

A Look at the Practice of Risk Classification: Integrative Review

REVIEW

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Abstract

Introduction: The increase in the number of patients in emergency services/emergency brought the need for screening/risk classification as a way to organize the urgency and emergency care in the health institutions.

Objectives: Know how to develop the risk classification practice in the Brazilian reality using the scientific production, the insertion of nurses in risk classification using the Brazilian scientific production.

Methods: An integrative review was carried out, the data occurred during September 2015 in the following databases: Scientific Electronic Library Online (SciELO), Medical Literature Analysis and Retrieval System Online (Medline), and the Latin American and Caribbean System of Information on Health Sciences (LILACS) "Google Scholar."

Results: It found 9,874 articles and selected 33 for analysis. The results were organized in 04 categories: Risk classification as assistance qualifier; risk classification's organization; operation weaknesses of the risk classification and nurse's role in risk classification.

Conclusion: We conclude that the risk classification qualifies the assistance in emergency services; there are many difficulties for the

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risk classification's operation and the nurse has been established as a professional with technical and legal competence to perform the risk classification.

Keywords

Nursing; Health Services;
Emergency Health Services.

Introduction

The creation and implementation of the main Risk Classification protocols (RC) used in urgency and emergency services occurred in some countries that had already universalized its health system in the late 80s, in a networking context, organizational model of the current health systems in Brazil. In the global environment, the most known protocols are: Australian Model (Australian Triage Scale - ATS); Canada Model (Canadian Triage Acuity Scale - CTAS); Model of Manchester (Manchester Triage System - MTS); American Model (Emergency Severity Index - ESI); Andorra Model (Model Andorrà del Triage - MAT) [1].

This need for screening/risk classification occurred due to the increase of patients in the urgency/emergency services, ie, the overcrowding of these services. In the late 50s there was a change in medical practice: the private and family doctors became rare, the visits became scheduled appointments in offices and the First-Aid post became the main point of care when offices were closed, especially on holidays and weekends. In addition, more doctors became specialists, with few general doctors [2].

The First-Aid posts started having a big increase in demand, even for patients with less severe problems. All this led to the need to implement a method for classification and identification of those patients with immediate priority care. Doctors and nurses who had experience with the actual screening process on the battlefields introduced the technology in civil emergencies with extreme success. The first reference in screening that was

not in a major disasters period was in 1963 at Yale [2].

Faced with the Brazilian reality, that was not better than the other countries, in 2001, after a pilot project carried out in some hospitals, it was implemented the National Program of Humanization of Hospital Care (PNHAH). In 2003, then comes the National Humanization Policy (PNH) which aims to cover all existing actions in the field of humanization, making them more solid and equitable in a proposal [3].

Among the actions proposed by the PNH, the RC earns a great highlight in the organization of urgency and emergency care in public institutions. The RC aims to prioritize the care taking into consideration the risk of death or harm to health and also the degree of suffering. [4]

According to the Ministry of Health (MOH), RC can be made by any graduated health professional, however the nurse is indicated as the professional with competence to perform RC in emergency services [5].

In its scope, the Federal Nursing Council (COFEN), through Resolution No. 423 of April 9, 2012, shows that, regarding the nursing staff, the risk classification and prioritization of assistance in urgency services is only for the nurse, due to the legal provisions of the profession. For this, the nurse must be equipped with the knowledge, skills and abilities to ensure technical and scientific rigor to the procedure. [6]

In this context, our objectives were: to know how to develop the practice of risk classification in the

Brazilian reality using the scientific production; to know the insertion of nurses in risk classification using the Brazilian scientific production.

From these goals, we developed the following guiding questions: how the reception with evaluation and risk classification has contributed to improving the quality of care in urgency/emergency services in the Brazilian reality? How is the organization/structure of the risk classification in the Brazilian reality? What are the weaknesses/difficulties of the risk classification's operation in the Brazilian reality? What is the perception of the work of nurses in the risk classification in researches focused on the Brazilian reality?

