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QUALITY OF RECEPTION WITH RISK CLASSIFICATION IN THE EMERGENCY SERVICE

QUALIDADE DO ACOLHIMENTO COM CLASSIFICAÇÃO DE RISCO NO SERVIÇO DE URGÊNCIA

CALIDAD DE ACOGIDA CON CLASIFICACIÓN DE RIESGO EN EL SERVICIO DE URGENCIAS

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ABSTRACT
Objective: Evaluate the dimensions of structure, process and result of the reception with risk classification carried out in the Emergency Care Units. **Method**: This is exploratory research, with a quantitative approach, collected via electronic form, by: characterization of the professional and application of the "Instrument for Assessment of Welcoming with Risk Classification". **Results**: Based on the average score evaluation in each dimension involving the services, only one of them achieved a satisfactory degree score in the Process dimension, with 26.83 and 26.52 for the Outcome dimension. In the total average ranking, all dimensions received a precarious degree, according to the applied score. **Conclusions**: Although the results indicated the Process and Result dimension as satisfactory for one of the services, it is still not able to suggest quality, which requires improvements in all dimensions, with emphasis on periodic training for nurses who perform the reception with a classification of risk.
Descriptors: Embracement; Screening; Pre-Hospital Care; Quality; Nursing.

RESUMO
Objetivo: Avaliar as dimensões de estrutura, processo e resultado do acolhimento com classificação de risco realizado nas Unidades de Pronto Atendimento. **Método:** Trata-se de pesquisa exploratória, com abordagem quantitativa, coletados via formulário eletrônico, dividido em duas partes: caracterização do profissional e aplicação do "Instrumento para Avaliação do Acolhimento com Classificação de Risco". **Resultados:** Com base na avaliação por pontuação média em cada dimensão envolvendo os serviços, apenas um deles, alcançou a pontuação de titulação satisfatória na dimensão Processo, com 26,83 e 26,52 para dimensão Resultado. Já no ranking médio total, todas as dimensões receberam titulação precária, de acordo com o escore aplicado. **Conclusões:** Embora os resultados tenham apontado a dimensão Processo e Resultado como satisfatórios para um dos serviços, ainda não é capaz de sugerir qualidade, o que requer melhorias em todas as dimensões, com destaque para treinamentos periódicos aos enfermeiros que desempenham o acolhimento com classificação de risco.
Descritores: Acolhimento; Triagem; Atendimento Pré-Hospitalar; Qualidade; Enfermagem.

RESUMEN
Objetivo: Evaluar las dimensiones de la estructura, proceso y resultado de la recepción con clasificación de riesgo realizada en las Unidades de Atención de Urgencias. **Método:** se trata de una investigación exploratoria, con enfoque cuantitativo, compilada electrónicamente, mediante: caracterización del profesional y aplicación del "Instrumento de Evaluación de Bienvenida con Clasificación de Riesgo". **Resultados:** Con base en la evaluación del puntaje promedio de las dimensiones de los servicios, solo uno de ellos obtuvo puntajes satisfactorios en la dimensión Procesos, con 26.83 y 26.52 en la dimensión Resultados. En la clasificación general media, todas las dimensiones recibieron una puntuación precaria. **Conclusiones:** Si bien los resultados indicaron la dimensión Proceso y Resultado como satisfactoria para uno de los servicios, aún no es capaz de sugerir calidad, lo que requiere mejoras en todas las dimensiones, con énfasis en la formación periódica de los enfermeros que realizan la recepción con calificación de riesgo.
Descriptores: Recepción; Poner en pantalla; Atención prehospitalaria; Calidad; Enfermería.

INTRODUCTION

In several countries, care for acute illnesses in the emergency sector has experienced rapid development in recent years, not only from a professional medical point of view, but also in terms of health policy, given a growing tendency to seek emergency services for patients who present varied complaints.[1-3]

In addition to existing structural and economic problems, challenges linked to the organization of the service are described, including the installation of flows, sector management and relationships established between user and professional.[4]

The emergency pre-hospital service is defined as that carried out outside the hospital environment, being divided into mobile and fixed. Emergency Care Units (UPAs), conceptually considered as a fixed emergency pre-hospital service, specifically represent, in Brazil, a gateway to access other health care devices in both the private and public spheres.[1,2,5]

As a powerful strategy to promote quality in emergency care in the face of high demand in this sector, reception with risk classification is emerging, enabling active listening and user classification according to the severity presented, in addition to establishing network and flow agreements.[6]

It can be observed, therefore, that the increase in demand in emergency services also contributes to a hostile environment and distancing from humanization in assistance and reception with risk classification.[7]

In view of the above, the following question arose: Does risk-classified reception occur with quality in UPAs in the North Center of Goiás? Therefore, the objective of this article is to evaluate the dimensions of structure, processes and results of reception with risk classification carried out in UPAs in North-Central Goiano.

