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ASSESSMENT OF THE PHYSICAL AND HUMAN RESOURCE STRUCTURE OF A PSYCHIATRIC EMERGENCY SERVICE¹

Aline Aparecida Buriola², Leandro Barbosa Pinho³, Luciane Prado Kantorski⁴, Laura Misue Matsuda⁵

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² Ph.D. in Nursing. Professor, Undergraduate Nursing Program, *Universidade do Oeste Paulista*. Presidente Prudente, São Paulo, Brazil. E-mail: aliburiola@bol.com.br

³ Ph.D. in Nursing. Professor, Graduate Nursing Program, *Universidade Federal do Rio Grande do Sul*. Porto Alegre, Rio Grande do Sul, Brazil. E-mail: lbpinho@ufrgs.br

⁴ Ph.D. in Nursing. Professor, School of Nursing and Graduate Nursing Program, *Universidade Federal de Pelotas*. Pelotas, Rio Grande do Sul, Brazil. E-mail: kantorski@uol.com.br

⁵ Ph.D. in Nursing Fundamentals. Professor, Undergraduate and Graduate Nursing Program, UEM. Maringá, Paraná, Brazil. E-mail: lauramisuem@gmail.com

ABSTRACT

Objective: identify the perception of professional, users and family members about the structure of the psychiatric emergency service in a general hospital.

Method: study through Fourth-Generation Evaluation, involving 30 respondents (15 professionals, nine users and six family members). The data were collected through documentary analysis, semistructured interview, non-participant observation and participant observation.

Results: the data analysis and discussion were executed using the Constant Comparative Method, articulated with the National Humanization Policy and the National Mental Health Policy. The following needs were verified: adaptation of the physical structure for psychiatric emergency care to children; more human resources; better use of protocols; and reduction of children's hospitalizations for long periods.

Conclusion: the relation between child care in an inappropriate location and the insufficient number of employees serves as a factor that makes it difficult to put the care practice recommended by the National Mental Health Policy in practice.

DESCRIPTORS: Psychiatric emergency services. Service structure. Care. Care humanization. Nursing. Assessment.

AVALIAÇÃO DA ESTRUTURA FÍSICA E DE RECURSOS HUMANOS DE UM SERVIÇO DE EMERGÊNCIA PSIQUIÁTRICA

RESUMO

Objetivo: identificar a percepção de profissionais, usuários e familiares sobre a estrutura do serviço de emergência psiquiátrica de um hospital geral.

Método: estudo realizado por meio da Avaliação de Quarta Geração, com 30 respondentes (15 profissionais, nove usuários e seis familiares). A coleta de dados ocorreu por meio de análise documental, entrevista semiestruturada, observação não participante e observação participante.

Resultados: a análise e a discussão dos dados foram operacionalizadas por meio do Método Comparativo Constante, articulados com a Política Nacional de Humanização Política Nacional de Saúde Mental. Constatou-se a necessidade de adequação na estrutura física para o atendimento de emergência psiquiátrica de crianças; necessidade de mais recursos humanos; melhor utilização de protocolos; e redução de internações de crianças por longos períodos.

Conclusão: a relação entre a assistência infantil em local inadequado e o insuficiente número de funcionários atua como fator que dificulta a prática assistencial preconizada pela Política Nacional de Saúde Mental.

DESCRIPTORIOS: Serviços de emergência psiquiátrica. Estrutura dos serviços. Cuidado. Humanização da assistência. Enfermagem. Avaliação.

EVALUACIÓN DE LA ESTRUCTURA FÍSICA Y DE RECURSOS HUMANOS DE UN SERVICIO DE EMERGENCIA PSIQUIÁTRICA

RESUMEN

Objetivo: identificar la percepción de profesionales, usuarios y familiares sobre la estructura del servicio de emergencia psiquiátrica de un hospital general.

Método: estudio realizado por medio de la Evaluación de Cuarta Generación, con 30 respondedores (15 profesionales, nueve usuarios y seis familiares). La recolección de datos ocurrió por medio de análisis documental, entrevista semiestructurada, observación no participante y observación participante.

