Original Article

Violence against nursing professionals in the embracement sector with risk classification

A violência contra os profissionais da enfermagem no setor de acolhimento com classificação de risco

La violencia contra los profesionales de enfermería en el sector de acogida con calificación de riesgo

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ABSTRACT

Objective: To know the types of violence and the factors that contribute to the violence suffered by the nursing team in the embracement with risk classification (EWRC).

Methods: Descriptive study of a qualitative approach, carried out in a regional reference hospital in the emergency area of the west of the state of Rio Grande do Norte, with 10 nursing professionals. The data were collected through an interview and analyzed by the collective subject discourse technique.

Results: It is evidenced that professionals suffer violence from users, from other professionals, and the verbal violence predominates. They point out as causes for that the lack of user information, professional posture and the failure of the primary care.

Conclusion: There is a need to work with continuing education with health professionals and educational activities with users about the EWRC, in order to promote harmonious relationships between professionals and users, so that they can understand the dynamics of work in care networks.

Keywords: Nursing. Violence at work. User embracement. Emergencies.

RESUMO

Objetivo: Conhecer os tipos de violência e os fatores que contribuem para os atos violentos sofridos pela equipe de enfermagem no acolhimento com classificação de risco (ACCR).

Métodos: Estudo descritivo de abordagem qualitativa, realizado em um hospital regional referência em urgência e emergência do oeste do Estado do Rio Grande do Norte, com 10 profissionais da enfermagem. Coletou-se os dados através de entrevista e analisou-se pela técnica do discurso do sujeito coletivo.

Resultados: Evidencia-se que os profissionais sofrem violência por parte dos usuários, de outros profissionais e predomina a violência verbal. Apontam como causas a falta de informação do usuário, a postura profissional e a falha da atenção primária.

Conclusão: Há a necessidade de trabalhar a educação permanente com os profissionais de saúde e atividades educativas com os usuários sobre o ACCR, no sentido de promover relações harmônicas entre profissionais e usuários e que estes possam compreender a dinâmica do trabalho nas redes de atenção.

Palavras-chave: Enfermagem. Violência no trabalho. Acolhimento. Emergências.

RESUMEN

Objetivo: Conocer los tipos de violencia y los factores que contribuyen a la violencia sufrida por el equipo de enfermería en la acogida con calificación de riesgo.

Métodos: Se realizó un estudio descriptivo de enfoque cualitativo, realizado en un hospital de referencia regional para la atención de emergencia del oeste del Estado de Rio Grande do Norte, con 10 profesionales de enfermería. Se recogieron los datos a través de entrevistas y se analizó mediante la técnica del discurso del sujeto colectivo.

Resultados: Es evidente que los profesionales sufren violencia a manos de los usuarios, otros profesionales y la violencia verbal predominante. Se señalan como causas la falta de información del usuario, el comportamiento profesional y la insuficiencia de la atención primaria.

Conclusión: Existe una necesidad de trabajar la educación continua con los profesionales de la salud y actividades educativas con los usuarios de la ACCR, para promover las relaciones armónicas entre los profesionales y los usuarios, y que éstos puedan comprender la dinámica de trabajar en redes de atención.

Palabras clave: Enfermería. Violencia en el trabajo. Acogida. Emergencias.

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INTRODUÇÃO

The embracement in the Hospital Emergency Services (HES) is offered along with the Risk Classification actions. From this perspective, the "Embracement with Risk Classification" (EWRC) guideline has as main purpose embracing, classifying the risk of the offense, and directing the clientele to medical care according to the severity of the case[1].

Within the scope of the Unified Health System (SUS), several emergencies services and general hospital emergency services use the EWRC protocols to identify patients who need immediate treatment, according to the potential risk, from a user-centered care, guaranteeing the humanization of care, thus avoiding exclusion practices[2].

The embracement to the user in the HES can be carried out by any health professional qualified for this purpose, however, the Risk Classification is the competence of the nurse and it is performed during the first stage of the Nursing Process, raising the user's main complaint and, based on a pre-established protocol, classifies it into a color system[2-3].

The EWRC implementation strategy may lead to an understanding of the reasons why some episodes of violence at work in the emergency health happen. The embracement and the risk classification of the user are made so that the nursing professional listens to their complaint, observes their signs and symptoms and directs them to an immediate care or with a certain waiting time, according to the protocol[1].

The information of the hearing and the physical examination base the classification according to the severity of the case, which will determine the waiting time. The color red means immediate care; yellow, service in up to twenty minutes; green, service in up to two hours and blue (outpatient), when the patient is referred to the social worker or served after users classified as red, yellow and green[4].

