

NURSES' SPEECH ON APPLICATION OF THE MANCHESTER PROTOCOL IN HOSPITAL URGENCY AND EMERGENCY

DISCURSO DE ENFERMEIROS SOBRE APLICAÇÃO DO PROTOCOLO DE MANCHESTER NA URGÊNCIA E EMERGÊNCIA HOSPITALAR

DISCURSO DE ENFERMERAS SOBRE LA APLICACIÓN DEL PROTOCOLO DE MANCHESTER EN URGENCIA Y EMERGENCIA HOSPITALARIA

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How to cite this article: Nurses' speech on application of the Manchester protocol in hospital urgency and emergency. Rev Enferm Atenção Saúde [Internet]. 2024 [access: ____]; 13(3): e202437. DOI: <https://doi.org/10.18554/reas.v13i3.7972>

ABSTRACT

Objective: To analyze the speeches of nurses from a hospital urgency and emergency service, regarding the use of the Manchester Protocol. **Method:** This is a field research, with a mixed approach and descriptive nature, carried out with nurses working in risk classification. Data collection occurred through a socioeconomic form and a semi-structured interview script, using the Collective Subject Discourse to organize and analyze the data. **Results:** 14 central ideas were identified in the expressions of the 8 nurses interviewed. The potential of the Manchester Triage System is: optimizing time for risk classification and organizing the flow according to clinical priority, impacting user waiting times, who generally welcome the protocol. **Conclusion:** It was noticed the assistance of users with varied complaints or those that did not correspond to the profile of the institution; failure in the health care network and administration of multiple classification protocols.

Descriptors: Risk Assessment; Triage; Emergency Nursing.

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RESUMO

Objetivo: Analisar os discursos dos enfermeiros de um serviço de urgência e emergência hospitalar, referente à utilização do Protocolo de Manchester. **Método:** Trata-se de uma pesquisa de campo, com abordagem mista e natureza descritiva, realizada com enfermeiros atuantes na classificação de risco. A coleta de dados ocorreu através de um formulário socioeconômico e roteiro de entrevista semiestruturada, utilizando-se o Discurso do Sujeito Coletivo para organização e análise dos dados. **Resultados:** Identificou-se 14 ideias centrais nas expressões dos 8 enfermeiros entrevistados. São potencialidades do Sistema de Triage de Manchester: a otimização do tempo na classificação de risco e a organização do fluxo de acordo com a prioridade clínica, impactando na espera do usuário que, geralmente, acolhe bem o protocolo. **Conclusão:** Percebeu-se o atendimento de usuários com queixas variadas ou não correspondentes ao perfil da instituição; falha na rede de atenção à saúde e administração de múltiplos protocolos de classificação.

Descritores: Medição de risco; Triage; Enfermagem em Emergência.

RESUMEN

Objetivo: Analizar los discursos de enfermeros de un servicio de urgencia y emergencia hospitalaria, sobre el uso del Protocolo de Manchester. **Método:** Se trata de una investigación de campo, con enfoque mixto y de carácter descriptivo, realizada con enfermeros que actúan en clasificación de riesgo. La recolección de datos ocurrió a través de un formulario socioeconómico y un guión de entrevista semiestructurado, utilizando el Discurso del Sujeto Colectivo para organizar y analizar los datos. **Resultados:** Se identificaron 14 ideas centrales en las expresiones de los 8 enfermeros entrevistados. El potencial del Manchester Triage System es: optimizar el tiempo de clasificación de riesgos y organizar el flujo según la prioridad clínica, impactando los tiempos de espera de los usuarios, quienes generalmente agradecen el protocolo. **Conclusión:** Se notó la atención de usuarios con quejas variadas o que no correspondían al perfil de la institución; falla en la red de atención de salud y administración de múltiples protocolos de clasificación.

Descriptorios: Medición de Riesgo; Triage; Enfermería de Urgencia

INTRODUCTION

In 2011, the Emergency Care Network (RUE) was established in the Unified Health System (SUS), through the reformulation of the National Emergency Care Policy of 2003. The implementation of the RUE was important, since it corroborates the articulation and integration of health equipment, aiming at the qualification and expansion of humanized and integral access to emergency and urgency services.¹

However, emergency services are often used as a gateway to resolve various

health complaints, including less complex and outpatient situations. As a result, these services are overcrowded, constituting a problem on a global scale. This results in users staying longer in the service and interferes with the medical team's decision-making time. In view of this, undesirable outcomes can occur, such as additional costs and even increased mortality, due to failure to provide timely care.²

Thus, the Ministry of Health (MS) has outlined strategies to reorganize emergency services and the work process in order to

provide care based on different degrees of specificity. Thus, in 2004, through the National Humanization Policy, Reception with Risk Classification (ACCR) was identified as a way of changing the work process, management and health production in emergency units. Risk Classification (RC) is characterized as a dynamic process for identifying patients who require immediate care, according to the potential risk of death, in addition to health problems and degree of suffering.^{3,4}

The Manchester Triage System (MTS) was developed by nurses and doctors in the city of Manchester, in the United Kingdom, with the aim of prioritizing care in emergency units, considering clinical criteria.⁵ It is based on the identification of the patient's main complaint, based on signs and symptoms, and, through flowcharts and discriminators, establishes clinical priority for care and maximum time for first medical care.⁶

Therefore, through the MTS, patients are classified into clinical priority levels I, II, III, IV and V, which range from “emergency” to “non-urgent”, and correspond respectively to the colors red, orange, yellow, green and blue, which are equivalent to the service time of zero minutes, 10 minutes, 60 minutes, 120 minutes and 240 minutes.^{6,7}

