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Original Article

MANCHESTER PROTOCOL AND USER POPULATION IN THE RISK ASSESSMENT: THE NURSE'S VIEW

PROTOCOLO DE MANCHESTER E POPULAÇÃO USUÁRIA NA CLASSIFICAÇÃO DE RISCO: VISÃO DO ENFERMEIRO

PROTOCOLO DE MANCHESTER Y POBLACIÓN USUARIA EN LA CLASIFICACIÓN DE RIESGO: MIRADA DEL ENFERMERO

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Objective: to understand the nurse's view on the use of the Manchester protocol and on the user population in the risk assessment of an Emergency Care Unit (ECU). Method: qualitative case study based on Comprehensive Sociology of Daily Life; open interviews were carried out with 12 nurses who perform the risk assessment. Results: there was a reversal of flow of users between the basic network and urgency/emergency services resulting in overcrowding in the ECU and work overload due to lack of information and effective communication in the Health System (public-private) to make users aware of the real function of the urgency/emergency service. We also identified flaws in the management of the ECU. Conclusion: despite the challenges to perform risk assessment as a welcoming and equanimous strategy to meet the demand, the nurses believed that the Manchester protocol has brought safety to the practice and quality to the care provided.

Descriptors: Assessment. Urgency. Emergency. Nursing. Hosting.

Objetivo: compreender a visão do enfermeiro sobre a utilização do protocolo de Manchester e a população usuária na classificação de risco de uma Unidade de Pronto Atendimento (UPA). Método: estudo de caso qualitativo fundamentado na Sociologia Compreensiva do Cotidiano; utilizou-se a entrevista aberta com 12 enfermeiros que realizavam a classificação de risco. Resultados: havia uma inversão de fluxo de usuários entre a rede básica e os serviços de urgência/emergência, o que resultava em superlotação da UPA e sobrecarga de trabalho advindas da falta de informação e comunicação eficaz do Sistema de Saúde (público-privado), para que os usuários conhecessem a real função de um atendimento de urgência/emergência. Também foram identificadas fragilidades na gestão da UPA. Conclusão: apesar dos desafios para a concretização da classificação de risco como uma estratégia acolhedora e equânime das demandas, o enfermeiro entendia que o protocolo de Manchester trouxe segurança para a prática e a qualidade da atenção prestada.

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Descritores: Classificação. Urgência. Emergência. Enfermagem. Acolhimento.

Objetivo: comprender la mirada del enfermero sobre el empleo del protocolo de Manchester y la población usuaria en la clasificación de riesgo de una Unidade de Pronta Atención (UPA). Método: estudio de caso cualitativo basado en la Sociología Comprensiva del Cotidiano; se utilizó la entrevista abierta con 12 enfermeros que realizaban la clasificación de riesgo. Resultados: había una inversión de flujo de usuarios entre la red primaria y los servicios de urgencia/emergencia, lo que resultaba en hacinamiento de la UPA y sobrecarga de trabajo derivadas de la falta de información y comunicación efectiva del Sistema de Salud (público-privado), para que los usuarios pudieran conocer la función real de una atención de urgencia/ emergencia. También se identificaron deficiencias en la gestión de la UPA. Conclusión: a pesar de los retos para la consecución de la clasificación de riesgo como una estrategia acogedora e igualitaria de las demandas, el enfermero entendía que el protocolo de Manchester trajo seguridad para la práctica y la calidad de la atención prestada.

Descriptores: Clasificación. Urgencia. Emergencia. Enfermería. Acogida.

Introduction

Emergency services are seen by the Brazilian population as one of the entry doors to the public and private health care system. They have been considered a place to treat any type of complaint, because of their fast and resolute actions. Because of this, users seek emergency care units (ECU) not only for urgent or emergent care, but also as a way of covering the gap left by the precariousness of primary and outpatient care provided in Brazil.

Urgency and emergency services are important components of health care in Brazil and they receive a demand that is beyond its capacity. The reality of urgency services is marked by the inversion of flow of users between the basic network and these services. This results in overcrowding and overloading of ECU teams. Overcrowding represents the imbalance between supply and demand, which can be aggravated by organizational problems such as care without clinical criteria, which can cause serious harm to patients. Excessive screening not only wastes resources but also causes delays in treatment for more severe cases[1-2].

Furthermore, it is necessary to overcome the perception of the population and of many health professionals that complex and effective care is offered in hospitals, with diagnostic exams and complex procedures, thus disqualifying the role of primary care[3].

