Original article

Embracement with risk classification in the emergency department from the perspective of older adults

Acolhimento com classificação de risco em serviço de emergência na perspectiva do idoso

Acogida con clasificación de riesgo del servicio de emergencia desde la perspectiva de las personas ancianas

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ABSTRACT

Objective: To assess practices of embracement at the patient intake area of the emergency department of Porto Alegre Clinicas Hospital from the perspective of the older adults.

Methods: Qualitative investigation using the case study approach with 30 older adults trough semi-structured interview between July by November 2010. Data were assessed by thematic analysis with the Nvivo software suite.

Results: Responses focused on wait times and on the role of nurses in patient classification. User embracement practices enhanced the work process and highlighted the direct contact between nurses and users.

Conclusions: The care needs of the older adults, the respect for the assessment protocol intervals and work on internal and external network can be improved in order to qualify attention to these patients.

Keywords: User embracement. Geriatric nursing. Emergency service, hospital. Nursing. Aged.

RESUMO

Objetivo: Avaliar as práticas de Acolhimento na Classificação de Risco do Serviço de Emergência do Hospital de Clínicas de Porto Alegre na perspectiva do idoso.

Métodos: Pesquisa qualitativa do tipo estudo de caso, realizada com 30 idosos, por meio de entrevista semiestruturada, no período de julho a novembro de 2010. As informações foram analisadas por análise temática com apoio do *software* Nvivo.

Resultados: As respostas centraram-se no tempo de atendimento e no processo de trabalho. A prática do acolhimento com classificação de risco melhorou o processo de trabalho e destacou a atuação do enfermeiro de modo direto com o usuário.

Considerações finais: O atendimento de necessidades do idoso, o respeito ao tempo previsto pelo protocolo e o trabalho em rede interna e externa podem ser melhorados a fim de qualificar a atenção a esses usuários.

Palavras-chave: Acolhimento. Enfermagem geriátrica. Serviço hospitalar de emergência. Enfermagem. Idoso.

RESUMEN

Objetivo: Evaluar las prácticas de acogida en la clasificación de riesgo del Servicio de Emergencia del Hospital de Clínicas de Porto Alegre en perspectiva del anciano.

Métodos: Estudio de caso con un abordaje cualitativo realizado con 30 personas mayores a través de entrevista semiestructurada entre julio hasta noviembre 2010. Las informaciones fueron analizadas por el análisis temático con apoyo del software Nvivo.

Resultados: Las respuestas se centraron en el tiempo de atendimiento y en el proceso de trabajo. La práctica de la acogida con clasificación de riesgo ha mejorado el proceso de trabajo y ha destacado la actuación del enfermero de modo directo con el usuario.

Conclusión: La atención a las necesidades de las personas ancianas, el respeto por el tiempo del protocolo y el trabajo en red interna y externa se pueden mejorar con la finalidad de calificar la atención a estos usuarios.

Palabras clave: Acogimiento. Enfermería geriátrica. Servicio de urgencia en hospital. Enfermería. Anciano.

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INTRODUCTION

In the last decades, there has been a significant rise in emergency services (SEs) usage. The inadequate search for health care in these services is conditioned by many factors, such as, the disproportionate relationship between supply and demand of the service, a lack of integration in the health care system, and the low level of responsibility and quality of assistance in the services which make up the health care network, amongst others[1].

Confronted by these adversities, conceptions for attendance and classification of risk are discussed and implemented in Brazilian Emergency Departments, with reference to the Politica Nacional de Humanização (PNH) – National Humanization Policy. This policy emphasizes the need to assure a complete care and to amplify strategies that protect the rights and citizenship of the Brazilian population, with the aim of reorganizing work processes and modifying the social relationships between users, workers and managers in their everyday healthcare service experience. One of the devices proposed by the PNH is the "Acolhimento com Avaliação e Classificação de Risco" (AACR) [2] – Embracement with Evaluation and Classification of Risk.