METHOD

This is an exploratory study, with a quantitative approach to data collection and analysis. This research was carried out in Emergency Care Units considered as Fixed Pre-hospital Service (SPHF) in the Central-North Macro-region of the state of Goiás, made up of 05 health regions. The period for data collection was from October 2019 to February 2020.

The study included four units, one from each region of the macro-region in question, cited in this work as SPHF I, II, III and IV. One of the regions was not included in the study because it did not have an active UPA during the research period.

Through coordination, the telephone contacts of nurses from the units involved were provided so that an invitation

to participate in the research could be made, carried out in three attempts, offering more information and enabling the provision of the link to access the questionnaire.

A population of 57 nurses from the four services involved were invited to participate in the research. Service I had 30 nurses, 13 agreed to participate in the research. Service II had 10 nurses, of which 5 participated. Service III had 8 nurses, 7 agreed to participate and Service IV had 9 nurses working, 6 of whom participated in the research, resulting in 31 participating nurses.

Nurses who worked directly or who had experience in reception with risk classification were included in the research. Those who were not fully performing their duties and nurses with a contract of less than three months without previous experience in reception with classification were excluded.

Data were collected using an electronic form composed of two parts, the first being the sociodemographic and professional characterization of the participants and the second consisting of the questions from the "Instrument for Assessing Reception with Risk Rating - RRR" constructed and validated by Bellucci Junior and Matsuda.[7]

The instrument has 21 questions based on three Donabedian dimensions of health assessment (Chart 1): structure (items 1 to 7), process (items 8 to 14) and result (items 15 to 21). The 21 items are represented on a Likert scale, graduated into five levels, which according to the score will vary from "completely disagree" to "completely agree", represented by the number 05 as maximum agreement and number 01 as minimum agreement. Responses with values of 01 and 02 points are considered as discordant, responses with a value of 03 points are considered null or indifferent and values equal to 04 or 05 points are considered as concordant.

Table 1 demonstrates the variables referring to the three Donabedian dimensions: the structure, process and result of the RRR, involved in this study.

Table 1. Variables linked to RRR

Structure	Process	Result
Installation where service is provided	Activities that are carried out to provide service	Changes in user behavior
Materials	Relationships established between professionals and users	Health effects obtained through the care received
Human Resources		
Organizational structure		
Financial		

The results obtained through the Reception with Risk Classification instrument were tabulated using Microsoft® Office Excel Software, to obtain the calculation of absolute and relative frequency, measures of central tendency and subsequent descriptive statistical analysis. The instrument's own score was used to analyze the dimensions and evaluate the RRR regarding its quality, with the following titration for the dimensions: Excellent for an average score of 31.5 to 35; Satisfactory from 26.2 to 31.4; Precarious from 17.5 to 26.1 and Insufficient for a score between 7 and 17.4.

Like all research involving human beings, this study was submitted and approved by the Research Ethics Committee, with CAAE opinion: 15988719.4.0000.5078 corresponding to what is established by resolution 466/12.

RESULTS

31 participants were evaluated with an average age of 31 years (4.8), 94% of nursing professionals were female. With regard to training, 77% had some type of specialization, 13% had a bachelor's degree and 10% a master's degree. Regarding experience in reception, the average was 6.55 years (3.42), as shown in table 1.

