaction[17].

It is essential to understand the reasons why professionals feel satisfied, or not, at work[16]. The difficulties encountered, concerning the organization of work should be investigated, making them known, because when one detects them, it becomes possible to analyze them, and from that point on, one can create ways to resolve them, so that professionals feel stimulated to participate enthusiastically in the development of their work process. For this investigation to be possible, it is important that there is a good channel of communication between managers and employees, so that obstacles can be

viewed by everyone involved, so that they can build together possible ways to solve the difficulties.

It corroborates with these data, that the central task that nurses play in the context of welcoming with risk classification is being facilitators, taking responsibility for the service organization starting at users' entry in the health service until the moment they are attended by the medical staff and the resolution of their complaint[14]. The authors added that the model of welcoming risk classification enables the reorganization of the work process, enabling nurses to take their subject's role in the process and starting to conduct it independently, not getting appart from events.

The fact that nurses have participated in the process of both the construction and the improvement of the protocol adopted by the emergency service, reflects the appreciation of their technical and scientific knowledge by managers, a fact that gives value to nurses.

One can notice that although nurses reveal difficulties in their daily work in the welcoming with risk classification, they also feel satisfied, recognized and valued by other team members, which shows visibility of their autonomy and professional respect. It is understood that the tendency of satisfied professionals with the development of their work is to increase the productivity and the quality of their service as well, increasing the chances of reaching a common goal, to increase the levels of users' satisfaction.

The daily practice of welcoming with risk classification makes nurses recognize themselves more within the services and it creates satisfaction with their work. One can also say that the appreciation of nurses' knowledge by other team members is an important booster for the conduction of practices with more satisfaction.

Conclusion

This study allowed one to understand the reality experienced by nurses about the proposal of welcoming with risk classification in an urgent and emergency service. It was possible to identify the understanding of the subjects about the proposal, as well as the facilities and difficulties encountered in exercising their daily activities in this unit.

One noticed that, in spite of the internal difficulties of the unit and with the absences and gaps in network services, nurses consider that the proposal of welcoming with risk classification contributes significantly to the reorganization of the services flow for users who need the unit studied.

It is important a discussion between the network managers from the urgent and emergency service, reference and counter-reference pacts with the service, which would allow the proposal to be known by all the professionals involved, so that users were directed properly.

One considers that welcoming with risk classification is an important tool for the qualification of the service, however it needs an expansion of discussions between managers and the staff so that this proposal is understood in all its dimensions: in the humanization and in classification of users, and also, to be followed and respected by everyone.

It is noteworthy that the implementation of the welcoming with classification requires a broad and deep qualification of everyone involved in the process, including professionals from the emergency care service, from the basic health units, from institutions who receive patients from urgent and emergency services, and from the community itself, which should be properly clarified to understand the new format of the service. The changes introduced in the health care system should be widely publicized by the media

to inform the process to be implemented and thus achieve the participation of everyone in this new process of care of the Unified Health System.

It is believed that this kind of study can help nurses in the management of assistance actions carried out with users of urgent and emergency services, enable improvements in the services' flow, increase professionals' and patients' satisfaction, and provide opportunities for better visibility of the service.

It is considered as a limitation of this study its conduction in only one urgent and emergency service. It is recommended the conduction of further studies of this nature in order to increase knowledge about the subject and create opportunities for the improvement of the quality of care provided in these services.

Collaborations

Weykamp JM, Pickersgill CS and Cecagno D contributed to the study design, analysis, data interpretation, article writing and final approval of the version to be published. Vieira FP and Siqueira HCH contributed to study design, article writing and final approval of the version to be published.

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