REUFPI
Revista de Enfermagem da UFPI
ISSN 2238-7234

Original

Participatory development and implementation of an instrument for the nursing process in urgent and emergency care

Desenvolvimento e implementação participativa de instrumento para o processo de enfermagem em urgência e emergência

Desarrollo e implementación participativa de un instrumento para el Proceso de Enfermería en urgencias y emergencias

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How to cite this article:
Lins DC, Milhomens RS, Bezerra STF. Participatory development and implementation of an instrument for the nursing process in urgent and emergency care. Rev. enferm. UFPI. 2026 [Cited: ano mês abreviado dia];15: e6916. DOI: 10.26694/reufpi.v15i1.6916

Abstract

Objective: To analyze the meanings produced by the nursing team regarding urgent and emergency care, aiming to develop and implement an instrument for operationalizing the Nursing Process. **Methods:** This is a qualitative action research study that consisted of developing an instrument for operationalizing the Nursing Process and implementing it with the nursing team. Five nurses and nine nursing technicians participated. Semi-structured interviews were conducted. Data were organized and analyzed based on the production of meanings, grounded in discursive practices, according to Spink. **Results:** The analysis generated categories that revealed insecurity regarding structural conditions, the absence of specific protocols, and a demand for training. Based on the problematization process, a new instrument for the Nursing Process was developed, assessed, and collectively validated. Its implementation re-signified the Nursing Process as essential for optimizing care and ensuring safety in care delivery. **Conclusion:** The study identified weaknesses, needs, and care-related potential, as well as enabling the Nursing Process instrument development and implementation. The team's positive adherence demonstrated that the instrument is essential for care planning, humanization of care, and the consolidation of nursing as a science.

Descriptors:
Nursing Care. Emergency. Nursing Process. .

Whats is already known on this?
The Nursing Process is recognized as an essential tool for improving the quality of care, promoting professional autonomy, and organizing nursing practice, although challenges remain regarding its effective implementation.

What this study adds?
The study presents the development and implementation of an instrument for the Nursing Process in urgent and emergency care services, which was positively received by the nursing team.

Resumo

Objetivo: Analisar os sentidos produzidos pela equipe de enfermagem sobre o atendimento de urgência e emergência, visando ao

desenvolvimento e à implementação de um instrumento para a operacionalização do Processo de Enfermagem. **Métodos:** Trata-se de um estudo qualitativo do tipo pesquisa-ação, que consistiu na elaboração de um instrumento para a operacionalização do Processo de Enfermagem e a implementação junto à equipe de enfermagem. Participaram cinco enfermeiros e nove técnicos em enfermagem. Aplicou-se a entrevista semiestruturada. Os dados foram organizados e analisados seguindo a produção de sentidos, com base nas práticas discursivas, conforme Spink. **Resultados:** A análise originou categorias que revelaram insegurança em relação às condições estruturais, ausência de protocolos específicos e demanda por capacitação. A partir da problematização, um novo instrumento para o Processo de Enfermagem foi desenvolvido, avaliado e confirmado coletivamente. Sua implementação ressignificou o Processo de Enfermagem como essencial para a otimização da assistência e a segurança no cuidado. **Conclusão:** A pesquisa identificou fragilidades, necessidades e potencialidades assistenciais, bem como viabilizou o desenvolvimento e a implementação do instrumento de Processo de Enfermagem. A adesão positiva da equipe evidenciou o instrumento como essencial para o planejamento do cuidado, a humanização do atendimento e a consolidação da enfermagem enquanto ciência.
Descritores:
Cuidados de Enfermagem. Emergência. Processo de Enfermagem.