The nurse in the MTS has some responsibilities, such as: reducing the

patient's waiting time, acting quickly in more serious cases, optimizing resources, evaluating the user's main complaints and classifying care according to the patient's clinical conditions. Thus, it is understood that theoretical knowledge is essential for CR, since hospital emergency care requires the nursing professional to be aware of the various health situations, as well as critical analysis for making specific decisions.⁸

It is important to emphasize that nurses working in CR must have essential skills in their care, such as qualified listening, clinical reasoning, correct assessment of the complaint reported by the patient and knowledge of the care network, for correct referrals when necessary.⁹

Since the nurse is primarily responsible for CR, it is important to analyze his/her conception in the application of the most widely used protocol for triage in Brazil, the MTS, because by identifying how the protocol is applied and the main difficulties faced by nurses, it is possible to promote studies in order to create strategies to face these challenges.

Thus, the objective is to analyze the discourses of nurses working in a hospital emergency service, regarding the use of the Manchester Protocol.

METHOD

This is a field study with a mixed approach of descriptive nature. The study was carried out in a public hospital that is a reference for the population of the Cariri Macroregion. The institution is a pioneer in the state network in the interior of Ceará, and is located in the municipality of Juazeiro do Norte. It has 294 beds: 174 in the ward, 49 in the emergency room, 28 in the day hospital, 20 in the adult intensive care unit and 15 in the semi-intensive care unit. Among the services offered are: Outpatient Clinic, Surgical Center, Surgical Clinic, Medical Clinic, Traumatology-Orthopedics, Intensive Care Unit, Stroke – Acute, Special Care Unit – Adult and Emergency.¹⁰

In addition, it has support services for assistance, which consist of: Transfusion Agency, Customer Service Center (NAC), Material Center, Pharmaceutical Assistance Center, Clinical Engineering, Nutrition and Dietetics Center, Physiotherapy, Human Resources, Speech Therapy, Hospital Infection Control Service (SCIH), Clinical Analysis Laboratory, Imaging Service, Maintenance Engineering and Social Service. Among the management support services are: Study Center, Information Technology Center (NTI), Patient Management and Safety Center (NUGESP), Ombudsman and Specialized Service in Engineering and Occupational Medicine (SESMT).¹⁰

The hospital has ten nurses working as risk classifiers, eight of whom were interviewed between January 19, 2023 and January 20, 2023. In this sense, considering the objectives of the study, an intentional non-probabilistic sample was used, which consisted of higher-level nursing professionals working in Risk Classification. Thus, the inclusion criteria used were: nurses on the hospital's permanent staff, who work with the application of the Manchester protocol, regardless of the time they have worked in the sector. The exclusion criteria were: professionals who were not present at the service during the collection, due to illness, vacation or maternity leave, and professionals who refused to participate.

Data collection was carried out using a socioeconomic form and a semi-structured interview script. The following data collection devices were used to conduct the interview: a cell phone voice recorder for accurate transcription of participants' statements, and a field diary to collect impressions during data collection and other information relevant to data analysis.

For data analysis, the Collective Subject Discourse (CSD) technique was used. In research with CSD, thoughts are collected through individual interviews, using open-ended questions with ample room for participant expression, aiming to recover the essence of plural opinions,

which will constitute collective discourses, or CSD.¹¹

This methodological process involves the following operators: Central Idea (CI), Anchors (AC), Key Expressions (CE) and DSC. CE are literal transcriptions of the participants' expressions that reveal the essence of the announced thought, synthesizing a Central Idea. Anchors, in turn, are generic statements to emphasize an opinion.

The data were presented using mixed tables, indicating the CI and the frequency of each CI identified in the participants' speeches (and/or AC), in addition to the presentation of the DSC, enabling a global analysis of the participants' verbal expressions.¹²

The project was approved by the Research Ethics Committee (CEP) of the proposing institution with opinion 5,819,226 and CAAE: 65815022.8.0000.5055 and opinion 5,841,592 of the co-participating institution, with CAAE: 65815022.8.3001.5684. Because the

research involved human beings, participants were also able to express their interests by signing the Free and Informed Consent Form (FICF).

RESULTS

The socioeconomic profile of the eight nurses interviewed showed that they were unanimously female (100%), with 87.5% declaring themselves to be of mixed race/ethnicity and 12.5% white. Their ages ranged from 29 to 49 years, with the 29 to 39 age group predominating (75%) and regarding marital status, the majority were married (87.5%). Regarding their professional profile, the predominant level of education was specialization (37.5%).

Regarding the length of experience in risk classification, it was possible to collect statements from professionals with more time in the sector, some with more than 10 years (37.5%) and others between 1 and 5 years (25%), as well as those with less time, up to 1 year (35.7%). The aforementioned data and others can be seen in Table 1.

TABLE 1 – Study sample profile (n=8). Crato, Ceará, Brazil, 2023

Variable	n	%
Gender		
Feminine	8	100
Color/ethnicity		
White (a)	7	87.5
Brown	1	12.5
Age range		
From 29 to 39 years old	6	75
From 40 to 49 years old	2	25
Marital status		
Single	7	87.5
Married	1	12.5
Level of education		
Postgraduate studies	2	25
Specialization	3	37.5
Master's degree	2	25
Graduation	1	12.5
Time of experience in risk classification		
Up to 1 year	3	37.5
Between 1 and 5 years	2	25
More than 10 years	3	37.5

Source: Direct research, 2023.

When asked about the characteristics of the STM that have the potential to impact the reorganization of work flows and processes in Emergency and Urgent Care Services, the professionals revealed three Central Ideas that can be seen in Table 2.

