NURSES' PERFORMANCE IN RISK CLASSIFICATION IN EMERGENCY CARE UNITS

Laysa Balieiro Pinheiro[1] Marcos Renan Miranda Neres[2] Luiz Fernando Balieiro Pinheiro[3] Walter Pereira de Matos[4] Caio César Chaves de Lucena[5] and Erick Bruno Monteiro Costa[6]

[1]State University of Pará, Belém, Pará, Brasil
enf.laysabalieiro@gmail.com
[2]State University of Pará, Belém, Pará, Brasil
enfmarcosneres@gmail.com
[3]Federal University of Pará, Belém, Pará, Brasil
nandobalieiro7@gmail.com
[4] Federal University of Pará, Belém, Pará, Brasil
walter-matos@outlook.com
[5] Federal University of Pará, Belém, Pará, Brasil
caacesar19@gmail.com
[5] University of Amazon, Belém, Pará, Brasil
enfoerickbrunomonteirocosta@gmail.com

ABSTRACT

This study aims to identify, in the literature, the role of nurses in risk classification in emergency care units - 24 hours (ECU). integrative review, performed from the databases LILACS, MEDLINE, SCIELO, BDENF and COLLECIONA SUS, with articles published from 2009 to 2019, using the descriptors in Health: Emergency Nursing; Emergency health services; Patient Screening, with the final sample consisting of 10 productions. There was a prevalence of the BDENF - Nursing Database, totaling 60%. Regarding the temporal distribution, it was noticed that the publications occurred mainly in 2017 (40%) and 2016 (40%), followed by 2014 (20%). As for the methodology approached 40% of the studies used the quantitative approach, 40% the qualitative and 20% the methodological approach. The results allowed us to identify the following categories: Humanization in the services of Emergency Care Units-24hs; The work process of nurses in ECU; Training of professional nurses and continuing education in ECU.

KEYWORDS: *Emergency Nursing; Emergency health services; Patient Screening*

I. INTRODUCTION

Since 2010, Brazil's Public Health System has been organized into Health Care Networks, which consist of various levels of health services with different technological capacities and are supported by technical, logistical, and financial management systems. The objective is to ensure comprehensive care for patients [1].

The Urgency and Emergency Care Network (RUE) is one of the five priority networks and is responsible for providing urgent and emergency care throughout Brazil [2]. All levels of healthcare, including primary care provided by basic health units and Family Health Teams, intermediate care provided by the Mobile Emergency Care Service, Emergency Care Units (ECUs), and hospital-based medium to high complexity care, must be involved in emergency care [3].

The Emergency Care Units (ECUs) serve as intermediate structures between Basic Health Units and hospital emergency departments, working together to form an organized Emergency Care network. A

24-hour ECU is responsible for providing effective and high-quality care to patients with acute or exacerbated clinical and/or surgical conditions, stabilizing them and conducting initial diagnostic investigations. They also determine the need for referral to more complex hospital services [4].

In this context, the crucial role of nurses in the 24-hour Emergency Care Units becomes evident. These professionals perform a range of integrated tasks in the ECU environment, including assisting patients, managing medication, and coordinating the nursing team [5].

The Humanization Policy proposes the use of the Reception with Risk Assessment and Classification (RRAC) technology in emergency care to reorient the assistance policy by emphasizing the values of humanization and quality of care. The goal is to streamline and reorganize care based on patients' real needs. The Ministry of Health assigns the initial evaluation of patients arriving at the ECU to nurses [6-7].

However, to effectively use this tool, nurses must understand all the components involved. Therefore, it is essential for nurses to have a deep understanding of the Reception with Risk Classification-Protocol (RRCP) and its application.

The present study presents itself as a potentially important tool in the sense of providing up-to-date information on the role of nurses in risk classification in the 24H ECU, supporting a greater understanding of the subject, and, mainly, offering more information with regard to participation of the nurse in this process.

In addition, it will be possible to contribute to the advancement of Nursing by gathering information from scientific production on the topic addressed and, thus, making it possible to critically evaluate and suggest specific improvements in the process of applying the RRCP, promoting improvements when necessary.

