Perception of a nursing team in the implantation of a reception with risk classification sector for pregnant women

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Abstract

Objectives: to analyze the perception of a nursing team in the implantation of a Reception with Risk Classification (RRC) sector for pregnant women.

Methods: a descriptive cross-sectional study with a qualitative approach performed in a private hospital and linked to the Public Health System in Feira de Santana city in Bahia State in 2016. 10 nursing team professionals participated in the study that provided direct care for the pregnant women who were in labor and in puerperium. A semi-structured questionnaire was applied with questions identifying and characterizing their sociodemographic profile and an interview addressing questions about RRC sector, the advantages of implanting RRC sector to care for the pregnant women in labor and the possible changes in the implantation in the professionals' routine.

Results: the interviewees recognize that the RSRC is a way to administrate in the health services, reorganizing the work process, ensuring the quality of care, so its implementation is useful to differentiate care for pregnant women, with humanization and sensitivity, and create a bond among the professionals and the health users.

Conclusions: the implementation of the RRC sector establishes improvement that ensures a relationship of trust among the health users and the professionals and the effectiveness of care for pregnancy emergencies and urgencies.

Key words *Reception, Classification, Pregnant women*

http://dx.doi.org/10.1590/1806-93042018000200004

Introduction

The practice of reception has been considered a gateway to establish a relationship of trust and exchange information and experiences between the professional and patient in the health area in general. This practice admits that each human being is unique, as well as his/her health needs, it should occur in a qualified way, listening is an indispensable tool to collect and analyze information of each health user's needs, such as fears and expectations, offering answers to the health users in order to promote satisfaction when he/she is being attended.[1-3]

During the pregnancy period, there may be several intercurrences complicating the health of the pregnant woman and the fetus. In this case, the reception establishes a relationship of trust among the health users and the professionals, optimizing care and ensuring the success of the procedures performed.[3] In order to encounter health needs and reduce the risk of maternal and fetal death, the risk classification acts as a dynamic process, identifying women who need immediate treatment according to the potential of risk, health problems or the level of suffering presented.[4,5]

In 2003, the *Política Nacional de Humanização* (PNH) (National Humanization Policy) was developed for those who sought to practice the Public Health System principles in the health services.[6] The PNH does not have norms that regulate or normalize the policy, but allows principles and guidelines to be present in the legislations of other policies, such as rule number. 1,459, on June 24, 2011 in the first article, The Stork Network which consists of a care network aimed to ensure women's right to reproductive planning and humanized care during her pregnancy, childbirth and puerperium; and rule number. 2,395, on October 11, 2011, the fourth article, Guidelines on Hospital Component on Emergency Care Network: III - prioritized care, by the means of reception with Risk Classification, second level of suffering, urgency and case of severity.

In 2004, the *Ministério da Saúde* (MS) (Ministry of Health) initiated the implementation of the Reception with Risk Classification (RRC) in maternity hospitals, a strategy that aims to host women, guided by the risk classification, prioritizing the care of those in more severe situations.[5,7]

There are several models of risk classification for health users, such as the Manchester Triage System (MTS), most commonly used in Brazil, which is based on the evaluation of the urgency of the signs and symptoms presented, defined by colors (red, orange, yellow, green and blue). The criteria for risk classification is according to their level and priorities have the blue color "priority IV (non-urgent)", the green color "priority III (not very urgent)", the yellow color "priority II (urgent)", the orange color "priority I (very urgent)", the red color is characterized as "emergency and top priority".[1,3]

Therefore, this study brings subsidizes to rethink about care by the way these patients have been approached by the nursing team, despite the recognition of existing differences in the reception, their work has been carried out without distinction. Thus, we hope to contribute significantly in the incentive to the accomplishment the reception in the health units so that the care quality can be promoted and continuously be offered for pregnant women. Based on the above considerations, the following problem arises: What is the perception of a nursing team in the implantation of a RRC sector for pregnant women in a private maternity hospital in Feira de Santana, Bahia?

Thus, the objective of this study is to analyze the perception of a nursing team in the implantation of a RRC sector for pregnant women.

Methods

This is a cross-sectional study with a qualitative descriptive approach. The scenario of this study was in a private hospital of a medium complexity, linked to the *Sistema Único de Saúde* (SUS) (Public Health System), located in Feira de Santana city in Bahia State.