TABLE 2 – Relationship between central idea (CI) of question 1, proportion of responses according to research participants and DSC for question 1

<i>Question 1:</i> In your opinion, what are the characteristics of the Manchester Triage System (MTS) that have the potential to impact the reorganization of work flows and processes in Emergency Services?		Nurses classifying the STM service	
Central Idea (CI)		N	%
TH E	Color classification, organizing the waiting time in the service	3	37.5
B	Discriminators and flowcharts, organizing the internal flow of the service according to clinical priority	8	100
W	Focus on the main complaint, ensuring faster service	2	25.0
Total number of informants = 8*			
DISCOURSE OF THE COLLECTIVE SUBJECT			
DSC A: In fact, we use the Manchester Protocol to differentiate the risk of each patient. If the patient is at high, imminent risk of death and is classified as red; if the patient is an orange patient, their care is also prioritized; if the patient is yellow, then they will have to wait a little, or if the patient does not have the characteristics to be treated by our service, then we will advise them to seek out a basic health unit or an emergency care unit. So the			

Manchester Protocol itself is very important, especially for high complexity services. Here at the institution, we only treat red, orange and yellow patients, and then patients with a lower degree of complexity, such as green, blue and white, are directed to the network, or can even be treated, but then they need the evaluation of the team leader. We can organize and not leave a patient who is in a more serious condition waiting for a long time, so by truly following the times, we do not leave a waiting list in the emergency room.

DSC B: So, through Manchester, we can see the issue of severity, right? Of the patients, who has priority. When several patients arrive at the same time, we can assess which one really needs more immediate care and which one can wait. Most people arrive complaining of “pain” and pain is a nonspecific symptom, your pain is not the same as mine, but the other discriminators, the other symptoms, are what will make me try to organize the flow of patients. Manchester is made up of 50 flowcharts and within them there are discriminators, according to the patient's complaint we can [...] allocate him within this flowchart, this discriminator, and from there the care time is directed. It is a very clear and objective system, because with each discriminator that we discard or add – we cannot deny a discriminator – we stop at that discriminator and get a more realistic idea of the patient's needs and the classification becomes more effective, it is better for us to direct the patient's needs based on something real, something organized, which we know is used all over the world. It (the MTS), let's say, allows for direction, a filter, a screening of patient profiles, it gives direction to the care and the organization as a whole. Many patients arrive from outpatient clinics, primary and secondary care. So, in a way, it organizes the service, ensures care that is appropriate to the patient's needs and reduces overcrowding, when patients who do not fit our profile are directed to the network.

DSC C: The main characteristic I think is that it is well-targeted to the patient's main complaint, and then we can do a real triage based on that complaint. It is a safe system that can always predict that complaint for a level of care, and it is faster. We always say that it overestimates the patient's complaint, so it has to be well applied. Because it is a classification system, it has this characteristic, right? Of sometimes overestimating complaints, but it is for the patient's protection, really.

Source: Direct research, 2023.

* A speech can present more than one IC

A portion of 37% of nurses agree with the Central Idea A that the classification by means of colors, where the maximum time for medical care is defined, makes the service more organized, so that the most seriously ill patient does not wait longer for care. It is worth noting that the institution in question, as it is a highly complex tertiary service, only serves patients classified as red, orange and yellow, with some exceptions, as expressed in the speeches.

Central Idea B gathered the opinion of all participants (100%) that because the Manchester Protocol has discriminators and flowcharts, it makes the service flow organized according to the patient's clinical priority, especially when there are several patients in the unit and it is necessary to direct more agile care to the user with the most serious complaint, something that would be more complex if they were pre-defined diagnostic flows, for example.

In Central Idea C, 25% of participants report that focusing on the patient's main complaint ensures greater agility in care, as the system can direct the complaint to a level of care, favoring a faster process.

For the second question, which referred to the challenging aspects of STM in the experience and/or dynamics of the service, the central ideas are represented in table 3.

TABLE 3 – Relationship between central idea (CI) of question 2, proportion of responses according to research participants and DSC for question 2

Question 2: What aspects of STM do you consider to be particularly challenging in your experience and/or in the dynamics of your service? (Would you like to report any situation you have experienced?)?

Central Idea (CI)		Nurses classifying the STM service	
		N	%
TH E	Care for patients with complaints that do not correspond to the service profile	6	75.0
B	Psychiatric patient care	1	12.5
W	Care for patients with nonspecific, multiple or non-clinical complaints	3	37.5
D	Patient care using multiple protocols/flowcharts	1	12.5

Total number of informants = 8*

DISCOURSE OF THE COLLECTIVE SUBJECT

DSC A:It's actually challenging when a patient comes in with a complaint, but they don't really fit the profile for our service. We don't have some specialties, we're not a reference for pregnant women, or children, we're not a reference for cardiac care, and sometimes we receive these patients, many times, you need to advise them, right? That the patient won't be treated here, because it's not a reference. Not so much for cardiac patients, most of them, if it's an emergency they come in and everything, but pregnant women, children [...] end up being points of conflict. It's challenging [...] Like (pause) telling the patient that they have to look for [another] service, and they're already distressed by the situation and want to be treated. For them (pause) their pain, their problem, even if it's a problem they've had for six months, they understand that it's an emergency. But they insist because, like, here they see it as a place that has everything to do, to get some exams more easily and for free, these are the patients classified as blue, green, white. The green and blue patient is not a system issue, it is an agreement. Since the hospital stopped treating blue and green patients here, they make a counter-referral, right? They advise the patient to seek out the municipal public health system, since they are not at risk. So, it is a challenge for us, because some accept it and understand it, while other patients confront us, come to question us, and are even aggressive in the way they speak, and we always have to try to maintain a balance so as not to confront each other. And when it gets to that point, we call the emergency team leader to listen and provide guidance and reinforce everything that was said. Some leave complaining, whining, cursing. But there are others who, for the most part, understand. This demands a lot from the nurse. There is also that fear because, for me, since I cannot give a diagnosis, I cannot tell the patient that what he has is not serious, based on what he reports all the time, the signs are not showing, but he is saying that he has it, then [...] tell him to go to the UPA, and what if there at the door he really feels something more serious? So, there is this guidance, it is complicated that way, because, sometimes you classify as