This study aims to identify, in the literature, the role of nurses in risk classification in 24-hour emergency care units, with a view to defining the profile of publications and analyzing the focus of publications on the categories.

In this way, the steps for carrying out the study will be presented in the methodology, represented through a flowchart. The results will be presented in a table and discussed next.

II. METHODOLOGY

An integrative review was carried out, a method that allows the analysis of studies with different methodologies (quantitative and qualitative) and enables the synthesis of available evidence on a given subject. This research method also allows general conclusions about a particular area of study [8].

For the construction of the integrative review, six different steps were taken: identification of the theme and selection of the research question; establishment of inclusion and exclusion criteria; identification of pre-selected and selected studies; categorization of selected studies; analysis and interpretation of results; presentation of the knowledge review/synthesis [9].

The research theme was identified through the following question: How does the nurse act in risk classification in 24-hour emergency care units?

A search was carried out in the literature, through consultations in the electronic medium, using the Scientific Electronic Library Online (SCIELO), Latin American and Caribbean Literature (LILACS) and National Library of Medicine (MEDLINE) databases, (BDENF) and National Collection of Information Sources of the SUS (Coleciona SUS) through the Virtual Health Library (VHL), since it allows simultaneous search in the main national and international ones.

The Health Sciences Descriptors (DeCS) selected for the literature investigation were: Emergency Nursing; Emergency Health Services; Patient Triage; and Nursing. After being selected, the descriptors were combined using the Boolean operator “AND”, and categorized based on the inclusion and exclusion criteria used for sample selection.

Inclusion criteria were: text available in full or provided by the original source; available electronically free of charge; that addresses the subject of the study; available in Portuguese; published from 2009 to 2019.

As for the exclusion criteria, the following were adopted: literature review articles; duplicate articles in the same database; repeated articles in different databases; study population that did not have a diagnosis of pre-eclampsia; clinical case reports.

The initial sample consisted of 652 articles, of which: 4 in SCIELO, 648 in BVS, which groups the databases MEDLINE, LILACS, BDENF Coleciona SUS.

After selecting the initial sample, comprising 652 articles, it was decided to subdivide the refinement into two moments: the applicability of the inclusion criteria and reading the titles and abstracts of the articles. Described below.

Moment I: Applicability of the inclusion criteria

At first, the inclusion criteria were applied: period from 2009 to 2019; Portuguese language and full article available electronically free of charge. In which a total of 60 studies were identified. Subsequently, duplicate articles were excluded with the help of the "Zotero" program, which resulted in a total of 47 selected articles. Therefore, these articles served as the object of analysis at first, reading their titles and abstracts.

Moment II: reading the titles and abstracts of the articles

In the second moment, the titles and abstracts of the 47 articles that were previously selected were carefully read, which resulted in the exclusion of 34 studies. The selection was completed by reading the full text of the documents. In the analysis of the full text, 13 articles were identified in full. At the end of the critical reading of the articles in full, 10 works remained as a data source for this research, as shown in the Figure below:

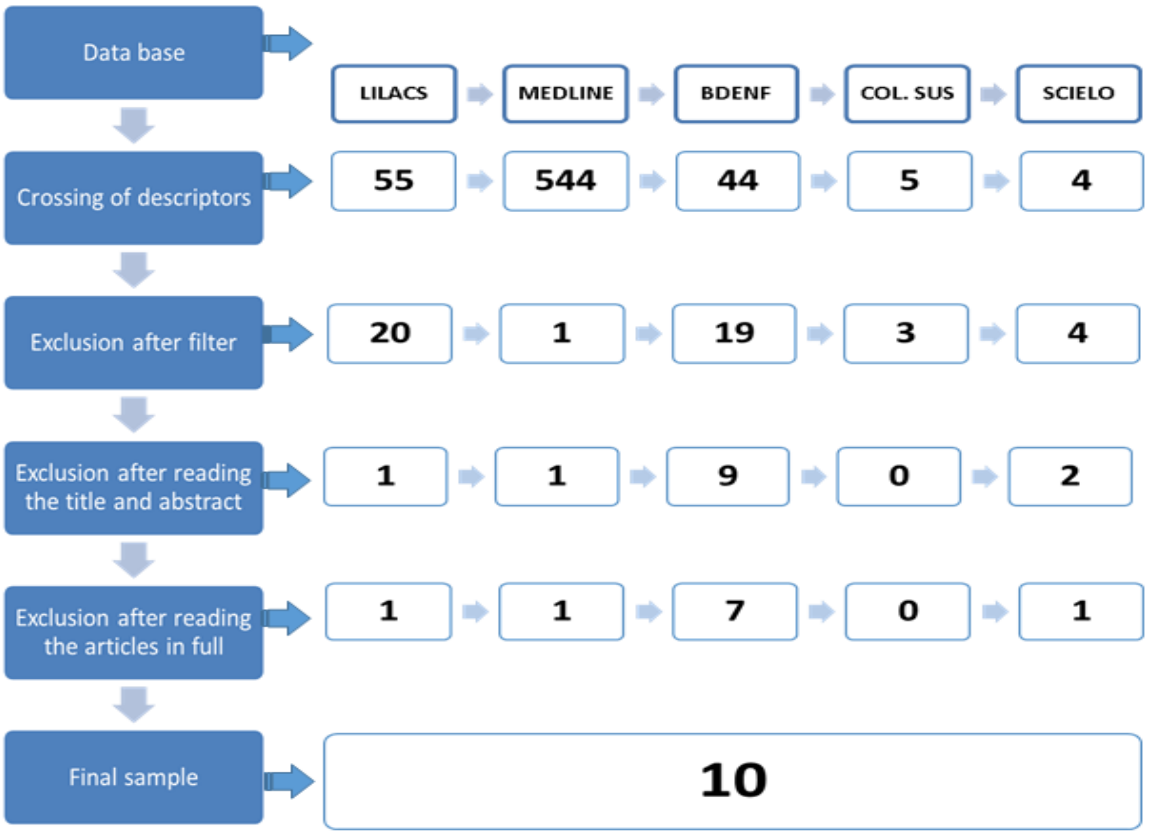

Figure 1. Sample selection process flowchart.

For the analysis and subsequent synthesis of the 10 articles that met the inclusion criteria, an instrument was developed for the collection of information, analysis and subsequent synthesis of the selected studies, adapted from the instrument validated by Ursi [10].

The analysis and interpretation of the data were carried out in an organized and synthesized way through the elaboration of a synoptic table that comprises the following items "number, title, authors, database, year of publication, objective of the study, type of study, sample population, main results (shown in synoptic table 01).

The thematic analysis technique was used for an understanding of the thematic nuclei mobilized in the construction of the study problems [11]. After this procedure, the studies were categorized into thematic groups, which supported the interpretation and presentation of the review results. A critical analysis of the selected studies was carried out, observing the methodological aspects, the similarity between the results found. This analysis is carried out in detail, seeking answers to the different or conflicting results in the studies.

A discussion of the main results in conventional research is made. The results were based on the critical evaluation of the selected studies, comparing the studies and the themes addressed in relation to the proposed research object. The data were analyzed and discussed against the selected bibliography, using charts, tables and graphs when necessary. Thus, scientific knowledge about the role of nurses in risk classification in 24-hour emergency care units was observed. As a conclusion of this integrative review, a summary of available evidence was prepared, with the production of results (the synthesis of knowledge is presented below in the results).

III. RESULTS

In this study, 10 selected articles that met the previously established inclusion criteria were analyzed. These were organized and distributed according to the order of numbering, title, authors, database, year of publication, objective of the study, type of study and main results (Table 1).

Table 1. Distribution of articles according to numbering order, title, authors, database, year of publication, purpose of the study, type of study and main results.

N	Título	Authors	Data base	Purpose of the study	Type of study	Main results
E1	Nurses' perception of performing risk classification in the emergency service	CHAVES, et. al. 2014 [12]	SciELO	To know the perception of nurses about risk classification in the emergency service.	Qualitative	For the nurses in the study, risk classification is seen as a work organization tool that allows a closer nurse-patient approach. The necessary skills of nurses in risk classification were identified: knowledge of the scale used, clinical eye, patience and agility. The availability of risk classification scales was the main facilitator of the work. The greatest difficulties were the disorganization of the care network and the lack of knowledge of the protocol by the health team.