Initially, a meeting was held with a nursing team (composed of 20 nursing technicians and 06 nurses) and 02 hospital managers to present the project and raise awareness, they requested authorization to visit the sectors in order to know the development of the tasks and the routine of the hospital, as well as the professionals, enabling to collect the necessary data to develop the research. Subsequently, the Informed Consent Form was turned in. The total number of the nursing team working in the hospital in both shifts, 10 of them that were present on the day of the collection participated in the study and they met the inclusion criteria: nurses and nursing technicians from the Obstetric Center (OC) and Staff Accommodation (SA), and the exclusion were: nurses and nursing technicians who were on vacation and on maternity leave.

The research was approved by the Research Ethics Committee at the Faculdade Anísio Teixeira with CAAE protocol number 58729616.5.0000.5631, document number

1,780,776, observing all the pertinent recommendations, the signature on the Informed Consent Form, confidentiality and anonymity of the participants and other ethical conducts are provided in the 466/2012 Resolution of the National Health Council,[8] which deals with researches involving human beings.

The data collection was carried out in October and November of 2016, after the consent of of the referred institution. For the data collection, the semi-structured interview was used in which contained questions identifying and characterizing the participants' sociodemographic, training and work profile; inquiries about the RRC sector and point of views on the advantages of implementing the RRC sector to assist pregnant women in labor, maintaining the privacy of data collected during the interview.

The questionnaires were applied to the team in a confidential manner, in a private place, preserving the interviewees' identity the questionnaire was filled anonymously with only the interviewee's initials. We verified the validity of the content of the instrument that was considered satisfactory and the semantic, conceptual, items and operational equivalence, according to Beaton *et al*.[9] criteria.

The interviews were recorded with the aid of a voice recorder of a Moto G brand cell phone and literally transcribed by the authors after the authorization from the interviewees, and from the extensive and intensive readings, a search was made of the contents in an attempt to abstract the important messages that were implied. To ensure anonymity, the participants were identified by flower names.

The studied population was characterized by obtaining simple and relative frequencies of the categorical variables of interest. After reading the testimonies, the thematic categories were chosen, based on Bardin[10] method of content analysis (pre-analysis, material exploration and treatment of results), through the readings of the testimonies, associating with the pre-established objectives, seeking a foundation in the theoretical basis adopted.

Results and Discussion

There was a predominance of females (10) among the participants in this study, reinforcing the sex issue in nursing as a profession; there were 03 nurses and 07 nursing techniques, the ages were between 24 and 53 years old. Most of them were declared having mixed colored skin (06) and residents in an urban area (10).

It is necessary to consider the sociodemographic and training characteristics of the nursing team to identify their profiles that integrate the health services. In order to follow the advances of technology and the transformations in the society, as well as to develop strategies that promote the improvement of the developed activities, it is necessary to meet the health users' needs and improve the teams' working in a critical and reflexive matter in a professional scope.[11,12]

We observed that of the seven nursing techniques, 05 always worked in the SA. Among the technical assistances were in the OC, 01 has been working for approximately 1 year and the other for 4 years. Only the nurses assist in both sectors (OC and SA). All the interviewed nurses have less than two years of training and have been in the service between 4 months and 1.5 years. Only 03 of the participants of the sample had statutory employment, among them: 1 nurse; 07 were incorporated to the hospital by internal selection process and 06 reported that the monthly workload was equal to or greater than 150 hours.

The professionals' qualification and place of practice are essential to obtain their effective training for an effective care for the pregnancies, the normal childbirths and the immediate postpartum period.[12] On the other hand, it can be seen that nursing practice in a hospital is characterized by long working hours (night work, shifts), generating a physical and mental overload (stress).[11]

Considering the data collected, two categories of analysis emerged, as entitled: "Perception on the reception with risk classification" and "Advantages of implanting the reception with risk classification sector to assist pregnant women in labor".

Perception on the reception with risk classification

The most current concepts define the reception as a different way of dealing with the health work process and the interpersonal relationships that occur within the units.[3,13,14] Among the reports, it is noticed that the participants consider the reception a moment that the patient arrives at the unit and is hosted by listening to the patient's explanation.

