Research

IMPACT OF THE IMPLEMENTATION OF PATIENT ENGAGEMENT WITH RISK CLASSIFICATION FOR PROFESSIONAL WORK OF ONE URGENT CARE UNIT

IMPACTO DA IMPLEMENTAÇÃO DO ACOLHIMENTO COM CLASSIFICAÇÃO DE RISCO PARA O TRABALHO DOS PROFISSIONAIS DE UMA UNIDADE DE PRONTO ATENDIMENTO

EFECTOS DE LA PUESTA EM PRÁCTICA DE LA ACOGIDA CON CALIFICACIÓN DE RIESGO EN EL TRABAJO DE LOS PROFESIONALES DE UNA UNIDAD DE EMERGENCIAS

Kalyane Kelly Duarte de Oliveira [1]
Kalianny Kadidja Polline Soares Amorim [2]
Ana Paula Fernandes Nunes de Lima [3]
Akemi Iwata Monteiro [4]

[1] RN. Professor at the Universidade Potiguar. Master student Universidade Federal do Rio Grande do Norte – UFRN. Natal, RN – Brazil.
[2] RN in the Dr. Tarcísio de Vasconcelos Maia Urgent Care Unit. Natal, RN – Brazil.
[3] Under Graduate Student at Universidade Potiguar – UnP. Natal, RN – Brazil.
[4] RN. PhD. Professor at UFRN. Natal, RN – Brazil.

Corresponding Author: Kalyane Kelly Duarte de Oliveira. E-mail: kkoliveira@unp.br
Submitted: 04/01/2012 Approved: 26/09/2012

ABSTRACT

The objective of this work was to analyze the impact of the implementation of patient engagement with risk classification (ACCR) in the work of professionals of one urgent care unit. This is a descriptive, qualitative approach. Data collection was performed in the Dr. Tarcisio de Vasconcelos Maia Urgent Care (UC) Unit, with the participation of twelve professionals as subjects: three physicians, three nurses, three social workers and three nursing technicians. Data were collected through a semi-structured interview guide, and analyzed according to the collective subject discourse technique. The work was conducted under the approval of the ethics committee of FAMENE / FACENE, under protocol No. 121/2010. The results showed that knowledge about ACCR existed among UC professionals, cited as a way to humanize care and identifying differing responses regarding the ability of the implementation of ACCR in the UC concerned, showing structural and personnel deficiencies. The questions revealed different opinions about the changes to the UC after implementation – for example, improvements in patient care. The ACCR improved care in the UCs, creating a system of care order based on the greater risk of death and leaving behind the service model based on order of arrival. Moreover, it provided humanization of care, in the work with a multidisciplinary team. Therefore it was concluded that health services should be interconnected and seek integrated care of the user, providing improvements, and the entire staff of the institution should be engaged in the new delivery system, respecting its norms and routines.

Keywords: Humanization of Care; Patient engagement; Classification.

RESUMO

Objetivou-se com este trabalho analisar o impacto da implementação do Acolhimento com Classificação de Risco (ACCR) no trabalho dos profissionais de uma unidade de pronto atendimento.Trata-se de uma pesquisa descritiva de abordagem qualitativa. A coleta de dados foi realizada na Unidade de Pronto Atendimento Dr. Tarcísio de Vasconcelos Maia, com a participação de doze profissionais: três médicos, três enfermeiros, três assistentes sociais e três técnicos de enfermagem. Os dados foram coletados por meio de um roteiro de entrevista semiestruturado e analisados de acordo com a técnica do discurso do sujeito coletivo. O trabalho foi realizado sob aprovação do Comitê de Ética da Famene/ Facene, sob o nº 121/2010. Os resultados mostraram que existe conhecimento dos profissionais da UPA sobre o ACCR, citado como uma forma de humanizar o atendimento, e apontam respostas divergentes quanto à capacidade de instalação do ACCR na UPA em questão, mostrando deficiências estruturais e de pessoal. Os questionamentos revelam diversas opiniões sobre as mudanças da UPA após a implementação – por exemplo a melhoria no atendimento do paciente. O ACCR veio aperfeiçoar o atendimento das UPAs, criando ordem de atendimento segundo o maior risco de morrer e deixando o modelo de atendimento por ordem de chegada. Além disso, proporcionou humanização no atendimento, no trabalho com equipe multidisciplinar. Assim, concluiu-se que os serviços de saúde devem se interligar e buscar a atenção integral do usuário, promovendo melhorias, e toda a equipe da instituição deve engajar-se no novo dispositivo, respeitando suas normas e rotinas.