green, but he needed to have medical care. The green patient does not mean that he does not need medical care, it just does not fit the hospital profile. You classify based on the patient's main complaint, [but] that does not mean that in two hours the patient will not get worse, and if in two hours this patient does not arrive at the UPA? During the transfer to another care, he gets sick, whose responsibility is it? That falls on the shoulders of the classifying nurse. It seems that after COVID, either it's a coincidence – or not –, but the flow of some pathologies is increasing a lot, for example, stroke in younger people, heart attack in younger people, and before we had the age factor to be able to return with more safety.

DSC B:What I find challenging here is when a patient arrives that we consider to be psychiatric. I have never (pause) worked exclusively in a psychiatric service. Due to the routine that most people live, there are some factors that are triggering psychological problems more frequently, right? People with anxiety, with a thousand and one problems, somatizing (pause) you can see that there is more of a psychological factor than a physical illness [...] when I came here (pause) it was easier to classify because there were psychological pathologies, they existed and will continue to exist, but patients came more when they really had a physical problem, today they come for any detail and after COVID, that's when they come more.

DSC C:So, I think one of the biggest challenges is really understanding the real complaint. Sometimes people come with very nonspecific complaints, or with multiple complaints. It's a bit difficult to get to the [...] complaint, we can even overestimate the patient's complaint and then it really changes the classification! We often see patients who report a complaint of pain – which is a nonspecific discriminator – but you check the vital signs and the patient is stable, you do a detailed physical examination and you don't find any pathology, but he insists, persists, in reporting some problems that you're seeing, right? He may very well, in front of us, [say] that he has a lot of pain and then we score it in a way that he will be seen earlier and the patient is then in the hallway fine, walking, talking, doing everything normally as if he weren't feeling anything. I've had patients come here reporting that they had numbness in their arm, but during the interview, they moved their arm, the arm that was numb (pause) while talking and moving, then they said that their voice was slurred, but they didn't have any type of aphasia, dysphasia, nothing like that, their diction was perfect. It's challenging to try (pause) to show the patient that everything they're saying is not in line with the clinical situation.

DSC D:In addition to using Manchester here, in the classification, we also open many protocols. So, we know that with Manchester, we have to classify the patient in three minutes, and we will only see the vital signs of that patient according to what is requested, which you will follow, choose the flowchart and you will define which discriminator and for that there are discriminators that you use that do not need to see any vital signs, understand? Either you will see only a blood glucose level or you will see the Glasgow, you will see according to what the flowchart asks for. But since we have other flowcharts, we end up spending more time with the patient in the room, because we need to see all the signs to define other hospital protocols.

Source: Direct research, 2023.

* A speech can present more than one IC

Central Idea A was prevalent (mentioned by 75% of those interviewed) and highlights that one of the challenges in the dynamics of the service is linked to the fact that, in some cases, it is necessary to advise the patient to seek another service in the municipal care network, whether primary or secondary, because the institution in question does not have a profile for non-urgent and non-urgent care, in addition to

not being a reference for some medical specialties, and this is due to government agreements.

Given this fact, some users understand that certain complaints are not part of the profile that the institution serves, on the other hand, other users receive guidance in a negative way, sometimes expressing verbally aggressive attitudes, requiring resilience from the nurse to deal with the situation.

Another relevant point concerns the fear of changes in the clinical status of patients classified as having a lower priority level and who need to seek care at another level of care. Some nurses point out that the patient's situation may worsen during the process of being transferred to primary or secondary care, and the responsibility ends up being attributed to the classifying professional.

Central Idea B portrays the challenge for nurses when faced with patients with a psychiatric profile in the risk classification,

since they do not have professional experience in treating these specificities. It is also shown that the demand for psychiatric care has been growing in recent times, especially after the pandemic caused by SARS-CoV-2 (COVID-19).

In Central Idea C, 37.5% point out the challenge in understanding the main complaint in patients who present nonspecific complaints or multiple complaints, in addition to the difficulty in classifying users when the reported complaint does not match the clinical condition that the person presents at that time.

In Central Idea D, it is addressed that the use of multiple internal protocols can increase patient waiting time, as it will take longer than the three minutes recommended by the MTS.

The DSC results for the third question, which sought to understand the factors that impact the effectiveness of the STM, are shown in Table 4.

