

WORK OBJECTIVE IN EMERGENCY WARDS: PROFESSIONALS' CONCEPTIONS

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This qualitative case study aimed to analyze how health team professionals perceive the work objective in one emergency unit. The place of study was a hospital emergency ward in the state of Rio Grande do Sul, Brazil. Data collection was conducted through observation and semi-structured interview. The results disclose the divergence between the health needs that make users seek health care in the emergency ward; and the work objective at that ward as highlighted by the professionals. The work team shows dissatisfaction due to the excessive search for care that cannot be classified as emergency, highlighting the number of attendances as a justification for resistance to perform the work and lack of commitment in care production.

DESCRIPTORS: emergencies; emergency medical services; patient care team; organization and administration

LA FINALIDAD DEL TRABAJO EN URGENCIAS Y EMERGENCIAS BAJO LA PERSPECTIVA DE LOS PROFESIONALES

Se trata de un estudio cualitativo, del tipo estudio de caso, que tuvo como objetivo analizar las concepciones de los profesionales del equipo de salud acerca de la finalidad del trabajo en una unidad de atención a las urgencias y emergencias. El campo de estudio fue una unidad hospitalaria de atención a las urgencias y emergencias del interior del Estado de Río Grande del Sur. Las técnicas para recolección de datos fueron la observación y la entrevista semiestructurada. Los resultados apuntan para la divergencia entre las necesidades de la salud que llevan a los usuarios a buscar la unidad y la finalidad del trabajo del local destacada por los profesionales. El equipo de salud revela insatisfacción con la búsqueda excesiva del servicio por pacientes, cuyas necesidades no pueden ser clasificadas como urgencia o emergencia, apuntando el número de atenciones como justificativa para la resistencia en realizar el trabajo y para la falta de compromiso con la producción del cuidado.

DESCRIPTORES: urgencias médicas; servicios médicos de urgencias; grupo de atención al paciente; organización y administración

FINALIDADE DO TRABALHO EM URGÊNCIAS E EMERGÊNCIAS: CONCEPÇÕES DE PROFISSIONAIS

Trata-se de estudo qualitativo, do tipo estudo de caso, que teve como objetivo analisar as concepções dos profissionais da equipe de saúde acerca da finalidade do trabalho em uma unidade de atendimento às urgências e emergências. O campo de estudo foi uma unidade hospitalar de atendimento às urgências e emergências do interior do Estado do Rio Grande do Sul. As técnicas para coleta de dados foram observação e entrevista semiestructurada. Os resultados apontam a divergência entre as necessidades de saúde que levam os usuários a procurar a unidade e a finalidade do trabalho do local destacada pelos profissionais. A equipe de saúde revela insatisfação com a procura excessiva de pacientes, cujas necessidades não podem ser classificadas como urgência ou emergência, apontando o número de atendimentos como justificativa para a resistência em realizar o trabalho e o descompromisso com a produção do cuidado.

DESCRIPTORES: emergências; serviços médicos de emergência; equipe de assistência ao paciente; organização e administração

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INTRODUCTION

Urgent and emergency hospital wards are part of the hospital component of the care system set up by the National Urgent Care Policy (PNAU) in Brazil. The work objective of health teams at these wards is to deliver care to patients who arrive in a severe state, to receive non-urgent cases and reorder them to basic or specialized outpatient services in the health care network⁽¹⁾.

The PNAU's basic premise is to guarantee access and welcoming in health services, according to technological complexity, which should be organized regionally, hierarchically and orderly, preventing deaths caused by incorrect medical interventions or treatments, avoiding death or temporary and permanent physical disabilities⁽¹⁾.

Some urgent and emergency hospital services are hierarchically organized and comply with the recommended care model. The organization model of an emergency hospital unit in the interior of São Paulo state stands out, which changed its work organization and urgent case management, contributing to set out the overcrowding by reducing the number of consultations and the occupation rate and increasing the mean hospital time, case complexity and mean cost of hospitalizations, turning into a reference centre for high-complexity care, as well as for professional education and training in urgent care⁽²⁾.

Despite these advances, urgent care still displays many weaknesses as, in most urban centers, care decentralization is subtle and the ordering of care flows is in an early stage. The traditional emergency care organization model predominates, determined by users' spontaneous demand, culminating in overcrowded emergency rooms and, consequently, low quality of care delivery, long waiting times for appointments, examinations and surgeries, as well as a lack of hospital beds and trained professionals⁽²⁾.