Palavras-chave: *Humanização da Assistência; Acolhimento; Classificação.*

RESUMEN

El presente trabajo tiene como objetivo analizar el impacto de la puesta en práctica de la Acogida con Calificación de Riesgo (ACCR) en profesionales que trabajan en la atención de emergencias. Se trata de una investigación descriptiva de enfoque cualitativo. La recogida de datos se llevó a cabo en la Unidad de Atención de Emergencias Dr. Tarcisio de Vasconcelos con doce profesionales: tres médicos, tres asistentes sociales y tres técnicos de enfermería. Los datos fueron recogidos a través de entrevistas semi estructuradas y analizadas de acuerdo con la técnica del discurso del sujeto colectivo. El trabajo fue realizado con la aprobación del comité de ética de FAMENE / FACENE bajo el número 121/2010. Los resultados muestran que los profesionales conocen la ACCR, citado

como una forma de humanizar la atención, y dan respuestas divergentes en cuanto a la capacidad de instalación del ACCR en las UPA en cuestión, señalando las deficiencias estructurales y de personal. Las preguntas revelan opiniones diferentes acerca de los cambios después de la aplicación de UPA, tales como el cuidado de los pacientes. El ACCR ha venido a mejorar la atención de las UPM, creando orden en la atención al dar prioridad según el riesgo de muerte y no por orden de llegada, como se hacía antes. Además, ha humanizado la atención prestada y el trabajo con personal multidisciplinario. Por lo tanto, llegamos a la conclusión de que los servicios de salud deben estar vinculados entre sí y buscar la atención integral del usuario, para promover mejoras. Además, todo el personal de la institución debe comprometerse con el nuevo modelo, respetando sus reglas y rutinas.

***Palabras clave**: Humanización de la Atención; Acogida; Clasificación.*

INTRODUCTION

Health as a right of all and duty of the State is an achievement of the Brazilian people, achieved despite difficulties existing in the area of health. In 1988, the new Constitution came into effect, establishing the Unified Health System (SUS), whose principles and directives are: universality, comprehensiveness and equity in health care, as well as decentralization, hierarchy and regionalization of the health actions. [1]

The SUS provides a hierarchy of services, respecting the principles of referral and counterreferral in the three levels of care. However, establishing the hierarchy remains a challenge – for example, urgent care / emergency services, in most public hospitals in Brazil, are inefficient, resulting in low quality of care, long waiting time and accumulation of patients in the corridors of the Urgent Care (UC) units. [2] These facts are favored by the malfunctioning of primary care and are reflected in the great demand placed on UC units.

The UC units, in most cases, provide rapid response to user needs, especially those with acute and serious complaints, promoting palliative care for them, access to different technologies, services or connections with others. However, its profile of emergency and urgent care is delayed when it must perform care for users with pathologies which require primary care rather than urgent care services. [2]

By means of the context, SUS has been confronted with the need to follow the deployment of the National Humanization Policy (NHP), since its creation, which aims at humanization in all health services. The importance of this policy in urgent / emergency care should also be stressed, because relevant points are consolidated through it, such as: reducing lines and waiting time with patient engagement and problem resolution based on criteria that classify risk; users must know who the professionals are who care for their health, and the health services are responsible for their referral territory; health units ensure information to the user and the user's code of rights of SUS, as well as participatory management of the professionals and users. [1]

The humanization of care requires that health professionals interact with users about experiments and experiences and, thereby, lead to different actions, great possibilities for resolutions of problems, and the means to facilitate work in health, always seeking improvements for the user. [3]

Given the above, one can cite the *Patient Engagement with Risk Classification* (ACCR) as a tool for this mission, a device by which the Ministry of Health (MH), through the NHP, seeks through analysis, service agility from the perspective of a preestablished protocol, the degree of user needs, providing attention centered on the level of patient complexity, and not on the order of patient arrival. In this way, an assessment and classification of need is conducted, distanced from the traditional concept of triage and its exclusionary practices, because everyone will be served. [4]

Patient engagement and hospitality, or the receiving of the patient in a courteous and comprehensive way, and humanely promoting health is emphasized. This form of humanized care delivery means that the society must be educated about the levels of health care and knowing where to go for the appropriate health service. Society should also be oriented about the functionality of the care delivery system to be aware of the waiting time.