Methods

This study consists of an integrative literature review that can be differentiated from literature review since it is structured in critical summaries of researches on a topic of interest aimed at contextualizing the research problem. It is restricted to relevant studies that point to new data related to the research objectives. While that synthesizes the results of previous research, ie, completed, and shows, particularly the conclusions of the literature corpus about a specific phenomenon, comprises, therefore, all the studies related to the research question that guides the search of this literature. The summarized and compared data allow to obtain overall conclusions about the research problem [7].

For this, the following steps were followed: 1) formulation of the problem, 2) data collection or definitions about the literature search, 3) evaluation of the data, 4) data analysis and 5) presentation and interpretation of results [7].

The data search occurred during the month of September 2015, with the following databases: Scientific Electronic Library Online (SciELO), Medical Literature Analysis and Retrieval System Online (Medline) and the Latin American and Caribbean System of Information on Health Sciences (LILACS).

For this, we use the following keywords: (host) OR (risk classification) OR (screening) AND (nursing) OR (nursing emergency) OR (support staff to the patient) OR (nursing staff) OR (nursing emergency) OR (human resources for health) OR (support to the patient staff) AND (emergency) OR (emergency hospital service) OR (emergency medical services) OR (health institutions) OR (health services). In addition to these bases, we also researched the "Google Scholar" using the terms "emergency AND risk classification".

Thus, we find: 31 productions in the Scielo database; 165 in the Medline; 528 in Lilacs and 9150 on "Google Scholar." However, from the inclusion and exclusion criteria, only 33 articles were selected.

The articles were selected from the reading of the titles, meeting the following inclusion criteria: papers discussing the risk classification theme in Brazilian reality, published in English, Portuguese and Spanish, from 2003 to 2015. Importantly, 2003 is a reference year in which was established the risk classification in the context of PNH. As exclusion criteria, we defined as those productions that, although they were inserted in the subject, did not bring subsidies to answer the guiding questions.

For data analysis, we built a data collection script, where we assembled some of the following information: author, year of publication; data base; journal; title; methodology; main results and conclusions. For the analysis of the research data, we used the content analysis technique, which, according to Bardin, can be defined as a set of analysis techniques of communication that uses systematic procedures and objectives of description of the message content to obtain indicators, quantitative or not, that may create opportunities for inference of knowledge regarding the conditions of production/reception of these messages. [8]

Results

From the searches of the 04 bases were selected 33 articles. In Table 01, we present these articles, distributed by author, year, title, journal and database. The articles are sequenced in the order they were selected and identified by the number preceded by the letter order "A", thus, article A01 to article A33. This reference is intended to identify the article in the text, in the presentation of results. **(Table 1)**

Regarding the year of publication, the studies followed the period 2007-2014. The years that most published on this theme were the years 2012, 2013,

2014, with 5, 6, 11 publications respectively. In the early years after the start of the Policy, 2003, 2004, 2005, 2006 were not identified articles related to this issue on this database.

Regarding the journals, we observed that many authors have used 23 different magazines to publish their work, and the Rev. Latino-Am. Nursing, the one that most published on the topic with 05 articles. Regarding databases, 21 articles were found on Google Scholar exclusively, 10 in LILACS and only 02 exclusively in that database; a scientific production was found in SCIELO and also on Google Scholar and in Medline, however,

Table 1. Distribution of the domains and facets of QoL. João Pessoa, PB, 2015.