The nursing professional of the embracement sector is the first to contact the user who is in a fragile situation of illness; in addition, the nurse who is responsible for classifying and deciding the severity and, consequently, the time of care of the case, may be vulnerable to suffer violence by the users themselves, companions, or even other professionals of the service.

Some characteristics in the environment of the public hospitals in Brazil, especially in the emergency care sectors such as the emergency care, may contribute to the aggravation of the situation of violence at work against the health professional, such as overcrowding, workload, staff shortages, and material shortages[5].

Violence is understood as the deliberate use of physical force or power, real or threatening, against yourself, against another subject, or against a group or a society, which proves or is likely to result in injury, death, psychological harm, developmental or deprivation deficiency[6].

Violent actions or behaviors grow gradually and silently in the routine of workers in general, causing repercussions on the daily work and health of workers. The International Labor Organization (ILO) defines violence in these spaces as any incident or behavior by which a person is assaulted, harmed or humiliated by another person at work or as a result of it[7].

In this context, it is questioned: what types of violence and factors contribute to the violent acts suffered by the nursing team in the embracement with risk classification?

Researches that discuss the context of violence suffered by nursing professionals in health services are important because they contribute to a greater knowledge and visibility of the problem, allowing the formulation of actions by the managers. In this sense, the study aims at knowing the types of violence and the factors that contribute to the violent acts suffered by the nursing team in the embracement with risk classification.

METHOD

This is a descriptive study of a qualitative approach. It has been performed in the embracement sector with risk classification of a general hospital in the city of Mossoró/RN. The choice for the research location has occurred due to the aforementioned hospital serving as reference in emergency care for the municipality and surrounding cities of the western region of Potiguar.

Participating in the study were the nursing workers from the embracement sector with risk classification. The following inclusion criteria have been used: being a nurse worker (nurse and/or nursing technician) in the sector, and having worked in the service during the period of data collection. The total population of the study corresponded to 10 nursing workers (five nurses and five nursing technicians) of the sector that met the criteria used, being the sample equal to the total population of the research.

In order to recruit the participants, previous contact has been made with the nursing coordination of the hospital in order to have access to the work shifts of the sector, in this way, the participants have been approached according to the work shift and in the hospital.

The semi-structured interview has been used as a data collection technique, in which questions such as: has the professional suffered any type of violence in the sector? If so, of what nature? What factors have contributed to this violence? The data was collected in October and Novem-

ber of 2014. At the time of the interviews, the professionals and researchers gathered in a room near the embracement sector, interviewing the technicians and, then, the nurses, so that the sector would not go without the professional.

For the analysis of the data, the Collective Subject Discourse (CSD) technique has been chosen, since it is a modality of presentation of qualitative research results, which has testimonials as raw material, in the form of one or several speeches-synthesis, written in the first person singular, expedient that aims at expressing the thought of a collectivity, as if this collectivity were the emitter of a discourse[8].

From the transcribed speech, the most significant parts have been separated, which comprise the key expressions (KEX). These KEX correspond to Central Ideas (CI), which are the synthesis of the discursive content manifested by the interlocutors. From these elements, the syntheses discourses have been constructed, which are the CSDs, which correspond to the group or collective thought, as if they were an individual discourse about the violence suffered and factors that contribute to violent acts against the nursing professionals[8].

The participants of the research have signed the Informed Consent Term (TCLE) and, in order to protect their identity, the results of the collective subject's discourses will be presented according to the coding "CSD" and the cardinal number corresponding to the Central Idea. The study was approved by the Ethics Committee in Research of the Universidade Potiguar, under the opinion No. 859.754, CAAE: 35050714.6.0000.5296, on September 10, 2014.

RESULTS AND DISCUSSION

Regarding the study participants, five are nurses and five are nursing technicians, all of them female, distributed in the age group of 30 to 59 years old, prevailing the age group of 50 to 59 years old.

As for the training time, two people are between two to ten years of training, one person is between 11 to 20 years of training, six people are between 21 to 30 years of training and a person has more than 30 years of training. Of the interviewees, four have only one employment relationship, while five of them have two employment relationships and one has three employment relationships.

About the time of action in the Embracement with Risk Classification (EWRC) sector, it varies from seven months to ten years. It is emphasized that in the hospital unit, the EWRC was implanted 10 years ago. Among the participants, five said they had been trained to work in the EWRC sector, and five said they have not had the training.

From the analysis of the interviews, the Collective Subject Discourses (CSD) have been constructed, exposed and discussed in the following topics.