Thus, based on the above context, the ACCR service deployment on the Dr. Tarcisio de Vasconcelos Maia Urgent Care Unit (TVM-UCU) was initiated in February of 2010, and since that date the care routines were changed. Given this situation we asked: What impact has ACCR had on the work of health professionals in the TVM-UCU?

The overall objective of this study was to analyze the impact of implementing patient engagement with risk classification for professionals working in an urgent care unit in Mossoró. The specific objectives were: to analyze the knowledge of health professionals interviewed about patient engagement with risk classification for work, and to identify from the opinion of health professionals interviewed, changes in attendance and the level of user satisfaction after the implementation of patient engagement with risk classification in the work environment.

METHODOLOGY

This study was characterized as a descriptive, qualitative approach. Data collection was conducted in the Dr. Tarcisio de Vasconcelos Maia Urgent Care Unit, located in Mossoró-RN, in September of 2011.

The population selected was health professionals working in the TVM-UCU, composed of 27 physicians, 18 nurses, 13 social workers and 50 nursing technicians. Given the difficulty of inter-

viewing professionals, due to the workload of the service, only one representative from each professional category, in turn, participated, representing the morning, afternoon and evening shifts.

Thus the sample consisted of twelve health professionals chosen to represent their respective categories: three nurses, three social workers, three physicians, and three nurse technicians. For the validation of the sample, inclusion criteria were established which were: being a part of the TVM-UCU professional cadre since the time of ACCR implementation, and agreement to participate in the research.

The instrument for data collection was a guide for a semi-structured interview. In the first part, participants were characterized in relation to the professional category, title and length of service. In the second part of the interview, we explored issues related to the theme, such as: knowledge about patient engagement with risk classification, difficulties in implementing the strategy at the research site, changes that occurred in the UC after the implementation of patient engagement, and even the perception of professionals about the level of user satisfaction after the functioning of the ACCR.

The signing of the Terms of Free and Informed Consent Form (TFIC) by the subjects occurred prior to the application of the data collection instrument, and all were informed about the research objectives and procedures, emphasizing the voluntary nature of their participation, and ensuring anonymity. The collection occurred in September of 2011, with the approval of the project by the Ethics Committee of Facene/Famene João Pessoa-PB, with the CEP certification 121/10.

Data were analyzed by means of the Collective Subject Discourse (CSD) analysis technique, which consists of a joining, in a discourse-synthesis, of key phrases with the same central idea. According to the authors, individuals dissolve and incorporate in one or more collective discourses which expresses a social representation about a particular theme of the collective to which they belong. This method permits the representation of findings by the similarity of the responses. Therefore, the following steps were followed: successive readings of discourses; previous analysis of decomposition of responses; selection of central ideas and key phrases present in each of the discourses. [5]

RESULTS AND DISCUSSION

The characteristics of the sample were collected, using the variables: age, gender, and length of professional training, to provide a better understanding of the profile of the professionals participating in the research. In this sense, the twelve health professionals comprising the sample included three nurses, three social workers, three physicians, and three nurse technicians.

Regarding the type of post-graduate education of the professionals interviewed, seven of the professionals had completed specialization, one had completed a residency and four had not completed post-graduate work. Regarding the length of service in the unit studied, it can be noted that one of the professionals was in service for almost one year; ten, between one to five years; and one, between five to ten years. This showed that the majority of respondents supported the establishment and implementation of ACCR in the TVM-UCU, which had occurred nine months previously.

Regarding the question referring to the length of service in the professional category, the data showed that ten of the professionals were working in the profession for more than ten years; two, from one to five years; and one, between five to ten years, showing that the majority of the professionals interviewed had significant experience, enabling them to reveal the opinion of the impact of the new care delivery model for humanization, ACCR, on their work, because they experienced several realities about the process of engaging the user.

When they were questioned about the definition of patient engagement with risk classification for the work, three central ideas arose: humanizing the care, care in order of severity of disease, and the strategy to reduce the demand for ambulatory cases in UC.