Resumen
Objetivo: Analizar los sentidos producidos por el equipo de enfermería sobre la atención de urgencias y emergencias, con el propósito de desarrollar e implementar un instrumento para la operacionalización del Proceso de Enfermería. **Métodos:** Se trata de un estudio cualitativo del tipo investigación-acción, que consistió en la elaboración de un instrumento para la operacionalización del Proceso de Enfermería y su implementación con el equipo de enfermería. Participaron cinco enfermeros y nueve técnicos de enfermería. Se aplicó una entrevista semiestructurada. Los datos se organizaron y analizaron siguiendo la producción de sentidos, con base en las prácticas discursivas, de acuerdo con Spink. **Resultados:** El análisis dio lugar a categorías que revelaron inseguridad con respecto a las condiciones estructurales, ausencia de protocolos específicos y demanda de capacitación. A partir de la problematización, se desarrolló, evaluó y confirmó colectivamente un nuevo instrumento para el Proceso de Enfermería. Su implementación resignificó el Proceso de Enfermería como esencial para la optimización de la atención y la seguridad del cuidado. **Conclusión:** La investigación identificó fragilidades, necesidades y potencialidades asistenciales, además de posibilitar el desarrollo y la implementación del instrumento del Proceso de Enfermería. La adhesión positiva del equipo evidenció que el instrumento es esencial para la planificación del cuidado, la humanización de la atención y la consolidación de la enfermería como ciencia.
Descriptores:
Atención de Enfermería. Emergencia. Proceso de Enfermería.

INTRODUCTION

As a science of care, nursing is constantly evolving and, throughout history, has attributed meanings to its practice and professional values. Florence Nightingale highlighted the importance of

planning and organization in patient care. Through her practices and studies, she introduced a scientific and methodical approach that transformed nursing into a structured profession. Her contributions included the use of detailed records and systematic observations to understand patients' needs, implement interventions, and assess outcomes. This legacy laid the foundation for developing the Nursing Process (NP), which integrates assessment, diagnosis, planning, implementation, and assessment, ensuring individualized, humanized, and evidence-based care.[1-2]

Since the early days of the profession, the systematization of nursing care has been a fundamental pillar for strengthening the theoretical foundations that support nurses' knowledge and practice. This approach results in the creation of a methodological instrument that organizes and directs care, contributing significantly to the advancement of nursing as a science by structuring care actions in an orderly and evidence-based manner. In this context, the NP can also be highlighted as a work method that provides visibility and autonomy, fostering professional empowerment. Thus, in addition to improving the quality of care, its benefits also directly extend to nurses.[3]

Nurses working in urgent and emergency care services must be prepared for situations involving known or unknown risks. As key actors in this context, nurses not only provide direct patient care but also manage the unit, coordinate the team, and organize the flow of care. This duality of roles requires nurses to have the autonomy to make sound decisions, ensuring comprehensive care without causing harm to patients. It is essential that professionals have solid theoretical and practical knowledge, enabling them to act competently at all stages of care, from triage to clinical intervention. In addition, continuing education is essential to ensure that nurses are prepared to face daily challenges.[4-5]

In Brazil, the Urgent and Emergency Care Network is organized and regulated within the Brazilian Unified Health System (SUS - *Sistema Único de Saúde*). This network includes health promotion, prevention, and surveillance, Primary Health Care, the Mobile Emergency Care Service and its emergency medical regulation centers, stabilization units, the Brazilian National Health Force of SUS, Emergency Care Units, and the set of 24-hour emergency services, hospital services, and home care.[6]

The nursing team in urgent and emergency care services needs to develop its work process through actions that demonstrate scientific knowledge, technical skills, care management, and leadership in order to ensure quality care. However, several challenges are faced in these settings, such as insufficient staffing, lack of adequate training, the use of inefficient forms, resource shortages, limited time, and the absence of standardized terminology, which is a significant problem, given that this is one of the essential elements for the effective functioning of the process.[7]

It is important to mention that, when analyzing the care context, numerous situations in patient care are identified that require the NP operationalization, which constitutes a substantive aspect of the profession. Therefore, the applicability of nursing care in the context of urgent and emergency care becomes relevant to the service population, since systematized care improves outcomes by providing individualized, dignified, sensitive, effective, and humanized care, aimed at promoting, preventing, and restoring health.

Given the above, the use of a scientific methodology that systematizes and enhances the quality of nursing care is necessary. Thus, the object of this study is the NP implementation in the urgent and emergency care services of a Mixed Health Unit (MHU).

Therefore, this study aimed to analyze the meanings produced by the nursing team regarding urgent and emergency care, with a view to developing and implementing an instrument for operationalizing the NP.

METHODS

This is a qualitative action research study based on Thiollent,[8] conducted from December 2021 to April 2022. The action plan consisted of developing an instrument for operationalizing the NP in urgent and emergency care services and implementing it with the nursing team of an MHU. The study was conducted in a municipality in the countryside of Rio Grande do Norte, in northeastern Brazil. It is located in the Alto Oeste Potiguar region, 400 kilometers from the state capital, Natal. The COnsolidated criteria for REporting Qualitative research guidelines were followed.