Violence in the embracement sector with risk classification of the hospital under study

The professionals, when asked if they had already suffered any type of violence in the EWRC sector and of what nature, have evidenced three Central Ideas: **we are exposed to suffer violence from users, violence by professionals, verbal violence predominates.** The discourses are illustrated according to figure 1.

The Central Idea 1 shows that professionals are exposed to various types of violence in the EWRC sector, even though the **verbal violence** reports prevail. This is due to the fact that, usually, the professional who suffers the most violence is the one who provides care at the emergency entrance door and who has the initial contact with users arriving at services in a fragile situation[9].

A quantitative study of the same theme revealed that the emergency units are the ones that present the most violence to the health worker, and that the nursing auxiliaries/technicians present themselves as the most affected category and those who are more concerned about the issue[10-11].

A survey conducted with health professionals at an emergency service in Porto Alegre (RS) in 2008 showed that 100% of the nurses, 88.9% of the nursing technicians, and 88.2% of the nursing auxiliaries were victims of occupational violence. These professionals did not formally record the aggression suffered and, among these events, 95.2% were of verbal aggression type and 33.3% due to moral or sexual harassment[12]. It is important to highlight that these values show that the professionals report having suffered more than one type of aggression.

Another survey conducted in a general hospital in Rio de Janeiro in 2012, indicates that most of the interviewees were victims of occupational violence (76.7%). The main causes were the companions (87.0%), followed by the patients (52.2%). The form of violence suffered by all the participants of the research (100%) was the verbal aggression[5].

According to the professionals' discourse, violence occurs due to the fact that users generally disagree with the classification received for their clinical condition, especially when they are not considered emergency outpatient care. Thus, when their demand is not resolved immediately, and the user does not get the answer he or she expects, a conflict of interest is generated, in which the users end up committing violence against the professionals.

Central Idea	Collective Subject Discourse
(1) We are exposed to suffer violence from users	*Yes, and much, we are exposed to violence at all times. We are the "iron head" of the hospital, everything that comes here has to go through the embracement; and when we say that the user is not going to be treated here in the hospital because he/she is not an emergency care, they get violent and scold us with the worst words and even threaten to hit us ... We suffer more violence from the users. (CSD1)*
(2) Violence by professionals	*Another thing that happens here is when we put in the hospital the users to be attended, being ambulatory, for several reasons; being from the countryside; for living away from the UPA's; for not having a basic unit near their houses [...]; we let them to be taken care of here, but then it generates another problem for us, the doctors come and they also attack us, they throw the medical record in our faces saying that this type of care is not here. We suffer aggression from both users and doctors. (CSD2)*
(3) Verbal violence predominates	*The violence we suffer is mostly verbal, no doubt, but we are afraid of suffering physical, because patients get very upset when they know they will not receive care here; there was a patient that even a gun showed, threatening us [...], and physical violence does not happen, because we often leave when users are very upset and violent. (CSD3)*

Figure 1 – Central ideas and discourse of the collective subject regarding the questioning: Have you ever suffered any kind of violence in the EWRC sector, of which nature?

Source: Research data, 2014.

When users are classified as outpatient (blue) and referred for care in another area of the health system, they do not understand and/or do not accept the protocol determination. Sometimes this classification causes the user to behave aggressively and hostile, bringing with it the violence, which causes wear to both the professional and the user.

The Central Idea 2, **violence by professionals**, points out that aggression against the EWRC professionals does not only come from users. The medical team is also the protagonist of this aggression to the professional.

Other studies point to the occurrence of violence arising from interpersonal relationships, being mentioned as the main agents of violence, in addition to patients and companions, male co-workers and bosses[12]. The working conditions in emergency health services can be elements that contribute to disagreements among professionals and to the sense of violation of their goals and expectations. Still, the double and long working shifts of these categories favor the physical and emotional exhaustion, which make them possible precursors of conflictive situations[11].

A Latin American study indicates that the aggressors in the work spaces can be colleagues or co-workers, and that one of the characteristics that can contribute to the violent act is the fact that they are male, in addition to previous history, problems related to childhood, being young, consuming illicit drugs and carrying fire guns[13].

In addition, violence among doctors and nurses may be related to a historical and cultural hierarchical submission issue among the health professions, since the idea of some professions being superior to others is still a phenomenon present in services.

The nursing team, for the most part, is composed of women who can often suffer violence through authoritarianism and domination by the medical team, which is sometimes represented by the male figure. Although our society has evolved towards gender equality, there is still a vulnerability in being a woman, so there may be a greater risk of suffering violence at work[5].

It is highlighted that nursing professionals are considered as the category in the health area that most suffers from violence at work. This is due to the greater direct contact with the users - demanded by the care (nursing object of work) - and the long hour-shifts in the call regime, being thus exposed for a longer time[11].