AACR refers to the method of operating the SEs working processes, orientating towards a good relationship between all of those who participate in the care of the patient. It must be developed through an ethical posture, the sharing of knowledge and with good communication between the participants. Attendance in these services is no longer an isolated action, it has become a device to put into action the internal, external and multidisciplinary networks and any other commitments necessary for the patients needs[3].

In the SE where this current study has been developed, an increase in demand for reception of the elderly has been observed. According to data from this institution's Management Information Database System, in general, an increase in the rate of usage of the emergency services(SE) by the elderly has been identified. This is not unexpected, given changes in the demographic and epidemiological profile of the Brazilian population. The number of admissions for this service has doubled between 2006 and 2013, while the number of admissions of people over 60 years of age has tripled in this same period. It is already evident in the literature that when the elderly are compared to other age groups, they show a greater consumption of healthcare services, greater admission rates and longer hospital stays[4].

As the elderly population has increased, specific policies such as the National Healthcare Policy for the Elderly have been introduced to guarantee the rights of this age group and the necessary for their needs[5]. These policies prioritize the integrity of the care, retaining the individual's rights and an undertaking both systematic and multidisciplinary, which bring together the principles of the Brazilian's healthcare system and the PNH[2,5]. In this way, it is clearly relevant to evaluate everyday practices directed towards this population group.

At the international level, the study of elderly users of the SEs is focused on the standards of use of these services and the effectiveness of the assistance, however the insertion of them in the context of the Brazilian reality is different[6-8]. In a national context there are studies which derive from the attendance from the perspective of the elderly patients in general and of the professionals. There are, still, investigations referents to the evaluation of care in the emergency services[9-10]. However, when reviewing the literature databases at *PubMed* and *Scielo*, using the descriptors, reception, geriatric nursing, emergency hospital service, infirmary and elderly, there were no records of any national study referring to attendance assessment practices and risk classification in the SE from the perspective of the elderly.

Researching this theme is challenging due to the innumerable aspects to be overcome during attendance at the SE, such as overcrowding, fragmentation of work and taking into consideration the specific reception of the elderly due to their heterogeneity and characteristics. So, the question for this research study is: How do the elderly assess the AACR practice in the SE of a university hospital?

The evaluation of humanizing practices within the perspective of a healthcare policy presupposes the evaluation of ongoing processes and analysis of the results. But this requires the interaction of all involved in the process of care and the management and the assessment of the impact of these practices on the health and quality of life of the population[11]. In this scenario it is important to recognize and value the dimension of parties involved, especially the users, since their experiences and perceptions indicate transformations in healthcare practices.

This investigation aims to contribute to the organization of the healthcare network and hospital management, providing benefits for the implementation of public health policies and its contextualization in everyday healthcare assistance practices. Also intended is to give the opportunity for reflection on the quality of the process of assistance given to the elderly, the challenge being to mediate between technical competence and humanizing practices so fully attending to their needs.

Based on the above considerations, the study objective was to assess the emergency (SE) AACR practices at the Hospital de Clinicas de Porto Alegre (HCPA) based on an elderly perspective.

METHODS

This is a qualitative research using case studies, developed in the Emergency Service (SE) of HCPA. The method employed aims, amongst other things, to help in understanding the organizational phenomena, preserving the holistic and significant characteristics of real life events[12].

HCPA is a general, public and university institution linked to the Education Ministry and to the Federal University of Rio Grande do Sul. It has 749 beds, attends high and medium complexity cases and is considered a reference in the state of Rio Grande does Sul and other southern states too. The SE has 49 beds and 9 pediatricians, offering services in the areas of clinical, surgical, gynecological and pediatric medicine. At the time that this study took place, the SE was structured in the following care areas, for non pediatric patients: AACR, Short stay admissions room (to attend patients of intermediate risk), Internment Unit (for high risk patients) and Vascular Unit (to attend patients at grave risk). At the reception where AACR takes place, a nurse sees the patient, and after being classified, he/she waits to be seen by a doctor.