TABLE 4 – Relationship between central idea (CI) of question 3, proportion of responses according to research participants and DSC for question 3

Central Idea (CI)		Nurses classifying the STM service	
		N	%
T H E	I do not see any factors that impact the ineffective application of the protocol.	3	37.5
B	The attitude of users and other health professionals	4	50.0
W	The precariousness of the health care network	2	25.0
D	The limitations of the protocol	2	25.0

A N D	The internal protocols of the hospital institution	2	25.0
Total number of informants = 8*			
DISCOURSE OF THE COLLECTIVE SUBJECT			
<p>DSC A:I think that (pause), there is nothing, I can't see anything, at least in my experience, that really impacts the lack of effectiveness, I can't see anything that has repercussions. The protocol makes us very confident, very secure. Depending on the patient's clinic, you can choose more than one flowchart, but you stop at the same discriminator and the same priority, it makes us very confident that you really know that you are choosing the correct classification, do you understand?</p>			
<p>DSC B:In our daily lives, there is misinformation. The patient comes with a lot of people. The story is very confusing. People don't know how to tell the story. And something that should be quick. We waste time trying to understand the story. You waste time thinking: but what happened? And the person says: "No, it's because I don't know what!" Then they mix up some stories - a medicine they took, a food they ate - with what they're feeling. In the end, you end up not knowing how to tell what happened. I think it's more common in strokes. It's hard to extract the story from stroke patients. Sometimes it's a seizure. The patient had a seizure at home and is in a post-ictal state. This can confuse the classifier and they open it as an acute neurological deficit and open a stroke protocol, but it's not. [Also] when the person comes in and says: "No, I just have a headache, and a headache that won't go away." So, you end up having a protocol with a symptom that you try to see if the care would be here, and then it ends up not being very applicable, because the patient just came in and said: "no, I have a headache"; "okay... but tell me more about this headache!", and the patient feels (pause), like we think it's a lie, or that I'm belittling them, and they don't report anything else. There are patients that we explain that if they are classified as green or blue, they will have to wait longer, because we don't stop receiving patients classified as yellow or orange or red, there will always be a patient who is a higher priority, and then there are patients who, due to culture, right? They come to the hospital first, but they could go to the UPA or the PSF, you know? Sometimes, unfortunately, we see [also] some people who come wanting to intimidate us, people who, like, are from the hospital itself and come with a relative, with something that would not be an emergency, there would be no indication to stay or come in, you know? It gets in the way (pause), it's not our profile and I can't get around it to put a patient who doesn't fit our profile, you know? So we have this difficulty, because it's a tertiary hospital and it treats many more serious patients.</p>			
<p>DSC C:So, we live in a very complicated context, where the municipal network, for example, is not well structured. We see many patients coming here looking to perform a test that they already have a request for, but they were unable to do so. So, let's say that if we let ourselves be carried away a little by emotion and everything, we tend to want this patient to arrive at a (pause) higher risk classification than they really would be, quite absurd! So, we serve forty-five municipalities and are an open door to the demand for stroke. We are a reference in stroke and we notice that doctors refer patients as suspected stroke who do not have a stroke. We have difficulty classifying this patient, because – on paper – it is one thing, when we see the patient it is different. These referrals that are not reliable to what the patient is feeling make it very difficult to perform the Manchester, because they come through the bed regulation center. It is different to apply the Manchester based on the demand that they send from the municipalities. I'll give you an example, from several that I've seen happening: diabetic patients, heart patients, and doctors from [neighboring] municipalities realize that they can't handle all that demand, so they just say: Stroke, when they arrive here for us to be able to classify in three minutes, to get the entire</p>			

history of this patient, who has nothing to do with stroke, this makes it very difficult for us to apply the Manchester test!

DSC D: Here we take the discriminator and the symptom, right? You'll come to me and say: "Oh, I have a headache", and I'll ask: "Did you get hit? Did you fall? Did you faint? Did you vomit? Do you have stiffness in the back of your neck? Where is the pain? Is the pain only in the back of your neck? Is the pain all over your head? How long has it been going on?", because time also influences, but the patient is classified as green and, sometimes, this patient may be having a hemorrhagic stroke, but I'm not here to define the diagnosis, right? So, it has happened that a simple headache has turned into a hemorrhagic stroke and the patient ends up in an ICU, intubated and everything. So, the Manchester Protocol will classify the patient by complaint, by the complaints of that patient at the time, it turns out that that patient, by the complaint, is a green patient, is a blue patient, but he brings some exam that shows that he is a patient like that, more serious, understand? That he has a problem that deserves attention, so it's (pause) difficult, right? We, in the classification, have to be alert and see how we can help that patient. There are exceptions to everything, and one of the exceptions, for example, is a case like this: the patient with kidney failure, has altered urea and creatinine tests, but at that moment, his complaint is mild. You can see that he doesn't have any complaints of yellow or orange, but those tests show that he is a patient who deserves attention. So we have to have common sense, regardless of the color, everything has to have common sense.

DSC E: Some factors that have an impact [are] the protocols that we have to open. So, for example, this patient, I wasn't supposed to check her blood pressure, right? She's in intense pain, it's a kidney crisis, it's intense pain [...] what does the protocol ask for? Temperature and pain. In this flowchart, Manchester, it would only ask for two vital signs: temperature and pain. But according to the internal protocol, we check all the signs, of all the patients, so it's already a deviation, you know? It ends up that we (pause), the patient is in pain, with intense cramps, and you're making her waste time looking at things that the protocol doesn't ask for?

Source: Direct research, 2023.

* A speech can present more than one IC

Central Idea A shows that 37.5% of the nurses interviewed do not identify aspects that influence the ineffectiveness of the application of the MTS. DSC A also points out that the Manchester Protocol provides safety and reliability in the risk classification process.

In contrast, in Central Idea B, 50% of participants argue that attitudes on the part of the user, such as failure to communicate their complaint in detail, hinder the correct identification of flowcharts/discriminators. It is also stated that the conflict of interest on

the part of other professionals when bringing family members to the service with some demand interferes with the dynamics of the nurse's work, as it is not possible to "cheat" the system to assign an overestimated risk classification to that patient's complaint.