Urgent and emergency hospital care services correspond to the demanded care profile in a more agile and concentrated way. Although overcrowded, impersonal and acting on the patients' main complaint, these sites join consultations, medication, nursing procedures, laboratory exams and hospitalizations⁽³⁾ that enable them to solve problems in the users' viewpoint.

A study carried out at an emergency unit in Rio de Janeiro indicated that the work process was

mainly organized to support the consequences of demand, rather than actually producing its goals, as the large number of attendances by the health team had interfered considerably in the work process⁽⁴⁾. By working at the entry door of a public emergency hospital, professionals are charged with a demand that exceeds what care services have been organized to recognize and intervene in. This organization is not restricted to material, technological and staff conditions, but equally includes the way work processes used at these services are organized and managed⁽⁵⁾.

Care demands at emergency units are excessive and do not remain limited to what is considered a health need. They are often characterized by patients who turn to health care to solve a wide range of social problems they face in their daily life⁽⁶⁾. The consultation type attended at a public pediatric urgent care service evidenced heterogeneous attendances and revealed that the service was characterized by attending severe cases, in line with its mission, but also by welcoming non-urgent cases⁽⁶⁾.

The different conceptions of users, the population and health professionals to define urgent care have been appointed as one of the determining factors of overcrowding at urgent hospital care units⁽²⁾. Divergence can be identified between the work objective at units with a traditional urgent and emergency care models and their users' needs, who have their own criteria to characterize what represents an urgent case, which do not always coincide with biomedical parameters and the rational organization of the health care system⁽⁴⁾.

Emergency care nurses, who are responsible for coordinating nursing teams, need to seek means to manage nursing care, visualizing patient needs holistically, conciliating organizational objectives and nursing team objectives⁽⁷⁾. However, when professionals deliver care in urgent situations, they do not manage to visualize users' trajectory and the difficulties these go through to satisfy their health needs. Hence, it is important to understand these situations in order to make care more welcoming, using an approach that leads to a qualified solution and satisfies users⁽³⁾.

A recent study on work organization at urgent and emergency care services highlights that care is readily delivered to users, identifying and analyzing their demands and health needs from the users'

focus⁽³⁾. This paper aims to add elements to analyze urgent and emergency care work and its objective, considering the application of the PNAU as a background and focusing on hospital care professionals' conceptions. The authors intend to contribute to discussions on this problem, emphasizing the health team's potential to change reality in the organizational structure of health institutions.

Based on the described situation, this research aims to analyze health team professionals' conceptions on the objective of their work at an urgent and emergency hospital care unit.

METHOD

This qualitative research apprehends reality and analyzes health team professionals' conceptions⁽⁸⁾. The methodological design is a case study, which permits a more in-depth observation of the study unit, considering its singularity⁽⁹⁾.

The research was carried out at the emergency unit of a public teaching hospital, which is a referral institution for this type of care, in an interior city in the state of Rio Grande do Sul. The service attends to spontaneous demands and formal and informal referrals from fixed pre-hospital units (Basic Health Units, Family Health Units, Specialized Outpatient Clinics, among others) in the city where the hospital is located and from hospital units in the other cities included in a region of approximately 1,162,787 inhabitants. Until the time of data collection, urgent care was organized without welcoming to classify the degree of risk or a medical regulation central.

Data were collected through observation and semistructured interview⁽¹⁰⁾. Observation focused on the work process of the unit's health team and was guided by the following aspects: object, agents, instruments and work objective. Hence, the different agents were observed during the emergency work process and when they articulated to deliver patient care. Agents were selected for observation according to the function they performed, seeking to cover the different services delivered at the emergency unit. Activities considered relevant to capture subjects' relationships and the way the work is organized were also selected, as well as some spaces in which these relations occur more significantly. Semistructured interviews were held to identify how the professionals' conceive the objective of the work they perform, using

the following guiding questions: how do you see the work performed at the emergency unit? How is urgent and emergency care organized at that unit? Which health team professionals get involved in the work process, in what way?

The study subjects were the professionals working in the health team at the study unit between June and September 2007. The subjects were selected intentionally, prioritizing the inclusion of nurses, nursing technicians and auxiliaries, followed by other team members. Twenty-nine subjects participated in the interviews (seven nurses, nine nursing technicians, one undergraduate nursing grant holder, two medical-clinical physicians on duty, one resident physician, two doctoral students from the medical course, one secretary, one general service aid, two guards, one nutritionist, one physiotherapist and the administrative coordinator-nurse at the unit.