Nº	Author	Year	Title	Magazine	Database
A01	Bellucci Júnior; Matsuda	2012	Implementation Of The Host System With Risk Classification And Assessment And Use Of The Analyzer Flowchart.	Texto Contexto Enferm	Scielo;Google Scholar
A02	Vituri	2013	Reception With Risk Classification In Teaching Hospitals: Evaluation Of Structure, Process And Outcome.	Rev. Latino-Am. Enfermagem	LILACS; Google Scholar
A03	Madeira; Loureiro; Nora	2010	Risk Classification: Service Profile In A Municipal Hospital In Eastern Minas Gerais.	Revista Enfermagem Integrada	Google Scholar
A04	Rossaneis	2011	Characterization Of Care After Implementation Of Reception, Assessment And Risk Classification In A Public Hospital.	Rev. Eletr. Enf.	LILACS, Google Scholar
A05	Nascimento	2011	Risk Classification In Emergency: Evaluation Of The Nursing Team.	Rev. Enferm. UERJ	LILACS, Google Scholar
A06	ULBRICH	2010	Nursing Protocol In Emergency Care: Subsidies For The Reception Of Victims.	Cogitare Enferm.	LILACS, Google Scholar
A07	Diniz	2014	Clinical Demand For A Unit Of Emergency Care, According To The Manchester Protocol.	Rev. Eletr. Enf.	Google Scholar
A08	Silva	2014	Assessment Protocol And Risk Classification Of Patient In Emergency Unit.	Rev. Latino-Am. Enfermagem	Google Scholar
A09	Albino; Grosseman; Riggenbach	2007	Risk Classification: An Urgent Need In A Quality Emergency Service.	Acm Arq. Catarin. Med.	Google Scholar
A10	Oliveira	2013a	Impact Of The Implementation Of The Reception With Risk Classification For The Work Of Professionals From A Unit Of Emergency Care.	Reme Rev. Min. Enferm.	LILACS, Google Scholar
A11	Bellucci Júnior	2015	Reception With Risk Classification In Emergency Hospital Service: Evaluation Of The Process Of Care.	Rev. Enferm. UERJ	Google Scholar
A12	Maciel-Lima; Carabagiall	2014	Right To Health: Limits And Potential Of Reception With Risk Classification.	Revista Jurídica	Google Scholar
A13	Pinto, A. R	2014	Reception With Risk Classification: Highlights Aspects.	Revista Rede De Cuidados Em Saúde	Google Scholar

N°	Author	Year	Title	Magazine	Database
A14	Silva; Bolpato	2013	Proposed Deployment Of Reception Protocol Assessment And Risk Classification In The Emergency Room Of Barra Do Garças-Mt.	Revista Eletrônica Interdisciplinar	Google Scholar
A15	Oliveira; Silva; Costa	2012	Risk Classification By The Nurse: A Literature Review.	Revista Baiana De Enfermagem	Google Scholar
A16	Santos	2014	Recepation With Risk Classification: A Wire Guide Of Emergency Management.	Revista Saúde E Desenvolvimento	Google Scholar
A17	Souza	2011	Risk Classification In The First-Aid Post: Agreement Between A Brazilian And Manchester Institutional Protocol.	Rev. Latino-Am. Enfermagem	LILACS, Google Scholar
A18	Pinto Júnior; Salgado; Chianca	2012	Predictive Validity Of Manchester Risk Classification Protocol: Assessment Of The Evolution Of Patients Admitted In An Emergency Service.	Rev. Latino-Am. Enfermagem	LILACS, Medline, Google Scholar
A19	Oliveira	2013b	Reception With Risk Assessment And Classification: Agreement Between The Nurses And The Institutional Protocol.	Rev. Latino-Am. Enfermagem	LILACS, Google Scholar
A20	Souza	2014	Nurses' Perception Of The Realization Of The Risk Classification In Emergency Service.	Invest Educ Enferm	LILACS
A21	Souza; Bastos	2008	Reception With Risk Classification: The Process Experienced By Nursing Professionals.	Reme Rev. Min. Enferm.	Google Scholar
A22	Acosta; Duro; Lima	2012	Nurses' Activities In Screening Systems/Risk Classification In Emergency Services: Integrative Review.	Rev. Gaúcha . Enferm	LILACS
A23	Coutinho; Cecilio; Mota	2012	Risk Classification In Emergency Services: A Discussion About The Literature On The Manchester Triage System.	Rev. Med Minas Gerais	Google Scholar
A24	Cavalcante	2013	Reception With Risk Classification: Humanizing Proposal In Emergency Services.	R. Enferm. Cent. O. Min.	Google Scholar
A25	Zanelatto; Dal Pai	2010	Recepation Practice The In The Emergency Service: Perspective Of Nursing Professionals.	Ciência, Cuidado E Saúde	Google Scholar
A26	Lima Neto	2013	Reception And Humanization Of Care In Adult First-Aid Posts: Perceptions Of Nurses.	Rev Enferm Ufsm	Google Scholar
A27	Caveião	2014	Nurse's Challenges In The Implementation Of Risk Classification In Mixed Unit.	Rev Enferm Ufsm	Google Scholar
A28	Rodrigue	2014	Design Of The Nursing Staff On Reception With Risk Classification.	J. Nurs Ufpe On Line.	Google Scholar
A29	Duro	2014	Nurses' Perception Of The Risk Classification In Emergency Units.	Rev Rene.	LILACS, Google Scholar
A30	Teixeira; Oselame; Neves	2014	The Manchester Protocol In The Unified Health System And Work Of Nurses.	Revista Da Universidade Vale Do Rio Verde	Google Scholar
A31	Weykamp	2015	Reception With Risk Classification In Urgency And Emergency Services: Applicability In Nursing.	Rev Rene	Google Scholar
A32	Bohn	2015	Nurses' Perception About Using The Manchester Risk Classification System Protocol.	Ciência, Cuidado E Saúde	Google Scholar
A33	Damasceno	2014	Reception With Risk Classification In The Emergency Care Network: Prospects For Nursing.	Caderno De Graduação-Ciências Biológicas E Da Saúde-Unit	Google Scholar