The first central idea that emerged was **to humanize care:**

> *To better receive the patient who comes to the urgent care and emergency room. It is a very opportune way to receive the user [...]. Users have the chance of being more humanely engaged. It is a tool for improvement of care to ensure that urgent care is provided for people at the right time.*

This central idea refers to the understanding that the ACCR is a way to humanize care and expressed this in CSD, which revealed that the professionals who used the ACCR humanized care, as patients were classified according to a protocol established by MH, not only in accordance with the vision demonstrated by the professional about the severity of the patient. We remember that, even with the existence of a protocol, the humane evaluation recommends the observation of anxieties, fears and concerns and not only premonitory signs and symptoms of risk of death. [6]

One negative aspect of patient engagement prior to the implementation of ACCR was that it was often being performed by employees of the security sector, porters, auxiliary or general services, where they defined the priority of care. This situation left the individual exposed, in poor environmental conditions, inhumanely, along with the fact that serious cases were not prioritized. [7]

With this strategy, the ACCR requires trained professionals with clinical vision and perception of possible health problems of the user, regardless of how these signs are expressed, and with-

out judgment and without being despised, but with careful assessment to avoid further damage to the health of the user. It is important to consider the individual subjectivity and objectivity of a complex biomedical definition of an emergency situation. [7]

The work process is determined by one's objectives, the idealization of the ends that were planned, by the worker, well before its completion. The worker interacts with the user in the process, in search of the desired result, and this exchange of subjectivities is expressed in the conception of health and disease from those who produce and those who receive care, as well as the mode of production of the same. [8]

Another central idea was about the definition **care by order of severity of diseases:**

> *To prioritize the care that is really urgent and emergent [...]; to prioritize the care of those in most need. It is a way to filter the urgent and emergency from the ambulatory issue. It is a way of making sure that the user is treated according to the need of the pathology, and not in order of arrival.*

It is, according to this idea, the need to care for people suffering from more serious pathologies. With this statement, the NHP shows the risk classification as a dynamic process of identifying patients who require immediate treatment, based on level of health or degree of suffering. [4]

The noted discourse brings us to the benefits of patient risk classification, because the focus of this process is to assist the patient in a more humane and precise manner, functioning as a tool or means for the UC units to conduct their work in accordance with their objectives.

The ACCR is completed in a way that the professional nurse listens to user complaints, observes his signs and symptoms, and moves him to immediate care or with a determined delay, according to the institutional protocol. [4]

The Ministry of Health recommends that risk classification should be evidenced preferably by color, with four levels of classification, ranging from most severe to least severe (red, yellow, green, blue). This identification must be made in the patient chart, and not directly on the patient (bracelet, for example) because the classification is variable, given the possible changes in the patient's clinical status. [9] The colors indicate the severity of the patient and the waiting time for medical care.

The leadership of the TVM-UCU, together with the nurses of that service, formulated a manual of norms and routines for all professionals who use it as a means of information about various nursing procedures, norms and routines of the institution. An example is the ACCR protocol, which discusses the waiting time within the classification: red, immediate care; yellow, care within 20 minutes; green, care within two hours; and blue, referred to the social worker or attended after patients rated red, yellow and green.

This form of classification makes the ACCR strategy "dynamic, because it is necessary that, periodically, the risk of those who have not received care, or even those whose waiting time after the classification is higher than that which was established in the protocol, are reevaluated." [4:45]

Other professionals define ACCR as a **strategy to reduce the demand for outpatient cases in UC:**

> *When the classification is rated blue, that characterizes care of the primary care clinic, ambulatory care. The ACCR is not discarding the patient, but rather it is a direction to better meet the demand, it is a care strategy used to better meet demand.*

In this speech, it is emphasized that professionals seek to make referral and counter-referral for the patients who need care at the UC, and not only at the UC, and it also points out that professionals believe the ACCR is a strategy for triaging users that need immediate attention and the patients who need monitoring in primary care, to thereby direct them a manner consistent with the reality of UC.

The implementation of actions that stimulate the humanization of the urgent care and emergency department in the SUS network follows parameters for validation, that includes patient engagement suitable to the demand, with criteria for risk assessment, ensuring referral access to other levels of care, to guarantee referral and counterreferral, resolution of urgency and emergency, providing access to hospital facilities and the secure transfer according to the needs of the patients. [10]

Regarding the question about the difficulties of establishing patient engagement with risk classification in the unit of work for this research, professionals identified only one central idea, **organizational and structural difficulties:**

> *Lack of physical infrastructure [...] Should have more working conditions for this implementation, such as, at the moment the ECG, HGT, pulse oximeter machines are broken. Another point is that a professional nurse needs to be present for the classification. The assessment is to be made primarily by the nurse, but sometimes we realize that is made only by the technical nurses.[...] The biggest difficulty that we encounter is with the referral units. There is no ability to deploy patient engagement with risk classification because UC does not function at night. At night, we have no way to bridge the gap between the UC and the PCC.*

This idea reveals that, despite professionals agreeing with the implementation of the ACCR, there are still faults in the physical structure and primary materials, along with organizational problems for effective and satisfactory care.