Table1. Characterization of nurses working in fixed pre-hospital service

SPHF Variable		I n(%)	II n(%)	III n(%)	IV n(%)	TOTAL n(%)
Gender						
	Male	0(0,0)	1(3.23)	0(0,0)	1(3.23)	2(6.45)
	Female	14(45,16)	3(9.68)	7(22.58)	5(16,13)	29(93.55)
Education						
	Graduation	1(3.23)	0(0,0)	2(6.45)	1(3.23)	4(12.90)
	Specialization	10(32.26)	4(12.90)	5(16,13)	5(16,13)	19(77.42)
	Master's degree	3(9.68)	0(0,0)	0(0,0)	0(0,0)	3(9.68)
Age (years)		32.21 3.17±	28.50 1.73±	27.57 3.55±	36.33 6.35±	31.48 4.86±
ER time (months)*		40.43 17.75±	54.00 6.93±	21.14 14.18±	42.83 29.59±	6.55 3.42±

*Time of experience in reception with risk classification.

Donabedian Dimensions

According to Donabedian[8], the multidimensional assessment of care is an arduous task, as there is a need to obtain measurable data capable of offering information about the quality of medical care. Thus, in his study he points out that data can refer to dimensions of structure, results or processes, with the main requirement being ease of access, presence of routine, valid and measurable data.

When addressing quality in the health service, the present study will consider research that used the RRR quality assessment method based on Donabedian evidence that considers three dimensions, as mentioned previously, the Structure that corresponds to the facility where the service is provided: materials, human resources, organizational and financial structure; the Process refers to the activities that are carried out to provide care, in addition to the relationships established between professionals and users; and, finally, the Result, which has to do with changes in users' behavior and the effects on health, obtained through the care received.[8]

In this study, the results by Donabedian dimensions are linked to the four fixed pre-hospital services belonging to the Central-North macroregion of Goiás.

Structure Dimension

As for the Structure dimension, it was considered Precarious with an Average Score (PM) equivalent to 24.98 (Table 2). In the item aboutmeetings and periodic training aimed at workers who work in reception

with risk classification, a low score was recorded in the Average Ranking (RM) in the four services investigated (Item 3, RM=2.57; 2.00; 2.33; 1, 29) and Average Ranking for All (RMT) of 1.87. Most of the items in this dimension presented a RMT of neutrality and agreement when scored between 3 and 4. In terms of environmental signaling, SPHF II (Item 6, RM= 2.50) presented a level of disagreement, as did SPHF I (Item 7 , RM=2.71) for communication between the team.

Table 2. Assessment of the reception structure dimension with risk classification in fixed pre-hospital services in Central-North Goiano

SPHF[§]- Variable Item/Dimension	**I RM***	**II RM**	**III RM**	**IV RM**	**All RMT[†]**
1 User/companion comfort	3.21	4.00	3.71	4.17	4.13
2 Welcoming atmosphere	3.79	4.50	4.14	4.67	4.43
3 Periodic training	2.57	2.00	2.33	1.29	1.87
4 Privacy in consultations	3.14	3.50	4.67	3.50	3.65
5 Companion reception	3.57	3.00	3.67	3.29	3.39
6 Environmental signage	3.29	2.50	3.00	4.33	3.90
7 Communication between the team	2.71	3.25	4.50	3.79	3.61
Structure Dimension (PM)[‡]	**22.29**	**22.75**	**26.02**	**25.02**	**24.98**

*RM - Average ranking;
[†]RMT – Average ranking of all;
[‡]PM - Average score;
[§]SPHF - Fixed Pre-Hospital Service;

Process Dimension

The Process dimension presented a Precarious assessment with regard to the average score (PM=24.80) when considering all services (Table 3). However, it presented an average score of 26.83 for SPHF IV in isolation, thus guaranteeing a Satisfactory evaluation for the Process in this specific service.

Table 3. Assessment of the welcoming process dimension with risk classification in fixed pre-hospital services in Central-North Goiano

SPHF[§]- Variable Item/Dimension	I RM*	II RM	III RM	IV RM	All RMT[†]
8 Assessment of non-serious cases	3.14	4.00	2.86	2.83	3.63
9 Knowledge of RRR conduct ‖	2.86	2.00	3.14	3.17	2.37
10 Relationship between leadership/followers	2.00	3.25	3.00	4.00	2.77
11 User safety and comfort	4.43	4.00	4.14	4.83	4.80
12 Discussion about flowchart	1.86	3.25	2.29	3.17	3.13
13 Primary care by case severity	3.21	3.25	3.14	4.17	3.93
14 Waiting time information	4.43	3.75	3.43	4.67	4.16
Process Dimension (PM)[‡]	**21.93**	**23.50**	**22.00**	**26.83**	**24.80**