Nurses have been the professionals indicated to evaluate and classify the severity of those who seek emergency services. Risk assessment is a tool that helps the nurse to assume the role of regulating the demand for care and determining priorities in the care of patients. This classification is also useful for users who have less urgent complaints to be informed about the probable waiting time for receiving medical care[4-5].

Protocols have been used to support the nurses' practice in risk assessment. These are instruments that standardize the actions of this sector and provide legal support for the decisions taken[4]. Protocols are useful tools; however, they are not enough and must not be used alone, since they do not include factors such as cultural and social aspects that may be fundamental for an adequate risk evaluation of each patient. In the reality studied, the Manchester Protocol is used for risk assessment. This is considered a tool that facilitates the identification of critical patients seeking emergency units. This protocol works through flowcharts that help in the evaluation made by nurses, promoting more confidence at the moment of assessment[6].

In view of the current scenario of urgency units, which have to deal with the challenge of carrying out risk assessment every day, the question is: How does the nurse experience the assessment process using the Manchester Protocol in an Emergency Care Unit?

The study has the objective to understand the nurse's view on the use of the Manchester protocol and on the user population in the risk assessment of an Emergency Care Unit.

Method

This is a qualitative case study[7] based on the theoretical framework of Comprehensive Sociology of Daily Life[8] in an Emergency Care Unit in Belo Horizonte, Minas Gerais, Brazil.

Case study is used as research strategy in organizational and management studies, contributing in a unique manner to the understanding of complex phenomena, at the individual, organizational, political and social levels, allowing the preservation of significant features of real life events[7]. The aim of this study is to reach the individual level, considering the nurses' experience in risk assessment in an ECU.

The Comprehensive Sociology of Daily Life "allows an inductive approach" and, when working with "sociality, the imaginary or the everyday", should no longer produce "contents", but rather operate as a "point of view"[8:19]. Thus, comprehensive sociology is not meant to explain phenomena, but rather to understand them.

The study was carried out in an ECU in Belo Horizonte, which assists users of the Unified Health System (SUS) and users of the private health network. The ECU has 15 nurses who perform risk assessment.

As evidence for data collection, open and individual interviews were carried out in October/November 2012, lasting 17 minutes on average, recorded and transcribed in full-length. Data saturation was indicated by literal replication[7] until the sample was complete, giving meaning and defining the set that subsidized the analysis and interpretation of the data[9]. As a criterion for inclusion of participants, these had to work with risk assessment for at least six months. Of the 12 nurses included in the survey, 83.4% were women, the average age was 30.6 years, the time elapsed since completing vocational training ranged from 3 to 8 years, and the performance in the ECU was 3.68 years on average.

Data were analyzed according to the thematic content analysis technique. The research was developed according to the phases: material exploration, treatment of results, inference and interpretation[9].

The research followed the directives and norms regulating research involving human beings and was developed after approval of the project by the Ethics Committee of the Pontifical Catholic University of Minas Gerais (CEP PUC-Minas) under the CAAE-0410.0.213.0003-11 and authorization of the Research Ethics Committee of the institution, under CAAE-009/2012. Anonymity of participants was guaranteed through the adoption of pseudonyms chosen by them, corresponding to precious stones.

Results and discussion

The contents of the data analysis were organized into three thematic categories presented below: Users and risk assessment: (lack of) information, waiting time, risk screening and acceptance; Access, reception and uniqueness in risk assessment; and Manchester Protocol in the routine of ECU nurses.

Users and risk assessment: (lack of) information, waiting time, risk screening and acceptance

Risk assessment is a dynamic, complex and safe process to establish risk assessment strategies in the view of the nurses participating in the study. The method takes into account the needs of the people and dignifies life and living. However, there are challenges for materializing the daily life in the ECU into equanimous and universal actions in health.

Although the risk assessment is experienced by the population that seeks the emergency service, users often misinterpret it, believing that the symptoms they have fit into a more urgent level of classification than the actual level, as exposed in the report:

> *People don't have much sense. Even though they have information framework, they often confuse the issue of*

> *assessment, as soon as they arrive they begin by saying they must receive the color yellow, or orange. And that's not what must happen, because we nurses have to evaluate the patient and the severity, and make the classification, to give a color that corresponds to the real situation of the moment*. (Blue Quartz).

