WORK PROCESS OF NURSES IN THE RECEPTION WITH RISK RATING

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: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ___...
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.4,5

It is believed that changes in the nursing work process must occur with the insertion of the RRR in emergency services.6 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-
The work process of nurses in the reception with risk rating

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. Although 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. 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.

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. 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. 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. 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.

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 would not be enough to detect priority in this patient. Thus, 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.

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.

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.

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.

Our clinical action is also a working tool, the clinics that we brings, the knowledge that we bring is a working tool.

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.

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.
enyone 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 impose 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. Its technical directionality and its production depend on the collective work, most of the times. Here it is the interdisciplinary potential of the RRR, which goes beyond the multiprofessional walls and limits. It is not framed in a hegemonic knowledge, but depends on the inter-relationships 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 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).”

REFERENCES
Work process of nurses in the reception with risk rating