Resultados: el análisis y la discusión de los datos fueron operacionalizados por medio del Método Comparativo Constante, articulados con la Política Nacional de Humanización Política Nacional de Salud Mental. Se constató la necesidad de adecuación en la estructura física para la atención de emergencia psiquiátrica de niños; necesidad de más recursos humanos; mejor utilización de protocolos; y reducción de internaciones de niños por largos períodos.

Conclusión: la relación entre la asistencia infantil en local inadecuado y el insuficiente número de funcionarios actúa como factor que dificulta la práctica asistencial preconizada por la Política Nacional de Salud Mental.

DESCRIPTORES: Servicios de emergencia psiquiátrica. Estructura de los servicios. Cuidado. Humanización de la asistencia. Enfermería. Evaluación.

INTRODUCTION

The new approach to mental health care, marked by deinstitutionalization, considers the psychiatric emergency service as units of care necessary for the (re)organization of mental health care,¹⁻² because they promote the rapid stabilization of the acute episode in the mental disorder, with referral proposals for the continuity of care in substitutive units.³⁻⁴

Psychiatric emergency units initially appeared as isolated initiatives of some university centers or public hospitals, mainly in large urban centers,⁵ with the goal of performing clinical and psychosocial diagnoses in situations of thought, emotion or behavior disorders that require immediate care. In this regard, the priority of these services is to avoid damages to the mental, physical and social health of individuals, as well as to contribute to building the premises of the deinstitutionalization³ and humanization of mental health care.

Another relevant point is the fact that psychiatric emergencies are pointed out as the basis for the regulation of admissions in the Mental Health Care Network, thus contributing to the organization of the flow of users,⁶ permitting the reduction of unnecessary hospital admissions, with the transfer of mental health care to primary care and the deconstruction of the exclusionary character that permeates psychiatric care.⁵

In Brazil, despite advances in mental health care, with regard to the organization of the system and the redesign of the network, many services, mainly in public health care, still remain in precarious situations, especially regarding the structure and the quality of care.⁷⁻⁸ Thus, it is relevant to conduct studies in order to evaluate mental health care, so that the results obtained can contribute to

the definition of proposals aimed at the implementation of humanized and qualified care.

Based on the above, this study is justified mainly by the need to look at the new modalities of mental health care, such as psychiatric emergency units in general hospitals, aiming for a qualitative assessment. Thus, this study is based on the following question: "how do professionals, users and family members perceive the structure of a psychiatric emergency service?" To answer this question, the objective of the study was defined as identifying the perception of professionals, users and family members about the structure of the psychiatric emergency service in the general hospital.

METHOD

Study carried out from February to June 2014, in a psychiatric emergency department of a general hospital. As a theoretical-methodological basis, the Fourth-Generation Evaluation was used, based on the hermeneutic-dialectic approach, with constructivist and responsive characteristics. The hermeneutic-dialectic process is hermeneutical because it is interpretative, and it is dialectical because it proposes the discussion of divergent opinions, in order to obtain a consensus about the object under evaluation.⁹

The Fourth-Generation Evaluation is the union between the responsive approach and the constructivist method. The responsive approach uses stakeholder claims, concerns and issues as organizing elements of the evaluative process, determining which aspects should be considered in the study.⁹

Regarding the study site, the psychiatric emergency unit is located within the physical plant of a general hospital, with its own space for emergency

mental health care. This service has 16 beds and a team of 32 professionals: six psychiatrists, nine nursing technicians, six nurses, four security guards and four receptionists, a social worker, a psychologist and a secretary, who work on shift duty.

For this research, the Fourth-Generation evaluation was applied in practice through contact with the field (meeting with the service team, users and family members to present and discuss the research proposal); identification of stakeholders or interest groups (professionals, users and family members); development and expansion of joint constructions (application of the hermeneutic-dialectical circle); presentation of the data to the interest groups (carried out based on the negotiation process, which consisted in the organization of each group's constructions, validation of the information and verification of consensuses); and, finally, construction of the end results of the evaluation process (definition of thematic axes, according to excerpts / testimonials qualified after negotiation).