The representativeness of the groups investigated in action research is more qualitative than quantitative. As a result, the use of non-probability samples is recommended, using intentionality as the selection criterion. A purposive sample is one selected based on characteristics considered relevant by the

researchers and research participants. This type of sample is more appropriate for obtaining data in qualitative research.[9]

For this study, nursing professionals who were permanent staff members of the MHU and those who worked shifts at the unit were invited to participate, provided that they worked in urgent and emergency care; those who were away from work or on leave were excluded. Selection was based on convenience, and participants were approached personally at their workplace, with no refusals. To ensure participant anonymity, the pseudonyms "NUR." and "NUR. NUR. TEC." were used, followed by a number according to the order in which the interviews were conducted.

Semi-structured interviews were used as the data collection technique, guided by an interview script containing eight topics for discussion. The interviews were conducted by the author Dayane Carlos Lins, an undergraduate nursing student, who had previously undergone training with her advisor, Sara Taciana Firmino Bezerra. The proposal was presented to the participants beforehand, informing them that it was an undergraduate thesis. All interviews were audio-recorded using a digital voice recorder and stored on an external hard drive for subsequent analysis. Each meeting lasted approximately one hour, with only the researcher and the research participant present. To produce the analytical categories, all interviews, including the interview conducted during the instrument implementation meeting, were transcribed in full. The data produced throughout the study were organized and analyzed following the production of meanings, based on discursive practices,[10] and coded by one of the authors.

Thus, throughout the interviews, the meanings attributed by the nursing team to their practice during urgent and emergency care, as well as their perceptions of the NP, were identified. Their statements revealed their understanding of this methodology and indicated how it could contribute to improving their praxis. The analysis began with immersion in the body of information collected through the interviews, seeking to bring forth the meanings for interpreting the collected data and defining the categories, the next stage of the analysis process.

In this study, the technique of constructing maps of association of ideas was used. The objective was to systematize the procedure for analyzing discursive practices, seeking formal aspects of linguistic construction, the repertoires used in this construction, and the implicit dialogism in the production of meanings. The construction of the maps of association of ideas began with the definition of general thematic categories that reflected the study objectives. Subsequently, the interview content was allocated to these categories.

The application of this technique followed the following steps: a) use of a Microsoft Word processor to digitize the audio-recorded interviews; b) organization of the transcribed statements in a table in Microsoft Excel to facilitate data visualization and analysis. All statements in a column corresponded to the same category, enabling the horizontal reading of each interview.[10]

The "Nursing Process in Urgent and Emergency Care" instrument was developed to meet the needs of critically ill patients requiring urgent and emergency care, including essential data for their identification and safety, as well as fields for recording the type of occurrence and a complete physical examination covering their psychobiological needs.

Based on Wanda Horta's Theory, the instrument prioritizes patient identification data, such as name, age, gender, place of origin, date of birth, Individual Taxpayer Registration number, and National Health Card number. To identify health problems, the instrument focuses on patients' psychobiological needs, following a head-to-toe sequence.

In addition to the Basic Human Needs (BHNs), the Glasgow Coma Scale was included to assess the level of consciousness, especially in cases of traumatic brain injury. The nursing diagnoses were developed based on the Nursing Diagnoses Classification system.[11] To select the main diagnoses, the profile of urgent and emergency cases at the MHU was considered, focusing on the most frequent illness profiles: trauma-related, cardiovascular, and neuropsychological.

Nursing prescriptions follow the Nursing Interventions Classification system.[12] The nursing progress notes section allows for the recording of critical analyses of patients' progress over 24 hours. At the team's request, the instrument included a section for medical prescriptions. During the development of the instrument, challenges arose in selecting the most relevant items for the medical history and physical examination, as well as in organizing them in a way that would make the instrument self-explanatory and easy to understand. The decision to include a limited number of diagnoses was intended to bring professionals closer to this practical reality.

The instrument implementation seminar was held remotely on September 8, 2022, through the Google Meet meeting platform. The meeting was scheduled in advance with the participants via WhatsApp, and the meeting room link was sent a few hours before the meeting. The meeting was recorded using OBS Studio and archived on Google Drive, and was subsequently transcribed in full.