For organization of the flow of service in the UC, better clarity of its function, the organization of care through axis ratings is necessary, divided into colors (red and blue) and areas (red, yellow and blue) that show the level of patient risk. [6]

The red axis is related to the critically ill patient with risk of death, and is composed of three main areas: the red, the yellow and the green area. In the red area is the emergency room; the yellow area is composed of a room for patient stabilization; the green area is composed of the observation rooms, divided by gender and age. [6]

The blue axis is composed of non-serious patients. This axis is comprised of three service areas: Area 1 – spaces for patient engagement, risk classification, waiting for medical care, reception; Area 2 – area of medical care; Area 3 – areas of medical and nursing procedures. It is important that the areas of procedures are close to the consulting rooms to encourage teamwork. [6]

Still citing the organizational structural for care, one should also take into account the proximity of the medical and nursing consulting rooms from the professional lounge and the minor surgery room, which should be inserted at the entrance of the institution, in order to accelerate the process of care. However, this division was not performed in the UC and engaged and classified patients await service in the same room, except for the most serious cases, which are directed immediately to the minor surgery room, where stabilization occurs, or to a bed on the nursing units.

It was noticed, too, that there is need for periodic review of ECG and HGT devices, as well as defibrillators, sphygmomanometers, surgical tables (for change of decubitus), and pulse oximeters, since they are usually found defective and slow patient stabilization, given the delay of some abnormal findings.

The UC has already trained professionals to conduct the ACCR, and the professional nurse is able to implement the objectives of the NHP, because the curriculum guidelines for undergraduate courses make clear that training is focused on health care, which makes this professional capable of managing actions of NHP, such as the ACCR. To accomplish this, the nurse works with a multidisciplinary team, which is well informed as to the purposes of the new process of patient engagement and uses the same language in care, avoiding injustice during diverse situations of the users.

It should be noted that, in the UC, the cases that are not considered emergency care and are classified as blue are referred to the social worker, who forwards them to a PCC or health facility appropriate to the situation of the patient. It is noteworthy that some cases classified as blue are seen in this unit – for example, the administration of prescription drugs and catheter exchange.

It is fitting for professionals of the UC, responsible for the ACCR, to inform the user about the risk classification process, the waiting time according to her clinical condition, promoting the satisfaction of the patient and the family members and avoiding unpleasant discussions due to lack of information. The time that the patient should expect to wait, however, depends not only on the classification but also on the quantity of physicians working at the time. Generally, there is only one clinician and a pediatrician, which slows down the care delivery, especially when an emergency arises because the professionals tend to focus solely on that event.

This study highlights the importance of the presence of a nurse in ACCR, because this professional is trained for its completion, and is responsible for it. The ACCR is an activity performed by a professional nurse of a higher level, preferably with experience in an urgent care department and after specific training about implementing patient engagement. It is important to address that the conduct of nurses in ACCR should be respected and be backed by higher levels within the institution. [9]

It was noted that, at times, the ACCR was completed by technical nurses, which is not recommended by the principles and directives of the ACCR. The nurse, with her extensive knowledge of abnormal findings, should follow the protocol of patient engagement as the unique referral for conducting such activity.

The central idea confirms the difficulty of achieving one of the objectives of the ACCR, which is to humanely welcome and engage all patients. It is important that patient engagement provides comprehensive care and qualified listening, that it is a posture of all professionals in the institution, and that it has as a principle to listen and provide adequate responses. This way of acting allows humane service, with resoluteness and accountability. [11]

Among the difficulties already mentioned, one of those evidenced in the ACCR was that of referring users to the PCC. The lack of coordination between the network of health services, poor access, and lack of medical professionals in the PCC meant that there was difficulty in referring users for care that was specialized and appropriate to their disease.

This lack of interconnection between health units hurts the comprehensiveness proposed by the SUS, which is the comprehensive care to patients at all levels of health care. And this affects the quality of care provided to patients. [12]

This idea refers to the difficulty of working with referral and counter-referral and having no way of referring the patients, since UC does not function at night, on weekends and holidays.

Therefore, when the patient arrives at the UC, he receives care and is oriented by the professionals about the cases treated in UC, which is a service to meet emergencies, and on the deployment of ACCR, emphasizing that at another time patients should be directed to the PCC. The PCC works with the promotion and prevention of health problems, and must conduct, then, an active search for users who need routine care and users who do not seek a primary care clinic.