Thirty people (Stakeholders) participated, 15 of whom were professionals, nine were users and six were family members. The inclusion criteria of the professionals were: to be a professional assigned to the department under study for more than six months and to provide direct care to the person with mental disorder and/or his family in the emergency department. The criteria for the users and family were as follows: formal acceptance to participate, being 18 years old or more and having been attended at least once in the psychiatric emergency department in the three months prior to the survey. Patients who had a medical diagnosis of severe or incapacitating mental disorder and companions who were not present when the patient was attended at the emergency department were excluded.

The field contact meeting was held in January 2014. Then, in February of the same year, a non-participant observation of the care dynamics established in the service was performed, totaling 61 hours of observation, as a way to approach the object of study. To do so, the researcher was inserted in the field in the three service periods, performing free observation to identify the care dynamics established in the department. After the non-participant observation, participant observation began, which lasted from March to June 2014, totaling 152 hours. For this stage, a more systematized observation of the care aspects was established, by means of the immersion in the factors that had been little understood in the non-participant observation. At that

moment, the researcher participated actively in the care activities developed at the study site, aiming to understand the care process in the service.

The material produced in the participant and non-participant observation process was not used in this article as an analysis product for the elaboration of the results presented, even though the observations were recorded in a field diary that could serve as a database for future publications. It is also worth emphasizing that this process was important for the researchers to approach the object of study, since it granted an experience of the actual context of the service and experiences that permitted verifying the activities that took place.

The interview phase began in May and ended in June, when individual interviews were held with the stakeholders, which took between 45 and 75 minutes. The interview with the first member of the group was guided by a semi-structured script, containing the following questions: in your perspective, what is the psychiatric emergency service like? What are the weaknesses and potentialities of this department? The question that originated the present study arose from an emic construction of the first interviews in the interest groups, so that the respondents were also asked about "how they perceived the physical and human resource structure of the psychiatric emergency department".

The interviews were organized based on the hermeneutic-dialectical circle. For this method, the first interview was performed with respondent 1, called R1 and, at the end of his interview, he was asked to indicate another respondent, designated as R2, so that he could point out new formulations about the psychiatric emergency service. Prior to the interview with R2, however, the themes, concepts, ideas, values, concerns and central issues proposed by R1 were synthesized by listening to the interview audio in order to extract the relevant points that would permit construction 1 (C1), which served as a source of information for the interview with R2, who was also invited, at the end of his interview, to indicate a new respondent, R3.

To do so, the interview with R2 permitted a new construction, called C2, which, in turn, served to direct the interview with respondent 3 (R3) and so on. This collection process was repeated equally in the three interest groups: professionals, family members and users. As the initial respondent (R1) of the professional circle, the one with the longest time working at the department was elected; for users, the one with the largest number of hospitalizations in the Emergency department; and for the family

member, the relative who accompanied the service user in at least two visits during their stay.

After the completion of all dialectical hermeneutic circles, which occurred when the the indications of the subjects in the circle started to be repeated, the data were transcribed in full, beginning the organization and analysis phase of the previous results to be presented at the negotiation meeting in thematic axes.

The content of the interviews was initially analyzed by means of the Constant Comparative Method, which consists of analyzing the data by listening to the audio-recorded testimonies soon after their collection, aiming to identify the constructions of each respondent and presenting the content of the previous interviews during the subsequent interviews in order to achieve new formulations about the issues pointed out in the statements and, later, to group the categorical units to be presented and discussed at the negotiation meeting.

The negotiation stage occurred independently with each group, after scheduling the date and time of the meeting, and was attended by most of the interviewees. For that moment, a printed material was produced, containing the synthesis of interview data, and delivered to each member of the group. Afterwards, the results obtained in the interviews were explained with the help of PowerPoint, aiming at the discussion, validation and negotiation of the data, as the priority axis of the evaluation.

Thus, after the negotiation stage, the data were reorganized based on the constructions and consensus established by the interest groups, to

be described in this study in the form of thematic axes. For that, extracts/excerpts/segments were extracted, which were grammatically edited and presented contents concerning the physical structure of the service under evaluation.

This research complied with all ethical and legal requirements in force in Decree 466/12 and the project was registered in the Standing Committee on Ethics in Research Involving Human Beings, *Universidade Estadual de Maringá*, under CAAE: 25786714.0.0000.0104 and Opinion 623.496. All participants signed two copies of the Free and Informed Consent Term and, to ensure their anonymity, the extracts will be identified by the letter P (professional), U (user) and F (family member), followed by the number indicating the order in which the interviews were conducted, and brief characteristics.