In compliance with the ethical principles of research, autonomy, beneficence, nonmaleficence, justice, and equity,[13] this study was submitted to and approved by the Research Ethics Committee of *Universidade do Estado do Rio Grande do Norte*, through Consubstantiated Opinion 5,157,343/2021 and the Certificate of Presentation for Ethical Consideration 52645321.5.0000.5294.

RESULTS

The study included a total of 14 participants, five nurses and nine nursing technicians. Table 1 describes the sociodemographic characteristics of study participants, who were categorized according to variables such as sex, age group, professional profile, and educational background.

Table 1. Sociodemographic data of the nursing team at the Mixed Health Unit. Rio Grande do Norte, Brazil, 2022

Variables	Nursing technicians	Nurses
	n (%)	n (%)
Gender		
Male	1 (11.1)	2 (40.0)
Female	8 (88.8)	3 (60.0)
Age group (years)		
20 to 25	2 (22.2)	1 (20.0)
26 to 30	3 (33.3)	2 (40.0)
31 to 35	-	2 (40.0)
36 to 40	3 (33.3)	-
> 40	1 (11.1)	-
Length of training (years)		
0 to 5	4 (44.4)	3 (60.0)
5 to 10	4 (44.4)	1 (20.0)
10 to 15	1 (11.1)	1 (20.0)
15 to 20	-	-
Length of service		
Up to 6 months	-	1 (20.0)
6 months to 1 year	2 (22.2)	1 (20.0)
1 to 5 years	6 (66.6)	1 (20.0)
> 5 years	1 (11.1)	2 (40.0)
Educational background		
Technical degree only	7 (77.7)	-
Undergraduate degree only	-	2 (40.0)
Specialization	2 (22.2)	3 (60.0)
Field of specialization		
Urgency and emergency	2 (22.2)	3 (60.0)

Source: prepared by the authors (2022).

A predominance of females was observed among the nursing technicians and nurses: young adults with a reasonable length of education and professional experience who had invested in their qualifications through *lato sensu* graduate courses, particularly in the area of urgent and emergency care.

Concept of urgent and emergency care

Participants defined "urgency" as care that is relatively rapid and can wait for up to one hour, whereas "emergency" was defined as immediate care, in which the patient cannot wait to be attended to:

> An emergency is a situation that poses an immediate risk to the patient's life; in other words, once they arrive, care has to be provided immediately. An urgent situation is one that does not pose an immediate risk, but it nevertheless has to be resolved within a short period of time because, if it is not resolved within a short period, it can lead to the patient's death (NUR. TEC. 03).

> Urgent and emergency care is a service in which the patient has an acute complaint that needs to be addressed within a short period of time, following what is established in the protocols. Urgency refers to those cases in which I have a present complaint, but I have a period of time for care that can extend up to one hour. In an emergency, no; I have to act on the patient's complaint immediately, so they will not wait to be attended to. That would more or less be our routine. In an urgent situation, I have a patient who can wait despite the complaint, which is still characterized as requiring rapid care, but a patient with an emergency complaint cannot; they need to be attended to immediately (NUR. 05).

Profile of urgent and emergency cases

Participants' statements revealed a certain homogeneity in morbidity and mortality profiles, which can be classified as acute exacerbations of chronic cardiovascular, psychiatric, and trauma-related conditions:

> We have already attended to victims of automobile accidents, rollovers, and motorcycle accidents are very frequent... people who take medications (NUR. TEC. 05).

> For instance, if it is pain, in cases of fever, convulsion or epileptic seizure, an accident, or a stab wound, we take them directly for care in this emergency situation (NUR. TEC. 06).

> Sometimes, the most common urgent situation we have here is a hypertensive crisis; that is what we have most often, or pain (NUR. 01).

> Sometimes, a patient who is a victim of a stroke or a heart attack arrives (NUR. 02).

> Children with fevers reaching 40 degrees, epilepsy, stroke. Urgent cases are more often episodes of diarrhea, fevers, children with very high fevers, especially during this period, the flu outbreak that has just started, psychiatric outbreaks, which also happen very frequently (NUR. 03).

Safety in urgent and emergency care

Some participants reported feeling well prepared to provide care in urgent and emergency services due to their specializations and training courses in this area.

> Yes, I feel 100% confident because I am someone who has already taken courses, a small specialization at the technical level, and based on what I learned, I try to put what I learned into practice, which is why I feel confident (NUR. TEC. 06).

