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User embracement and risk classification: health professionals' and users' perceptions

Acolhimento e classificação de risco: percepção de profissionais de saúde e usuários

Acogida y clasificación de riesgo: percepción de profesionales sanitarios y usuarios

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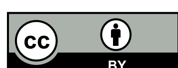
ABSTRACT

Objective: To know health professionals' and users' perceptions of user embracement and risk classification in an urgency/ emergency service. **Methods:** A qualitative exploratory descriptive study was conducted in an urgency/emergency center of a hospital in the countryside of Rio Grande do Sul, Brazil. Data were collected in August and September 2017 through semi-structured interviews with 15 health professionals and nine service users. The analysis followed the assumptions of content analysis and three thematic categories emerged: Professionals' daily work in relation to user embracement and risk classification; User's difficulty in understanding the risk classification made by professionals; Importance of training for teamwork in user embracement with risk classification. **Results:** The users have little knowledge about user embracement with risk classification and its functioning. The professionals do not feel prepared to work with this system due to lack of adequate training and sometimes end up inappropriately classifying the users, which may worsen the clinical picture and prognosis in addition to hindering the delivery of comprehensive care. **Conclusion**: The users do not understand clearly the criteria adopted to carry out the user embracement with risk classification protocol, which generates conflicts between professionals and users. There is a need to rethink ways to inform users about the importance of this system.

Descriptors: User Embracement; Classification; Risk; Emergency Relief; Emergencies; Nursing.

RESUMO

Objetivo: *Conhecer a percepção de profissionais de saúde e usuários em relação ao acolhimento com classificação de risco em um serviço de urgência/emergência.* ***Métodos:*** *Estudo exploratóriodescritivo, com abordagem qualitativa, realizado em uma unidade de urgência/emergência de um hospital do interior do Rio Grande do Sul, Brasil. A coleta de dados ocorreu em agosto e setembro de 2017, através de entrevista semiestruturada realizada com 15 profissionais de saúde e nove usuários do serviço. A análise obedeceu aos pressupostos da análise de conteúdo, emergindo três categorias temáticas: O cotidiano de trabalho dos profissionais em relação ao acolhimento e classificação de risco; Dificuldade do usuário em compreender a classificação de risco estabelecida pelos profissionais; Importância da capacitação para atuação em equipe no acolhimento com classificação de risco.* ***Resultados:*** *Os usuários possuem pouco conhecimento sobre o acolhimento com classificação de risco, assim como sobre o funcionamento do mesmo. Os profissionais não se sentem preparados para trabalhar com esse sistema em função da falta de treinamento adequado, por vezes classificando os usuários de forma inadequada, o que pode agravar o quadro clínico e o prognóstico, além de dificultar a efetivação da integralidade do cuidado.* ***Conclusão:*** *Evidenciou-se que os usuários*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não têm clareza a respeito dos critérios utilizados para a realização do Protocolo de acolhimento com classificação de risco, gerando conflitos entre profissionais e usuários. Há necessidade de se repensar as formas de esclarecer os usuários quanto à importância desse sistema.

Descritores: *Acolhimento; Classificação; Risco; Socorro de Urgência; Emergências; Enfermagem.*

RESUMEN

Objetivo: *Conocer la percepción de profesionales sanitarios y usuarios respecto la acogida con la clasificación de riesgo de un servicio de urgencia/emergencia.* ***Métodos:*** *Estudio exploratoriodescriptivo de abordaje cualitativo realizado en una unidad de urgencia/emergencia de un hospital de Rio Grande do Sul, Brasil. La recogida de datos se dio entre agosto y septiembre de 2017 a través de entrevista semiestructurada realizada con 15 profesionales sanitarios y nueve usuarios del servicio. El análisis obedeció a los presupuestos del análisis de contenido del cual emergieron tres temáticas: El cotidiano de trabajo de los profesionales respecto la acogida y la clasificación de riesgo; Dificultad del usuario de comprender la clasificación de riesgo establecida por los profesionales; Importancia de un equipo preparado para la acogida con clasificación de riesgo.* ***Resultados:*** *Los usuarios tienen poco conocimiento sobre la acogida con clasificación de riesgo así como el funcionamiento del mismo. Los profesionales no están preparados para trabajar con ese sistema por no tener entrenamiento adecuado, algunas veces clasificando los usuarios de manera inadecuada lo que puede empeorar el cuadro clínico y el pronóstico además de dificultar la efectuación de la integralidad del cuidado.* ***Conclusión:*** *Se ha evidenciado que los usuarios no están seguros de los criterios utilizados para la realización del protocolo de acogida con clasificación de riesgo lo que genera conflictos entre profesionales y usuarios. Hay la necesidad de repensar las formas de aclarar los usuarios sobre la importancia de ese sistema.*