RESULTS

The results were analyzed based on three thematic axes, resulting from the clustering of the information units, and validated during the negotiation meetings with each interest group, that is: 1) the physical environment influencing humanized care in mental health; 2) material resources as an instrument needed for the proper care dynamics; and 3) human resources and their involvement in the care process.

In Table 1, the summary of the interest groups' constructions is displayed, elaborated during the negotiation process that took place after the end of the hermeneutic-dialectical circle.

Table 1 - Structure evaluation of the Psychiatric Emergency Department of a General Hospital - West of the State of São Paulo, 2014

Place	Professionals	Users	Family members
Psychiatric emergency service	<p>1) Physical environment: appropriate to observe patients; screening location with little privacy; improper physical space to attend to children.</p> <p>2) Material: absence of clinical protocols; underused routine protocols.</p> <p>3) Human resources: lack of professionals; frequent withdrawal of professionals from the sector; need for exclusive social service for the emergency department.</p>	<p>1) Physical environment: comfortable; restricted environment supports the treatment dynamics - avoids flights.</p> <p>2) Human resources: team welcomes the user, fast care; lack of social worker, occupational therapist and psychologist.</p>	<p>1) Physical environment: small, improper environment to attend to children.</p> <p>2) Human resources: Lack of professionals to welcome and inform the service users and their family; need for psychologist at the service.</p>

The physical environment influencing humanized care in mental health

The physical structure was considered suitable. This may be related to the fact that, in the service investigated, the nursing station is located at the center of the unit, it has two lateral windows that permit seeing the nursing wards. This fact allows the team to observe and intervene more quickly in cases of agitation and/or aggressiveness of the patients, as can be evidenced in the following statement:

the nursing post has those observation windows. This helps both the doctor and the nurse to always look at the patient, so that he can know his condition better and be able to help more (P1- physician, 36, at the department for three years).

Another aspect that draws attention in the physical structure is the treatment given to this space, because all the wards have air conditioning, cheerful colors on the walls with collages, pictures and good lighting.

The room, the point of care, is marvelous. I remember that I woke up with the air conditioning on, everything clean and smelling, a marvel for the treatment [...] (U2 - 38, has depression, attended at the service four times).

As a weakness, the moment of triage is observed, carried out at the Reception, with a large number of people transiting. As a result, the interest groups consider this procedure inappropriate, since it exposes and constrains the user, compromising the humanized care in mental health, as explained in the excerpts below.

The place of the screening is not appropriate because nursing ends up asking the patient what he came to do there, so it's an embarrassing business [...] to be exposed, everyone passes, so that exposes the patient (P1).

Another weakness related to the physical structure is the small space for such a large demand of people, with distinct characteristics for the care in mental health. This information came from relatives:

I think there should be more room to leave the more agitated person in a separate room [...]. My son stayed in the room with a boy who screamed all night, so he would talk to me like this: 'mother I do not want to go through this again, see these sick people, take me away' (F2 - 63 years old, mother of a boy with a drug addiction).

Another factor that interferes in the availability of physical space is the frequent referral of children who abuse drugs by judicial agencies and other mental health care units. This factor is evidenced below.

The space is not suitable for a child, especially when they stay here one, two, three months [...]. It is a pity and harms our service because we do not know what to do with the children referred by the judge (P3 - nurse, 37 years old, has worked in the department for one year and six months).

During the data collection phase, the presence of a child hospitalized by a court order was verified, who had been there for about a year and six months. According to the documents analyzed, this is a recurring problem, since some records were found of children who remained at the Service for several months, which certainly causes difficulties for the staff and also for the care provided to the child/adolescent.

Material resources as an instrument needed for appropriate care dynamics

The lack of and/or underutilization of clinical protocols and routines was the second most cited weakness among the interest groups.

[...] for me, the difficulty here is to follow the protocol, for everyone to speak the same language. This would help the professional to feel that he has an organization, but the compliance with those rules does not happen, so there is confusion in the care [...] (P2 - physician, 30 years old, has worked in the department for four years).