Central Idea C highlights that the precariousness of the care network is also a factor that may contribute to the ineffectiveness of the MTS. Because the municipal network does not have an adequate structure, some patients seek emergency services to perform tests

requested by other professionals, and because they understand the deficit in other levels of care, nurses end up allowing subjectivity to prevail in the assessment. In addition, the failure of the referral system is portrayed, since other municipalities refer patients to the service, reporting a certain pathology that is referenced in the service.

Central Idea D presents that a limitation of the MTS is the issue of verifying only the momentary complaint, without considering other aspects that can interfere with the health of the user, such as, for example, considerably altered exams.

Central Idea E reinforces the perception that the use of multiple protocols of the institution impacts the classification of risk in a timely manner, and interferes, above all, with patients complaining of intense pain.

Considering the nurses' perspective, when asked about how users welcome the MTS, two Central Ideas were found, and the prevalent CI for the question was that most users welcome the MTS in a positive way (mentioned by 62.5% of the nurses interviewed). The discourses of the collective subject are shown in Table 5.

TABLE 5 – Relationship between central idea (CI) of question 4, proportion of responses according to research participants and DSC for question 4

<i>Question 4: In your opinion, how do users, in general, receive the STM? (Do they receive the rating positively or negatively? Why do you think so?)</i>			
Central Idea (CI)		Nurses classifying the STM service	
		N	%
THE	Most people receive the STM negatively	3	37.5
B	Most people welcome the STM positively	5	62.5
Total number of informants = 8			
DISCOURSE OF THE COLLECTIVE SUBJECT			
<p>DSC A: I think most people receive it negatively, even though they don't say it, but their bodies speak, right? And there are those who [pause] don't accept it, they fight it head on, they get upset. There are people who come here thinking that their complaint is extremely urgent, for them, their case can't wait, especially regarding the pain discrimination, because the one who will evaluate the issue of your pain will be me, but the one who is feeling [the pain] is you [...] here we have, look, the faces of those who are in pain, we have the issue of evaluating by vital signs, we know when a person is in a lot of pain, that unbearable pain, but I won't know your pain, I'll imagine what it's like – from what you say and from the presentation you give me –, but I won't know. There are people who feel pain and don't show it, right? There are people who simulate pain that makes you swear they are on the verge of death, and when you see the patient, see all the tests, see everything, the patient has nothing, he just wanted to take the medicine. From experience, in other places, I know patients who come in complaining of pain and the doctor can prescribe all kinds of medicine, but he wants morphine, he wants dolantina, and until he gets where he wants, he</p>			

won't stop saying he is in pain, and that is bad. They also think that their pain criteria are undervalued. Besides, most [of] them already know the labels and know the waiting time, so they come to the door and say: "I can't take it anymore, I'm in pain, put the red one right away, put the red one", and then I say: "the red one is for imminent risk of death, that is not your case", "yes, why don't you know!" Sometimes, we classify the patient and they need to be seen within an hour: "Oh, does the person have to die to be seen?" Then we end up saying: "No, they don't have to die, but if a person came here with the pain you're in now and you arrived with a stab wound, a gunshot or an accident, needing intubation, and I put [the person] first and left you for later, do you think I would be doing the right thing?" That's when they stop and start to understand that the pain wasn't as intense. But they [still] get annoyed, because they sit and wait, something that used to happen – when there was no protocol – the doctor would stay in the office and it was just: so-and-so comes in, leaves, comes in, leaves, they waited, but they saw all these patients coming and going, but not today, if the patient is classified as having an hour in the yellow category, the doctor is not obliged to see the patient at the same time, he has up to an hour to see the patient. So, if he doesn't see the patient right away when he arrives and he sees the doctor coming and going, walking, and he's sitting there waiting, he wonders why the doctor doesn't come to see him, so he thinks it's the fault of the classifier, who put that color on him and said he's not being seen. Right at the beginning, I think it was due to the patients' temperament, with that agony, with that feeling that they were really in pain, because you were inexperienced, You were afraid of leaving him waiting too long and something worse happening [...] you ended up classifying him as orange, when he could be yellow.

DSC B: I believe that they mostly receive it positively, depending on the complaint, the protocol classifies the patient as a priority for care and the service happens. I think that today, since the hospital has been in operation for 12 years, the population is more aware of what is actually provided here and, as a result, they kind of accept the Manchester Protocol, right? So, they understand that there is a protocol that will guide this issue of assessment for medical care. They understand today that the level of complexity that is provided in the service is a higher level. So, when we actually classify patients as green, blue, who are not treated here and are returned to the network, they are able to accept it in a better way, because before (pause) there was a lot of friction, but today they are able to understand it better, many people already understand, already accept it. Personally, as a classifier, I am very clear, I often even show them, because it is based on what they have, what they are feeling, their demand, that we classify, it is not something invented, I show them, I say: "look, this is the flowchart, this is the discriminator, you fit this profile here [...] we will see how your vital signs are, see if there are any changes, but, probably, based on your complaint, you will not fit our profile, and then we will classify, we cannot cheat on anything, understand?" Then we say that we are a large hospital and that the green one is [...] it does need care, but, unfortunately, we do not provide care here, and most people accept it well.

Source: Direct research, 2023.

Central Idea A argues that most users receive the risk classification negatively. One of the factors that triggers the non-acceptance of the definition of clinical priority is the fact that some users are unaware of how the classification works and

the criteria used to define a high-risk priority. There are users who arrive at the service with the idea that their complaint is very urgent or even emergent, without understanding that high risks are linked to major health problems and the risk of death.