During data collection, SE had an Assessment Protocol with risk classification adapted from a Canadian Trial Model [13] having colours for severity parameters and attendance: purple – for immediate attendance; red – for high risk (attendance within 10 min); yellow – for intermediate risk (attendance within1 hour); green – for low risk (attendance within 4 hours). A nurse applies the protocol and a nursing technician checks the vital signs.

The study was carried out using 30 intentionally older patients who met the criteria for inclusion: to have been discharged from HCPA emergency to their homes or to another internment unit of the hospital and having stayed at least 24 hours in SE. The sampling was considered appropriate for the collection of data in a qualitative research [14]. 10 elderly people at severe risk were chosen for the interview, 10 others at high risk and 10 more at an intermediate risk, to the end of obtaining information from the patients in all areas of the SE.

Elderly patients excluded were not able to respond at an interview during the period the information was collected, having died after admission to HCPA emergency (SE); patients discharged to their homes outside the city of Porto Alegre or transferred to the Intensive care Unit; patients graded as low risk, those having stayed less than 24 hours in SE; and institutionalized elderly whose responsible was a long-term institution professional.

The participants responded in a semi-structured interview designed for the current investigation. The script was built up of questions which involved the reason for the elderly seeking care in the SE , how they was attended by the reception in SE, and an assessment of this embracement. Before the information collection period, a pilot study was made with 2 elderly to ensure a clear understanding of the questions made, none were identified as difficult. Note that none of these patients took part in the final work and there were no changes to the questions proposed by the researchers for the semi-structured interview.

The interviews were scheduled by phone by the first researcher, after the elderly were discharged from SE and they took place from July to November 2010. Data from their medical records was collected prior to the interview, such as age, gender, origin, risk grade and unit in the SE. This data provided benefits for the interview structure and for the analysis of the data collected. In order to identify the elderly cared for in the SE, daily, the primary author of the article searched an electronic admissions list record. From this list, the patients were selected by order of occurrence and the ones graded as *grave, high risk and intermediate risk* who were discharged from SE to another internment unit or to their homes were invited to take part in this study.

From the 30 interviews, 20 were made in an internment unit in the hospital mentioned and 10 in homes for the elderly. The option to hold the interviews in these places was due to the lack of privacy in the SE, and so constraints in their replies were avoided. The interviews were recorded and transcribed by the first author, and were on average 28 minutes long. There was only one case where two interviews were made with the one patient; this was due to a press of time on the patient to see the interviewer and so the need to carry on with the interview at a second time.

During the interview, in order to help the study participants understand where the attendance was going to be, they were shown photos of the AACR sector. During the interviews, 22 elderly patients chose to be accompanied by a family carer. It is to be stressed that the carer did not respond for the patient in the meeting.

The information was analyzed using Minayo theme analysis, composed of a pre-analysis, exploration of the material, treatment and interpretation of the results [15]. How the information was organized and the creation of categories was supported by the *software Qualitative Solutions Research Nvivo (QSR Nvivo)* 2.0. The use of the material and how the results were treated ware realized by the first and last author, individually. Afterwards, they compared the results achieved and arrived at a consensus.

The Project was presented to the SE before it was applied. After that it was approved by the Research Ethics Committee (nº 100087) and the participants signed an Informed Consent Form. The researchers signed a terms contract for the use of the institution data. The development

of the work met the national Ethics Standards in research with the use of human beings[16].The participants remained anonymous, being only recognized as Elderly 1, Elderly 2, and so forth. This study was extracted from a master dissertation entitled: "Embracement assessment in the emergency department of the Hospital de Clinicas de Porto Alegre from the perspective of elderly people" [17].

RESULTS AND DISCUSSION

Among the 30 interviewees, 18 were male, aged between 60 and 89 years. Regarding their origins – there were 17 from Porto Alegre, 11 from the metropolitan region and 2 from the countryside. The existing link between them and the hospital was the most frequent reason given for seeking attendance in the SE.