E2	Risk classification in emergency services from the perspective of nurses	DURO, C. L. M. 2014. [13]	LILACS	Evaluate risk classification in emergency services from the perspective of nurses.	Exploratory, quantitative study of opinion measurement through the Delphi technique	The evaluation of the clinical state through the development of qualified listening to the users' complaints was identified as one of the actions of the nurses in the risk classification, and the autonomy in the exercise of this activity was considered as one of the potentialities. As for the training needed to carry out the risk classification, clinical knowledge was indicated as the basis for decision-making in prioritizing patient care. Professional experience in risk classification was also identified for judging the priority of patient care and intuitive ability was identified as a facilitator. For this, nurses need communication and conflict coping skills with users.
E3	Nurses' daily work in welcoming with risk classification in the Emergency Care Unit	RATES, H. F. 2016 [14]	BDENF	To analyze the daily work of nurses in Reception with Risk Classification (ACCR) in an Emergency Care Unit	Qualitative study	There is a specific practice of professionals who (re)invent care based on their intentions and pressures. Users also move around, create their own itinerary and, like professionals, operate their tactics with a view to achieving their intentions in the therapeutic process. Finally, the daily work at the RRAC is (re)invented at each act by the professionals and also by the users who practice that place, overcoming the rules and norms. They are uncontrollable tactics of subjects that reframe the social system, operate astute escape and produce their own order of place.
E4	Reception with risk classification: what place is this?	RATES, et. al. 2016 [15]	BDENF	Getting to know Reception with Risk Classification (ACCR) as its own place and spaces created by the subjects.	Qualitative approach case study	The RRAC goes beyond an environment or a posture adopted by professionals, it is a place of its own, as it is delimited by norms, previously established rules that attempt to circumscribe subjects and isolate them. In addition, in this particular place, spaces are delimited based on the path that each professional and user undertakes within the RRAC. Each one has their own doing, their intentionality, their experience stimulated by situations that circumstantial that environment.
E5	Risk classification in an urgency and emergency unit in the interior of São Paulo	PAGLI OTTO, et. al. 2016 [16]	BDENF	To present the profile of the Urgency and Emergency unit sector of a Hospital in an interior of São Paulo.	Quantitative, retrospective, transversal	The use of risk classification protocols is beneficial for users and the team, as it standardizes people who use urgent and emergency services. It reduces the risks caused during the wait and provides more security for people who use the emergency service.
E6	The thinking of nursing in urgent and in-hospital emergency services	CARDO SO, et. al. 2016 [17]	BDENF	To extract from nursing thought the elements applied for decision-making in urgent and in-hospital	exploratory-descriptive and analytical study	It was evident, in the nurses' report on the planning of work actions, a detriment of care actions in relation to management and a constant and diverse requirement to make decisions, which have exclusivity in their positioning.

				emergency care		
E7	The effects of training nurses on the assessment of patients with stroke	SANTO S. et. al. 2017 [18]	BDENF	To evaluate the effects of training nurses in the emergency service in recognizing the signs and symptoms of stroke and applying the National Institutes of Health Stroke Scale (NIHSS).	Descriptive, cross-sectional study with a quantitative approach.	The training of nurses responsible for screening patients with suspected stroke should be encouraged to optimize the care and treatment of these patients.
E8	Emergency Severity Index: accuracy in risk classification	SILVA, et. al. 2017 [19]	MEDLINE	Check the agreement between the estimated resources provided through the Emergency Severity Index	Analytical retrospective study with a quantitative approach.	Nurses' assertiveness indices in forecasting resources, in caring for patients in the emergency care unit, using the adapted Emergency Severity Index, were lower than those described in the literature with the original scale. There was low concordance between the diagnostic tests planned by the nurses and those performed. No association was observed between the correct prediction of the number of resources and time since graduation, time of experience in emergency services and time working in the unit of study.
E09	Nurses' opinion on risk classification in emergency services	DURO; LIMA; WEBER 2017 [20]	BDENF	The objective of the study is to evaluate the opinion of nurses about risk classification in emergency services.	Exploratory, quantitative study	The nurses indicated that the risk classification organizes the flow of patients and reduces the waiting time, for those in serious condition, for care. For this, they use clinical knowledge, professional experience and the ability to manage conflicts. The nurses disagreed that the risk classification provides the patient with care and privacy, as well as the existence of periodic training for the exercise of this activity.
E10	Nurses' perception of risk classification in emergency care units	DURO, et. al. 2014 [21]	LILACS	Evaluate the perception of nurses about risk classification in emergency care units	Methodological study	The results indicate that the risk classification contributes to the organization of the users' service flow, intervening in severe cases, avoiding sequelae. Difficulties were described, such as inadequate physical facilities, overcrowding, disagreement in the prioritization of cases between doctors and nurses and lack of articulation between the emergency care network and primary care