> Yes, although, you know, knowledge is something very vast. We never know everything; there is always something in the service that you deal with according to the demands. Demands arise, and you realize that you need to improve every day. I also have a prehospital care course; I am an emergency responder. This gives the professional a sense of security, right? Knowing how to provide care correctly (NUR. TEC. 05).

The interviewees also emphasized that having training or specialization in this area is an important advantage for ensuring safer and higher-quality care. However, nurses were the ones who most often reported feeling insecure when dealing with urgent and emergency situations:

> Sometimes I don't, because we lack the means to work. But I have a specialty in urgent and emergency care, and so, given the possibilities, I don't feel insecure (NUR. 01).

> So, we don't feel secure, but, you know, we have confidence. It is because urgent and emergency care presents adverse situations. At any moment, a different situation may arise, and we may not be prepared at that moment, but the service may not have the supplies we need to attend to that emergency. Nevertheless, within what we have here, we try to provide care in the best way possible (NUR. 02).

> I do. I am a specialist in urgent and emergency care. I think the main deficiency in the sector is not so much the team, but what we have available. We have medications, but

> sometimes we don't have an adequate ambulance, we don't have adequate prehospital care, because there is no SAMU here, for instance (NUR. 04).

> I believe there is always something to improve in professionals and in the service, so talking about safety is talking about a very personal aspect. In some situations, yes, I still have some insecurity, but I understand that, with deeper theoretical and practical knowledge, I can address this need in order to obviously always strive for better, higher-quality, and more effective care, which is essential for patients requiring urgent and emergency care (NUR. 05).

Protocols in urgent and emergency care services

Participants discussed the existence of protocols that guide their clinical practice in the service:

> There is a risk classification protocol there, which is not widely used, but, for instance, when I am at the reception desk completing the form, I try to perform this classification fairly, really in a way that meets the requirements of this classification (NUR. TEC. 05).

> There isn't one. Actually, there is a protocol displayed on the wall, which is the classification of urgency, emergency, and non-urgent cases according to the designated colors, but, unfortunately, here, within the Mixed Health Unit, there is no way to follow it to the letter; it is used more for urgent cases. They are widely used for urgent cases because people do not know very well how to identify what is urgent and what is an emergency (NUR. TEC. 07).

> Here we have, at the reception desk, the banner for the Manchester Triage System, but we do not use the protocol much here. The protocol is used only in PSF care situations (NUR. 02).

Another important aspect addressed concerns nursing protocols. When asked about standardized instruments to guide nursing care in urgent and emergency services, the interviewees unanimously stated that these were not available in the unit:

> So, here in the unit, care is still somewhat weakened because there is no protocol to follow. We act more according to the need. The patient arrives, and we check vital signs; we look at the patient's condition, analyze what they are presenting, and then we can act; there is no specific protocol, there is no sequence of care (NUR. 02).

> We still do not have a specific nursing instrument: what we have is a risk classification form, but it is not specific to nursing; we have a space for nursing notes, but it is small. In short, we do not have a nursing form implemented in the urgent and emergency services (NUR. 05).

Training needs

The team agrees on the need for updates to the protocols in urgent and emergency services. Regarding the NP, there is a discrepancy between the theoretical foundation and its still incipient application in clinical practice:

> Yes, this training on the systematization of nursing care is necessary to qualify us as professionals and improve our care for the public (NUR. TEC. 06).

> I think it would help a lot, especially regarding the approach of separating urgent and emergency patients and providing training so that we can intervene better, know how to classify and separate them, and help improve care throughout the unit (NUR. TEC. 07).

> When we feel that there are weaknesses in the service where we work, regarding these issues, it is always good to seek to improve our work and the way we provide care to the public (NUR. 02).

> Yes, I believe it is necessary, especially for us. I speak as a Brazilian nurse: we have a strong Systematization of Nursing Care in the theoretical setting, in our education, in our

> training. We discuss the Systematization of Nursing Care a great deal, but it is still very incipient in practice (NUR. 05).

Implementation of the Nursing Process instrument in urgent and emergency care

Comprising items that address the patient population's health needs, the instrument is based on Wanda Horta's Theory. Through this instrument, the nursing team obtains data in a holistic and comprehensive manner, enabling the identification of nursing diagnoses, care planning, implementation, and assessment of care. The instrument also provides space for notes from other professional categories involved in patient care.