*RM - Average ranking;
[†]RMT – Average ranking of all;
[‡]PM - Average score;
[§]SPHF - Fixed Pre-Hospital Service;
‖ACCR- Reception with Risk Classification

When asked about the knowledge of those who work in the sector about the conduct described in the Reception with Risk Classification protocol, SPHF II presented the highest level of disagreement (Item 9, RM= 2.00) and RMT of 2.37. Regarding leaders and their communication with RRR professionals, there was a low level of agreement (RMT=2.77). Regarding the clarity and objectivity of the flowchart, SPHF I and III obtained RM=1.86 and 2.29 respectively, while the other two services II and IV presented this issue with RM=3.25 and 3.17.

The item that deals with the professional's contribution to making the user feel safe and comfortable, obtained the highest final average ranking in the study (Item 11, RMT= 4.80). Primary care for the user, according to the severity of the case and not according to the order of arrival (Item 13, RMT=3.93); the passage of all patients through the RRR , including non-serious patients (Item 8, RMT=3.63) and the information provided about the likely waiting time for care for those who are not at immediate risk (Item 14, RMT=4.16) demonstrated a tendency towards neutrality and agreement regarding the issues.

In item 14, when asked whether users who are not at immediate risk, as well as their family members, the likely waiting time for care is informed, with the SPHF presenting a RM of 4.43; 3.75; 3.43 and 4.67 respectively.

Result Dimension

As for the Result dimension, it obtained the highest average score (PM=25.45) among the previous ones, but it

was not exempt from receiving a Precarious title (Table 4). In this dimension, SPHF IV also achieved the Satisfactory titration score (PM=26.52), in isolation. The item that deals with the reevaluation of waiting cases presented the lowest final average ranking for this dimension (Item 18, RMT=2.67). The counter-reference also presented levels of disagreement in the final score (Item 20, RMT=2.97).

Table 4. Assessment of the reception result dimension with risk classification in fixed pre-hospital services in Central-North Goiano

SPHF[§]- Variable Item/Dimension	**I RM***	**II RM**	**III RM**	**IV RM**	**All RMT[†]**
15 Trained team	4.14	4.75	3.57	4.67	4.67
16 Humanization of care	2.86	2.25	3.50	3.14	3.03
17 Integration into the healthcare team	3.29	3.25	3.29	4.00	3.97
18 Reassessment of waiting cases	3.36	2.25	2.29	3.50	2.67
19 Prioritization of serious cases	3.86	4.75	4.83	4.57	4.48
20 Counter reference	3.14	3.25	3.33	2.64	2.97
21 Satisfaction with ACCR results ||	2.86	3.00	2.71	4.00	3.67
Result Dimension (PM)[‡]	**23.50**	**23.50**	**23.52**	**26.52**	**25.45**

*RM - Average ranking;
[†]RMT – Average ranking of all;
[‡]PM - Average score;
[§]SPHF - Fixed Pre-Hospital Service;
[||]ACCR- Reception with Risk Classification

Despite the average ranking of the other items in the Result dimension presenting values of neutrality and agreement, there are some SPHF that presented disagreement in some items, such as SPHF I and II, which disagreed that the humanization addressed in item 16 occurs at all stages of the process to the user service, scoring respectively RM=2.86 and 2.25. On the other hand, the prioritization of serious cases (Item19, RMT=4.48) and the training of the team to serve the user and companion in a welcoming and humane way (Item 15, RMT=4.67), achieved high agreement.

With regard to professionals working in this sector feeling satisfied with the implementation of Reception with Risk Classification in care, SPHF I (RM=2.86) and III (2.71) report some dissatisfaction, while SPHF II (RM=3.00) indicates neutrality and the IV (RM=4.00) indicates satisfaction with the RRR results.