The project was approved by the Research Ethics Committee at the Federal University of Rio Grande do Sul (CEP No 2007688). Professionals received a free and informed consent term, which guaranteed ethical aspects in accordance with Resolution 196/96 by the National Health Council⁽¹¹⁾.

Data analysis followed the guidelines of the qualitative method: ordering, classification in relevant structures, synthesis and interpretation⁽⁸⁾. Data collected through observations were coded with the letter "O", while data from interviews were marked as "I", followed by the description of the observation or interviewed professional's category.

RESULTS AND DISCUSSION

In the work process at the emergency unit, it was evidenced that the professionals' conception of their work objective is related with attendance to patients suffering from organic alterations, resulting in drastic health problems or sudden threats to life and demanding immediate therapeutic measures.

[...] *our work objective is care delivery to patients in severe conditions* (I-Nurse).

The motives that make users attend emergency units, however, may be different: guarantee of health service access, privileged flow and geographic location, possibility of undergoing complementary examinations and receiving medication not available in basic care⁽³⁾.

Moreover, users' perception of something severe is directly related with how they self-assess their health state. The health service will be chosen according to this perception of what is simple or severe, almost always resulting in a spontaneous search for health services⁽³⁾.

Through the observations and interviews, a large demand by users whose needs were not classified as urgency or emergency was verified, which led to dissatisfaction in the health team, according to the statement below.

This is a medium and high-complexity hospital. Only emergencies should be attended here, not simple consultations. People come here to take a pregnancy test or for actuation, they think it's a health station (I – Nursing Technician).

Against health professionals' expectations, users can seek care in case of health changes they consider important. In this sense, a pregnancy test for women who cannot or do not want to get pregnant, and actuation for a respiratory disease patient who cannot purchase the machine to do it at home, may become urgent needs for users.

The divergence between what users and health professionals think was identified in a study about urgent care at an emergency care unit. It was highlighted that, according to the professionals, in elective cases, usage was undue and mischaracterized the urgent care mission, putting an extra burden on already stressful work. As a result, users had to justify their need in order to receive care⁽¹²⁾.

It seems that health professionals do not understand and even disdain these user demands. They relate the large non-urgent care demand at the unit with their activity overload and decreased care quality in urgent or emergency cases.

A research carried out at an emergency unit found that 74% of attendances are characterized as non-urgent or emergency⁽¹³⁾. These units are often used as an escape valve for health services, impairing care delivery to acute and severe cases, which are considered adequate for these services' goal, as excess demand leads to task accumulation and a consequent overload for the entire professional team, also contributing to increased hospital costs.

Emergency care professionals face conflicts every day because they work in an overcrowded environment, not always having adequate human and technological resources and physical structure, without conditions to offer users safe and high-quality accommodation⁽⁵⁾.

Everything gets more difficult when things are overcrowded, attendance takes more time, patients wait for hours at the reception, there are not even enough attendance rooms because emergency cases arrive and they occupy the emergency room, and people have to wait for that patient to be attended before someone else can be called. In the mean time, clinical and surgical care take turns in another room, when an accident victim arrives they need the room, when a patient with a cut arrives he needs stitches and then the patients who are waiting here have to keep on waiting, unless the patient is feeling bad, then they put him inside, but if it's not an urgency or emergency he has to wait (I – Nurse).

Professionals acknowledge users' difficulties to get treatment and also perceive their suffering when they come to a health service and do not receive the care they expect. The patient volume and the stress caused by attendances outweigh the welcoming of cases and accountability for care production though, so that the relation between health teams and users varies between heroism and abandonment.

The constantly overcrowded waiting rooms and corridors of the urgent care rooms, together with the high occupation rates of observation beds in the difference care components of the health system entails flexibilization of urgent care professionals' care standards and ethics⁽²⁾.

As a result of the biomedical conception and the lack of human and technological resources, patients in emergency situations who come to the service are prioritized to the detriment of patients under observation or already stabilized. Thus, it was identified that professionals act according to their conception of urgency/emergency, prioritizing care delivery to severe and acute problems, with potential life risk.

[...] we prioritize patients who come to the emergency unit, because it is not a hospitalization unit (I – Nursing Technician).

In this conception, the emergency unit should be a transitory site to deliver initial care to users and, as soon as their clinical conditions are stabilized, to refer them to a hospitalization or specialized unit. However, most of the times, users' long stay at the unit increases the potential of conflicting situations between patients and professionals, which reveal different conceptions about the work objective at the emergency unit.