From the elderly assessments of the AACR, the categories created were, – attendance duration and work process. One should note that the narrations were grouped according to the elderly risk classification – *grave, high-risk and intermediate risk* – taking into consideration the different healthcare processes for each sector of internment in SE.

The results of this study make clear the assessment for a humanized action from the point of view of the users. This action constituting a central axis of the evaluation process since, usually, the patient is excluded from the creative process, agreement and execution of actions in healthcare [11].

Evaluation of attendance duration

In the evaluation of the time interval between reception and medical attendance, it was verified that the greater part of the elderly classified as *grave* received immediate assistance as required by the protocols of the Institution in the study, as identified in the following statement. This practice permits a flow, adequate for the demands, in terms of prioritization for reasons of gravity, facilitates flow of service and gives a greater quality and security in the care offered.

> *This last time was much quicker. I arrived and they took me straight in, checked my heart, did nebulization. I couldn't breath[...].(Elderly 13)*

Among the elderly classified as *high risk*, five of them told us that they were seen within 10 to 15 minutes:

> *It was very quick. When I arrived I was bad, with a terrible pain in my stomach [...] I was seen soon after I arrived. As I was ill, I don't remember how long it was, but not longer than 15 minutes. (Elderly 1)*

All others waited between 15 minutes and 2 hours to be seen by the doctor. Another investigation which evaluated the organization of work in the attendance of patients in an SE in the Northeast of Brazil, also describes situations where the time recommended for attendance, after risk classification, wasn't adhered to[19].

> *This part takes a long wait[...] today I got here before it was even noon , it was after 2pm when I was called, she [the nurse] told me: "Sir, you are going to be quick because you've got a fever, otherwise you'd be seen only late in the evening" (Elderly 25)*

The elderly classified as *intermediate risk* said that they waited for about 3 hours to be seen by a doctor, but understood that the waiting time was related to the severity of the health problem. Some told us that they'd rather wait to be attended than have to go to another hospital, they were already used to this reality but still trusted the service. Others said that there was no other way except to wait.

> *It takes a long time. I have already waited here for 5 hours to be seen. If someone arrives in a bad way, it is quick. They take them in and everything works. But, thank God, this is not my case. So, I just have to wait my turn. [...] What can I do? We, all have to wait, we must be patient. (Elderly 2)*

> *I've been coming here since it was the guard doing the screening. Today, a lot has changed. Now it's the nurse. When the case is serious, you're in quickly. When it is not we must understand that we will have wait a bit. Last time I came, it took me 1 hour. It wasn't long. (Elderly17)*

They highlighted that during their long wait they should have their basic needs cared for, such as being fed, pain relieved and have the right to a companion:

> *It has taken 3 hours for me to be seen by the doctor. The nurse told my daughter that I was going to be have a longwait. I was in pain, hungry and tired, but I had to wait. (Elderly 8)*

> *They should allow us to have the family with us[...](Elderly 4)*

On the one hand, the elderly seem to understand and accept that attendance varies according to its seriousness. As the majority of the elderly interviewed had already a link to the service, it seems that they were follow-ups of the work process in the AACR in SE and they valued the assistance given. These aspects could justify the patience and compliance when related to the waiting time, as we identified in the statements.

On another hand, some criticized the long wait and identified the needs not attended, such as pain and difficulties in getting food. We know that the number of patients who use the service is higher than its attendance capabilities, which impacts directly on the attendance time, in the quality of care given and in the implementation of AACR[1,8-9].

We observed that the *grave* patient was seen immediately and that AACR surpasses the practice used so far in emergencies, based on the order of arrival of the patients, providing more resolute assistance with regard to clinical logic. The difficulty pointed out is the delay for the other patients. It is important to consider the characteristics of the elderly, most of who, have multiple co-morbidities and dependencies, and therefore have less of a physical condition to wait for a long time to see a doctor.