The nursing workers are the most vulnerable because they are the professional category whose predominant gender is female[12]. The gender is a relevant factor in determining who will suffer labor violence. Female professionals are more likely to receive violent acts as well as younger people with little work experience[13].

The violence against women or gender violence is outlined in the face of the still very strong inequalities between the sovereignty of men and women, the rise of both gen-

Central Idea	Collective Subject Discourse
(1) Lack of information of the user	*What contributes to this violence is the lack of information from the user, where to look for the right care for their problem, they do not understand that here is a hospital destined for emergency care [...], any pain they feel, they run to the hospital, they do not know that the embracement exists precisely to classify the risks, to give better assistance to the people who really need emergency treatment; this disinformation of the users on where to go to get health ends up generating the overcrowding of the hospital, and everything falls here [..], and the cities of the interior send a lot of unnecessary cases here, they have no commitment with their user [...] As we often block the entrance of the type of care that is not an emergency, it ends up generating discomfort and they are dissatisfied, causing violence, since we are the professionals who transmit this information. (CSD1)*
(2) Professional posture	*The posture of us, professionals, is what often contributes to violence, the user comes to seek care because he/she is in need, he/she does not come by chance, he/she does not leave his/her house for nothing [...], then they get here and will not have the care they are looking for, because it is not an emergency care, and the professional only says that this kind of care is not here, does not inform where they have to go, they simply say no and that is it (CSD2).*
(3) Primary care failure	*If primary care worked as it should, the patient would not come here looking for non-emergency care [...], if his/her problem were solved in primary care, he/she would not overcrowd the hospital with diseases that have been aggravated by lack of treatment in the beginning; the primary care is paramount, the fault is in the network, if the system worked well, we would not live with the "knife in the neck", we would not be suffocated here, because we do not work alone, the network has to work as it should [...]. The truth is that health is scrapped, our SUS is in the ICU, we trying to work with the health we have. (CSD3)*

Figure 2 – Central Idea and Discourse of the Collective Subject regarding the questioning: What factors do you believe contribute to this violence?

Source: Research data, 2014.

ders in the professions and in social issues, which allows the task of extinguishing it to be still arduous. This generates feelings of helplessness, professional restraint, failures and guilt of the nurses over themselves and the aggression suffered. Faced with the fact that gender violence affects health professionals, an initiative is indispensable for more research that, in some way, directs action against this fact[14].

Among the violence found against the nursing class, the verbal violence is more common, as expressed in Central Idea 3, **verbal violence predominates**. It can manifest in many different ways, among them: threats, swearing, demoralization and intimidation[9].

Verbal violence is considered as a form of psychological violence. This is because of the verbal threats, racial discrimination, harassment, abuse, intimidation, which can cause/harm the individual's physical and mental well-being[7].

A study carried out in public hospitals in the region of Murcia in Spain showed that 22.8% of the nursing workers suffer daily/weekly verbal violence and about 71% reported their frequency at least once a year. As for physical violence, 1.2% of the workers suffer aggression every day or at least once a week, and 19.9% suffer physical violence annually. Most of the aggressions were made by the patients, especially those who were irritated by the waiting time for care[15].

Other studies carried out in Brazil also evidenced verbal violence as the most frequent among the nursing workers. Often, this type of violence is not valued by the team, since most professionals do not register the episode. But these events can lead the worker to suffering, triggering accidents, illness, bullying, compromising relationships in the work and family environment[5] .

The nursing professionals should be aware of the violence suffered at work and should report it whenever they are victims, in any situation, since there are repercussions on the mental health and the quality of life at the work of these subjects[16].

Factors that contribute to the violence suffered by the nursing team in the EWRC sector

When the study professionals have been questioned about what factors contribute to violence, they suggest the following Central Ideas: **Lack of information of the**

user, professional posture, and primary care failure. The discourses of the collective subject are expressed in figure 2.

The Central Idea 1, **lack of information of the user**, becomes an aggravating factor for the violence to happen. This disinformation causes the users to look for care in hospitals that have as a priority the emergency care, and, when they receive their risk classification according to their particularities, they present difficulties of acceptance of the classification, as already problematized in Central Idea 1 of the previous category.

The prioritization of the service generated by the risk classification is poorly understood by the population, who believe that they are being in some way impaired, and it can generate in the users behaviors of violence against the professional[9].

The lack of information and the excessive demand of users in the emergency service can cause a decrease in the quality of care, generating in the user feelings of anxiety, frustration and loss of control that, together with the long waiting time for care, and service fragmentation, are pointed out as possible causes for violent behavior by the health system user[9,17].