By means of the discourse, one can analyze that no professional highlighted facilitating points in the implementation of ACCR, demonstrating various difficulties in the implementation process of the protocol.

Regarding the questioning about the changes that occurred with the implementation of patient engagement with risk classification at work, the central ideas emerged: improving care and few changes.

In the central idea in which the professionals affirmed that the deployment of ACCR **improved care,** the following discourse emerged:

> *Yes, in the sense of having a new dynamic of care [...] the patient is being treated faster and more appropriately; people move into care based on criteria of severity [...]. Today, preference is given to people who are most in need of care. When a person needs it, certainly he will know that this prioritization makes the care flow better; but there is still resistance from some people who work all day and have no time to make an appointment at the PCC. It is necessary that all professionals incorporate the ACCR.*

With the ACCR, the patient has to be attended more precisely, depending on the severity of his clinical condition.

The classification of risk is a tool that, in addition to organizing the waiting line and altering the order of care, for the greater risk of death or a greater degree of suffering, has other objectives that are also relevant: the guarantee of immediate care of the patient with an elevated risk of death and the passing of information to less severe patients and their families about the probable waiting time for medical care. [6]

Some users resist and will only value the ACCR when they need priority care. Given this fact, professionals reveal that the risk classification is difficult for the population to understand, since they do not know how the protocol functions that determines who has priority for care. This type of priority is poorly received by patients who are referred to the PCC.

The UC professionals always seek to make the link between the UC and PCC, but the conduct is displeasing to people who really do not have time in their schedule when the PCC is open. Studies confirm that the cases referred to PCC for investigation and monitoring become delayed, and symptoms worsen dramatically which make patients seek the UC services again to treat the same complaint. By virtue of these situations, those responsible for the ACCR receive all patients who need care and assistance consistent with what the UC can provide. The care of the UC patient is not denied, but the referral to the PCC during its hours of operation, by the social worker.

According to the Ministry of Health, the protocol of the institution should be appreciated by the entire team that works in an urgent care unit: nurses, technical nurses, physicians, social workers, administrative employees. The UC protocol is based on the MH, where necessary adjustments were made for the population of the region, and the changes should be absorbed by all employees of the service, in order to work in harmony. Accordingly, if the ACCR is applied correctly, it ensures the accessibility of the patient and optimizes the time and work of professionals of the UC. [9]

Another idea that was a departure from the opinion of many of the professionals was that the deployment had led to **few changes:**

> *Few changes, because the thing is not as it should be. The change was the order of entry, the same things that came before are coming anyway.*

This core idea shows that professionals believe the ACCR can still improve, as related to the physical structure of the UC, to better accommodate users, by means of working conditions relevant to appropriate care for the user.

Some studies underscored the need to improve the quality of care for emergencies, as evidenced by the objective of the QualiSUS program, in which quality is defined as the level of expectations and standards of care satisfactory for the needs of individuals and families. [7]

The Ministry of Health established the protocol for risk classification as a tool for inclusion, so it is not meant to refer anyone away without care, but rather to organize and guarantee care for all. [6]

One must understand that there are existing factors, such as low problem resolution and difficulty working in primary care, along with the difficulty of change in cultural habits and beliefs of the population, which lead the user to seek medical care where the door is open, culminating in overcrowding of the UC units. [2] Due to this situation, the urgent and emergency services experience an accentuated demand, but is not the goal of ACCR to leave people unattended, but when possible, to refer them to an appropriate service.

Regarding the questioning about the level of user satisfaction with the deployment of patient engagement with risk classification in the workplace, there were three central ideas: users who like the care, those who are not satisfied, and those who considered it difficult to evaluate.

Users who **liked the care** reported:

> *The care was not of good quality, but it is much better than the particular. It is a process where continued education tends to overcome any dissatisfaction, because as with every beginning there is a bit of concern, prejudice, but now they accept it in a more tranquil manner.*

The collective subject discourse addresses the user's satisfaction in the face of the new humane care delivery system, but a continued action becomes necessary in order that users

can understand the process of change designed to best serve them. It is very important that the organization of urgent and emergency care by means of the ACCR is disclosed and the referral to be given is clearly explained, once the risk is classified. [6]