Source: Authors.

3.1 Sample characterization

The sample was characterized according to the year of publication, the database and the study methodology. It was found that the BDENF Database – Nursing had the highest number of selected articles, totaling 60%. Regarding the temporal distribution, it was noticed that the publications occurred mainly in the years 2017 (40%) and 2016 (40%), followed by the years 2014 (20%). As for

the methodology addressed, 40% of the studies used the quantitative approach, 40% the qualitative and 20% the methodological approach.

IV. DISCUSSION

After the detailed reading and analysis, it was decided to group the categories found as follows: Humanization in the services of the 24-hour Emergency Care Units; The work process of the nurse in the ECU; Training of professional nurses and permanent education in the ECU.

4.1 Humanization in the services of the 24-hour Emergency Care Units

The overcrowding of emergency services is one of the main problems of the Urgency and Emergency Network. The main causes of this phenomenon are: the breakdown of the Primary Care network, the increased demand for health services, the reduced number of beds and the insufficient number of doctors and nurses.

This reality has led to customer dissatisfaction, due to the long waiting time, in addition to compromising the speed of care for more complex cases in these services, which may contribute to the increase in mortality of these individuals [15].

As a resolution strategy in 2004, the National Humanization Program implemented Reception with Risk Assessment and Classification in emergency services, with the aim of providing quality care, commitment, dignity and respect to all people who seek these units. It should also organize the care by severity, because by identifying patients in urgent conditions, user satisfaction is increased, congestion is reduced, the flow of care is organized and the resources to be used by the patient are directed [1].

Humanizing assistance encompasses the provision of services, human resources and dense or light technologies and infrastructure aimed at safe care with a guarantee of comfort and well-being for SUS users, with their effective participation. The AACR in the 24-hour ECU services allows the patient to be welcomed and seen as a whole, thus humanizing the work and guaranteeing timely care for each need [12-13].

The RRAC aims to improve access to health services by promoting changes by providing a faster response to users with acute conditions that require immediate intervention. In this sense, it contributes to the safety of nurses in the evaluation and promotes advances in the quality of care, constituting a work organization tool, in addition to providing care with greater responsibility and safety.

In this context, highlighting such protagonism of nurses shows conditions for the possibility of contributing to nursing care, since in the opportunity of attending to one of the PNH devices in the exercise of their function in daily practice, nurses can highlight their work in dialogue with system users. These transformations aim to improve the relationship between professionals and users, regarding the way of assisting them, through qualified listening and a classification according to the degree of risk, and also through greater integration between team members [12-13].

Nurses consider that the purpose of risk classification is to prioritize care for users with potential risk of harm and adequate use of available resources, according to the severity of the clinical condition. This result corroborates the findings of other authors, who claim that risk classification contributes positively to the organization and prioritization of care [17, 21].

It is considered that nurses have the potential to change work practices, reduce waiting times and improve the provision of care to users in emergency services. One study demonstrated that properly qualified and trained nurses are capable of managing and treating more than 30.0% of emergency care cases. According to the study subjects, the risk classification allows a greater approximation between nurses and patients.

