Original Article

The (in)visible in the daily work routine of nurses in triage with risk classification*

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RESUMO

This is a qualitative approach case study seeking to comprehend the daily work routine of nurses working in triage with risk classification at an emergency care unit. Michel de Certeau's theory on everyday life was used as a reference. The data were collected using open interviews with 20 nurses and observation at the place of work, and were subjected to thematic content analysis. It was found that the daily working life being studied has strategic elements; the Manchester Protocol, impositions and obligations. Such elements endeavor to isolate the subjects into a normative site, a visible structure, where they can be controlled, monitored and demanded of. However, the daily work routine has (in)visible tactics, specific to each subject practicing in the site. These are care practices that bypass the strategic elements. It was concluded that the daily work routine under study goes beyond the routine, despite regulation, with visible and invisible daily tactics emerging. These are resourceful practices, the nurses own form of care/way of doing things that deals with micro resistance.

Descriptors: Emergency Nursing; Triage; User Embracement; Classification; Work.

* Article from the Doctorate Thesis entitled "The daily work routine of nurses in Triage with Risk Classification at an emergency care unit" defended in the Postgraduate program of the Nursing School of the Federal University of Minas Gerais (Programa de Pós-Graduação da Escola de Enfermagem da Universidade Federal de Minas Gerais), on November 29th 2016.

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Received: 08/09/2017. Accepted: 06/12/2018. Published: 12/05/2018.

Suggest citation:
Rates HF, Cavalcante RB, Alves M, Santos RC, Machado RM, Macedo AS. The (in)visible in the daily work routine of nurses in triage with risk classification. Rev. Eletr. Enf. [Internet]. 2018 [cited _____];20:v20a29. Available from: https://doi.org/10.5216/ree.v20.48608.

INTRODUCTION

Nurses working in triage with risk classification (TRC), have been recognized as important as a result of their training, which covers technical and biological issues, and social and emotional aspects, which make receptive and remedial practice possible[1]. The insertion of a nurse into TRC has optimized the flow of patients, reduced time spent waiting for medical attention, and, consequently, promoted patient satisfaction[2-3].

In Brazil, implantation of TRC has presented difficulties and challenges to institutionalization, with the necessity for readjustment[4-5]. Professionals do not feel sufficiently qualified and suffer in the face of the tensions experienced[6]. Insufficient implementation of the National Policy for Emergency Care should also be highlighted as it makes TRC inefficient, especially in patient care[4-5].

It is in this complex scenario that a nurse is challenged and must construct their daily work routine through their practices, which are often invisible, making it necessary to know their daily routine. Indeed, it is the work of such a professional that needs to be absorbed and learned, with the aim of its perfection and legitimization. However, it is necessary to learn the daily routine in TRC as something beyond a simple routine work scenario.

The concept of the daily work routine adopted in this study is of a space where power relations are manifested and enmeshed in daily practices, which materialize through “tactics” of the daily routine that reframe the defined site. They represent visible and invisible practices that (re)invent the daily routine, redefining what has been given as a rule (imposed strategies). The strategies intend to define a specific site that may be exemplified not only by the rules, but also by the policies, protocols and social behavior models, so as to exercise power and confer spatial and temporal stability on the sites being restricted[6].

By understanding the reality of the daily work routine of nurses in TRC, the hope is that it will contribute to advances regarding the role of the professional in this field, their visible and invisible daily practices, and the tactics engendered in their own professional knowledge. Furthermore, the hope is also to increase attention to the daily routine of nurses in the sphere of emergency care, and more specifically in TRC.

Thus, based on Certeau’s perspective of everyday life[7], the following guiding question is proposed: How is the daily routine established for nurses working with TRC at an emergency care unit? This study sought to understand the daily work routine of nurses working in triage with risk classification at an emergency care unit.

METHOD

A single, qualitative approach case study proposing to elucidate on an, as of yet, unpublished phenomenon[8], which is a daily analysis unit of the work of nurses in TRC. Certeau's[7] perspective of everyday life was adopted for the present study, which is characterized as something beyond the routine, enabling the advancement of knowledge on visible and invisible practices of nurses. Use of a qualitative approach is justified by the necessity to grasp the phenomenon that is constructed through the experience of the subjects, their perceptions and subjectivities[9].

The study scenario was an emergency care unit (Unidade de Pronto Atendimento - UPA) in a medium-sized municipality in south-east Brazil. The municipality is the headquarters of the Regional Health Superintendent and a reference for 54 municipalities in the surrounding area. The UPA is considered Size III, with a capacity of 350 patients per day[10]. The choice to conduct the study at this unit was justified by the access of the researchers and for being the only UPA in the municipality.