The implementation seminar for the "Nursing Process in Urgent and Emergency Care" was attended by 13 people, including one researcher, one observer, and 11 nursing professionals, comprising five nurses and six nursing technicians, through the Google Meet platform.

Professionals considered the instrument to be highly important for systematizing care for critically ill patients, particularly as a resource for optimizing care in cases of transfer to a higher-complexity service and/or for patients admitted to observation beds in the unit. This is because it provides greater support for collecting information from the patient and family, in addition to enabling important data recording on clinical condition progression.

Finally, it was approved by all participants, and its implementation in the service was agreed to begin after the suggested changes were made. Thus, the suggestions were accepted, and it was decided that a new meeting would be held to present the complete instrument to all team members.

Chart 1. Nursing Process in urgent and emergency care. Rio Grande do Norte, Brazil, 2022

NURSING PROCESS IN URGENT AND EMERGENCY CARE

PATIENT IDENTIFICATION

Name:	DN:	Age:	Emergency Very urgent Urgent Little urgent Non-urgent
N° SUS:	N° CPF:	N° RG:	
Admission:	Origin:	Gender: ( ) M ( ) F ( )	

Type of occurrence: ( ) Traffic accident ( ) Drowning ( ) Fall ( ) Burn ( ) Suicide attempt ( ) AMI ( ) Stroke ( ) Venomous animal bite ( ) Hemorrhage ( ) Acute pain ( ) Vomiting ( ) High fever ( ) Seizure
Other: _____Diagnostic hypothesis:_____

MEDICAL HISTORY DATA

Previous medical history: ( ) HT ( ) DM ( ) AKI ( ) CKD ( ) Heart disease ( ) COPD ( ) Neurological ( ) Other
( ) Allergies:_____ ( ) Use of prostheses and orthoses ( ) Current medications: _____

PSYCHOBIOLOGICAL NEEDS

NEUROLOGICAL

Level of consciousness	**Speech**	**Pupils**
( ) Conscious ( ) Drowsy ( ) Stuporous ( ) Comatose ( ) Confused ( ) Sedated	( ) Aphasia ( ) Aphonia ( ) Dysarthria ( ) Dyslalia ( ) Dysphasia	( ) Isochoric ( ) Anisocoric ( ) Photoreactive ( ) Non-photoreactive ( ) Mydriasis ( ) Miosis

GLASGOW COMA SCALE

Eye opening	**Verbal response**	**Motor response**	**Pupillary reaction**
4 - Spontaneous 3 - To voice 2 - To pain 1 - None	5 - Oriented 4 - Confused 3 - Inappropriate words 2 - Incomprehensible words 1 - None	6 - Obeys commands 5 - Localizes pain 4 - Withdrawal 3 - Abnormal flexion 2 - Abnormal extension 1 - None	2 - Inexistent 1 - Unilateral 0 - Bilateral
SCORE:	**13 to 15: mild trauma**	**9 to 12: moderate trauma**	**3 to 8: severe trauma**

Respiratory pattern	**RESPIRATORY/OXYGENATION**	**Using:**
RR: _____BPM ( ) Eupneic ( ) Dyspneic ( ) Bradypneic ( ) Tachypneic ( ) Orthopneic	**Pulmonary auscultation** ( ) Vesicular breath sounds + ( ) Adventitious sounds - ( ) Crackles ( ) Rhonchi ( ) Wheezes ( ) Crepitations ( ) Chest tube	( ) Nasal Cannula ( ) Venturi Mask ( ) Non-rebreather Mask ( ) BiPAP ( ) CPAP ( ) Tracheostomy

CIRCULATION

HR: _____BPM BP: ____x ____ mmHg Capillary refill: ( ) ≤ 2s ( ) ≥ 2s T:___°C	Pulse: ( ) Rhythmic ( ) Arrhythmic ( ) Full ( ) Thready ( ) Absent	( ) Venous access ( ) PIV ( ) CVC ( ) Jelco n°_____

