REME • Rev Min Enferm. 2016; 20:e969
DOI: 10.5935/1415-2762.20160039

RESEARCH

WORK PROCESS OF NURSES IN THE RECEPTION WITH RISK RATING

O PROCESSO DE TRABALHO DO ENFERMEIRO NO ACOLHIMENTO COM CLASSIFICAÇÃO DE RISCO

EL PROCESO DE TRABAJO DEL ENFERMERO EN LA ACOGIDA CON CLASIFICACIÓN DE RIESGO

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Submitted on: 2016/04/06 Approved on: 2016/09/02

ABSTRACT

Objective: to describe the nursing work process in the Reception with Risk Rating (RRR) in the Emergency Unit of a municipality in Minas Gerais. **Methods:** qualitative case study in which data were collected through semi-structured interviews with nurses and submitted to thematic content analysis. **Results:** the main purpose of the work process in the RRR was identified as giving priority to patients who are under high clinical risk, and also providing guidance and clarification to users and verifying clinical exams. In relation to the object of the work process, this was related to complaints from users and their articulation with tools and knowledge on professional practice. Sensibility was recognized as necessary in the relationship between professionals and users, as this increases the quality of the listening. Knowledge, as a soft-hard technology, was recognized as an extension of the professional, able to direct the care. Hard technologies were also mentioned. All professionals of the institution were pointed as agents of the rating process and the nurse was emphasized as the classifier. The final product of the work was not conceived as something finished and materializable as an object, but as the actual implementation of the assistance that is consumed when it is produced. **Conclusion:** there are inter-relational elements and technologies in the nursing work process of RRR. There is an interdisciplinary potential, subjectivities and contextual situations that pervade the scenario and require improvements in their work process.

Keywords: Emergency Medical Services; Emergency Nursing; User Embracement; Working Conditions.

RESUMO

Objetivo: *descrever o processo de trabalho do enfermeiro no Acolhimento com Classificação de Risco (ACCR) na Unidade de Pronto-Atendimento de um município de Minas Gerais.* ***Métodos:*** *estudo de caso de abordagem qualitativa em que os dados foram coletados a partir de entrevistas semiestruturadas com enfermeiros e submetidos à análise de conteúdo temática.* ***Resultados:*** *a principal finalidade do processo de trabalho no ACCR foi reconhecida como priorizar o paciente que tem alto risco clínico, além da orientação do usuário, o seu esclarecimento e verificação de exames clínicos. Em relação ao objeto do processo de trabalho, esteve relacionado às queixas dos usuários e sua articulação com instrumentos e saberes da prática dos profissionais. A sensibilidade foi reconhecida como necessária na relação profissional-usuário, qualificando a escuta. O saber, como uma tecnologia leve-dura, foi reconhecido como uma extensão do profissional, capaz de direcionar o cuidado. As tecnologias duras também foram mencionadas. Todos os profissionais da instituição foram destacados como agentes do processo de classificação e enfatizou-se o enfermeiro como o classificador. O produto final do trabalho não foi concebido como algo acabado e materializável como um objeto, mas a própria prestação da assistência que é consumida, no momento que é produzida.* ***Conclusão:*** *existem elementos e tecnologias no processo de trabalho do enfermeiro no ACCR que são inter-relacionais. Há uma potência interdisciplinar, subjetividades e situações contextuais que perpassam o cenário e exigem aperfeiçoamentos em seu processo de trabalho.*

Palavras-chave: *Serviços Médicos de Emergência; Enfermagem em Emergência; Acolhimento; Condições de Trabalho.*

How to cite this article:
Rates HF, Ahmed M, Cavalcante RB. Work process of nurses in the reception with risk rating. REME – Rev Min Enferm. 2016; [cited _____ ___ ___]; 20:e969. Available from: _____ DOI: 10.5935/1415-2762.20160039