The lack of clinical protocols to direct medical practice was pointed out as one of the aspects that also compromises the organization of the health team and, consequently, care.

[...] I think I should have a clinical protocol because all the professionals would speak the same language. Everyone will follow the same thing, because here, every doctor acts in a way and if that existed, everyone would understand better... (P7 - nurse, 37, has been in the service for two years).

The fragility in the use of documents was also pointed out by the users and confirmed at the negotiation meeting, when they said that the initial service is disorganized, since the team has no information regarding the background history of the users already attended.

In the emergency, the initial care could be more organized. The people do not know if it's the first or second time we're there, what medicine they used. So, there should be a file on the computer with the person's story to help the professionals in the organization of the initial care (U7 - 29 years old, chemical addict, attended twice in the department).

I think there is a lack of organization because there was a day when I needed some documents to be delivered to the INSS (Brazilian social security department) and they could not find them at all, it turned out that after two days they found that paper for me [...] (F5 - 32 years old, mother of adolescent with anorexia).

Human resources and their involvement in the care process

Human resources were identified as a structural and organizational weakness of the service, emphasizing the need to increase the number of employees, especially the members of the nursing team, who are often reassigned to other sectors of the institution.

The staff is poor [...]. For example, sometimes there's one nurse for three sectors. It does not work because it is a constant lottery here. [...] the service can get burdened at any time, and when this happens, the nurse cannot handle it (P4 - physician, 35 years old, has worked in the department for a year and two months).

Under-staffing is also associated with the difficulty social service and psychology professionals experience when they are forced to attend to other sectors of the hospital, negatively affecting the incorporation of qualified health actions.

Social service was better when they worked here 40 hours, because there was one working for us the whole day. Now, they are two working 30 hours, and it's changing all the time. I do not know whom to turn to. The social service got a little out of control (P1 - physician, 36 years old, has worked in the department for three years).

Another aspect that proved to be fragile, unanimously among interest groups, was the frequent relocation of psychiatric emergency staff to other hospital care units and vice versa.

[...] the number of staff is not good, and to make matters worse, if I have four employees at my clinic, I never get all four. Someone is always relocated to cover another clinic [...], most of the time we work with two employees. The others are reassigned (P7 - nurse, 37 years old, has worked in the department for two years).

Every time the nurse or the auxiliary nurse is relocated, he always arrives completely lost or completely terrified [...]. Sometimes he comes walking with his back against the wall. I've seen auxiliaries this way, they get hyper alert, any noise, they jump (P4 - physician, 35 years old, has worked in the service for a year and two months).

Users also indicated the need for an occupational therapist in the emergency department,

believing that, even in cases of short-term hospitalizations, this professional could favor the patients' acceptance of the treatment.

In those four days that I was in the emergency, I was not obliged to do anything, and I think there should be someone to give some activity like reading, painting something [...]. Thus, the person ends up accepting the treatment (U5 - 33 years old, chemical addict, attended twice).

Despite the limitations related to the health team, the constructions about the care actions established by the human resources in the service are perceived as welcoming and humanized as, in the negotiation process, the users unanimously perceived the care as fast and effective.

I arrived and was taken care of. It was my mother and I and we were welcomed, they paid attention to me ... and that was what I considered best in the emergency, the reception, because I felt supported, cared for by someone (U1 - 36 years old, drug addict, attended in the department five times).

It is worth emphasizing that the users describe the health care as a welcoming moment of practice that respects individuality and protects the person with mental disorder and his family as subjects who need care.

DISCUSSION

The suitable physical structure in the health units is in line with what is advocated by the National Humanization Policy, with respect to the concept of environment,¹⁰ thus promoting a place of care that is welcoming and leads to the humanization of mental health care. This aspect is also valued by users and particularly takes into account the maxim that organized places produce more qualified health actions.⁷ Therefore, discussions about the physical structure are important and should be considered a priority, since the implementation of the environment, as a way of valuing the physical space, permits the construction of effective and humanized health actions.

In relation to the fragility in the physical structure, the only place that is indicated as in need of structural adaptations is where the nursing team performs the screening, that is, where initial care is provided to the user and the family, which occurs in the same space as the reception.