Initially, some users ignored the strategy, however, when faced with a situation that required urgency in attendance, they saw the real purpose of the delivery system. Demand for UCs involves factors that define the choice by this user. Therefore these were observed: the severity or urgency of the problem, the resoluteness of the service, service agility, patient engagement, the lived experiences of the patients and families, the dexterity in referral to other services; and the relationship established by the user with the professionals. [2]

In studies the assertion was encountered that ACCR provides a regulation of access to the most appropriate services, providing comprehensive care. Although the UC service is not able to respond to some demands of individuals, it is responsible for referring the user to a site that responds to their needs, following the principle of referral and counter-referral. [13]

Another idea identified when questioning the professional about user satisfaction with the implementation of the ACCR was that some **were not satisfied,** as evidenced by the discourse:

> *The user questions the waiting time, even when oriented on the new strategy, especially those that are classified on the blue axis, the dissatisfaction is even greater when we send them to the PCC, because you are always going to have people who are not informed, do not know how the thing works.*

This idea emphasizes the need for continuing education for the population, so that they understand and collaborate with the strategy. It was perceived that there will always be people with little or no information about the ACCR, causing them to agree or disagree with the strategy.

It is known that the demand from users for UCs occurs for several reasons, and one of them is because the user prefers to seek the open doors of the emergency services rather than to wait in line for scheduling of PCC. Responses to their needs and manifestations of them can express what the user thinks about the problem, whose definition includes the concept of health and illness perceived by the user in his social relationships and daily life. [2]

The central idea also shows user dissatisfaction about waiting time and the referral to the PCC. In studies, it was reported that the main events that generate dissatisfaction of the population are: the delay in resolving their health problems; the waiting time to be attended by medical and nursing staff; and, the poor reception in the health services. [7]

The population experiences the moment, but people do not live with those factors that made them unhappy. By contrast, the population witnessed a new way to manage the UC, that is with the ACCR; care became more humane, the most severe cases were prioritized, and modifications were made in its structure to better accommodate the user. For some UC professionals, even with so many changes to improve flow and care, some users still judge the care badly.

The last central idea identified with the questioning of user satisfaction, was that this was considered **difficult to assess,** as with the following discourse:

> *It is difficult to assess. A person can only understand the need and know that it is a useful service when he comes with pain and can be serviced first. Some accept well and are referred by us to PCC, others want to come and to be attended. For those who really need it, certainly, the user is gratified with what has changed [...], for those who are classified as green or blue, they do not like it, others love the ACCR and praised the work of the people, and other users have other demands and are stressed with the waiting time.*

It is perceived that the user only demonstrates satisfaction when he is treated quickly. As said, when the user manifest satisfaction when the medical care is done immediately, but this only happens when the patient's clinical status is serious, since the care delivery system selects these cases to be served immediately. Then, in the opinion of a professional, it is difficult to assess and inform the user of the waiting time.

The ACCR is understood to be a humane care delivery system that, in addition to making care humane, selects the most serious cases to be treated immediately and, with this, establishes the waiting time for minor cases. Despite this waiting time being established for users with negligence and contempt, care becomes more comprehensive and humane, as the user passes through a qualified listening with trained professionals.

The central idea also encompasses user dissatisfaction because of waiting time, by referral to the PCC and, at the same time, there are users who are satisfied with the implemented strategy, which provides improved care to the population. As noted, the waiting time is not identified as good service for the user who is unaware of the purpose of the ACCR, but the well informed user about the objectives of this care delivery system reveals enormous satisfaction.

CONCLUSION

The ACCR is a delivery system created by the humanization by the NHP of MH, deployed in the services of that UCs of this state, whose principles were used to organize the urgent care / emergency service that was disassociated from its core focus: to care for the priority cases.

The work exhibited brought researchers the view that professionals of the TVM-UCU had knowledge about the principles governing the ACCR, especially the need for this delivery system to improve care, as well as to organize the flow of service. It is for professionals to act according to the protocol established in the unit and adapt to it in the different situations which they face.

In the opinion of the professionals, the ACCR can be initiated in the UC, it was perceived that although installed, needs exist for it to be better conducted as proposed by the Ministry of Health. Lack of physical infrastructure, materials needed for the proper functioning of service and continuing education of professionals were identified. Opinions differ regarding changes in service after the implementation of the ACCR. It was observed that the majority of professionals regarded positive changes with the implementation of the ACCR in the UC, and that such changes were reflected in the improvement of care and attention to urgent patients. However, some professionals who knew the principles of ACCR ignored the change in the order of care and reported that a decrease in the demand of the user should occur, without taking into consideration that all change happens gradually, not suddenly.