The authors Duro, Lima and Weber [20] and Rates et. al. [15] converge in terms of their results when they state that welcoming the patient, as recommended by the National Humanization Policy, is an intervention device that allows analyzing the work process with a focus on interpersonal relationships. It promotes a change in relationships between professional, user, social network and among professionals themselves, through humanitarian and solidary parameters. Therefore, humanizing assistance in emergency care services is essential to organize flow, improve service quality and promote problem solving.

4.2 The work process of the nurse in the ECU

Faced with the need to organize care, the authors Paglioto et al. [16] and Chaves et al. [12], point out that the risk classification promotes improvements in the nurses' work process, establishing management, flow, systematization, time optimization, as well as enabling the prioritization of care for those with potential risk of injuries in the Emergency Care Units.

In the study by Paglioto et al. [16] it was identified that the risk classification allows establishing a prediction of service to users through priorities according to the clinical condition and no longer by order of arrival. The parameters provided for in the risk classification protocols standardize and provide greater security for the assessment carried out, being essential for the safety and identification of the severity of the users and their allocation at the correct level of care. There was emphasis on the prioritization of needs, which reduces the risk of aggravation and sequelae resulting from the long wait for care.

There is a purpose of the work process of nurses in the ACCR that is established by a protocol, which is established from the need to act in health, develop their work in care and intervene in a reality that needs a solution. The production of care in this scenario is built from its relationship with the patient. Thus, the clarification, orientation, verification of the examination and the conduction of the user are responsible actions mediated by listening and the decision to meet the need of the user at that moment [19].

The instruments used were also recognized in the work process. First, sensitivity was recognized as an instrument, a light technology, necessary in the relationship with the user in their listening process in the RRAC. Clinical knowledge was also cited as guiding work tools for risk classification. Knowledge, as a light-hard technology, is recognized as an instrument of possession, an extension of the professional, capable of directing care. On the other hand, other instruments, representing hard technologies, were mentioned as present in the work process, such as the system that streamlines patient triage (TRIUS), oximeter, thermometer and risk classification form [15, 20].

Risk classification benefits nurses as it grants them autonomy. They are able to identify the immediate result of their work, acting as regulators of the entry points of the emergency services. As a result of these characteristics, these professionals feel valued and recognized by users and their co-workers [19].

Thus, welcoming with risk classification seems to represent an opportunity to recover the true meaning of professional practice, the value of work and teamwork, and the search to solve users' demands. It is necessary to develop skills such as: qualified listening, teamwork capacity, clinical reasoning and mental agility for decision making to work in their activities in the risk classification service in the ECU.

The study by Santos et al. [18] points out that the signs of disorganization of nursing services are related to different professional conducts reflected in lack of standardization of procedures, non-use of nursing care methodology and lack of norms and routines. The standardization of emergency nursing care, in this way, through protocols; Allied to the risk classification, it can support the development of nursing interventions, in a systematic and organized way, guaranteeing agility, safety and completeness of care that will reflect on the quality of care.

4.3 Training of nursing professionals and permanent education in the ECU

The qualification of nursing care is necessary for effective assistance, for which it is up to the nurse to master clinical knowledge and guidelines for the correct referral of users, prioritizing those who need emergency care, reducing the risk of death and sequelae [4]. The studies show that the training of professional nurses regarding the use of protocols used in risk classification standardizes care and optimizes the service, thus improving quality.

It was verified that the majority of the nursing team professionals who work in the 24-hour ECU come from the Basic Health Units and, for this reason, they had difficulties in starting work at this new level of care. Therefore, these employees need a theoretical-practical basis with an emphasis on emergency care, before putting their knowledge into practice [18].

The National Policy for Permanent Education in Health ratifies that this situation provides for the appreciation of the work process itself as a learning motivator, capable of transforming practice based on discussions of daily situations. Transformation at work is only possible with the participation of all

those involved, motivated by the desire to develop the best of their service, in a healthier, more organized and committed way [22].

It is important that health institutions promote spaces for the team to discuss these problems; and that these moments favor the growth of the group, becoming an opportunity to carry out permanent education. Professionals say, however, that meetings at the ECU are held to resolve administrative problems and that there is no time for exchanging knowledge.