Descriptores: *Acogimiento; Clasificación; Riesgo; Socorro de Urgencia; Urgencias Médicas; Enfermería.*

INTRODUCTION

Urgency/emergency care is a different type of health care in which decisions are mostly made in a short time. In that regard, the Emergency Care Network (*Rede de Atenção às Urgências - RAU*) needs to articulate its actions at the three levels of health care in order to expand and improve the quality of users' humanized and comprehensive access to these services[1].

Emergency care services are recognized as "entry points" of the Unified Health System (*Sistema Único de Saúde - SUS*) and sometimes face high demands and overcrowding, which makes it difficult to identify care priorities. Some of the factors related to the overcrowding are: the fact that these services are used as the first choice to obtain health care, the increase in the demographic population and life expectancy, and the prevalence of chronic diseases or the demand for care in their acute phase[2].

Faced with this reality, the Ministry of Health (MoH) implemented in 2009 the User Embracement and Risk Classification (*Acolhimento com Classificação de Risco – ACCR*) program, which consists of a dynamic process of identification and prioritization of care aimed at distinguishing critical and non-critical cases[3]. Some of the instruments used worldwide for user's assessment are the following: the Manchester Triage System (The Manchester Protocol – MTS) in England, the Australasian Triage Scale (ATS) in Australia, the Canadian Triage and Acuity Scale (CTAS) in Canda and the Emergency Severity Index (ESI) in America[4].

In Brazil, urgency/emergency care is delivered through Emergency Care Centers (*Unidades de Pronto Atendimento - UPA*), the Family Health Strategy (*Estratégia Saúde da Família - ESF*), Pre-Hospital Care (*Atendimento Pré-Hospitalar - APH*) and in the emergency room or urgency/emergency wards of hospitals. In these settings, the Manchester protocol is one of the instruments used to assess the user. It is also currently used in other countries, such as the Netherlands, Sweden, Spain, Portugal and England. It consists of flow charts that assist professionals in the identification of complaints reported by users and in the definition of measures to be taken[5].

The user is classified according to priorities into one of five levels: emergency – identified by the color red and with zero minute waiting time; very urgent – the color orange is used and the waiting time is up to ten minutes; urgent – the badge is yellow and the waiting time is up to sixty minutes; not very urgent – color green and with a waiting time of up to one hundred and twenty minutes, and not urgent – color blue with a waiting time of up to two hundred and forty minutes. An amount of waiting time for medical care and reassessment by the nurse is set for each level[6].

The assessment of the clinical picture must be performed by a trained professional and should not exceed five minutes. This assessment involves a combination of data on the identification of problems presented by the user

and evidence found in the analysis of their general condition. It is, therefore, an instrument based on warning signs and symptoms that allow classification into levels of severity[6].

The user embracement with risk classification (*Acolhimento com Classificação de Risco - ACCR*) must be performed by a multidisciplinary team. However, nurses are the professionals in the team indicated for the assessment of the user's clinical condition as they have communication and assessment skills and knowledge of the ethical, legal, technical and scientific principles that govern their profession[7]. In this context, user embracement is not restricted to an attentive and friendly action taken by the professional. User embracement implies the coordination of responsible and effective care with the aim of overcoming and eliminating barriers that hinder or prevent the population's access to services. Through risk classification, professionals seek to make equity effective and hence enable access to health services and the reorganization of the work process, thereby making user embracement and listening possible and placing the team on the front line to embrace and listen to users[8].