There were a total of 22 nurses at the UPA. A total of 20 participants were included after meeting the following selection criteria: minimum professional experience of two years, specialization course in emergency care; carrying out TRC and direct care on both day and night shifts. The exclusion criteria were: professional experience of less than two years, not having completed a specialization in emergency care; and exclusive actions in care.

Data collection was carried out through observation of the daily work routine and semi-structured interviews, conducted in a room at the UPA by researchers previously trained in data collection. The interviews lasted an average of 40 minutes and were recorded and transcribed in full.

The interview script consisted of questions related to the profile of the respondents, as well as the following questions: Talk about your daily routine in triage with risk classification; Talk about the practices you carry out during your daily routine; Would you like to add anything about your daily work routine? The interviews were identified with the letter E, followed by the number of the interview from one to 20.

The technique of observation was also chosen, considering that data collection through observation is relevant for the study of emergency care, as it provides detailed information on events, situations, activities and systems of knowledge that mold the emergency care environment[11]. The observations were recorded in a field diary as observation notes (ON). Data collection occurred between the months of January and March 2015.

The data were submitted to thematic content analysis[12]. In the 1st phase, pre-analysis or skim reading was carried out. The first contact with the documents consisted of analyzing and becoming familiar with the text; the material was then prepared; the observation notes recorded in the field diary and the transcriptions of the interviews constituting the corpus of the study.

In the 2nd phase, exploration and codification of the material was carried out. The recorded units, the nuclei of meaning, the context units and finally the thematic categories were extracted. Treatment of the results occurred in the 3rd phase, with the emergence of two categories: “Strategies in triage with risk classification: Manchester Protocol, impositions and obligations” and “Tactics in the daily routine of triage with risk classification”.

The study conformed to Resolution 466/2012 of the National Health Council and was approved by the Ethics Committee for Human Research of the Federal University of Minas Gerais, under decision nº 799.271/2014. The participants manifested their compliance with the study via signing of a Consent Form (TCLE).

RESULTS

Strategies in triage with risk classification: the Manchester Protocol, impositions and obligations

The Manchester Protocol used in risk classification stands out for its guidance of TRC, as it can strengthen assertive decisions and reduce the possibility of error. Moreover, in the observations and interviews it was possible to note that the protocol hides routine uncertainties, generating a false sense of security, whereby, that which does not fit the rule (protocol) can be excluded, as it has the backing of the protocol.

[...]The nurses make the classification based on the protocol. They seem to feel secure with it. Some even say that it is their technical support (ON).

The risk of you making the mistake in triage of saying: this one here is green and he can wait so long [...] The risk has been reduced a lot because you have guidance! (E5).

As a strategy, the Protocol is validating legitimized knowledge defined *a priori* and inhibiting classification based on the subject's own knowledge and conceptions.

Before implanting the Manchester Protocol, we had a certain risk classification in the old emergency room. But it was like this... you didn't have any protocol, you would go more by your knowledge, empirically (E17).
The protocol serves as validated directional knowledge (ON).

Another characteristic of the protocol that gives it strategy status is its effect of standardization regarding the language of the subjects involved (professionals and users).

[...] Sometimes we lose a "quiet" patient that doesn't talk about their pain, and then when you look, it is a serious patient, having had a heart attack, who is sitting there "quietly". Without the classification you didn't have a parameter to measure this. Normally, the tendency is to give more attention to the patient that screams: "Ai! Ai! Ai!" Everybody helps this patient and the one that is quiet we think is ok. (E14).

Impositions and obligations were other forms of strategy materialization in TRC that emerged from the reports.

[...] our coordinator said that: 'everyone will have to pass in all the sectors [including classification], now, there is no other way, or whoever doesn't want it will have to leave the emergency room' [...] But I don't like classification very much, I thought that it had to be an aptitude, because I specialized, I did a postgraduate course in ICU, residency in cardiology, I wanted to work in my area, but as I work at a UPA I can't choose (E1).

Tactics in the daily routine of triage with risk classification

There is recognition of the Manchester Protocol as a strategy that guides the work in TRC. However, the passivity in accepting it as a rule does not materialize as expected, with it being constantly infringed. This is an initial tactic, that of "bypassing" the classification as a result of circumstantial situations (delays in receiving medical attention and patient waiting time).

[...] it often ends up with the nurse starting to bypass the classification. They bypass the classification because the doctor takes a long time to see the patient, because the patient is complaining or because they are too busy. Therefore, we lose the backing and the objective of the protocol [...] the tendency is for you to go back and classify as it used to be without the protocol (E12)!