The different expectations and understandings about the role of the health services in our country are factors that generate violent acts and, therefore, there is the need of studies that address the profile of the population assisted in such areas as: understanding the role of emergency services, prospects in relation to the service provided and experiences in the previous assistance in these services. From this, educational and orientation actions can be based[10].

The Central Idea 2 refers to the **professional posture**. According to the CSD, the professional transmits incomplete information, not clarifying and not directing the user to another sector, which would supply their demands. Thus, they appear as factors that arouse violent acts on the part of the users against the health professionals, especially the nursing team.

A rude or poorly placed response can cause a violent reaction on the part of the user. Just as there are factors that attenuate or inhibit violent situations, such as the professional's stance not to stimulate violence and to explain the situation to the user seeking to reassure him, there are also those that exacerbate the situation, such as: retaliating and responding in an ironic and debauched manner to a question from the user[9].

It is necessary for the professional to give the information from where the user can find the care that he/she needs and, also, to instruct him/her in a resolute manner in the face of the presented problems, so that the professional is able to establish links with the user. In this context, we emphasize that empathy, tenderness and affection on the part of the professional to the users can be important elements of the care so that an effective and humanized embracement can be provided.

Therefore, in addition to health education aimed at the assisted population, it is necessary to carry out training actions for workers in favor of professional commitment with a quality assistance and conditions to deal with conflicting situations arising from the social, economic and cultural aspects of the assisted[10].

Studies indicate that the nursing team reports having been assaulted due to users' frustrations with the health service, regarding the lack of sufficient human and material resources to meet the demand, together with the lack of work organization, as sources of violence. Users can become violent when they notice poor quality in the services or lack of commitment of the professional, or even when they realize that their rights are being denied[16].

The extravasation of these tensions will be directed to the professional who is present at the moment. As the nursing professional is, most of the time, in contact with the user, they will be the professionals who are most affected by the violence that come from the users or their companions[18].

The **primary care failure** appears as the Central Idea 3. Thus, a failure in the health care network is found in the CSD, where the deficit in relation to the primary health care hampers the health production, increasing the demand for care in the emergency networks, increasing the demand, the waiting time for medical attention, and the delay in solving users' health problems.

Studies point out that the emergency service stands out as being one of the main gateways for users. Emergency and non-emergency situations that could be resolved in the basic care network end up overwhelming the emergency, hindering the work of the health team and the quality of care provided to the users[19].

The emergency services situation is exacerbated by the insufficiency of the local health units, both in terms of coverage and in terms of access and resolution of care. These factors have led to the overload of the emergency services, making this area one of the most problematic of the Brazilian health system[20].

However, the problem of deficiency in the primary care network, corroborating with the findings of the present research and of previous studies, is a fact that stimulates aggression. Thus, it causes the same displeasure with the health services, and with this, it brings as a defense response the production of violent behavior against the professionals who provide assistance in the health services.

FINAL CONSIDERATIONS

The objectives of the study have been reached, once the types of violence have been identified, with verbal violence being the most prominent, committed by users and even by other health professionals; and the factors that contribute to the violent acts suffered by the nursing team in the embracement with risk classification, such as the lack of information of the users, the posture of the professionals and the failure in primary care.

As limiting points of the study, it is possible to mention the little time of the professionals to respond to the interview and the few professionals who underwent training before working at the EWRC. As positive points, it is possible to mention the participation of all the sector and the clarity of the factors that lead to the violence in the sector.

In view of the above, it is clear that the nursing professionals need to recognize and report violence, so that this problem can have a greater proportion of visibility. Thus, this allows governmental spheres, federal nursing councils and/or health institutions to think and implement measures to prevent violence and to protect these subjects.

It is hoped that, with this study, it will be possible to contribute to the comprehension and solubility of the transformations in the scope of the knowledge and practices of the embracement with risk classification, mainly in the hospital segment, regarding the participation of users and other health professionals in these services, and in the construction and implementation of the healthcare network.

The importance of working on EWRC education and violence issues is also underlined. To this end, the Permanent Education in Health is proposed as a strategy that allows changes in the context of the health worker, in order to understand about the EWRC and to establish relations of bond with the users. In this way, it is expected to reduce this problem and minimize the impacts caused by it.

The study contributes to the nursing area, since, among the health professionals, the nursing categories are the main victims of violence within their work environment. In this sense, it is evident the need of developing knowledge to improve the working conditions with the managers, to generate awareness about the rights of the professionals, and mechanisms of denunciation and defense against occupational violence.

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