There is evidence that the use of this protocol in health care services interfered in an antagonistic way in users' access. On the one hand, there was an increase in waiting time, users faced difficulties in getting medical care, and there were some setbacks regarding scheduling of non-acute cases. However, the guarantee of care, the open door to the service, the end of care on a first-come, first-served basis and the organization of spontaneous demand[9] should be highlighted.

SUS has been seeking to improve users' access on a daily basis and in order to do so it develops public programs and policies, including the National Health Promotion Policy (*Política Nacional de Promoção de Saúde – PNPS*), created in 2006 and redefined in 2014 to develop and strengthen the transversal role of promotion across Health Care Networks (*Redes de Atenção em Saúde – RAS*) and thus favor humanized care practices anchored in comprehensive care[10]. In addition, this policy seeks to improve the intersectoral and intrasectoral articulation with regard to: Health Surveillance, Primary Health Care (*Atenção Primária à Saúde - APS*) and Urgency and Emergency Networks (*Redes de Urgência e Emergência - RUE*) in the territory[10]. Thus, the RUE is understood as one of the forms of care that produces health.

The relevance of this study on the ACCR in this service should be highlighted because its results may contribute to the (re)planning of the provision of urgency/emergency services in order to favor the humanization and the quality of care.

In view of the considerations outlined above, the following research question was elaborated: what are professionals' and users' perceptions of the user embracement with risk classification (*Acolhimento com Classificação de Risco – ACCR*) in an urgency/emergency service? For this purpose, this study aimed to know health professionals' and users' perceptions of user embracement and risk classification in an urgency/emergency service.

METHODS

This qualitative exploratory and descriptive study[11] was carried out in the urgency/emergency ward of a philanthropic hospital in the countryside of Rio Grande do Sul.

This institution has more than 120 beds and is a reference health care center in the Northwest Region of Rio Grande do Sul, Brazil. It covers two health care coordination offices and serves approximately 1,200 thousand users. It is a regional reference in four specialties: neurology, traumatology, oncology and renal therapy. It also provides services to different health insurance holders, with more than 80% of its users coming from SUS[12].

The study population consisted of 45 health professionals working in the urgency/emergency ward (physicians, nurses and nursing technicians) and 150 service users who were receiving care during the data collection period (August and September 2017).

Inclusion criteria were: being a health professional and working in the service for at least six months. Inclusion criteria for users were age over 18 years, mental fitness to answer the survey and previous experience with the ACCR. Thus, exclusion criteria were: professionals who were on leave of any nature during the period of data collection and users with cognitive limitations or neurological sequelae that could restrict participation at the time of the study. The sample was then composed of 15 health professionals and nine users.

The participants were invited face to face and we explained the objective of the study to each of them. After that, a date was scheduled for the beginning of data collection through semi-structured interview, a basic technique of data collection in qualitative studies[11].

The interview was held using a guiding question (how do you see user embracement and risk classification in an emergency/emergency service?). The interviews were previously scheduled and held individually in a reserved

room in the health care facility. They were recorded using a digital recorder to ensure reliable material for analysis and lasted an average of 15 minutes. Sampling was terminated when the research objective was achieved according to data saturation criteria[13].

The data were analyzed using the thematic analysis technique[14], which consists of three phases: pre-analysis (general reading of the collected material considering the researcher's critical thinking about the text and the study object), exploration of the material (identification of core meanings and construction of categories to answer the research question) and treatment and interpretation of the results (the discussion of the data based on a theoretical framework. Academic articles and the current legislation were used in this phase).

Thus, it was possible to organize the results into three thematic categories, namely: Professionals' daily work in relation to user embracement and risk classification (resulting from professionals' and users' statements); User's difficulty in understanding the risk classification made by professionals (resulting from professionals' and users' statements); Importance of training for teamwork in user embracement with risk classification (resulting from professionals' statements).

This study respected the ethical aspects of research as dictated by guidelines and regulatory standards for research involving human beings[15]. The participants signed an Informed Consent Form and the project was approved by the Research Ethics Committee, with Approval No. 2.202.477.