The time patients stay at the unit is a difficulty. The patient ends up being fully treated here, they can go home from here. It has happened that the patient was hospitalized, got

treated several days, and died, without being transferred to the hospitalization unit. It should not be like that. Some patients stay here for 30 days while it should be no more than 24 hours because this is an Emergency Unit (I–Nursing Technician).

The organization of the work process, without any risk level assessment, which tries to balance the disproportionality between the number of staff and patients, together with the deficient physical area, strengthens professionals' dissatisfaction, often expressed through resistance against doing work at the unit.

The physiotherapist says to the nursing technician: "The patient in bed eight wants to go to the bathroom and needs help!". The technician answers: "I'll be right there!". The physiotherapist waits for some time and then again asks the nursing technician to accompany the patient to the bathroom. As he perceives that she won't go, he finishes what he is doing and accompanies the patient (O – Physiotherapist).

The above observation evidences nursing technicians' resistance against assuming some activities inherent in their work. This situation can be understood as the naturalization of actions represented by negligence or hostility against users in the work environment. Some informants justify not doing the work and long waiting times to perform their actions based on the discourse of overcrowding, the inadequate number of professionals, high levels of requests for attendance by users and relatives, and especially on the work objective at the emergency unit, that is, if it is not an urgency or emergency, the case should not be attended and, if patients need to be hospitalized, they have to be forwarded to hospitalization units.

It should be highlighted in this sense that relations between health professionals and users are always permeated by discipline and power. Moreover, the fragmentation of the work process also contributes to the user's depersonalization by health team professionals, putting them forward as producers of non-care acts, although their professional exercise should be directed at ethics, life and health.

The hostility people meet in this environment can be understood as exacerbated manifestations related to the evolution of the classical hospital culture marked by isolation, to the impersonal attitude based on technicism or positivist medical scientificity, as well as to defense mechanisms due to outrageous work conditions, and also as a reaction to conditions of misery and social violence⁽⁴⁾.

Hence, sometimes, the number of attendances characterized as non-urgent is used to justify resistance against doing the work and lack of commitment with care production. In a way, discourse on the work objective at the urgent and emergency care unit protects professionals, as it always holds users accountable for improper use of the system. Besides, in the regulation of urgent cases, it discharges the emergency unit and the health care system with respect to understanding the users' needs and allocating the best alternatives to welcome and treat them.

The organization of this entry door to welcome users needs to be discussed, considering the repressed demand that reaches the urgent care services and emergency units and needs answers to its needs. Instead, it is observed that users are punished for improper use of the health system, making them peregrinate through other services in search of health care⁽¹²⁾.

Regionalization and hierarchization alone do not guarantee a decrease in the unnecessary inflow of users to higher-complexity levels. Users are expected to be welcomed not only in basic and secondary care but, basically, to receive problem-solving care at those complexity levels, avoiding unnecessary forwarding to tertiary complexity centers, particularly larger hospitals, leaving beds to users who really need them⁽²⁾.

Therefore, professionals, managers and users need to consider not only the biomedical dimension, but also the social and subjective dimensions involved in urgent care. Investments in professional qualification and management training remain low, however, with regard to understanding the system guidelines and planning actions in response to users' health needs.

It is fundamental to organize attendance better, define responsibilities and concretely arranged referral and counter referral schedules, so that regulation can play its ordering role and correct existing distortions at the entry door of the system. Nevertheless, the work process at urgent and emergency hospital care units needs to respond to users' needs, which is why these services exist.

FINAL CONSIDERATIONS

The emergency care unit is characterized by a high level of care demands, deriving from clinical and/or trauma situations with different degrees of

complexity. Due to this fact, associated with organization and management issues, the unit does not always offer adequate work conditions in terms of staff and material resource quantities, with a view to qualified care delivery.

Professionals sustain the biomedical concept, with care focused on the disease and on the task, instead of the person. They prioritize care delivery to users with severe and acute problems and demonstrate their dissatisfaction with non-urgent or stabilized cases through impersonal, hostile and even negligent care.

It is fundamental for managers, professionals and users to clearly understand the objective of the work carried out at the emergency unit, which should be agreed upon with other services and institutions.

Any divergence among these with lead to aggression and conflicts, resulting in dissatisfaction of all stakeholders in the process.

Hence, there is a need for broader discussions on the work objective at urgent and emergency care services, so that workers can adopt a critical posture towards their work process and become, together with users and managers, protagonists in a large-scale reorganization of the urgent care system.

In this context, the nursing team can expand its professional activities and play a paramount role. Nurses' central role as articulators offers them great opportunities to interact and influence professional actions at the emergency care unit, to the benefit of holistic and interdisciplinary care production.

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