> "It is the moment when the pregnant woman arrives at the unit and she is welcomed". (Tulip)

> "[...] It's talking to her about what's going on, explaining the risks. Reassuring". (Azalea)

> "When the patient is checked by the physician or by an obstetric nurse, she is examed and is seen how much the dilatation is". (Violet)

> "Care, protection. Have responsibility". (Lily)

To welcome someone means to give hospitality to, to give warm clothes to, to give credit to, to listen to; to admit, to accept, to receive; and to take into account.[15] The reception involves the woman's reception since her arrival at the health unit and this should be attitudes assumed by all professionals, having as a main focus on the subject, listening to the complaints, allowing to express concerns, doubts and anxieties and, in this way, ensuring the process of accountability, bonding and articulation with the other health services through a humanized and resolutive service.[3,16,17]

Pregnancy is a critical period of transition of personality development and tension biologically characterized by the metabolic changes of new adaptations. Thus, it is up to the nurse to integrate with the pregnant woman so she can feels safe, informed and oriented about everything that is happening,[17,18] as it can be read in the following statements:

> "It serves to us to welcome a woman in a situation where she finds her hormones freaking out., She needs, it doesn't matter how small is her complaint, she needs to welcomed [...]. There are women who arrives with a simple cramp pain and even the simplest pain, she needs to be listened to." (White Rose)

> "The patients are already oriented, because being welcomed, the nurse can explain things to her [...]". (Palm)

It is necessary to involve the health user as a subject in the process of the health production. The nurse should approach each pregnant woman, respecting their singularities and not losing sight of their social and family context in order to establish a frank dialogue, without judgments, with respect, tolerance, trust and preserve the other's individuality.[19,20] This way, the reception goes through the development of an empathy process during the service, trying to understand the other in their reality and needs.

The reception is a technical-assistance device that allows to identify care priorities according to their need for health/severity/risk (classification) or vulnerability according to the pre-established criteria,[21] as it can be observed White Rose speech: "*To welcome is to classify the woman in the obstetrics, it is to listen to her complaints and from there we can classify her risk*". In addition, the reception also promotes innovation and ease in care as it can be read in the following propositions:

> "It' will be great if that works because we need a lot of innovation. Health needs [...] and at the end it can be much easier". (Buttercup)

> "Where will you see the degree of evolution of this patient, if she is already in the expulsive phase, in a high level of dilatation". (Tulip)

It can be read in their testimonies that in addition to understanding a professional attitude that fully meets the patients' anxieties, it also means a way of dealing in the health services, reorganizing the work process, ensuring the quality of care and the bond formation among the professionals and the health users.[5]

The primary outcome happens with a collection of personal data from the health user, which after, she is sent to a designated space, the RRC sector, so that the obstetric history can be evaluated with vital data, so then the classification of the complexity and urgency can be defined for care.[1]

The advantages of implanting a reception with risk classification sector to care for pregnant women in labor

The most important factors to ensure effectiveness and quality would be to pay attention to the signs and symptoms, possibly presented by the pregnant women at the time of the reception, classifying them according to their respective degrees of priority. The "blue" can be consulted up to 4 hours and inform the possibility to be taken to to the Basic Health Unit (BHU). The "green" can be consulted up to 120 minutes and taken to a medical consultation without prioritization, but should be re-evaluate periodically. The "yellow" can be consulted in up to 30 minutes and is taken to a prioritized medical consultation, periodically re-evaluated. The "orange" is consulted as soon as possible, immediately taken to a prioritized medical consultation. The "red" should receive immediate care and should be taken for

medical evaluation, pre-delivery and/or to the obstetric block.[1]

It is plausible to observe that the interviewees recognize the need for a different care for pregnant women, considering the patient's physical and psychic situation; however, in their approach, they report that the implantation of this sector is influenced by both intrinsic and extrinsic factors, which should be taken in consideration in their care, such as: the patient's identification on the bracelet and had proper care:

> "The only thing is that the bracelet will only identify. That one over there, let's say a blue and a pink one. The blue one, you're going to give birth quickly, the rose will have to wait a little longer [...], the advantage is only this [...] because here the consult is in the OC, so anyway we know if it's going to be or not . [...] If it was over there in the front area, I would be consulted there at the OC and I would come back with the bracelet, we would already know. [...] If they implanted this way it would be ideal [...]". (Azalea)

> "This reception is very good [...], giving a better care for the patient [...]". (Buttercup)

The participants in this study pointed out that the implementation of the sector has main advantages to improve he patient's care, including by identifying their risk classification. This strategy seeks to implement integrated actions of prevention, cure and promoting health through care as a demand, according to the patient's reality.[4] We noticed in this sample that the nursing team emphasizes the need to carry out the reception in a strategic systematic action.