RESUMEN

El objeto del presente estudio fue describir el proceso de trabajo de enfermería en la Acogida con Clasificación de Riesgo en la guardia hospitalaria de un municipio de Minas Gerais. Se trata de un estudio de caso cualitativo cuyos datos fueron recogidos a partir de entrevistas semiestructuradas a enfermeros y luego sometidos al análisis de contenido temático. Se reconoció que el objetivo principal del proceso de trabajo en la Acogida con Clasificación de Riesgo (ACCR) es darle prioridad al paciente con alto riesgo clínico, además de orientar a los usuarios, su esclarecimiento y comprobar los exámenes clínicos. El objeto del proceso de trabajo está relacionado con las quejas de los usuarios y su articulación con los instrumentos y conocimientos de la práctica profesional. La sensibilidad fue considerada como necesaria en la relación usuario – profesional, sobre todo el saber escuchar. El conocimiento, como tecnología blanda-dura, fue considerado como una extensión del profesional, capaz de orientar los cuidados. También se mencionaron las tecnologías duras. Todos los profesionales de la institución se destacaron como agentes del proceso de clasificación y se realzó que el enfermero era el clasificador. El producto final del trabajo no fue concebido como algo acabado, que se puede materializar como un objeto, sino como la propia prestación de la atención que se consume cuando se produce. En el proceso de trabajo de enfermería en la ACCR hay elementos y tecnologías que se relacionan entre sí. Hay una potencia interdisciplinaria, subjetividades y situaciones contextuales que prevalecen en el escenario y requieren mejoras en su proceso de trabajo.

***Palabras clave**: Servicios Médicos de Urgencia; Enfermería de Urgencia; Acogimiento; Condiciones de Trabajo.*

INTRODUCTION

In order to follow the recommendations of the Ministry of Health and implement the Reception with Risk Rating (RRR) for the reorganization of the "emergency gateway", the State Health Department of Minas Gerais (SHD-MG) established the Manchester Screening System throughout the state of Minas Gerais in 2008.1 This is a risk rating tool for complaints of urgencies/emergencies that establishes clinical priorities and sets a maximum waiting time for receiving medical care.

In this context, the role played by nurses is important because their professional training covers not only technical and biological issues, but also social and emotional aspects that enhance a receptive and responsive practice to the population's needs.[2] Thus, nurses have been indicated by organizations to act in RRR considering their technical and relational abilities and skills.

However, the nurses' working process in this new scenario is still little known. This is traditionally characterized by urgent unpredictability regarding the severity of the state of the patient, requiring specific flexibility to the care, effective communication, in addition to the typical features of the work inherent to the health area, which is considered as live in action.[3] This work interacts all the time with tools and norms, forming a working process in which different types of technologies are articulated and shape a way of care centered on relations or guided by the logic of hard tools such as physical equipment.[3,4]

It is believed that changes in the nursing work process must occur with the insertion of the RRR in emergency services.[5] The present study is justified by the need to understand these changes and their influence on nurses, other professionals and users. Furthermore, it is important to understand their problems in order to intervene on the reality manifested in this changed environment of urgency and emergency.

This leads to the following question: how do nurses perceive their work process in the RRR? Thus, the aim of this study is to describe the nursing work process in the reception sector with Risk Rating in a Unit of Emergency Care.

METHODOLOGY

A case study with qualitative approach was conducted. The case study allows the investigation of complex social phenomena, preserving the holistic characteristics and significant events of real life, as well as the organizational and administrative processes.[6]

The scenario was one Emergency Care Unit (ECU) of a core-municipality in the expanded health region of the west of the state of Minas Gerais and the Regional Health Superintendency headquarters. The municipality is a reference to 54 cities in its surroundings. The decision to conduct the study in this unit was justified by facilitated access to the researcher and because the unit is the only fixed service offered by the public emergency system of the SUS at the region. The mobile service is provided by the Fire Department.