According to the professionals, users exhibit different behaviors when faced with the ACCR, ranging from acceptance to rejection of this new strategy. Thus, there is need for continuing education for the users, leading them to a better understanding of the changes occurring in the levels of complexity and their purpose.

These professionals face daily conflicts and struggles and conflicts in an overcrowded environment, with inadequate human resources, technology and physical infrastructure, which do not offer conditions to accommodate users with safety and quality, and difficult communication with PCC for referring of some users. Despite these obstacles regarding the implementation of the ACCR, there was already a process of evolution demonstrated, in which patient engagement established comprehensive, humane care, and prioritization of the care of patients with the highest risk of death.

It is important that UC professionals incorporate this new humane care delivery system, ACCR, and that they all conduct it in the same way, leaving no doubt to the users about its purpose and how it works. It is also necessary that professionals have continuing education about humanization and ACCR, aiming at efficiency and speed in the work of risk classification, always respecting the individuality of the patient and his comprehensive care.

REFERENCES

1. Brasil. Ministério da Saúde. Secretaria Executiva. Mais saúde: direito de todos 2008-2011. [More health: the right of all 2008-2011]. Brasília: Ministério da Saúde; 2010. (Portuguese).
2. Marques GQ, Lima MADS. Demandas de usuários a um serviço de pronto atendimento e seu acolhimento ao sistema de saúde. [Demands of users of an emergency service and their engagement in the health system]. Rev Latinoam Enferm. 2007; 15(1):13-9. (Portuguese).
3. Mota RA, Martins CGM, Veras RM. Papel dos profissionais de saúde na política de humanização hospitalar. [Role of health professionals in the humanization policy]. Psicol Estudo.2006; 11(2) 232-330. (Portuguese).
4. Brasil. Ministério da Saúde. Secretaria Executiva Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: acolhimento com avaliação e classificação de risco: um paradigma ético-estético no fazer em saúde. [HumanizaSUS: patient engagement with risk classifiation; ethical-aesthetic paradigm into healthcare]. Brasília: Ministério da Saúde; 2004. (Portuguese).
5. Lefevre F, Lefevre AMC, Teixeira JJV. O discurso do sujeito coletivo: uma nova abordagem metodológica em pesquisa qualitativa. [The collective subject discourse: a new methodological approach in qualitative research]. Caxias do Sul: Educs; 2000. (Portuguese).
6. Brasil. Ministério da Saúde. Secretaria Executiva Núcleo Técnico da Política Nacional de Humanização. Política Nacional de Humanização. [National Policy of Humanization]. Brasília: Ministério da Saúde; 2009. (Portuguese).
7. Bittencourt R J, Hortale VA. A qualidade nos serviços de emergência de hospitais públicos e algumas considerações sobre a conjuntura recente no município do Rio de Janeiro. [Quality emergency services of public hospitals and some considerations about the recent conjuncture in the municipality of Rio de Janeiro]. Ciênc Saúde Coletiva. 2007; 12(4):929-34. (Portuguese).
8. Marques GQ, Lima MADS. Organização tecnológica do trabalho em um pronto atendimento e a autonomia do trabalhador de enfermagem. [Technological organization of labor in an urgent care service and worker autonomy in nursing]. Rev Esc Enferm USP. 2008; 42(1):41-7. (Portuguese).
9. Brasil. Ministério da Saúde. Portal Saúde.Gov/Humaniza SUS. O que é o HumanizaSUS. [What is the HumanizaSUS?]. Brasília: Ministério da Saúde; 2009. (Portuguese).
10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas práticas de produção de saúde. [Patient education in practices of production in health]. Textos Básicos de Saúde. Brasília: Ministério da Saúde; 2006. (Portuguese).
11. Silva LG, Alves MS. O acolhimento como ferramenta de práticas inclusivas de saúde. [Patient engagement as a tool of inclusive practices in health]. Rev APS. 2008; 11(1):74-84. (Portuguese).
12. Maurer TC. Enfermeiro no acolhimento com classificação de risco na emergência pediátrica [monografia]. [The nurse in patient engagement with risk classification in pediatric emergency]. Porto Alegre: Universidade Federal do Rio Grande do Sul; 2010. (Portuguese).
13. Shimith MD, Lima MADS. Acolhimento e vínculo em uma equipe do Programa Saúde da Família. [Patient engagement and the bond in a team of the Family Health Program]. Cad Saúde Pública. 2004; 20(6):1487-94. (Portuguese).