To ensure anonymity, the participants were identified by means of a code consisting of the initial letter of their profession listed sequentially according to the order of the interview, as shown in the example: physician (P1...), nurse (N1...), nursing technician (NT1...) and user (U1...).

RESULTS AND DISCUSSION

The categories that emerged from the study will be presented and discussed in the light of the literature in this section: Professionals' daily work in relation to user embracement and risk classification (resulting from professionals' and users' statements); User's difficulty in understanding the risk classification made by professionals (resulting from professionals' and users' statements); Importance of training for teamwork in user embracement with risk classification (resulting from professionals' statements).

Professionals' daily work in relation to user embracement and risk classification

This category showed that in health professionals' work process, which is based on the Manchester protocol[5], factors such as the establishment of previously implemented routines, availability of human resources and users' access to exams are taken into account and sometimes cause work overload and delays in meeting users' needs, as shown in the following statements:

> *"The flow depends on each professional. Sometimes there is a user who needs care, so we classify the user, we inform the physician, but he does not come. He either needs an opinion from another physician who takes a long time to come to assess the user or relies on a test that is only done by the end of the afternoon and whose results only arrive at night. So, depending on the professional who is performing the exam, the professional who needs to come and assess and the availability, the user will experience a flow that will not have improved." (N4)*

In another statement, the physician said:

> *"[...] there are weekends when I work 36 hours on duty. In others I work 60 hours and deliver different services. I have no routine! We serve users with the most diverse complaints, so it is important to carry out an appropriate classification. It is not about failing to provide care, but it is about providing care through a system of priorities [...]." (P1)*
>
> *"User embracement and classification are very important, both for the institution and for the user. In my opinion, that part... is still being poorly managed." (NT8)*

The implementation of the Manchester Screening System (MTS) occurred two decades ago in several countries and became a support system for nurses to make decisions during triage, thereby allowing changes to the daily work of these professionals[16]. This fact reinforces the impact on daily practices since a single professional category is responsible for the triage of users and for carrying out other activities recommended in APS[5].

In this context, the work consists of a practice that aims to organize users' access to services in order of priority as they have support. In that regard, the ACCR is performed by the nurse with the assistance of the nursing technician:

"The user embracement and risk classification give support to the professional and the user. Nurses know that they will not make a random classification based on 'guesswork'. They will classify users according to the Manchester protocol, they will assign a color, and they know they can change that color too. Then, a user can be assigned a yellow badge, but he/she can change to an orange badge depending on the intensity of the pain. If it gets worse, the user will end up being classified and served sooner". (N1)

"The user must be prioritized according to the classification. If the user really needs immediate care. One should evaluate how long that user can wait. After they pass through the door, we must respond, there is no way to send the user away. There are some things that can be filtered, and that's because of this classification." (NT8)

The use of risk classification protocols is beneficial for users and the team as they standardize the service, reduce the risks caused during the wait and provide greater safety to users[3].

Another important aspect identified in the professionals' statements was the physical structure of the institution, which should offer better comfort to professionals and users, which could consequently allow the provision of a quality service. Given these aspects, it would be important to have a specific room to perform the ACCR to avoid stress and carry out an adequate assessment and classification. The following statements address that issue:

"We don't have a classification room, which would be very important, because there you can better serve the user." (NT8)

"The structure. The user can be classified and go to the waiting room. So, it would be important to have a glass door through which you could look at this user." (N1)

A study evaluated workers' opinions about the structure, the process and the result of the implementation of the instrument named Reception with risk classification (*Recepção com Classificação de Risco - RCCR*) (a name that is similar to ACCR) and revealed that the main aggravating factors for the management of this instrument are the lack of physical structure, problems in the relations with the multidisciplinary team and difficulty in carrying out the defined protocol. The authors concluded that if the essential protocol proposed by the RRR was in fact implemented in the emergency services analyze, it would still be necessary to make this system fully operational[17].

