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THE PERFORMANCE OF THE NURSING PROFESSIONAL IN THE RISK CLASSIFICATION IN URGENT AND EMERGENCY SERVICES AND THE PATIENT SAFETY

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Routinely, the Brazilian urgent and emergency services have a demand for care higher than the available care resources. This scenario leads to the need to establish a criterion for prioritizing care, in such a way as to ensure clinical justice for the patient. Accordingly, the risk classification assumes a unique importance, since it presupposes a logical decision-making about the level of severity of the patient for the management of waiting times for care[1].

Classifying patients with regard to clinical severity is inherent in the practice of emergency nurses. The assignment of a degree of risk to the patient is a complex decision-making process and classification scales, also called triage systems or protocols, which have been developed to guide the evaluation of the nursing professional[2]. Among these, one should highlight the Manchester Triage System (MTS), used in many Brazilian urgent and emergency services.

The safe patient care in urgent and emergency facilities starts from the proper assignment of the clinical priority level, which is influenced by different factors. Firstly, one should highlight the importance of the proper use of the protocol for risk classification on the part of nurses. In Brazil, the body responsible for training nurses in the use of MTS is the Brazilian Risk Classification Group. The training of nurses can be conducted by means of classroom or distance learning course. Nevertheless, it is worth highlighting that, until now, there are no studies that evaluate whether the training received by the nursing professional for the use of MTS is appropriate. A study performed in Spain with 41 nurses who have experience in the triage of patients showed that 65.8% of nurses thought they had poor training to deal with the prioritization of patients, and, although 48.7% of nurses were deemed suitable for this task, 46.3% disagreed that they were prepared for doing so [3].

Another factor that influences the proper indication of clinical priority is the reliability of the classification protocol. MTS has proved to be a reliable instrument, i.e., capable of reproducing the same classification results when used by different nurses. A recent meta-analysis study showed that the reliability of MTS is significant, and the agreement is higher among urgent and emergency nurses; and the use of the protocol in their country of origin, England, is closer[4]. One should highlight that, in Brazil, there is no requirement from the class council for that the nurse to have previous experience in urgent services or specialization in this field to deal with risk classification, which is a factor that should be rethought. Moreover, one should emphasize that a study of the cultural adaptation of MTS to Brazilian Portuguese is

in progress, which is important to increase the reliability of MTS in this country, which currently ranges from moderate to significant.

Lastly, one should highlight that risk classification, alone, does not ensure the appropriate management of waiting times for care. In addition to the classification, the service needs to be organized in care flows that ensure the continuity of care in the urgent service, and in other points of the care network. The care flows are essential to allow that access to medical care and care resources take place at the times determined by the guiding protocol, according to the level of severity of the patient. However, one should emphasize that the proper classification of the patient, which is a task for the nursing professional, is the first step to ensure the patient safety in urgent and emergency services.

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