In contrast, Central Idea B portrays that most patients accept risk classification positively. This is because users understand that priority is defined through a protocol and understand that the service in question, as it is highly complex, only deals with urgent and emerging complaints. DSC B also highlights that communication between the professional and the patient, in the sense of explaining how risk classification works, has a positive effect on user satisfaction.

DISCUSSION

The predominance of the idea that discriminators and flowcharts allow the organization of the internal flow of the service according to clinical priority emphasizes the discourse that the MTS is a clear and objective system that directs care and organizes the service, making it possible to perform a more effective risk classification when identifying the patient's need.¹³ In addition, it contributes to reducing overcrowding in the service, since low-risk or non-urgent patients should be directed to the care network.

However, overcrowding is related to the perception of most patients, who consider the emergency service as an uncomplicated gateway to care. It is also worth noting that due to a gap in the implementation of the referral and counter-referral system, in addition to the prevalence

of the medical-curative model, patients with demands that can be resolved in primary or secondary health care seek out emergency and urgent care services to respond to their problems.¹⁴

Providing care to patients with complaints that do not match the service profile can compromise the quality of the service flow and often cause problems for the patient due to delays, and for the professional due to having to deal with the stress of many users who do not understand the importance of CR. As an example of this, there is a study carried out in a general hospital in the city of Mossoró - RN, which sought to analyze the types of violence suffered by the nursing team in risk classification. The research indicates that because the classifying nursing professional is the first to contact the user in a delicate situation of illness and is responsible for classifying the severity and time of medical care, he or she becomes vulnerable to suffering violence from users, companions and even other professionals in the unit.¹⁵

Among the factors that interfere in the implementation of the MTS, a study addresses that one of the complaints of the survey respondents is linked to the fact that at times, the STM does not identify a flowchart related to the user's complaint.¹⁶ On this occasion, the professional has the alternative of carrying out the classification in a more generalized manner.

Another aspect that interferes with CR is the difficulty in identifying the main complaint. A qualitative study conducted in the northern region of Portugal agrees that this factor compromises the choice of a flowchart or discriminator, making this decision process complex. The nurses in the study also mention that this fact is a result of the multiplicity of complaints and their nonspecific aspect.¹⁷

That said, it is worth noting that some institutions limit themselves to explanatory banners about CR. However, users need to be educated about CR, since not everyone is familiar with it, and it should be taken into account that some patients do not know or cannot read, and/or have difficulty interpreting. In view of this, there is a need for support and guidance in the risk classification process to facilitate the user's acceptance process.¹⁸

FINAL CONSIDERATIONS

It was possible to identify the potential of the MTS as the optimization of time in the CR and the organization of the flow according to clinical priority, impacting the waiting time of the user, who generally welcomes the protocol. However, difficulties faced included the care of users with nonspecific, multiple or non-clinical complaints, as well as the care of those who do not fit the institution's profile. In addition,

the failure of the Health Care Network and the use of multiple protocols during the CR stood out.

In view of the above, there is a need to raise awareness among management bodies for greater resolution of the Health Care Network, especially with regard to Primary Care and Secondary Care, so that users are properly assisted and avoid overloading Tertiary Care services.

Furthermore, ongoing education among nursing professionals focusing on the application of the STM is important to ensure greater safety and encourage the search for more robust evidence that supports the use of this instrument to reorganize the care flows of hospital emergency and urgency services.

It is worth noting that a limitation of the study concerns the collection of data in only one hospital institution, a factor that may suggest the need to broaden the understanding of nurses' discourses in other institutions located in other municipalities in the region, as well as in other states, which is a field for further investigation.

REFERENCES

1. Ministério da Saúde (Brasil). Secretaria de Atenção à Saúde, Departamento de Atenção Especializada. Manual instrutivo da Rede de Atenção às Urgências e Emergências no Sistema Único de Saúde (SUS) [Internet]. Brasília: Editora do Ministério da Saúde; 2013 [citado em 12