The professionals interviewed in our study pointed out that the lack of equipment and materials and the physical structure of the facility were factors that hindered their work. Despite that, they were committed to giving all the support the users needed. The number of users going through the ACCR was high and many times the facility kept some patients hospitalized due to the lack of beds in other facilities, which generated an overload on Nursing professionals:

"Sometimes we lack material for us to work." (NT5)

"We needed more space for users because this is an ER [emergency room], sometimes there is an intubated user, there is a severely ill user. There is nowhere we can put users, they are on the gurneys overcrowding the ward. The ER is not meant for hospitalization, the ER is for urgency and emergency care. This delays and makes work difficult." (NT7)

According to the nurses evaluated, the priority is the care of the user. Such priority needs objective criteria to guide the dynamization of care in a space that requires immediate interventions. In addition, professionals seek to bond with users and their families during user embracement in order to offer a safe environment for alleviating anguish and suffering. Communication is an essential relational technology in such environment:

"I arrive, start my duty, check users' signs, fill in medical charts. I transfer everything to their charts, get the medication cards, go to the pharmacy, administer the medication, check on intercurrences. I see the appointments, the emergencies that arrive and also whether there is a patient in pain." (NT2)

"I check everything, I do everything calmly, it may be busy, but they are the priority. After everything is organized, I stick to the record books, the materials that need washing, those that need to be picked up at the sterilized materials center." (NT7)

"When I arrive here, I check what the priority is, if there is a seriously ill user. Then, I see those who are under observation. I always go with the physicians, they always ask us to accompany them, and then I do my routine job in the ward." (N2)

Risk classification in urgency/emergency services is a complex activity that depends both on the skills and competencies of nurses and on external and subjective factors. In that regard, the work environment, interpersonal relationships and communication[16] are fundamental aspects for nurses' proper performance of the ACCR.

The ACCR can be defined as an opportunity for the professional to develop user care plans. In order to do so, they need to be aware of possible changes that may happen in the clinical picture. Thus, warning signs described in some flow charts and validated scales can assist in decision-making[6].

When performing the ACCR, it is essential that professionals develop active listening[18] so that the real needs of the user can emerge from the perspective of comprehensive and effective care:

> *"The humane side of the care, of a user's embracement, of trying to put yourself in the user's shoes. This is what I find most positive." (P1)*

The humanization policy aims to implement the principles of SUS and is a challenge to health professionals, particularly in the context of urgency/emergency care. This is due to the high technological density and complexity of this type of care. Thus, the Ministry of Health launched the National Program for the Humanization of Hospital Care (*Programa Nacional de Humanização da Assistência Hospitalar - PNHAH*) with the aim of humanizing the hospital care offered to patients by bringing users, professionals, the hospital and the community closer together with the purpose of ensuring efficiency in quality and effectiveness of the services provided[19].

In this care space, it is essential for the professional to obtain specific skills and competences and link their technical and scientific knowledge to the humanization and singularity of care.

User's difficulty in understanding the risk classification made by professionals

According to the professionals included in this category, users have difficulty understanding the functioning of the ACCR since they would like to be served according to the order of arrival at the service. Given that, there is a need to carry out periodic explanations regarding this form of serving patients and replace the 'old maxim' that says first come, first served:

> *"Today, a lady was complaining that she had arrived first and was seen last." (N2)*
>
> *"Most of the time the user is not given guidance on the classification because the flow is remarkably high. The right thing to do would be to classify and guide the user." (N3)*
>
> *"The service was good, but I would like them to pay more attention to pain. The pain I am feeling now has no explanation! It's absurd!" (U5)*

Discernment about what is in fact urgent between users and professionals affects the relationship between them in a very significant way. A study carried out in Cape Verde revealed that users have little knowledge about triage with risk classification, which can contribute to overcrowding and thus hinder the treatment of cases considered urgent[20]. In that regard, an Italian study revealed that the use of an effective classification system implies a positive correlation between overcrowding and waiting time. The researchers pointed out that there was no loss in the care of users considered non-urgent and there was also no influence on the time taken to deal with more severe cases[21].