International studies have been showing that the SE environments is challenging for this age group, so it is important to give special attention and support to their psychosocial needs. They suggest qualified prehospital attention, the creation of assessment protocols for the elderly and the creation of specific SE's for them or the development of friendly attention strategies for the elderly [6-7].

Further, with regard to attending to the needs of patients waiting to be seen by a doctor, it is important to emphasize the need to assess and treat the complaint about pain. As old age advances, pain complaints tend to increase and intensify due to the many illnesses particular to this population group, so it is important for it to be recognized by healthcare professionals as well as being properly evaluated[20]. In this area, an action already implemented in the service, refers to the institutional protocol, which foresees medication offered to patients who are waiting to see a doctor. Starting from this, nurses need to be more aware of complaints of pain from the patients and apply the protocol.

Also highlighted are questions regarding needs that are not being addressed, such as access to food during the wait to see a doctor. It is clear, the weighting given most of the time, on part of the professionals, to attend to the principal complaint and classify its seriousness. Seen in these terms, nursing still shows a fragmented understanding of its working process, deviating its focus which should be the development of bonds with the patient and the attending to their needs[21]. The relationship between the workers and the users has been developing in a mechanical and superficial way, summed up in the production of interventions and functioning in a logic of "getting on" with work, creating a relationship without involvement and commitment to the work.

Assessment of the work process

In this category, positive and negative aspects of the work process were mentioned. The risk classification system was highlighted, being positively assessed by the elderly classified as *grave*, because they were all treated quickly.

> *Here, in the hospital there is a good system. If a person is very bad, they don't have to wait for long, the nurses look at you and they know. They act quick.(Elderly 20)*

The elderly classified as of *high and intermediate risk* valued the collection of information and the technical knowledge of the nurses. They also positively mentioned the guidance given during the attendance process, waiting for appointments and clarifications regarding future appointments:

> *I arrive, talk to the nurse, they check you and then you wait to see a doctor. The nurse told me: " The doctor will see you soon! Just wait[...]".I told her that I was throwing up blood and she said? "If you feel sick, let me know! If you throw up in the toilet, call me because I want to see it, ok?" And, I reply yes. (Elderly 23)*

> *The attendance was good in that part at the front where they ask a lot of things. They tell us the time the doctor will see us. It was very good, I have no complaints about it. (Elderly 14)*

The performance of the nurse in AACR presents itself as the one of the main strategies for offering quality attendance and work strategies are related to humanization actions of the cared for[18].

In a study in a hospital in Londrina, with nurses who started to perform AACR, it was observed that this working process brought repercussions for the professionals and patients. From a professional perspective, it was noticed that the nurse assessing the patients, gets to know the people who are waiting to be attended better, actively participates in direct assistance to the patient and takes decisions. From the patient perspective, the investigation gives the possibility of more humanizing and resolute attendance, helping each person according to their level of necessity [22].

In the emergency services, clinical knowledge is extremely important, since it allows identification of the signs and symptoms of illnesses which demand immediate attendance and intervention. However, the nurses action must contemplate also the value of the diversity of individuals, understanding that care is the result of the bond of interaction between professionals and patients[21-22].

As to negative evaluations, it was observed that elderly classified as *grave* didn't mention any negative situations.

Some elderly classified as *high risk* continued evaluating the attendance negatively due to the long waiting period to see a doctor. The patients classified as *intermediate risk* pointed out 3 negative aspects: (1) a dissatisfaction with the short duration of the doctor's appointment, which didn't provide for a good hearing and impacted negatively on the sequence of attendance; (2) service disorganization and a lack of guidance during the risk classification, resulting in misunderstandings about the on-going attendance within the service; (3) disorganization within the health care system, with regard to the long wait for hospital admission and the regulation of bed numbers for patients from other municipalities.