that article has also been found on Google Scholar and Lilacs.

After analysis the of 33 articles, we organized the findings in four relevant categories: Reception with Risk Evaluation and Classification (AACR) as an assistance qualifier in urgency/emergency services; Reception implementation and organization with risk evaluation and classification; Weaknesses in the operation of the reception with risk evaluation and classification; and Nurses' performance on the reception with risk evaluation and classification, presented below.

Category I. Reception with risk evaluation and classification (aacr) as assistance qualifier in urgency/emergency services

In this category we identified from the analyzed studies, how the risk classification has improved the quality of care in urgency/emergency services. In this way, the authors point out that the increase in quality of care in emergency departments with the implementation of Reception with Risk Evaluation and Classification (AACR) was because the service became based on the degree of risk/emergency/suffering/need of the patient, so more attention to the most severe patients (A04, A05, A10, A13, A21, A24, A29); another finding that justifies the improvement was to reduce the risks for patients who were waiting for care and provide greater safety for professionals (A02, A05, A08, A18, A23, A29); as well as for improvement in the organization of the flow of patients (A04, A21, A29, A31, A32, A33); by providing a greater humanization of care in urgency/emergency (A02, A10, A13, A24); to improve the user-professional relationship, decreasing anxiety and increasing user satisfaction level (A10, A21, A24); by demanding a reorganization of emergency services and health network as a whole (A01, A29); requiring a reorganization of the work process (which is no longer centered on the doctor,); being a multi-disciplinary and interdisciplinary work (A10, A21); serving as a tool to aid service management (A33, A21); Furthermore,

to ensure the resoluteness of user needs, standardize the service, involve the responsibility of the individuals involved in this process, organizing the service network and be based on the principles and guidelines of SUS (A24).

Category II. Establishment and organization of the reception with risk evaluation and classification (AACR)

From the analysis of some studies and based on that is proposed by the Ministry of Health, we verified how is the structure/organization/operation of the Reception with Risk Evaluation and Classification (AACR) in the context of Brazil.

For the service can be performed with reception and risk classification, are required to change the physical environment to ensure the following areas: reception where emergency bulletins are filled with room to wait and risk classification room, where the classification is performed by the nurse in order to enable privacy to patients. In addition, the sectors need to be organized to provide care according to the risk classification, ie, a red area, which comprises the reanimation/stabilization room, where the most serious patients are seen; yellow area where potentially serious patients are seen, and green and blue areas, intended for less severe patients (A21, A25).