In the view of nurses, based on their everyday experience, users arrive to submit to the assessment already with the idea that they must receive assistance before all. Therefore, when they receive a color that was not expected, they feel that their complaint did not received the necessary attention and they question the practice of nurses and their ability to classify risk:

> *The biggest dissatisfaction on the part of the user is exactly this one, since they already have a notion of what is risk assessment. Then he questions the classification we make, judging that we are unable to imagine the symptom he is presenting there*. (Turquoise).

Knowledge about risk assessment is inherent in the work process of health professionals and typical of that area. If people are unaware of the criteria used in this assessment, this is because of lack of information about the health care system, about the established standards, conducts and criteria used to qualify assistance, without preparing people to be part of it. Thus, users often search the service, receive an adequate response to their case, but they do not feel satisfied:

> *I think awareness on the part of the entire population is necessary, of what the assessment is, what purpose it has, where it comes from, that it's not the case that we invented it ourselves, because they think "that we put it on the computer and the computer defines it". No, it's not the computer. This is about vital signs, clinical data, the time of the complaint, the onset of signs and symptoms. Some people come here with a complaint that's been there for a month and want priority. One month is no longer urgent. But they have a little trouble understanding*. (Amethyst).

Therefore, even if the response is appropriate to the complaint, this return is frequently not seen as positive by the patient who seeks the unit with the expectation of being immediately attended, thus solving his problem. However, most of the time, this is not possible. Thus, it is not acceptable to keep attendance without prioritizing individuals in real urgent/emergent situation, especially because the overcrowding caused by the disordered search of users as a result of structural problems of the health care network[3].

Spontaneous demand for emergency services accounted for 97.7% of the consultations in a Study carried out in the countryside of São Paulo, Brazil. This study showed that the organizational structure of the service provides assistance regardless of the severity of cases, without any restriction of entry, which entails an overloaded and fragmented care, based only on the complaint[10].

Study[11] carried out in emergency medical services (n = 2,703 patients) in Sweden found that 16% of the patients were potential candidates for primary health care and pointed out as an implication the need to train nurses in pre-hospital care for evaluating and screening patients who really need referrals to emergency services.

The interviewed nurses also perceived the need for health insurance plans also offer effective information about the role of risk assessment, since many users who seek care are unaware of this practice:

> *Mane patients still resist assessment. I believe it is about education really, health insurance plans need to guide the patients. Sometimes the patient arrives here: "But screening? What's this? I was not informed... "so, it is about sending material to the customer's house before he needs it, so that he may get in here and know, "Oh, I have a problem, but I'll wait." There are patients who have bigger problems than mine, they need to go first"*. (Sunstone).

> *Stress here comes from this: little has the government informed about the risk assesment and about the Manchester Protocol. So, the population does not quite understand the purpose of risk assessment. Especially in the case of health plans and private consultations, they do not accept to make this assessment, because they think that they must be assisted immediately. They do not understand that it is for well-being. I think that information on risk assessment should be more widely spread*. (Blue Topaz).

The SUS user receives little information on the criteria of the Manchester Protocol for lack of communication on the implementation of this risk assessment instrument. When contracting a health plan, clients establish the relationship between payment made and guarantee of service. Because they ignore the criteria of risk assessment in an emergency unit, they demand

a faster and decisive service. This does not occur, though, due to the high number of people looking for the service.

There is a need, therefore, for health service providers also be involved in the dissemination of information on this practice, so that users may be aware of the real role of emergency services and of the assessment, optimizing the service. Another problem is that the demand of patients with non-urgent complaints ends up increasing even more the waiting time of all. This is an attribute of great importance in the evaluation of the user, as it may bring dissatisfaction with the service provided[12].

In the view of nurses, users often understand that risk assessment is a way to delay their care with the doctor, because the most urgent cases are receiving priority:

> *In this unit there are clients treated differently from others, because I have experience with attendance in public hospitals. There is a lot of demands, and they are misinformed of what the risk assessment is. So in my daily routine, most of the time, I experience aggression. They think we're causing them trouble, delaying care, when they're classified as green. They do not understand the importance of the nurse identifying the risk before they seeing the doctor, which does not happen in the order of arrival, but by the severity of each patient seeking the care in the unit. Sometimes, it is with much verbal aggression, even nervousness and complaints that are not even to be dealt here, but they are here every day.* (Jade).