The concern and even the annoyance due to the fact that the user is approached in a place that does not guarantee his privacy, is in line with the proposal of the National Humanization Policy that

proposes the reorganization of the care process in the health system in general, based on welcoming and humanized care. Therefore, a physical space is needed that promotes the implementation of problem-solving care, with the possibility of constructing solidarity behaviors between professionals and users, preserving their dignity through health actions based on free communication.¹¹

The reduced physical space is also pointed out by the family and users as a complicating factor in the effectiveness of emergency psychiatric treatment, since it induces the coexistence within the same space of people who experience moments of a severely altered mental condition with those that present less impairment. This fact may result in the non-recognition of the disease itself and, consequently, non-compliance with the mental health service.

A study that aimed to characterize clients in mental suffering attended in a psychiatric emergency department of a general hospital identified that there is a great demand for care and that the majority of users go to the service spontaneously.³ This voluntary search, deriving from a deficient primary health care,¹² makes the demand for emergency services grow even more, generating an overload, with consequent damage to qualified and problem-solving care.¹³⁻¹⁴

In short, the care for children interferes significantly in the physical space, and it is known that providing a differentiated care by age group is an important aspect for the quality of care in psychiatric emergency units, and jointly attending to children and adults in this scenario is considered inappropriate.¹⁵

The purpose of attending to children in psychiatric emergency services is to identify the initial clinical picture, the risks deriving from the presence of the mental disorder, the factors that lead to the exacerbation or worsening of the clinical condition, and the presence of family, social and extra-hospital health services for the continuity of treatment anchored in the family.¹⁶ Therefore, children should not remain in this environment for more than a few hours and, yet, there are cases in which they remain for months and even years.

Professionals also consider the presence of children in the service inappropriate, especially when care is provided as a result of judicial orders that forward minors, with no timetable for discharge, and even without any problem indicating a mental health emergency. Despite the fact that any situation involving children and drug abuse should be consid-

ered urgent, regardless of this situation, it certainly does not include a long stay in emergency services.

The statements reveal that the members of the health team present feelings of regret and dismay at the admission of children upon court orders, considering that the psychiatric emergency environment does not permit specific and problem-solving health actions for child psychiatric care. The statements show the professionals' concern with the quality of the health actions provided to the young, due to the deficiency of the physical structure and the impossibility of solving questions related to referrals by legal entities.

A study that described the articulations that take place between the Child and Adolescent Psychosocial Care Centers in the South of Brazil and the sectors of health, social service, education and justice, pointed out that the links between these services and specialized mental health care departments are necessary for the construction of psychosocial care in childhood and constitute the main strategy for the rehabilitation and inclusion of young people with legal problems.¹⁷

In these cases, the articulation among the various services that assist children and adolescents contributes to the fact that care responsibility is not attributed to only one health service, because child mental disorder, mainly due to drug abuse, is a growing problem in today's society and requires broad mobilizations from diverse sectors.

What the underutilization of existing protocols in the health unit is concerned, it can be affirmed that this aspect generates difficulties in the continuity of care provided in the emergency service, thus compromising the organization and optimization of health actions, and consequently, the problem-solving ability.

Therefore, it can be inferred that the underutilization of existing protocols, together with the lack of routines that organize medical and nursing care, are important weaknesses in the department investigated here, and certainly represent a complicating factor for the quality of the relations at work and for the construction of mental health actions.

The psychiatric emergency services allocated in general hospitals are recognized as central units for the proper orientation of the Psychosocial Care Network, both due to the management of emergency situations and the regulation of cases of mental health care within this network. Thus, it is of paramount importance to standardize care by means of protocols and routines that support the qualified practice of care.⁵

In relation to the poor organization of the patient's background information, one way of minimizing this problem would surely be the use of the electronic medical record as a tool to guide care. This resource consists of the electronic information registry, aiming to facilitate the multidisciplinary work through the complete access to the data related to each health service user.¹⁸ In the hospital investigated, this registry had only been installed in the intensive care unit.