DISCUSSION

In the present study, the evaluation of these dimensions indicated precariousness in the RRR in the units of the macro-region, as evidenced in other research, in which the

Structure, Process and Results dimensions received a low average score and were titled Precarious.[7, 9-12]

Great weakness was identified in the Structure dimension in terms of periodic meetings and training aimed at workers who work at ACCR. In the four services investigated, the worst levels of agreement were recorded in the average ranking for all services among the items evaluated. It is believed that the lack of periodic training directly influences the technical quality of the professional and, subsequently, the quality of care provided to the user.[13]

The demographic characterization of the nurses surveyed points to the already known scenario in the country's health services, where there is a predominance of females, and when considering the emergency service, there is a predominance of younger nurses in this sector.[4]

The fact that emergency services have a staff of young professionals does not make them more prepared to exercise the RRR based on the knowledge emanating from academic training, since the National Curricular Guidelines (DCN) of the Undergraduate Nursing Course of 200114, until then in force, does not address humanization in its text nor reception, to the detriment of the implementation date that precedes the Humanization Policy.

However, the Ministry of Health[6, 15], through HumanizaSUS, establishes spaces for democratization, dialogue and problematization as essential, in addition to the specific training of higher education nursing professionals to carry out the proposed activities.

In this sense, the services investigated require greater commitment from managers to offer training and periodic meetings, taking into account the inherent needs of the professional who joins a new service, with the inclusion of those who have been in the role for some time.

Regarding the item belonging to the Process dimension that addresses the professional's contribution to making the user feel safe and comfortable, a high score was obtained in the average ranking for the four fixed pre-hospital services and a higher level of agreement in relation to all other items evaluated, thus presenting the highest level of agreement in the study. Interesting data to be correlated with what is considered safety not only from the perspective of the RRR nurse. Therefore, further investigation of this item is suggested, also taking into account user perception.

Here, it appears that the safety affirmed by nurses is associated with the occurrence of primary care to the user, according to the severity of the case and not according to the order of arrival for the

passage of all patients through the ACCR, including those non-serious and the information provided about the likely waiting time for care for those who are not at immediate risk. Despite non-discordant levels, they demonstrate that there is still room for improvement in services, consequently resulting in increased patient safety.

The prioritization of care for critically ill patients through the ACCR showed high levels of agreement, considered a piece of data of significant relevance, since regardless of the protocol to be used, the objective of risk classification is to prioritize the order of care according to severity. of the patient's condition, with this same pattern of results found in some studies.[10-11, 16-17]

The affirmation of the passage of patients through the ACCR, including the non-serious ones discussed in item 8, demonstrated alignment with the National Humanization Policy, which presupposes the reach of everyone who seeks health services, offering responsible and resolute care, guiding the patient and the family regarding other health services for continuity of care, when applicable14, in addition to compliance with CFM Resolution No. 2,079/14[18], which confirms: "Every patient with a health problem who has access to the UPA must, obligatorily, be attended to by a doctor, and cannot be dismissed or referred to another health unit by a professional other than the doctor".

Assertive communication in the risk classification process is essential, and must guarantee the patient understanding of their condition and need to wait.[2] The research data indicate that users who are not at immediate risk, as well as their families, are informed about the probable waiting time for care, in line with the National Policy for the Humanization of Care and Management of the SUS, which recommends that emergency services guarantee such information.[6]

When asked whether the conduct to be taken described in the ACCR protocol is known to everyone who works in the sector, SPHF IV presented the highest level of disagreement and a total average ranking of 2.37. The finding of professionals who are unaware of the protocol leaves risk classification compromised, since protocols are tools that guide professional action, and their implementation is fundamental to achieving success in the risk classification process as a whole.[2]

It cannot be denied that there are some aspects of subjectivity in decision-making to classify users' risk, taking into account experiences and professional sensitivity, which may be linked to users' particularities or even limitations of the

service where the professionals responsible for the classification are inserted.[10] However, the lack of mastery of the protocol established in the unit, as a guide for technical guidance and logical reasoning, can lead to undervaluation or overvaluation in the measurement of risk, thus compromising the quality and safety of the entire process.[11] The combination of both knowledge, technical-scientific knowledge related to reason and subjectivity related to personal perceptions, expresses the complexity of the risk assessment action,and its proper balance will dictate the quality of the classification professional's decision-making.

Still in the Process dimension, with regard to leaders and their communication with ACCR professionals, there was a low level of agreement in the final ranking, which identifies the absence of a democratic relationship established between leadership and followers. In this way, the finding acts in opposition to what was established by the Ministry of Health[15], which through HumanizaSUS establishes that there must be spaces for democratization, dialogue and problematization in health services with encouragement to also welcome professionals.