The passive posture in accepting the protocol as the legitimate way continues to be deconstructed through voiced criticisms of what is regulated (flowcharts, TRIUS - healthcare unit triage software, estimated waiting time) and comparison with the demands of the reality established in TRC.

There are things on TRIUS that don't fit. For example, sometimes we assess a patient, but we can't fit him into the program. (E8).
[...] our time would be three minutes for each patient, which is sometimes not enough because TRIUS is really slow, it is a problem for us (E16).

Another subtle tactic recognized by the nurses is the agreement between the professionals to prioritize users with the same classification, based on their judgments and affinities, defining who should be seen with priority.

I have a good interaction with the receptionists and with the doctor on duty. So they already start prioritizing the patient because sometimes someone arrives to fill in the form and they note that he needs to do triage before those who are already waiting. It is a big help, they speed up the forms and, as I trust the medical professional, I can also take this straight to the doctor and even pass in front of others of the same color that are waiting (E7).

The users also have their tactics, resisting the risk classification and not accepting how the said rule is employed.

[...] I can perceive that the population doesn't accept the classification very well, they are always questioning the color they receive, they always believe that their problem is the priority, they get restless...(NO).
TRC is a little stressful, not because of the classification system, but because of the population, as part of them still don't understand the process of triage, the Manchester [protocol] *(E7).*

The active posture of the user in resisting standardization in TRC worsens in the form of aggressions that end up generating suffering for the professionals.

Out front we say that it is the entry door. Everything happens out front! There have been cases of being verbally abused; depending on whether we keep our distance they hit us! (E20).
[...]. I've already thought about quitting because of this physical and verbal aggression, because it generates extreme discomfort. I've been through it, and we've had colleagues that needed to take medication to tolerate the work and everything else. Today, I am more relaxed in relation to this, but I have already made a deal with my boss. I have a limited amount of time I have to be here, and I can't be left here too long or I start "going crazy" (E7).

In this scenario, in the imagination of the user, the nurse assumes a figure of domination that can guarantee or deny the possibility of care in the TRC. Thus, as they are on the front line (classification) they are culpable, they are the representation of the rule, they are the "other" and seen as a problem in the eyes of the user.

They really oppress us! In the sense that:
Oh we are there, I've been waiting here for three hours, they put this green wristband on me, you are to blame. They see us as the villain here (E15).
As one of the patients was very aggressive, as he wanted to be seen quickly, the nurse quickly decided to classify him as yellow. The patient himself said he wouldn't accept green or blue (ON).

The doctor is also indicated as one who exercises a "boycott" of the risk classification. Their tactics are to resist, ignore and criticize.

[...] One of the doctors approached a nurse and asked "Why did you put this?" He criticized the classification and said that the patient was to be called without classification. He continued, saying that they were doing things there however they liked (ON).

DISCUSSION

The daily routine in TRC is restricted by the elements that define it: the national policy; care protocol; impositions and punishments. Such elements can be understood as strategies for setting boundaries for a site in which there is a defined task that is expected to be carried out[7].

Written language is an instrument of power that tends to organize the data of socioeconomic production and consecrate social division, giving privilege to those who master the written codes[7]. As such, the strategies in the daily routine of TRC, especially through the Manchester Protocol, seek to isolate the subjects in a limited site, of prescriptive and validated technical mastery.

Healthcare protocols emerge as instruments that aim to provide orientation for care management. It is an attempt to validate and legitimize the care sustained in the association between practice and scientific evidence, but which does not accommodate new forms of action also practiced in the daily routine of the nurse[13].

Despite the nurses in the present study initially allowing their passivity in accepting the protocol of prescribed knowledge to shine through, there is a redefining of the proposed system in their daily routine in TRC. The act of "bypassing the classification" and not complying with predetermined times are elements that characterize a different way of working than that which is envisioned.

Furthermore, "deals" made in relation to the definition of the order of priority of the users are not embodied in visible rules. It can be perceived that, on the one hand, within the context of nursing work there is a

logic given by the instrumental reasoning that goes beyond the prescribed. On the other hand, the daily routine harbors tactics (the work itself) that create movements and inventions that are differentiated actions of each professional, which reinvent the daily routine so as to escape from the dominant models[7-14-15].