Classifying risk and considering the inequalities of demands implies humanizing health care, understanding each person in their singularity and with specific needs. Hence, welcoming people that are in need means providing care in a polite, humanized, ethical and resolute way[13]. In this sense, the allegation of lack of information on the part of clients and the denial to their requirements when inserting them in the process of risk assessment are incongruent, because they do not have this knowledge when hiring the Service or as Brazilian citizens who depend on the public health care service.

The difficulty people face to schedule consultations also contributes to the high demand for this Service:

> *The patient tries to make an elective appointment but unsuccessfully; so he comes to the emergency unit, which is the option he has. I do not blame the patient for that; the system itself has problems.* (Sunstone).

Nurses face a dilemma because they know that these patients do not need urgent care and they try to refer them to other services. However, the referrals are often ineffective, because there is no certainty of solving the problem. This is due to the absence of a counter reference system to support the guidance that patients receive in the emergency unit[3]. Obtaining decisive references, articulating all levels of health care and organizing the flow of patients are important elements for the promotion of comprehensive and universal care for all users.

The main challenges of the risk assessment are the precariousness of physical facilities, overcrowding of the units, the search for care by users in non-urgent clinical conditions, disagreement in the prioritization of cases between doctors and nurses, and the lack of articulation between the urgency care network and primary care[14].

The study points out the difficulties faced by the risk assessment service to work properly. These are caused by structural problems of the unit, little knowledge and information on the part of the population and due to the repetitive nature of the activity. In the view of nurses, risk assessment is an indispensable mechanism for the optimization of the assistance to users who present specific urgent and emergent clinical signs, but it does not exclude the usefulness of professional experience and nursing consultation[15]. Another frequent demand of users is medical statements:

> *There are several patients searching for medical statements, and this is clear, when the patient arrives here, the way he tells you, the complaint he is telling you: "Then, I could not go to work today..." Then you know he's looking for a medical statement. You know, you see it's really a headache that started today and he could not go work. So, you need to have that critical sense and do not let these go ahead the more serious patients.* (Sapphire).

Study[16] pointed out that the reality of emergency services has generated conflicts between users and professionals, once the definition of urgency is distinct in the view of these social actors. Health professionals often think users seek this service by not being aware of their specific responsibilities. However, one

informant states that, in the scenario studied, part of the population nowadays accepts better this instrument inserted in the work process of ECU professionals:

> *Risk assessment here in the unit of this hospital today is already a process that it is much more accepted by the population.* (Tiger's Eye).

It can then be said that effective communication could make the risk assessment in ECU units a reality proposed to assure the assistance and guarantee universal access to health in the Brazilian public and private healthcare system. In order for users not to seek emergency care without urgent or emergent complaints, it is necessary that they be clarified about this service, that they receive an adequate solution for their demand in the care network, and that the referral and counter-referral system be efficient and effective.

Access, Reception and Uniqueness in Risk Assessment

The practice of identifying people who need immediate treatment according to the potential for risk, health threats or suffering becomes more and more necessary, in view of the principle of equity in health actions. The use of risk assessment has benefits both for the institution that uses this tool and for the user who benefits from a humanized and agile care when necessary, since nurses are backed by a protocol and receive appropriate training for it, as demonstrated in the report:

> *Virtually all hospitals in BH use risk assessment, especially the Manchester protocol, in which the nurse undergoes training and can only classify through this training. And for the patient who needs immediate care is... the most benefited from it.* (Tiger's Eye).

Overcrowding makes it difficult to provide comprehensive care. It results in a fragmented assistance focused on immediate and specific actions to address the complaint expressed by the patient, disrupting care[5]. In line with this, it is imperative that the patient be hosted, so that the care be not only focused on the clinical complaint, but aimed at this human being in an integral manner, considering his singularity:

> *Of course each complaint is unique, each patient is unique and what we do there is to have a sense of what the patient is feeling to prioritize him in the care.* (Turquoise).

Reception in risk assessment is a strategy to organize care in emergency services, direct users correctly and serve them with integrality, universality and equity, as determined by the SUS[17].

Scientific knowledge and empathy are indispensable elements for professionals that receive patients with risk assessment. A humane stance, seeking to treat the user gently and listen to him in order to assist him in a comprehensive manner is of great importance to ensure the quality of the service, as the following report confirms:

> *It is very difficult to work with human beings, because the pressure you have to deal with is too big, you're dealing with lives. Trying to imagine, trying to put yourself in the place of the other is very important, because you think that you could be there, or your relative could be there. This facilitates a little, but it is not always enough for the patient because, when the patient comes, he wants to receive care, regardless of assessment or anything else.* (Turquoise).