Data were collected through interviews with semi-structured scripts with nurses who perform the RRR in the ECU, in the workplace, in the period between January and February 2015. There are 22 nurses working in the ECU with the Manchester protocol. However, one nurse refused to participate and one was on vacation, and, therefore, 20 nurses were interviewed. Each nurse received a code to ensure anonymity (letter N= Nurse and the number 1 to 20 for each interview). The participant nurses signed the Informed Consent form. Simple observations of the daily work of nurses in the RRR were also performed. These observations were recorded in a field diary.

Data were subjected to content analysis.[7] First, a "quick reading" was carried out, which allowed the first contact with the text to be analyzed and a more precise alignment of the study objectives. In addition, the formulation of hypotheses and the development of indicators that substantiated the final inter-

pretation were combined. In this pre-analysis, text cut-offs were made, corresponding the registration units and then these were coded. The selected registration units were part of the *corpus* used for the analysis and they followed the rules of completeness, representativeness, consistency and relevance. The next step was the transformation that followed specific rules for handling the plain text and performing the abstraction of representations of content that allowed the analysis of expressions about the reported characteristics. And finally, at the stage of processing the obtained results, inferences and interpretations, the classification of the elements that made up the final categories for convergence of context units was carried out.

All stages of the research are in accordance with Resolution nº 466/2012 and approved by the Ethics Committee of the Federal University of Minas Gerais (CAAE: 33125014.0.0000.5149).

DISCUSSION OF THE RESULTS

The work process of nurses in RRR: its elements and technologies

Participants recognized the elements of the work process in the RRR and its technologies. The purpose was recognized as a first element. For one of the nurses interviewed, her work has several purposes, but the main purpose is that the patient who has high clinical risk be given priority, preventing that the patient gets worse in the queue. Other purposes were also recognized: guidance, clarification and verification of clinical tests, despite nurses reported that the RRR is not the proper place or moment for these purposes.

> *I see that the main purpose is to prevent the patient from getting worse while waiting for medical care. It is to prioritize the care of that user that has a higher risk, that is the main purpose. But we have other purposes. You give guidance. Althoug this is not the place to do it, [...] with an orientation that could have been given in primary care, we end up doing there. We look at test results for the patient in the rating. Sometimes this patient was waiting a long time for the doctor to see the exams. [...] You manage to send him to go to primary care. But the main purpose of Manchester is obvious that is to prevent that the patient gets worse in the queue (N6).*

The RRR is considered a techno-assistential device that allows to reflect and change the ways of operating the service because it puts the relationship of access to health services, labor and management models into question.[8] These changes aim to improve the users' access to health services, transforming the traditional way of entry by means of queues and order of arrival, as well as they propose the humanization of relations between health professionals and users. Furthermore, it guides the care of patients by the clinical risk they present, raising the degree of bonding and trust between health professionals and patients.[9]

There is a purpose in the nursing work process in the RRR that is established by a standard (the protocol). This is previously established, but other purposes are recognized and built from their experience at work. It is a purpose that is established from the need to act on health, develop their practice in health, intervene in a reality that needs solution.[2] The production of care in this scenario is a goal built from its relationship with the patient. Thus, clarification, guidance, checking the medical exams and the referral of patients are sound actions mediated by listening and by the decision to meet the user's needs at that moment. The observed scene below illustrates this situation.

A patient admitted to the unit with complaints of pain when urinating; she was classified by the nurse in the RRR with green. Then, she was seen by the doctor, medicated and oriented to return when routine urine exams were ready. The user did not agree with the minimum waiting time of three hours to get this result of the test at hand (the laboratory is outsourced and is located in the reference hospital, far from the ECU, requiring transport, which in this case is done by a *motorcycle courier*). The user returned the next day; she was resubmitted to the classification. In this situation, the nurse assessed the results of the exams and told her they were normal. As the patient had no further complaint, she was referred to primary care to follow-up.

In relation to the object as a second element of the work process, this is not recognized only in the complaint of a person or the pain, but in its articulation with tools and knowledge, other components of a work process focused on care.