Despite all these points raised, as obstacles to work in the ECU, this service has characteristics that make life easier for professionals and that deserve to be highlighted even to justify their permanence in this level of care. Santos et al. [18], in their study, demonstrated that the deficiency in health promotion and education, mainly in knowledge about care for patients with stroke, contributes to a less humanized care for these patients. With this, the adoption of educational measures allows improving the knowledge and care of patients with stroke in the medical emergency service.

The training of nurses at the ECU allowed an increase in the general success rate in the post-test from 68.5% to 85.26% (in the post-test from 68.5% to 85.26%), which demonstrated the increase in knowledge of these professionals about risk factors, signs and symptoms, assessment and treatment of stroke patients. These results contributed to streamlining care at the ECU, with better screening and follow-up of these patients [18].

Deficiencies in health promotion and education, especially in terms of knowledge about care for stroke patients, contribute to less humanized care for these patients. With this, the adoption of educational measures allows improving the knowledge and care of patients with stroke in the medical emergency service [18].

PE, as a continuous process, favors the development and strengthening of skills that can be used as a dynamic factor for new knowledge, reducing the team's anxiety and minimizing the possibility of errors in care. It also allows promoting a set of personal characteristics of self-assessment, self-training and self-management, necessary to optimize teamwork [13].

It is a necessary tool to guarantee the quality of care and the achievement of results in nursing care, as it values professionals in their uniqueness, serving as an incentive for individual and collective growth. In addition, it allows for a look at their actions, as well as the analysis and reflection of the process, factors considered potential for the transformation of reality [13-14].

In this context, it is necessary to enhance the continuous sociability and sustainability of this knowledge, by encouraging reflection, participation and exchange of ideas as a result of social and cultural relations, which enhances decision-making [23]. Decision making is a consequence of human experience acquired over time within a particular context.

It is part of the experience, the ability of a professional to visualize situations within their contexts as a whole, drawing inspiration from previous experiences. At times, users are unable, for various reasons, to bring complete information about their illness process. And, for this reason, the professional's conduct deviates from existing frameworks in explicit knowledge [22].

V. CONCLUSION

The results made it possible to identify the following categories: Humanization in the services of the 24-hour Emergency Care Units; The work process of the nurse in the ECU; Training of professional nurses and permanent education in the ECU.

The studies identify the need for a humanized practice in risk classification to qualify assistance in the 24-hour emergency care units, they also point out that the risk classification protocol provides more autonomy for the professional nurse, in addition to organizing the service, however it is It is important that these professionals are trained and remain in constant learning, as permanent education enables changes in practices and resolutions to problems in emergency services when well integrated.

REFERENCES

[1]. MENDES, E. V. As redes de atenção à saúde. Ciência & Saúde Coletiva, Rio de Janeiro, v. 15, n. 5, p. 2297-2305, 2010.

[2]. RADEL, M. E.; SHIMIZU, H. E. Análise da implantação do Componente Hospitalar na Rede de Atenção às Urgências e Emergências. Saúde em Debate, v. 47, p. 39-55, 2023.

[3]. RICCIULLI, F. M.; CASTANHEIRA, E. R. L. O papel da Estratégia de Saúde da Família e Comunidade na Rede de Atenção às Urgências e Emergências. Revista de APS, v. 25, 2022.

[4]. BRASIL. Portaria nº 1601 de 07 de julho de 2011. Estabelece diretrizes para a implantação do componente unidade de pronto atendimento e o conjunto de serviços de urgência 24 horas da rede de atenção às urgências, em conformidade com a política nacional de atenção às urgências. Brasília (DF): Gabinete Ministerial; 2011.

[5]. SANTANA, L. F. et al. Atuação do enfermeiro na urgência e emergência: revisão integrativa da literatura. Brazilian Journal of Development, v. 7, n. 4, p. 35994-36006, 2021.

[6]. BRASIL. Política nacional de Humanização da atenção e Gestão do SUS. Acolhimento e classificação de risco nos serviços de urgência. [Internet]. Brasilia; 2009. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/acolhimento_classificaao_risco_servico_urgencia.pdf.