The resistance to and bypassing of the protocol deal with issues for the appeasement of conflict between the nursing team, the population and the medical team, which configure as circumstantial situations[7]. The inventions configure as different ways of working, agreements and negotiations used to deal with what arises in the daily routine. Therefore, these processes are anchored in the tactics of each individual when constructing their interactions, modifying processes, creating new precursors and breaking with the formal logic of the strategies that circumscribed TRC[7].

Besides the professionals, the users also forge tactics that constitute the daily routine in the TRC. The reality may reflect equivocal use of emergency services on the part of the population, by them seeking out the healthcare unit not in cases of emergency, but as the only gateway to health service[14].

Another posture of the user is to blame the nurse for the absence or inefficiency of care, for their supposed lack of recognition of the right of the other to be treated first, labeling them as the "villain". In the words of Certeau[7] "It is always the other, without their own responsibilities (the blame is not mine, but of the other; fate) and of particular properties that limit the site itself". So, for the user, resisting, labeling, blaming, displacing responsibility for the problem to others; may be an opportunity to shape the rule, to pressure for access through loopholes, maximizing guarantees in their demands for care. Here is an invisible action, constructed in the intentionality of the active user in their choices. However, in the perspective of Certeau[7], these acts of the users reveal the daily routine as a complex battlefield where the actions are aimed at meeting demands and are not always rational.

The battlefield is replete with redefined practices that lead to a certain liberty and (in)visible micro resistance which, in turn, is the basis for micro liberties, mobilizing (un)suspected resources and, thus, displacing the true frontiers of domination of the powers[7]. In this field, everyone with their own game of micro resistances/micro liberties makes the work environment tense, confrontational and stressful, subjecting the users and professionals to the risk of suffering[16-17].

Tensions were also found between doctors and nurses in the daily routine of TRC. These tensions are established through the Manchester Protocol, promoting a certain visibility of the nurse, placing them as an element interposed between the doctor and the user. However, what cannot be understood is the visibility conferred on the nurse as the figure of their autonomy in TRC. This is clear in the formal understanding of autonomy as the "capacity of self-governing through one's own means", whereby autonomy is beyond the prescribed and related to working with ability and competence[18]. To think of individuals as autonomous subjects is to consider them as protagonists within the collectives in which they participate, co-responsible for their production and that of the world in which they live.

The autonomy of the nurse, in its conceptual formality, does not materialize in the daily routine of TRC. The visibility and emphasis placed on the nurse frames them in their own site as per Certeau, as triage is generally carried out by this professional.

Things such as the tactics developed in the daily routine under study reinforce the autonomy of the doctor, since they continue to define the order of events related to user care, including how classification should happen.

In this context, the nurse astutely puts new ways of working into the daily routine, such as bypassing the classification, doing things differently to what has been envisioned, responding to the pressure of the users through non-systematic classification, seeking to escape the vigilant eye of the doctor, the user and the political pressures of the system.

In the context of nursing work there is a difference between that which is practiced and that which is prescribed by protocols and regulations, which are very different to the real work, which is (re)invented in the invisibility of the professional within their operational context. The practiced care is not always what has been prescribed or regulated; the care goes beyond the protocols, which empowers and confers autonomy on the professional, even in the invisibility of their actions in the daily routine of the nurse[15]. This scenario is determined by various singularities of the subject needing care, whereby the nurse creates liberties of action and impresses knowledge on the care provided to the individual, whereby their autonomy is their exercising of invisibility[15].

CONCLUSION

The daily routine of nurses in TRC is defined by visible strategies that regulate and standardize their work. On the other hand, it also encompasses tactics such as resourceful practices replete with intent, (re)inventing the previously established cultural system; the users resist classification, the professionals forge agreements, bypassing the rules, they develop (in)visible practices, establishing a network of micro resistance.

The nurse complies with the rules and articulates new forms of care from situations that pressure them to (re)invent the care and respond to the daily demands of the population and the service, which are not always convergent. This is a daily work routine forged from the use of strategies and the astute creation of tactics as a possibility of meeting the demands of users and professionals. The nurse carries out relevant and apparently visible work, but its invisibility flourishes when this work is defined by the demands of the population and doctors in the processes involving TRC. This investigation contributed to clarifying the daily practice of nurses in TRC, although the study has the limitation of having been conducted at only one healthcare service in a city in the interior of the state of Minas Gerais. Other studies are necessary to advance the understanding of the complex daily work routine of nurses in emergency units and in TRC, which harbors strategies and tactics (the work itself) in the construction and reconstruction of knowledge and practices.

Financing

The study relied on the financial support of the Coordination for the Qualification of Higher Level Staff in Brazil (CAPES) and the National Council for Scientific and Technical Development (CNPq).

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