- nov 2024]. 84 p. Disponível em: <https://biblioteca.cofen.gov.br/wp-content/uploads/2024/07/manual-instrutivo-rede-atencao-urgencias-emergencias-sistema-unico-saude.pdf>
2. Jesus APS, Okuno MFP, Campanharo CRV, Lopes MCBT, Batista REA. Manchester Triage System: assessment in an emergency hospital service. *Rev Bras Enferm.* [Internet]. 2021 [citado em 6 ago 2024]; 74(3):e20201361. Disponível em: <https://www.scielo.br/j/reben/a/prWmyPMW3LNVwXsqGMhghBQ/?format=pdf&lang=en>
 3. Souza CC, Araújo FA, Chianca TCM. Scientific literature on the reliability and validity of the Manchester Triage System (MTS) protocol: a integrative literature review. *Rev Esc Enferm USP.* [Internet]. 2015 [citado em 6 ago 2024]; 49(1):142-9. Disponível em: <https://www.scielo.br/j/reeusp/a/8PqLqcnNmCp7mkqPxLkKhdL/?format=pdf&lang=en>
 4. Silva ADC, Chianca TCM, Pádua DR, Guimarães GL, Manzo BF, Correa AR. Caracterização dos atendimentos de um pronto-socorro público segundo o sistema de triagem de manchester. *REME Rev Min Enferm.* [Internet]. 2019 [citado em 6 ago 2024]; 23(1):e-1178. Disponível em: <https://periodicos.ufmg.br/index.php/remear/article/view/49793/40313>
 5. Anziliero F, Dal Soler BE, Silva BA, Tanccini T, Beghetto MG. Sistema Manchester: tempo empregado na classificação de risco e prioridade para atendimento em uma emergência. *Rev Gaúcha Enferm.* [Internet]. 2016 [citado em 6 ago 2024]; 37(4):e64753. Disponível em: <https://www.scielo.br/j/rngenf/a/ZPt8CVtgXpftkT7MszL8KtP/?format=pdf&lang=pt>
 6. Moura BRS, Nogueira LS. Performance of the rapid triage conducted by nurses at the emergency entrance. *Rev LatinoAm Enferm.* [Internet]. 2020 [citado em 6 ago 2024]; 28:e3378. Disponível em: <https://www.scielo.br/j/rlae/a/TSVMjCJ9jfVJ6g6hyQ7Yh8K/?format=pdf&lang=en>
 7. Franco B, Busin L, Chianca TCM, Moraes VM, Pires AUB, Lucena AF. Associações entre discriminadores do Sistema de Triagem de Manchester e diagnósticos de enfermagem. *Rev Gaúcha Enferm.* [Internet]. 2018 [citado em 6 ago 2024]; 39:e2017-0131. Disponível em: <https://www.scielo.br/j/rngenf/a/TRpDZrc8CKSSBXCKyMR8DQc/?format=pdf&lang=pt>
 8. Lima DC, Ibiapina II GR, Silva ÁDM. Atendimento de emergência: conhecimento e aplicabilidade do protocolo de Manchester por enfermeiros. *Res Soc Dev.* [Internet]. 2021 [citado em 6 ago 2024]; 10(14):e47101421635. Disponível em: <https://rsdjournal.org/index.php/rsd/article/view/21635/19323>
 9. Roncalli AA, Oliveira DN, Silva ICM, Brito RF, Viegas SMF. Protocolo de Manchester e população usuária na classificação de risco: visão do enfermeiro. *Rev Baiana Enferm.* [Internet]. 2017 [citado em 6 ago 2024]; 31(2):e16949. Disponível em: <https://www.revenf.bvs.br/pdf/rbaen/v31n2/1984-0446-rbaen-rbev31i216949.pdf>
 10. Instituto de Saúde e Gestão Hospitalar. Unidade hospitalar. Hospital Regional do Cariri [Internet]. Juazeiro do Norte, CE: ISGH; 2022 [citado em 31 jul 2022]. Disponível em: <https://www.isgh.org.br/onde-estamos/hospital-regional-do-cariri>
 11. Lefèvre F, Lefèvre AM. Discurso do sujeito coletivo: um novo enfoque em pesquisa qualitativa (desdobramento). 2. ed. Caxias do Sul: Educs; 2005.
 12. Lemos ICS, Delmondes GA, Dias DQ, Menezes IRA, Fernandes GP, Kerntopf MR. Discourse of the collective subject as a method for analysis of data in ethnobiological research. In: Albuquerque UP, Lucena RFP, Cunha LVFC, Alves RRN, editors. *Methods and techniques in ethnobiology and ethnoecology*. 2nd ed. Nova York: Humana Press; 2019. p. 55-67. (Springer Protocols Handbooks).
 13. Cicolo EA, Peres HHC. Electronic and manual registration of Manchester System:

reliability, accuracy, and time evaluation. *LatinoAm Enferm.* [Internet]. 2019 [citado em 6 ago 2024]; 27:e3241. Disponível em: <https://www.scielo.br/j/rlae/a/BJHfppCkRvL8KmgX5Z6QTnm/?format=pdf&lang=en>

14. Baratieri T, Lentsck MH, Corona LP, Almeida KP, Kluthcovsky ACGC, Natal S. Fatores associados ao uso inapropriado do pronto atendimento. *Ciênc Saúde Colet.* [Internet]. 2021 [citado em 6 ago 2024]; 26(6):2281-90. Disponível em: <https://www.scielo.br/j/csc/a/g49hxmjshxxjQKLWrCJgR9D/?format=pdf&lang=pt>

15. Freitas RJM, Pereira MFA, Lima CHP, Melo JN, Oliveira KKD. A violência contra os profissionais da enfermagem no setor de acolhimento com classificação de risco. *Rev Gaúcha Enferm.* [Internet]. 2017 [citado em 6 ago 2024]; 38(3):e62119. Disponível em: <https://www.scielo.br/j/rgenf/a/RGRxYF4qtXRPKPt3fRxkvPQ/?format=pdf&lang=pt>

16. Santos CS, Morais SM, Abib MLVS, Andrade SN, Oliveira F. Sistema de Triagem de Manchester: percepções de enfermeiros de uma unidade de pronto atendimento do Centro Oeste Mineiro. *Revista Eletrônica Acervo Saúde* [Internet]. 2022 [citado 6 ago 2024]; 15(10):e10916. Disponível em: <https://acervomais.com.br/index.php/saude/article/view/10916/6641>

17. Costa FA, Torres RS, Sousa CP. Triagem de Manchester: percepções dos enfermeiros sobre os seus contributos e fatores que a influenciam. *Revista de Enfermagem Referência* [Internet]. 2022 [citado em 6 ago 2024]; 6(1):e21028. Disponível em: https://web.esenfc.pt/v02/pa/conteudos/downloadArtigo.php?id_ficheiro=4446&codigo=

18. Campos TS, Arboit Éder L, Mistura C, Thum C, Arboit J, Camponogara S. Acolhimento e classificação de risco: percepção de profissionais de saúde e usuários. *Rev Bras Promoç Saúde* [Internet]. 2020 [citado 6 ago 2024]; 33:9786. Disponível em: <https://ojs.unifor.br/RBPS/article/view/9786/pdf>

RECEIVED: 09/16/2024

APPROVED: 12/11/24

PUBLISHED: 11/2024