Nurse's decision-making process on risk classification: what is the theoretical basis for this practice in the health care scenario?

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Overcapacity of the services of urgency and emergency is a problem faced by different countries. In Brazil, due to the need of improvements in the care provided, the Ministry of Health established an Urgency and Emergency System that has risk assessment as the basic intervention in the assistance routine.

For the effective management of an urgency and emergency service, it is essential to establish an organization of care based on the criteria of risk stratification. The risk classification is a dynamic process of identification of patients that need immediate treatment, and it is based on risk potential, health hazards or the patient's suffering degree at the moment of arrival to the healthcare facility.

Nurse has been the professional chosen to perform the risk classification due to its competence in using clinical reasoning, evaluating the complaint and signs presented by the patient, considering the health status and making the correct decision regarding the clinical priority level. Some characteristics inherent to the nurse professional emphasize its suitability to perform the risk classification: clinical ability to identify signs and symptoms; listening skills aimed at recognizing the main complaint; ability to establish an empathetic relationship with the patient, reducing his/her anxiety, aggressiveness and impatience.

Assigning a risk degree to a patient consists in a complex decision-making process, in which it is necessary to choose the information to collect and what instruments to use for classifying the patients. This process aims at avoiding a decision solely guided by a subjective evaluation and the nurse's experience. Thus, many classification scales, also known as triage scales, have been developed to guide the nurses' evaluation of the case. Among these, it is highlighted the Canadian Triage Acuity Scale – CTAS, Australasian Triage Scale – ATS, and the Manchester Triage System – MTS; the last one being the most used in Brazil.

Although important, the triage scales themselves do not guarantee the success of the nurse decision-making process in the risk classification, and a wrong decision may affect the patient's health, in case any important clinical finding is neglected. Therefore, it is important for the patient safety to understand the process and strategies nurses use to make their decisions in the risk classification.

Nurses assess the patients; assign a severity score having as reference a triage scale; prioritize patients for medical treatment according to the severity classification; and determine the appropriate room for the treatment within the urgency and emergency service. Even though it may appear that establishing a level of priority to the patient is a "simple task" that only requires "following a protocol", these multiple and simultaneous decisions happen within an uncertain scenario, under time pressure and a stressful environment.

Thus, what is behind the nurse's decision-making process in the risk classification? Is there a conceptual model able to sustain this practice, which allows understanding what is the nurse's clinical judgment in this context?

Theoretical frameworks provide the structure for the decision-making and explain the philosophical basis of nursing care in different perspectives. Although few, there are some studies that have been trying to propose theoretical models, which explain the nurse's decision-making process in the risk classification. One of these models is based in the use of

automatic and intuitive "mental shortcuts" to solve problems. In the same line, nurses' previous experiences facilitate the decision-making process when they are subjected to assessment of patients with similar signs and symptoms. The decision-making process would be influenced by the clinical experience, being the clinical judgment based on probabilities.

Another theoretical model is based on the assumption that the nurse identifies and provides care to the relevant clinical characteristics. Then, the nurse proceeds to clinical reasoning, having as reference the empirical data, personal beliefs and attitudes, nursing knowledge and previous clinical experiences.

The model described as "Major recognition" has also been pointed as a possible theoretical framework able to explain the nurse's decision-making process in the triage. This theoretical model seeks to understand how the decision-making process is within a dynamic context, under time pressure, incomplete information, and involving different people, which applies to the risk classification scenario. It comprehends intuition and analysis, and describes three variations in the decision-making. The first variation involves recognition of a typical situation to the nurse; then, the nurse is able to recognize it and to quickly choose the actions, once the nurse knows what to expect following the events. The second variation encompasses the recognition of an atypical situation, in which the nurse will try to reenact in his/her mind a medical history to try to explain the findings and assist in the decision-making. The third variation is the mental preparation of a sequence of actions and their assessment with reference to the patient's findings. In case a sequence of actions is rejected, a new mental sequence is elaborated.

What I have noticed is that, both in research and scenarios that enable the discussion of the nurse's practice in the risk classification, the focus has been on themes related to guiding protocols used in the clinical practice, and the description of facilitating and inhibiting factors from the work environment. While it is acknowledged that complex structural and management matters influence the nurse's practice on the risk classification, which go beyond his/her power of governance and problem solving, the nurse's decision-making process in this healthcare context has been abridged to audits that aim at checking if the nurse followed or not a determined protocol, and to the practice routine within a health service and among others.

In Brazil, studies or discussion forums directed to the search and understanding of a theoretical and philosophical framework that is able to explain the nursing care in the risk classificationare unkown. Thus, there is a gap between the theoretical models and clinical practice. Therefore, it is necessary that nurses and researchers come together in the search for a theoretical model, which may already exist or needs to be created, in order to better understand nurse's decision-making process in this clinical scenario. I believe that this understanding is crucial to direct the educational institutions on the skills and competencies necessary to the classifier nurses, as well as to evaluate their accuracy in assigning level of priority to the patients. This will result in professionals more well prepared to the clinical practice, and in a safe practice, both for the professional and the patient. Let the challenge begin!

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