Regarding the inappropriate dimensioning of human resources, especially in the nursing team, it should be reminded that the Federal Nursing Council established appropriate nursing staffing in 2004,¹⁹ which health institutions do not always comply with, compromising the effectiveness of nursing care.²⁰

In a study that provided indications for the dimensioning of nursing staff in emergency units, it was identified that these health units suffer from the inappropriate dimensioning of human resources in nursing, appointing this fact as a complex problem for health institutions because it has several facets and, mainly, because it is intimately related to the quality of care, to the satisfaction of users, institutions and workers.²¹ In this sense, it is important to reflect and discuss about the need for appropriate staff dimensioning in health services, in order to create more qualified and problem-solving care actions.²²

The reports collected in this study also show the difficulty the multidisciplinary team experienced because the social worker and the psychologist do not stay at the emergency sector. The professionals appoint this aspect as a factor that makes it difficult to assertively construct mental health care, leaving the mentally retarded person and his/her family unattended in terms of care for their social and psychological needs.

The reassignment of professionals who are not specialized or accustomed to mental health care makes the dynamics and quality of care more difficult for the psychiatric emergency department, as some show fear of attending to people with mental disorders and/or present stigmatizing attitudes. This scenario of fear can compromise the service offered and generate dissatisfaction in the professional when having to act in an unknown environment, which causes discomfort.

The limited staff to carry out more welcoming and problem-solving health actions has been pointed out as a complicating factor of qualified health care.²³ Thus, the insertion of mentally ill persons

in the health services of general hospitals and the consequent increase in the number of attendances to this "new" demand require that the hospital be organized in order to offer qualified care, especially concerning training for mental health care, the quantity and quality of the multidisciplinary team, and that mental health care be humanized and problem solving.²⁴⁻²⁵

It should be added that the reality of psychiatric care in general hospitals is most often permeated by difficulties inherent in the physical area where the care process is constructed. In this context, the accomplishment of therapeutic activities tends to be compromised when associated to the deficiency in the number of specific human resources in the field of occupational therapy.³

A study carried out to reflect on the role of the general hospital in the mental health care network showed that the complex structure in this place, associated with the difficulties the multiprofessional team experienced, such as the insufficient number of professionals and lack of organizational structure, make it difficult to construct problem-solving and humanized care actions in mental health in this scenario.⁶ Thus, a process of reflection is emerging regarding the implementation of actions by the managers for the better distribution of human and material resources and the improvement of mental health care.

Welcoming as a form of care was evidenced as a more important aspect of the care dynamics. This humanistic form of care refers to the assumptions of the National Mental Health Policy and the National Humanization Policy, because it encompasses integral care in mental health, as a focus of problem-solving care.

CONCLUSION

This study revealed that the structure of the service under investigation is appropriate for the psychiatric emergency care in adults, because it counts on a welcoming staff, who performs care actions in a humanized and problem-solving way, and has comfortable rooms, a clean environment and fast and effective attendance. Some weaknesses were identified though: the need to comply with rules established by protocols; lack of manuals to direct clinical and nursing care; little space in comparison with the demand of users; inappropriate screening site; unplanned structure for child care; and the need for more human resources. Based on the data presented, it is concluded that the relation-

ship between the inappropriate physical structure to attend to children and the insufficient number of employees acts as a factor that makes high-quality care practice more difficult.

As a strength of this research, the fourth-generation evaluation method is emphasized which, using the constructivist, responsive and dialectical approach, permits the detection of weaknesses during the execution of the study. This is one of the advantages of this research process. It is noteworthy that, through this qualitative method of evaluation, during the negotiation stage with the group of professionals, a plan was established for articulation among the team members, with the proposal to build a project to be taken to the hospital management, aiming to adapt the triage site to better attend to the user.

The negotiation process also emphasized the need to resume existing protocols, as well as the construction of clinical flow charts, with the aim of standardizing psychiatric care. For this activity, physicians were responsible for describing the clinical care guidelines according to each disease; and the nurse for the immediate basic care flows, according to the mental condition the user presented.

The results of this research can serve as a basis for the supporters of the Psychiatric Reform movement to discuss the effectiveness of mental health care units, especially psychiatric emergency departments, in order to construct a welcoming and problem-solving care for patients with mental disorders and their family. Therefore, further research is suggested to understand the spaces where psychosocial attention is inserted, using new and/or recent methodological approaches, such as the one presented in this study, as a tool to construct scientific knowledge.

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