ABDOMEN/ELIMINATIONS

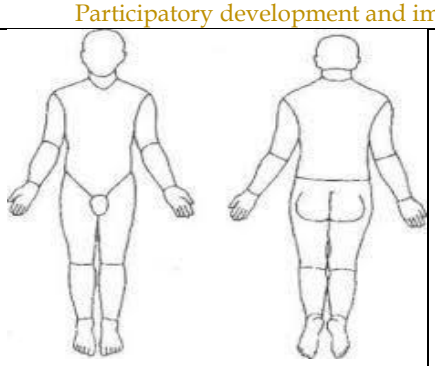
Nutrition: ( ) NPO ( ) NGT ( ) NET ( ) OGT
Food intake: ( ) Full ( ) Partial ( ) Poor appetite
Abdomen: ( ) Flat ( ) Flaccid ( ) Distended ( ) Globose ( ) Tender to palpation ( ) Visceromegaly ( ) Bowel sounds + ( ) -
Gastric output: ( ) Nausea ( ) Emesis ( ) Hematemesis ( ) Gastrostomy
Bowel movements: ( ) Spontaneous ( ) Diaper ( ) Colostomy ( ) Ileostomy ( ) Constipation ( ) Diarrhea ( ) Melena
Urinary output: ( ) Anuria ( ) Oliguria ( ) Polyuria ( ) Urinary frequency ( ) Hematuria ( ) Dysuria ( ) Pyuria
( ) Spontaneous ( ) Diaper ( ) Indwelling urethral catheter ( ) Indwelling urethral catheter ( ) Cystostomy

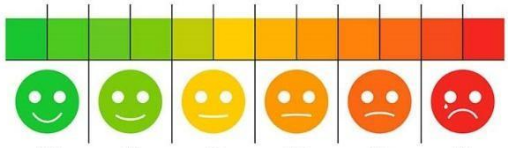
MUSCULOSKELETAL SYSTEM

Edema: ( ) UL (++++) _____( ) LL (++++) _____( ) Anasarca
Trauma: ( ) Closed fracture ( ) Open fracture ( ) Traumatic injury
Strength/tone: ( ) Preserved ( ) Hemiplegia ( ) Paresis ( ) Paresthesia ( ) Plegia ( ) Flaccidity ( ) Rigidity
In use: ( ) Plaster splint ( ) Traction ( ) External fixator ( ) Circular plaster cast

TISSUE INTEGRITY	**PAIN SCALE**

Open wound – OW ( )
Closed fracture – CF ( )
Open fracture – OF ( )
Puncture wound – PW ( )
Amputation – A ( )
Laceration – L ( )
Abrasion – A ( )
Burn – B ( ) I ( ) II ( ) III
Pressure injury – PI ( ) I ( ) II ( ) III ( ) IV ( ) NC





No pain | Mild pain | Moderate pain | Severe pain | Very severe pain | Worst possible pain

PSYCHOSOCIAL NEEDS
( ) Anxiety ( ) Depression ( ) Fear
( ) Schizophrenia ( ) Suicidal behavior

NURSING DIAGNOSIS	NURSING PRESCRIPTION	SCHEDULING
1 - Ineffective breathing pattern	• Report if respiratory rate is < 8 or ≥ 16 breaths/min.	
2- Impaired gas exchange	• Observe for and report respiratory distress, use of accessory muscles, and nasal flaring.	
3 - Impaired spontaneous ventilation	• Administer humidified oxygen therapy; • Keep the head of the bed elevated at 30°.	
4 - Ineffective airway clearance	• Perform upper and lower airway suctioning using aseptic technique.	
5 - Decreased cardiac output	• Report if SBP is ≤ 90 mmHg or ≥ 180 mmHg; • Report if HR is ≤ 60 bpm or ≥ 120 bpm; • Monitor for diaphoresis and cold or clammy skin.	
6 - Acute confusion	• Assess for changes in level of consciousness and report agitation, confusion, or stupor; • Orient the patient to time and place; • Implement bed restraints in cases of confusion and agitation.	
8- Deficient fluid volume	• Monitor for and report active bleeding and its location; • Maintain a patent venous access for rapid fluid infusion.	
9 - Anxiety	• Provide a quiet environment for rest; • Provide psychological support; • Request the presence of a companion.	
10 - Acute pain	• Use a numerical pain scale and administer prescribed PRN analgesics when the pain score is ≥ 5.	

MULTIDISCIPLINARY ASSESSMENT

_____
Professional signature

MULTIDISCIPLINARY ASSESSMENT

_____

Professional signature

DISCUSSION

The predominance of female nurses in care services, specifically in urgent and emergency care, is a reality observed in several settings, with a concentration of professionals between 30 and 50 years of age.[14-15] Furthermore, nurses are recommended to have a specialization in urgent and emergency care, in addition to ongoing training to address the specific demands of this context.[16] This is a relevant factor in the present study, as there was a predominance of specializations in urgent and emergency care.