The professional's decision to classify urgent and non-urgent cases can be misinterpreted by users who are seeking a solution to the problems that upset them and whose cause is unknown. Another study assessed the reliability of the Manchester protocol in terms of efficiency and found that it is considered substantial and that its problem-solving capacity is influenced by nurses' clinical experience. The Manchester protocol is a safe method for defining clinical priorities as long as the different classification flow charts are known[22].

However, a Brazilian study revealed that user dissatisfaction is related to the form of service organization. Some of the negative aspects included excessive bureaucracy in referral to the tertiary level of care, delay in care and lack of full-time physicians[23].

The user should be informed about the ACCR as many institutions have only one explanatory banner. It must be taken into account that some users do not know how to read it or cannot read or may have difficulties with interpretation. Thus, it is necessary to embrace users and provide guidance on this practice:

> *"I do not know what that is." (U1; U7)*
>
> *"I understand that there are priorities, but sometimes the first case served is not as urgent as the one who is there in severe pain." (U5)*
>
> *"I think it is good, but in my opinion, it is unfair [...] I arrived earlier, and they squeezed someone in." (U6)*
>
> *"No, I didn't get it, but I read the chart in the front." (U8)*

"User embracement is usually done by the nurse, but also by the [nursing] technician sometimes. User embracement starts from the moment we call the patient to check vital signs and write down the main complaint." (N4)

User embracement can be performed by any health professional, but it is up to the nurse to perform the risk classification. It should be noted that the correct classification of the patient, an activity under the responsibility of the nurse, is the first step to ensure patient safety in urgency/emergency services[(24)]. This should be clearly disclosed to users[(25)].

With regard to the flow of users, some of the professionals said that there is no homogeneity in the information. Thus, sometimes there is a lack of understanding of what ACCR is and what it advocates:

"There is a high demand, and then it turns out that you can't have that much time. Sometimes there are four, five, ten patients waiting, and then the quality of care is precarious." (P1)

"Sometimes we are unable to see patients exactly as we want." (NT2)

"They are users that fit this set of urgency and even emergency care. They are polytraumatized, have had a stroke..." (P3)

The ACCR itself does not guarantee adequate management of the waiting time for care. In addition to the classification, the service must be organized in care flows that guarantee continuity of care in the emergency service and in other points of the care network. Care flows are essential for access to medical care and care resources to occur within the time determined by the guiding protocol according to the user's level of severity[(24)].

The Manchester protocol is a predictor of the need for hospitalization and risk of death. It is useful for the management of health care in urgency/emergency services and it supports professionals regarding the sequencing of care strategies[(26)]. There is a need for continuity in scientific investigations to discuss potential modifications to the protocol so that it can be used more safely in urgency/emergency services[(26)].

The work overload and the delay in care occur as a result of several factors, including ESF coverage, i.e., sometimes users are not left unserved and referred to the urgency/emergency ward of the hospital due to the absence of physicians. This delay also tends to lead to user and professional dissatisfaction:

"We often call him [the physician] and he is in another procedure, so the blame always ends up on us." (NT5)

"As soon as the user embracement started being performed here in the ward, many people believed that the user could wait two hours, and that is the negative point." (NT6)

The previous statements show the importance of teamwork and that the dimensioning of personnel should account for the real needs of daily work, such as the performance of ACCR. In addition, it should be noted that the successful provision of care requires human resources in quantity and properly instrumentalized to deliver care. This situation can improve the problem-solving capacity of the service and also the users' and health professionals' satisfaction:

"Risk classification is important because it serves to ensure that the most serious patients are seen more quickly." (P2)

"I think that user embracement is well done and helps to know the degree of severity of the patient." (NT5)

According to the statements above, the time taken to see the service users is a decisive factor in meeting their needs and in stabilizing the risk or the acute situation presented by them.