The lack of communication between leadership and subordinates was also evident in the discussion about clarity and objectivity of the flowchart. The institution of flows and their periodic review are conditions for the quality of risk classification, and it is worth highlighting that the experience of the professional classifier can generate a rich contribution, since these professionals are routinely immersed in the services, and may be knowledgeable about the peculiarities and bottlenecks that limit the efficiency of the risk classification process.[4]

In the Result dimension, the item on the reevaluation of waiting cases presented the lowest final average ranking for this dimension. In agreement with this result found is the study by Inoue et al.[12], which cites the importance of raising awareness among professionals who work at RRR as a dynamic process, in which it is necessary to pay attention to the evolution of cases. In the research carried out by Bellucci Júnior et al.[19], it was observed that the implementation of the RRR brought improvements in the quality of care, having as one of the pillars the reevaluation of cases, but this process was not maintained and does not occur regularly according to 47,42 % of those surveyed.

The study by Hermida et al.[11] cites the high demand from patients and the overload of professionals due to the lack of sufficient human resources as the main causes of the lack of reevaluation. It is clear

that, despite the effective and measurable improvement in the quality of the ACCR with the reassessment of cases, it is still necessary to mobilize and raise awareness among professionals for this part of the process to occur.

Considered a major challenge in the emergency service, in this study overcrowding can be justified by the final value of RMT=2.97, referring to the lack of referral of low complexity cases to basic health care.

It is common agreement in studies on the subject that the fragility of referral and counter-referral systems means that primary care no longer plays its role as regulator and organizer of the network. The emergency service is the main gateway to other health care points, which leads to overcrowding by users who do not have the profile of these services, overloading professionals and compromising the agility and quality of care for patients with acute conditions. and bass.[4-5, 10, 12, 19-20]

Although the average ranking of the other items in the Result dimension presents values of neutrality and agreement, there are some services that deserve attention, such as SPHF I and II, which showed levels of disagreement when asked whether humanization in care is present in the unit in all stages of user service. Still in this regard, he was asked about training to serve the user and companion in a welcoming and humane way, which in turn presented a high level of agreement for the action in question.

The finding reveals professionals who work at RRR who are trained in welcoming and humane care, but the service in this regard is flawed by the team, while humanization is not present in all stages of user care, which can compromise the entire the process of solving the problem brought by the individual.

The National Humanization Policy operates based on clinical, ethical and political guidelines, with welcoming as one of its guiding concepts, which seeks to recognize the legitimacy and uniqueness of each individual's health needs. In view of this, it is clear that welcoming involves qualified assistance and listening with detailed verification of what the user carries with them, considering complaints to better resolve problems, with welcoming and humanization being inseparable elements and applied by the entire multidisciplinary team.[15]

Observing the dissatisfaction of professionals working in this sector, evidenced mainly by SPHFI and III, can be justified by the high demand that does not match the number of the team, overloading professionals in this sector and subsequently,

leading to stressful and confined working conditions.[10]

In short, the average ranking of the items present in the dimensions mostly demonstrated neutrality and agreement by being scored between 3 and 4 respectively. Research whose results corroborate the finding, judge that even with difficulty in implementing and executing the RRR, this result may be related to a positive perception of nurses about the instrument.[19] Or, the results found may be related to insecurity about what is well known about reception with risk classification, generating neutrality in responses.

CONCLUSION

The quality of service observed through the dimensions structure, process and result, identified that Central-North Goiano presents reception with precarious risk classification in the fixed pre-hospital services analyzed. Although the results showed the Process and Result dimension as satisfactory for one of the services, it is still not presented unanimously for the macro-region.

The lack of periodic training for nurses who perform reception activities with risk classification is a fact that may be the cause of unsatisfactory results in the practice of the services analyzed. Thus, there is a need for improvements in the activities carried out to provide care, relationships established between professionals and users, and the effects on health obtained through the care received, in a way that allows a change in reality and an increase in service quality.

It is considered that the results presented here cannot be generalized, as they were obtained in a specific moment and not in the long term, in addition to the reduced number of participants, physical structure and different risk classification system in the units. Reception with risk classification proposes continuous assessments of structures, processes and results in the services of the Unified Health System (SUS). Therefore, it is necessary to invest in continuous monitoring of the service with the adoption of instruments that verify the quality of the service, to improve the SPHF.

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