Regarding the flow, first, the patient fills the emergency bulletin at the reception; then it should be evaluated as soon as possible by the nurse in the risk classification (in no more than 10 to 15 minutes after the arrival of the patient). After that, according to the classification, it is driven either to reanimation/stabilization (if classified as red) or as a priority to meet the doctor's office (if classified as yellow), or keep waiting to be called for consultation (if classified as green or blue). The identification of this classification can be seen both at patient report or with the patient with a ribbon color (red, orange, yellow, green or blue), which is normally placed on the patient's arm (A04, A09, A10, A20, A21).

In addition to this internal flow if thinking about network service, it is necessary that the institution also agree with other health services, referrals of patients, ie, how will be the reference and counter reference of patients in the network, an external flow (A04, A09, A10, A20, A21).

Regarding the organization, it is necessary for the hospital to build and deploy, or use an existing clinical protocol, that supports the risk classification carried out by the nurse. A space in the emergency bulletin is essential, that is specific to record data relating to risk classification, and to identify this classification. Data as the main point, vital signs, comorbidities, medications and physical examination (A08, A10, A17, A19, A20, A21, A25).

There are some clinical protocols used internationally, and other Brazilians, who have been used, or served as a model for emergency services in the Brazilian reality: Manchester/England MTS ©, AST/Australia, CTAS/Canada, ESI/United States, Reception; and Risk Classification of the Conceição Hospital/Porto Alegre-RS; Reception Project at Municipal Hospital Mario Gatti/Campinas-SP; and Hospital Odilon Behrens/Belo Horizonte-MG; in addition, guidelines and protocols of Reception with Risk Evaluation and Classification in MS/Brazil. Note that some protocols classify the severity of patient on 5 levels, and others at 4 levels (A08, A17, A21).

The flow of patients should also be contained in a protocol recognized by the institution. Both protocols, clinical and patient flow, should be validated and evaluated constantly. The reception should be done by all professionals in all places and times. The classification in most services, is carried out by the nurse, the nursing technician assists in this process, especially in the verification of vital signs (A04, A06, A10, A17, A18, A19, A20, A21).

Category IV. Weaknesses in reception working with risk evaluation and classification (AACR)

In this category that addresses the difficulties faced on the routine of professionals working in the

risk classification, the following weaknesses have been identified in some services from the articles analyzed: Fragility of the reference and counter reference system, ie, the organization of external flow with the network (A02, A03, A10, A11, A12, A20, A31, A32); weakness in the structure of the health care system as a whole (A03, A05, A13, A20); inadequate physical structure of the service to organize care for risk classification (A02, A05, A10, A11, A12, A20); lack of knowledge of the users of the risk classification/need (A12, A10, A27, A31, A32); lack of agreement of the entire health team to risk classification strategy and medical staff's resistance to establish a multi-professional work with nursing (A10, A20, A27, A32); lack of materials and equipment for classification and appropriate assistance (A05, A10, A11, A13); qualitative and quantitative shortage of human resources (A10, A11, A12, A13); lack of beds in internment units, which also contributes to overcrowding of the service; crowded environment (A10, A12, A25); weakness in the reception, due to the lack of a comfortable and safe environment for the patient; lack of resoluteness and weakness in the personal relationship between user and health professional (A10, A12, A20); establishing internal flow from a institution protocol; reevaluation of protocol in use (A02, A10); can not meet the assumptions of the National Humanization Policy (A05, A11); lack of reevaluation of the classified patient (A02); Vulnerability disregard and user suffering at the classification time (A12) and incomplete record of the data contained on the classification bulletin (A07).

Category IV. Nursing performance in reception with risk evaluation and classification (AACR)

Regarding the nurses' work in Reception with Risk Evaluation and Classification (AACR), various studies show the nurse as a professional with technical and legal competence to perform risk classification (A09, A10, A11, A12, A13, A15, A16, A20,

A21, A26, A30, A33); some studies also point out that the risk classification gives autonomy and visibility to the work of nurses (A11 A20A21 A32) and the clinical protocol approved by the institution gives legal support for the nurses' classification (A17, A32). On the other hand, several studies point out the need for training of all professionals, especially nurses conducting the risk classification (A02, A03, A09, A07, A08, A11, A13, A14, A15 A16, A17, A19, A20, A23, A25, A28, A26, A31, A33). Moreover, as regards the nurse's role in risk classification, some articles (A20, A25, A26, A22, A30, A23) allowed us to identify some skills needed for nurses to work in risk classification.