> *I was terrified! I arrived and the nurse [nurse technician] took my blood pressure. After the doctor [nurse]asked me some questions. When I saw, I was in the crowd. Later they called me [for risk classification]and asked me what I was doing there, I had to wait and wait. As they say, sitting in the chair. Then I didn't understand anything else. I had no Idea where I should stay, but afterwards the doctor [nurse] explained. (Elderly5)*

> *It was a bit complicated when we came. the guard didn't want to let us in . They said: "do you come from [village]?". They wanted to know why. The only thing I know is that they had to call a boss, so I could get in. She explained that the hospital[name of city hospital] shouldn't have sent me here. But there were no beds. So what can we do . A doctor said that he talked to someone here and they would take care of me. (Elderly 16)*

From these results, it's believed that the practices could have been better regarding the assessment of some of the elderly, who show that the guidance from the nurse could have been more clear and objective. Note that some statements show that guidance was given at some point, but not by all the professionals who were there, like the statement where the patient says "lost in the crowd".

AACR is not only an objective tool which organizes demand, but it also informs patients that they are not at any immediate risk, and to the families the waiting time and any other information regarding the working process[1]. The necessity to improve the information in the AACR regarding the attendance flow was also identified in the study about embracement assessment from the perspective of the patients in general[20].

In addition, the elderly can present hearing and cognitive disabilities providing difficulties in processing the information given[6], which means that clarification regarding the work process of other professionals who works there is necessary, as well as about other sectors of SE and adequate time and place for attendance. Another aspect to be considered is that the elderly should be accompanied during the risk classification, to fully qualify the data collection by the nurse and also to provide a better understanding to the patient and their family about the attendance and any other guidance needed.

In summary, it is observed that studies that identify AACR assessment practices, similar to this current investigation, found that this method allows for a better working organization, speedy attendance, qualified hearing, greater determination of the health problems and better bonding with patients[6,9]. And furthermore, in this current study there were identified specific aspects in the attendance of the elderly, such as the impact of a long waiting period, the necessity of guidance according to their cognitive and physical aspect and the permanent presence of a companion.

It is important to consider that the implementation of AACR protocols alone doesn't make for a better attendance. This technology responds only to one part of care. Also necessary is the liaison with internal and external networks for the feasibility of the process and the establishment of clear flows of attendance. SE relates directly with all the other hospital units, so if the period of admission is longer , the patient turnover is smaller and the internment in emergency will be longer. A more or less quick reply from another sector, such as imaging and laboratory also has a direct relation with the decisiveness of these services.

For the nursing team, the results indicate possible interventions directed to the reorganization of the work process and qualified assistance based on the expectations and demands mentioned by the elderly. For this purpose it is important that the realization of embracement is not only in the AACR of the SE's, but, also, in all areas of attention in these services.

FINAL CONSIDERATIONS

The AACR as assessed by the elderly was centered on the waiting period until being attended and the work process. In relation to the waiting period, it was considered adequate by the patients at grave risk. However, some patients at a lower risk noted as a negative aspect the long wait to see a doctor. They highlighted that during this long wait they should have had their basic needs attended to and the right to have a companion.

Regarding the working process, the majority of the elderly assessed AACR positively, with emphasis on the agility of the nursing team and in the technical aspects of the nurses' performance. Although, it was clearly necessary to qualify the patients' suggestions about attendance flow

and improving listening in other service sectors, SE structure and the healthcare system's organization.

The findings of the current investigation make it possible to rethink actions in education, management and assistance, aiming to improve attendance for the elderly in the SE. We suggest revision and implementation of organizational strategies for attendance flows, developing skills in the team, as well as increasing networking amongst the units in first aid, basic healthcare units and other local services.

The limitations of this study are related to the fact that the elderly at low risk did not take part in this investigation. Normally the stay of these patients is less than 24 hours in the emergency service and, perhaps other aspects of their attendance assessment could be pointed out. We propose other studies to include these patients and assessing the attendance in other sectors in SE.

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