However, "[...] the notion of empathy is fundamental, for it means putting oneself in the place of the other, in order to understand him"[8:217]. Therefore, "[...] the universal is contradicted by the existence of a multiplicity of singularities"[8:87].

The context shows that the introduction of new technological tools in emergency services facilitates the work of the team, but can fragment the care provided and become a mere technical procedure, as it fulfills the objective of giving solution to the complaint of the patient but through mechanical care. Thus, even though risk assessment is based on protocols, nurses must seek humanization to understand patient care goes beyond the symptoms presented. An integral care is required, regardless of the degree of urgency:

> *Risk assessment is not the System. You have to remember that you are classifying the patient who is not in very urgent or emergent situation. Anyway, he's feeling bad, and he's not here because he wants to; he did not come for fun, although there are some who seem to do so*

> *indeed, he will not say: hey, I am doing nothing, I go to the hospital, it's not like that, do you understand? So, he is here and he is feeling bad, either urgent or emergent or not. First we have to remember that it is a person who is in front of you and we have to take care with our approach sometimes. It is really tiring, and the larger flow is of less urgent patients. So, they think we are not calling anyone, but it's because in fact we are absorbing the most serious first. So, you need to have, yes, a way and knowledge to be able to approach this patient.* (Blue Agate).

The perception of the user as a human being endowed with values, seeking to understand him in his biopsychosocial and spiritual context, is a very important step for professionals to practice an equanimous and more humanized care[18]. Thus, nurses working in urgency units must ally the technology used in risk assessment to their practice of care, respecting the right of users and assuring their dignity as the main focus of all care provided. It is precisely by being an integral part of this context that one can "apprehend or perceive the subtleties, nuances, and discontinuities of this or that social situation... we are an integral part (and interested) of what we desire speak"[8:49].

For health to materialize itself as an established social right, it is necessary to prioritize actions to respond to the needs and demands of users in a timely, integral and equitable manner, according to the universal law that must be guaranteed by the State[18] or by the private system hired by citizens who need health actions and services. Thus, the nurses participating in this study point to a user-centered practice[17] when they report a service based on humanized care, with a singular reception to meet the patients' needs, prioritizing the risk with equity, so that universal and integral access becomes the right of all Brazilians.

Manchester Protocol in the Routine of ECU Nurses

The Manchester protocol, according to the participants, is well accepted in the Institution and gives nurses more confidence in the initial care of the person:

> *The Manchester Protocol serves to prioritize assistance to those who are at greatest risk of life, classifying the patient in red, orange, yellow and green. I believe that this is the best way to organize a waiting cue in the urgency unit, because we, in a way, are backed by a protocol that is used in several countries. It is studied, and the consensus of what is the best; thus, I have much confidence in it and, so far, it has only brought me positive results.* (Sapphire).

The nurses realized that the use of risk assessment guided by the Manchester protocol allowed improvements in the service studied:

> *Well, the risk assessment came precisely to determine who are the most serious patients, who need to be treated first, because in the old days everyone was crowded in the emergency room and whoever screamed the loudest was attended first and, we known that someone who is feeling very bad sometimes cannot even shout, right? In a respiratory failure, shock, or hypoglycemia, you can see that most of these patients do not scream. So, risk assessment reverses this situation by screening the most serious patients who really need care more promptly and give us more confidence about those who can wait a bit longer for medical care.* (Blue Agate).

Nurses acting in risk assessment must have some indispensable skills in order to provide qualified assistance. Among them are qualified listening, clinical reasoning and agility for decision-making, correct evaluation and detailed description of the complaint presented by the user, and knowledge of the care network to effectively carry out the necessary referrals[6]. Some interviewees reported that the training offered to professionals who perform the assessment was not enough to subsidize the practice:

> *A course of one, two days, is too short. I don't know about today. I graduated in 2007 and did not see anything regarding risk assessment, Manchester protocol or other protocols. I came in here when the protocol was implanted. I came because of it, to work specifically in the assessment, and that maturity we gain with time.* (Sunstone).

The experiences of lived during activities, which are almost always trivial, strengthen ideas, help build relationships and make it possible to plan the future without necessarily being aware of this contribution. Everyday life is a fertile land[8]. Even with risk assessment, the time determined by the color that the user receives is not always fulfilled, increasing their waiting time and overcrowding the unit, as the report states:

> *The triage has the colors: the blue indicate the patient is to be sent to the basic unit; the green indicates assistance within 120 minutes; yellow, 60 minutes; but the real thing that happens is that the patient waits much longer than that, he is rarely assisted within the exact time.* (Blue Quartz).