These skills will be presented from the knowledge, skills and attitudes. Regarding the knowledge, it is important to be aware of the clinical protocol and flow, clinical, administrative knowledge, knowledge of the care network, and SUS principles. While in the area of skills are needed nursing skills in the risk classification to perform clinical evaluation quickly and efficiently in cases of emergency care, clinical sharp eye, critical and reflective thinking, record correctly, handling computerized equipment to the use of protocols that use computer systems. Finally, actions are needed to promote communication, patience, flexibility, willingness to qualified listening, making immediate decisions, intuition, to know how to deal with situations of occupational violence, working in multi-professional team and proactivity (A20, A25, A26, A22, A30, A23).

Discussion

In Brazil, the National Humanization Policy and National Attention Policy for Emergency recommend that all health services should deploy the Reception with Risk Evaluation and Classification (AACR) to provide the service of urgency/emergency [5.9].

For the risk classification to take place in an effective and resolute way, it is essential that each state structure/organize your state care network emer-

gencies as recommended by the Ministry of Health, [9, 10] and that the institutions of each municipalities, region and even the state as a whole, agree the reference system and counter reference through interagency protocols so that when doing the risk classification the nurse can give greater resolutions to the needs of users and can make referrals needed more security. The construction of this external flow of patients, ie, the network that allows effectively the reference and counter reference, as seen in the results, is one of the biggest problems faced in everyday life of nurses who perform risk classification.

However, if these structures still work in isolation and do not organize with other care networks, the result of the implementation of a protocol of these is less than its potential. This is a fact that has been observed, both here in Brazil and abroad. If we do not work on network, problems will not cease [1].

In this way, the quality needs to permeate all the care spaces because the actions taken at one location influence and at the same time are influenced by the care provided in other health care levels [11].

There is no doubt that the risk classification can contribute as assistance qualifier in emergency services, however, on a daily basis, external flow, lack of network structure, inadequate physical infrastructure, lack of knowledge of users, lack of team membership, lack of materials and equipment has prevented the development of this activity effectively. [1]

The nurse, due to the skills developed in their training, has been enshrined in the national scene as a professional with technical and legal competence to perform risk classification. In this sense, No. 423 Resolution of 9 April 2012, provides, with regard to nursing staff, risk classification and prioritization of assistance in emergency room as private nurses work, and for this the nurse should be equipped with the knowledge, skills and abilities to ensure technical and scientific rigor procedure [6]. However, it has a fundamental importance that in the

institution, there are clinical protocols and flows for greater safety of nurses in conducting this evaluation. [4]

For MS, the evaluation technology with Risk Classification presupposes the establishment of service agility from the analysis, from the perspective of pre-established protocol, the degree of user needs, providing attention focused on the level of complexity and not in order of arrival. [5]

In this context, the risk classification should be done by trained nurses to recognize signs and symptoms of gravity when the arrival of a patient in an emergency room. [12] Importantly, the need for training of all staff, especially nurses, on risk classification, was one of the clearest findings from the selected articles.

Conclusions

The analysis of 33 articles allowed us to have a look at how it is being developed risk classification in the Brazilian context and the inclusion of nurses in this activity.

In this way, the studies analyzed allowed us to identify that the implementation of Reception with Risk Evaluation and Classification is presented as a qualifier assistance in urgent and emergency services. The National Humanization Policy and Urgency and Emergency National Care Policy have been used as guidelines for the implementation and organization of the risk classification.

However, on a daily basis, the services are still facing many difficulties to actualize a risk rating in urgency/emergency services. Among the difficulties are the absence or disarticulation of emergency network in each region/state, with the fragility of the reference flow and counter reference patients.

The nurse has already established itself as a professional with technical and legal competence to carry out the risk classification, however, there is a need for training both of this professional and the whole healthcare team about this issue.

Finally, it is important to emphasize that the risk classification is a complex activity that requires the development of specific skills for a qualified performance.

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