> "Care organization has to be provided". (Carnation)

> "It would be good, because it would help [...] a patient in labor. It would be good to implant, it is necessary, mainly because we do not have this here, only those at risk, every hospital has, but here we do not have only one sector to prepare the patient". (Lily)

> "Because you have a patient who is already in the expulsive phase, this newborn is at the pelvic and the other one is 3 cm dilated and can wait. The one who is in the expulsive phase is the first one to enter to give birth". (Tulip)

On the other hand, Sunflower and Violet affirm that inside the unit the implantation of the sector would be inconvenient due to the space:

> "[...] We do not have room for that. We do not take care of a patient at risk [...], when she arrives, she is taken tto another normal hospital". (Sunflower)

> "If the blood pressure is high, if you have serious health problems, you also cannot stay because they do not have a better support for the patient". (Violet)

However, the reception is understood as a different way of dealing with the production of the health process, which is not limited to the creation of a special physical space nor does it requires a professional or a specific time.[16] Working reception with risk classification with pregnant women, besides the need for care, guidance, protection and patient support, it requires professional training.[19,20]

Thus, the implementation of the RRC sector establishes improvements that ensures a relationship of trust among health users and professionals, as well as the effectiveness in caring for emergency and urgent pregnancies, requiring specific care and counseling.

> "A at risk patient requires care, [...] because when it comes to maternity, she is a sensitive patient, right?". (Buttercup)

> "It is very important, we will be evaluating the patient in labor. Always near her observing". (Violet)

> "[...] When a pregnant woman arrives in the expulsive period or with pregnancy-specific hypertensive disorder (PSHD), she will be taken immediately to be consulted". (Palm)

The Ministry of Health advocates that counseling should be based on a relationship of trust, aiming to provide the person conditions to evaluate their own risks, to make decisions and find realistic ways to address their problems.[1-3]

According to the nurse, White Rose, other advantages of implanting this sector would be the reduction of cesarean sections and optimizing

admissions in the active phase of labor:

> "It would decrease the rate of cesarean sections, it would increase the chance of woman to be admitted to the active phase of labor, because there are many women who are admitted to the prodrome phase, then she is admitted with 1 centimeter, 2 centimeters in dilation, sometimes with a closed cervix, without being in labor at all, before 41 weeks, then the rate of cesarean section increases, [...]and in the risk classification we make a more elaborated consultation than it is really done [...]and there are women here who ends up giving birth without doing the fetal heart beat (FHB) auscultation and that makes it a bit difficult".(White Rose)

It is up to the health professional to participate in this care, encouraging dialogue, helping in the recovery of the self-esteem, offering support, understanding, comforting and guidance to devoid the value of judgment.

With this, we noticed that the nurse is a fundamental tool in caring and welcoming pregnant women in labor, so it contributes to an effective and agile assistance, being able to achieve greater resolution, addressing the logic of care according to the clinical situation for each pregnant woman, besides promoting a relationship of trust among the multi-professional team and the health user.[7]

Regarding the perception of the nursing team on implanting the RRC sector for pregnant women, it seems evident that this implantation establishes improvements that ensures a relationship of trust among health users and professionals and the effectiveness in caring for emergencies and urgent pregnancies. This can affirm that there are structural, organizational and situational determinants that emit the satisfaction of the nursing team towards the implantation of the RRC sector and demark the well-being of pregnant women in the care provided.

This study is limited by portraying a loco-regional reality, associated to the scarce studies that would aid in the discussion of the results found. Therefore, these limitations refer the need to investigate this issue in other scenarios. New researches should focus on the reflection among the pressures and the overload on the nursing team and their relation with the perception and meanings on the reception for pregnant women, with the intention of contributing to a better understanding of this process and the elucidation of the main factors that constitute them.

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Received on December 26, 2016

Final version presented on December 4, 2017

Approved on April 3, 2018