Importance of professional training to the work in the ACCR

This category describes the importance of professional training to the work in the ACCR. It is an important strategy and one that significantly helps in the development of actions in the ACCR. Professionals should essentially be trained in order to ensure effectiveness in their performance. Therefore, it is understood that institutions need to develop spaces for continuous training in order to improve the quality of the care offered in urgency/emergency services:

"Sometimes the person who performs the ACCR does not have adequate training [and], due to inexperience or lack of training, ends up classifying the user in the wrong way." (P2)

"We should receive more specialized training because we do it based on what we see in the user. This is the nurse's duty, he/she can classify the patient, say 'you have this, and you should look for your reference FHS because this is an emergency room'." (NT8)

The findings described above are corroborated by another study in which professionals said that they had little knowledge and suffered in the face of the tensions they went through[27]. Health institutions should incorporate the concepts of Continuous Health Education (CHE) according to the principles of problematization, contextualization of reality, innovative pedagogies and reflective thinking.

In this perspective, the problematizing conception can constitute an input for educational actions and indicates a conceptual advance on CHE in Brazil. However, continuous education actions sometimes happen to be disconnected from the work process. There are difficulties in understanding and applying them, with repercussions on health services. Moreover, the commitment of professionals and managers is a challenge[28].

In the ward where knowledge of the functioning of the ACCR was analyzed, the interviewees mentioned that lectures were given and that some of them also received the Manchester protocol book so that they could read and clarify doubts. Thus, it can be noted that many professionals still have doubts about the user embracement with risk classification and need to undergo new training overtime:

> *"I received no training. We were going to start Manchester, we were given the book to read, and some things were said about it. But it was very superficial, and every day you read and learn and improve." (N3)*
>
> *"They explained what it was going to be like, how we should act, and clarified some doubts. It was quite interesting." (NT2)*

CHE is one of the instruments of the work process that nurses use to improve the quality of the scientific and technical knowledge essential to assisting the user in the urgency/emergency areas. Thus, the purpose is to improve actions with regard to the practice of skills in nursing care. The nursing team working in urgency/emergency services feels the need for CHE to be incorporated into the services and acknowledge it as a great ally that facilitates the work process. The participants reinforced the idea that CHE is not restricted to technical knowledge and referred to it as something more comprehensive that favors personal and organizational growth[29].

Ordinance No. 2048[30] states that in order to perform risk classification, the health professional needs to receive specific training and apply the pre-established protocol as it does not require a specific specialization. It is believed that the lack of training can cause errors in the user classification process, which can generate false classifications, thus putting at risk the health of the population that seeks this type of care.

In this context, the PNPS[10] highlights the broader concept of health through the theoretical framework of health promotion. It is a set of strategies and ways of producing health individually and collectively which is also equivalent to urgency/emergency services as the latter use the ACCR as a tool that guides and organizes the flow and development of activities in these services, thus positively impacting the health of the community.

As implications for clinical practice, the present study findings can contribute to professional training through CHE programs as they have pointed out the strengths and limitations of the ACCR from the perspective of professionals and users. Given that, intervention studies should be carried out in order to enhance the actions already developed and overcome the existing limits so as to improve the quality of care provided to users of urgency/emergency services.

One limitation of this study is that it was conducted in a single location. However, it is believed that this study can support further research and discussions aimed at improving the ACCR and thus generate positive results in relation to the quality of care in urgency/emergency services.

FINAL CONSIDERATIONS

It was evident that the users did not clearly understand the criteria used to perform the ACCR, which generated conflicts between professionals and users. There is a need to rethink the ways to inform users about the importance of this system.

Although training is provided, not all the professionals have received it. Furthermore, because they were hired by the institution after the implementation of the ACCR, some professionals did not receive adequate training. Thus, there is a need for greater investment in training and updating of these health professionals and for readjusting material and infrastructure resources in order to improve the quality of care.

CONFLICTS OF INTEREST

The authors declare that there were no conflicts of interest in the development of this study.

CONTRIBUTIONS

Thais Santos Campos and Éder **Luís Arboit** contributed to the study conception and design; acquisition, analysis and interpretation of data; writing and/or revision of the manuscript. **Claudelí Mistura**, **Cristina Thum**, **Jaqueline Arboit** and **Silviamar Camponogara** contributed to the study conception and design and the writing and/or revision of the manuscript. All the authors approved the final version now published in the Brazilian Journal in Health Promotion.

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