[7]. JESUS, A.P.S. et al. Acolhimento com avaliação e classificação de risco: estrutura e processo do atendimento. clínica, v. 3, p. 4. 2019.

[8]. MENDES, K. D. S.; SILVEIRA, R. C. de C. P.; GALVÃO, C. M. Revisão integrativa: método de pesquisa para a incorporação de evidências na saúde e na enfermagem. Texto & contexto-enfermagem, v. 17, p. 758-764, 2008.

[9]. BOTELHO, L. L. R., CUNHA, C. C. A., MACEDO M. O método da revisão integrativa nos estudos organizacionais. Gestao Soc v. 5, n. 11, p. 121-36, 2011. Disponível em: http://www.gestaoesociedade.org/gestaoesociedade/article/view/1220

[10]. URSI, E. S. Prevenção de lesões de pele no perioperatório: revisão integrativa da literatura. [dissertação]. Ribeirão Preto: Universidade de São Paulo, Escola de Enfermagem de Ribeirão Preto; 2005.

[11] . MINAYO, M. C. S. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo (SP): Hucitec; 2010.

[12]. SOUZA, C. C. et al. Nurses' perception about risk classification in an emergency service. Invest. educ. enferm [online], v.32, n.1, p.78-86. 2014.

[13]. DURO, C. L. M.; et al. Percepção de enfermeiros sobre a classificação de risco em unidades de pronto atendimento. Rev rene. maio-jun; v. 15, n. 3, p. 447-54. 2014.

[14]. RATES, H. F. O cotidiano de trabalho do enfermeiro no acolhimento com classificação de risco na Unidade de Pronto Atendimento. 2016. Tese (Doutorado em Enfermagem) – Escola de Enfermagem da Universidade Federal de \minas Gerais, Belo Horizonte.

[15]. RATES, H. F.; ALVES, M.; CAVALCANTE, R. B. Acolhimento com classificação de risco: que lugar é esse?. Enferm. Foco. v. 7, n. 2, p. 52-56, 2016.

[16]. PAGLIOTTO, L. F. et al. Classificação de risco em uma unidade de urgência e emergência do interior paulista. Cuidarte enfermagem. v. 10, n. 2, p. 148-155. 2016.

[17]. CARDOSO, L. S. et al. O pensar da enfermagem em serviço de urgência e emergência intra-hospitalar. Rev enferm ufpe on line, recife, v. 10, n. 12, p. 4524-31, 2016.

[18]. SANTOS, J. V. S. dos et al. Os efeitos da capacitação de enfermeiros sobre avaliação de pacientes com acidente vascular cerebral. Rev. enferm. UFPE on line, p. 1763-1768, 2017.

[19]. SILVA, J. A. da et al. Índice de Gravidade de Emergência: acurácia na classificação de risco. Einstein (São Paulo), São Paulo, v. 15, n. 4, p. 421-427, 2017. http://dx.doi.org/10.1590/s1679-45082017ao3964.

[20]. DURO, C. L. M.; LIMA, M. A. D. S.; WEBER, L. A. F. Opinião de enfermeiros sobre classificação de risco em serviços de urgência. Rev min enferm. v. 21, e-1062. 2017.

[21]. DURO, C. L. M. et al. Percepção de enfermeiros sobre a classificação de risco em unidades de pronto atendimento. Revista RENE: Revista da Rede de Enfermagem do Nordeste. Vol. 15, n. 3 (maio/jun. 2014), p. 447-454, 2014.

[22]. BRUMMELL, S.P., SEYMOUR, J.; HIGGINBOTTOM, G. Cardiopulmonary resuscitation decisions in the emergency department: An ethnography of tacit knowledge in practice. Social. Science and Medicine, 156. pp. 47-54. 2016.

[23]. ACOSTA, A. M.; DURO, C. L. M.; LIMA, M. A. D. da S. Atividades do enfermeiro nos sistemas de triagem/classificação de risco nos serviços de urgência: revisão integrativa. Revista gaúcha de enfermagem, v. 33, p. 181-190, 2012.