> *I understand as a wider object, I mean, I do not think that the object of my work is the person's complaint, I understand that the object of my work is the knowledge along with a well-articulated tool, which in my view deserves some reforms, I think we deserve some adaptations of the Manchester Protocol to our reality, one dealing with the pain, the complaint, the disease of the other, ...so, my work object is this mix, it is not just a complaint or a person, or only my TRIUS [...] is this interaction (N3).*

The health work cannot be captured by the logic of dead work, expressed in equipment and structured knowledge, because its object is not fully structured and interacts with the other elements. Its action technologies include intervention processes in action, operating technologies of relationships, meetings, subjectivities, and structured knowledge, allowing a degree of freedom in order to carry out this work.[3] This way, the technologies involved in health work can be classi-

fied as soft, soft-hard and hard, as valises to accommodate the technological arsenal of health work.[3] In the first valise are the tools, the equipment such as machines, regulations, organizational structures (hard technologies); in the second, the structured technical knowledge, such as clinical medicine, epidemiology (soft-hard technologies); and in the third, the relations between subjects which have materiality in the own act (soft technologies). In the production of care, the professional uses the three valises, combining them in different ways, according to their way of producing care. Thus, there may be the predominance of the instrumental logic; in other cases, there may be a *modus operandi* in which the relational processes (intercessors) intervene for a work process to become more focused on soft and soft-hard technologies.[3]

Based on these considerations, it is necessary that the RRR contemplate the inseparability between the elements of the work process and the technologies, which cannot be separated in the core of the work. They are complementary, their interaction/coordination is needed. This was recognized by a nurse, but needs to be valued by the entire team. In another scene, this inseparability between elements of the work process and technology was also observed.

A patient admitted to the unit accompanied by a professional of the Mental Health Service, claiming unbearable abdominal pain ("as never felt before") in the lower right upper quadrant for many months. However, the inspection had not *facies* of pain or discomfort, or pain on palpation. The nurse went talking with her and she reported that the environment of the Reference Service in Mental Health (SERSAM) was causing her distress, that she "did not want to stay there because there is a place for crazies". In this situation, the discriminators of the Manchester Protocol Flowchart (hard technology) that would classify her woul not be enough to detect priority in this patient. Thus, the nurse used subjectivity, that is, a qualified listening (soft technology) for evaluating and conducting the case. The patient was classified (soft-hard technology) and assisted by the doctor.

Meanwhile, tool, object, knowledge and technology (soft, soft-hard, hard) pervade each other, transform each other and provide support to the care. You can not make health care in the RRR as a robot, but one should recognize it as a space for reflection, an articulated action, a movement in behalf of the individual that needs care.[3] In this sense, a complexity to be managed and incentivated within the work relations in the RRR is set up, the interaction between the various elements of the work process. The following scene endorses a situation where the user also appears as active in the therapeutic action.

Six-year-old patient with thalassemia minor, accompanied by her mother; she was admitted to the unit with complaint of lower limb pain and malaise. The mother showed much knowledge of all clinical basis and treatment of disease of her daughter. This important joint participation in the treatment directly influenced the direction of nurses to classify the child. He gave priority to the care of this child within the green classification by this context.

The means/tools were also recognized in the investigated work process. First, sensibility was recognized as a tool, a soft technology necessary in relation with the user, in the listening process when carrying out RRR.

> *Having sensibility is a great working tool in the rating, if you are not sensible, sometimes, things go unnoticed because sometimes the person cannot tell you everything that she or he is feeling (N4).*

There are ways to do a work that depend on interpersonal bond, but in the case of health, this is particularly decisive for the own effectiveness of the act. Health work necessarily materializes in people, in an inter-relationship in which the "consumer" contributes to the work process and is part of that process. The "consumer" provides information about what happened to him/her, the story of his/her complaint or illness, and his/her active participation in the fulfillment of the therapeutic plan is necessary. The patient is co-participant in the work process and often co-responsible for the success or failure of the therapeutic action.[10]

Other nurses cited clinical knowledge as guiding work tools for risk rating. Knowledge, as a soft-hard technology, was recognized as an extension of the professional, able to direct the care.