This fact can be explained by the large number of patients with non-urgent complaints and the worsening of the clinical situation of an already classified patient that may occur during the waiting time. It is necessary to monitor and reevaluate patients who have already been classified, until they receive the care to solve their complaints[6].

Interdisciplinarity of actions facilitates teamwork and the user is the most benefited by this. However, when actions are fragmented, the assistance is compromised:

> *It is no use that only nursing receives all the training to do this, because this is a function that involves all, from the reception to the doctor. There is the assessment, but before carrying out the assessment, cards must be prepared; before preparing the cards, passwords must be distributed. So, it is very important that the people who receive passwords have a notion of what means to be a priority patient; who is there at the reception, making the card, the importance of concentration when filling in the patient's data, because this record that the person is preparing "falls" in our hands there in the triage, all computerized. Once you have the screening, the professional that is in here has to be respected. So, we need to have a receptionist that really works, limiting this come-and-go of patients and their companions, because it's no use making a cue and give priority cards for everyone and try to pass one in front of the other, because this will not help at all.* (Turquoise).

It is undeniable that risk assessment and the use of protocols in emergency units bring numerous benefits to this service. The use of the Manchester protocol favors the selection of flowcharts based on patients' complaints, what determines the time to receive care[4]. The use of this tool also enables the management of the sector, facilitating the search for solutions to the fragilities found:

> *Risk assessment also gives you a management. It gives you an idea of how many non-urgent patients you are assisting, and how many are really emergencies. It can give you a sense to start managing your sector. Will I have to improve my resuscitation room, bring in more equipment? Will I have to bring in more employees, to stay at the unit, to apply the medications more often? Because the patient who is not very urgent, who has a fever, nausea, ends up medicated at some point. So, it also gives you management parameters; it ends up that, at the end of the month, with a data worksheet, you have management parameters. For the Institution, this is good, it is a positive thing, besides giving you greater confidence about who is waiting, you know what they are.* (Blue Agate).

Management is one of the subprocesses under responsibility of nurses. These professionals should consider care as something to be managed, always seeking to ensure that their practice do not become mechanical, but guided by scientific knowledge and rational and humane attitudes[19]. Therefore, reception with risk assessment as a management strategy is linked to actions of qualified listening, guarantee of access to care and management of the demand flow of the institution[20].

The informants explain what challenges are present while carrying out risk assessment in the ECU. Receiving the demand and classifying it based only on a protocol does not correspond to welcoming the needs and demands of people in a humane manner. It is necessary to produce health with safety, but grounded in a relationship of respect for the other as a human being.

The non-inclusion of other professionals who are involved in providing health care in the ECU represents a limitation of this study, because risk assessment triggers the assistance by other health professionals.

Conclusion

Risk assessment is a necessary tool in urgency services for the improvement of care and assurance of universal and equitable access to the resolution capacity of comprehensive health actions.

The results show that overcrowding in the service does not have an isolated cause, but results from factors ranging from the lack of information and effective communication of the Health Systems so that users are aware of the real function of an urgency/emergency service, up to the flaws in the management of the ECU.

Many were the dimensions addressed by the informants, with which they must be involved in the ECU daily work: welcoming, caring, protecting life, and treating. These, however, are challenging dimensions when considering the daily confrontation involved in the defense of life and in the assurance of the right to health.

The study allows us to conclude that, despite the challenges to the perform risk assessment in the ECU as a welcoming and fair strategy to cope with demands, the Manchester protocol has brought safety to the practice of nurses and quality to the service provided. The experience of the nurses raised reflections that can contribute to the improvement of the Private and Public Health Systems in the context of prompt assistance to urgent and emergent demands.

Collaborations

1. conception, design, analysis and interpretation of data: Aline Alves Roncalli, Danielle Nogueira de Oliveira, Izabella Cristina Melo Silva and Selma Maria da Fonseca Viegas;

2. writing of the article, critical review of intellectual content: Aline Alves Roncalli, Danielle Nogueira de Oliveira, Izabella Cristina Melo Silva and Selma Maria da Fonseca Viegas;

3. final approval of the version to be published: Robson Figueiredo Brito, Selma Maria da Fonseca Viegas.

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