> *Our clinical action is also a working tool, the clinics that we brings, the knowledge that we bring is a working tool (N3).*

In contrast, other tools representing the hard technologies were referred as present in the work process, such as the TRIUS, the oximeter, the thermometer and the risk rating form.

> *I have TRIUS, I have the oximeter, thermometers and has also the sheet that is the form that, when this one does not work (the TRIUS), I have another spare (N7).*

Agents/professionals were also recognized in the work process in RRR. All professionals of the institution were pointed as agents of the rating process and the nurse was emphasized as the classifier.

> *While the classifier is the nurse, the classification within the institution involve all professionals. From the doorman, the cleaning girl, the nursing technician, up to the receptionist, because everyone is involved, because ev-*

> *eryone has to understand the classification process and why it is important. (N12)*

The reception is not a space or only an environment, but an ethical stance; it does not imposes a specific time, nor a specific professional to do it, but implies the sharing of knowledge, anxieties and interventions. The one who performs the reception takes on the responsibility to assist others with their demands, with the necessary resoluteness. It is an action that does not end at the front desk and in the RRR, but that must occur at all moments of the health service, and must be carried out by all professionals that are involved.[11] Its technical directionality and its production depend on the collective work, most of the times.[12] Here it is the interdisciplinar potential of the RRR, which goes beyond the multiprofessional walls and limits. It is not framed in a hegemonic knowledge, but depends on the interrelationships that are established in the action of professionals.

The final product, as one of the elements of the work process, also emerged from the speeches of the participants and observations realized, but its recognition did not occur as a finished and materializable product as an object.

> *[...] the classification is much like a dynamic [...] I do not think I have a finished product, and that's it, it's over, thus, the product of my work is the organization of care flow (N3).*

> *[...] it is the patient cared for, assisted or forwarded. [...]((N14)*

In the following scene, the dynamics and complexity of the nursing work in RRR are perceived.

Elderly patients admitted to the unit, brought by relatives in a wheelchair, with nasoenteric tube, with tracheostomy; main complaint of prostration. History of multiple entries in service for pneumonia. The nurse assessed the user and classified him as yellow. However, when the nurse performed the pulmonary auscultation and due to the prostration, he decided to prioritize its assistance in the yellow classification and reported: "This I will lead to the doctor's hand". There was a change of service flow to provide immediate assistance and meet a demand of gravity of the case. After health care, the nurse went to the drug industry to verify if that prioritized patient had been medicated. For this professional, the final product was not only the classification performed, but the reception of the individual in order to solve his problem and the verification of the care provided by other health professionals.

The final product of the health work is the very provision of the assistance that is consumed when it is produced. There is no a product separated from the production process and the result of the work is not materializable. It is possible to say that the purpose of the work in the emergency is the recovery of the patient's health or the relief of the acute situation that led that patient to seek professional help; the product, consumed in the process of producing care, would result from the action, which may be the relief of the pain, the realization of a bandage, a surgical procedure, the administration of an analgesic or even orientation on disease prevention or health promotion.[13]

CONCLUSION

The description of the work process of nurses in the RRR carried out in the ECU showed that this is recognized from its elements (purpose, object, tools, products) and technologies (soft, soft-hard, hard). The interdisciplinary potential and subjectivities in the RRR, which need to be perfected, were highlighted. The listening time, the need for giving guidance to the user, team integration and valuation of knowledge are aspects that must be considered.

Regarding the limitations of this study, we identified the impossibility to generalizations due to the methodological framework used and its descriptive character. However, its relevance is endorsed and the need for future studies addressing the daily work of all professionals involved in the RRR, as well as the perceptions of users circumscribed in the RRR, are emphasized.

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