The meanings produced by the participants regarding the definitions of "urgency" and "emergency", anchored in the dichotomy between waiting time and imminent risk of death, resonate with internationally recognized terminologies, such as the Manchester Triage System. It is essential to know how to identify and understand the signs and symptoms presented by the patient in order to classify them correctly and intervene quickly and effectively, as nurses play a fundamental role in determining the appropriate course of action.[17]

The Urgent and Emergency Care Network prioritizes specific lines of care, such as cardiovascular, cerebrovascular, and trauma care, with the aim of expanding and improving access for patients in urgent and emergency situations. Scientific evidence, particularly from prehospital services such as the MHU, supports nursing team practices.[18]

Timely and accurate interventions are extremely important for patients treated in urgent care services, as time is a crucial factor that can significantly affect the patient's condition. Delays in care are associated with worse clinical outcomes, especially in cases of acute emergencies.[19]

Participants who reported feeling prepared to work in urgent and emergency care services highlighted the importance of specializations and training courses in this area. In this context, graduate education in urgent and emergency care is crucial for decision-making during critical situations involving patients.[20]

In addition, the balance between theory and practice is essential for safe practice. The educational process beginning in undergraduate programs or training courses is essential for preparing professionals by providing theoretical knowledge and appropriate practical skills to ensure quality outcomes.[21]

In the Brazilian context, the Manchester Triage System is widely used for triage in urgent and emergency care services. This protocol classifies patients based on a color-coded scale, considering signs and symptoms, clinical severity, and waiting time for care, with the aim of prioritizing patients and contributing to humanized care.[22]

Although the participants mentioned the existence of the Reception with Risk Classification Protocol in the unit, its implementation appears not to have yet occurred effectively. This contradicts the Brazilian National Humanization Policy guidelines, in addition to imposing limitations on care. Adoption of this protocol would optimize services, prioritize risks, and improve access to different levels of care within the healthcare system, meeting the various needs of patients.[22]

Consequently, the nurse's role in risk classification is essential. When properly trained, nurses who use the Manchester Triage System are able to conduct qualified listening, perform an accurate assessment, appropriately record and detail the reported complaint, apply clinical reasoning, and act promptly to prioritize care more effectively.[23] It is important that the nurses at the MHU in question take this responsibility, as recommended by the Ministry of Health.

Furthermore, the need to standardize the NP is emphasized, replacing outdated systems with patient-centered models that guide nursing practices. Implementing an instrument to operationalize the NP in the urgent and emergency care services of the MHU is essential for improving the quality of services, ensuring planned, effective, and appropriate nursing care interventions.[24]

The application of theoretical knowledge in clinical practice has been demonstrated in recent literature,[25] which presents the development of an NP instrument focused on standardizing care and facilitating team communication in urgent and emergency care services. These same objectives guide the instrument developed in this study for the MHU, but this study advances the way in which the tool was constructed. Developed based on discussions among the team itself and collectively assessed and confirmed through action research, the proposal meets the need for scientific standardization while respecting the service's reality.

Furthermore, in the aforementioned MHU, the gap between academic education and professional practice is a relevant issue, and continuing health education (CHE) can be a strategy to overcome it.[26] Thus, reviewing the curricula of technical and undergraduate nursing programs is an important strategy for overcoming barriers to the NP operationalization.

Regarding the "Nursing Process in Urgent and Emergency Care", its importance should be emphasized, considering that significant gaps still exist in nurses' understanding of the NP, who, although they recognize it as a valuable tool, often do not implement it fully. There is an urgent need to encourage professional qualification and team training for the use of these instruments in the provision of nursing care.[7]

The creation of a specific NP instrument for urgent and emergency contexts is essential and should comply with universal care protocols. Such an instrument should guide practice, promote more efficient care, and provide legal support for professionals. In addition, it facilitates communication through the systematic recording of information and is essential for ensuring continuity of care.[24]

The study presented operational limitations related to data collection, particularly regarding the interviews. There was frequent rescheduling of interviews due to municipal holidays, the increased workload caused by the peak of COVID-19 cases in the municipality during January and February, and participants' personal reasons. However, these circumstances only required adjustments to the schedule, without compromising the quality of the information obtained, methodological rigor, or achievement of the proposed objective

CONCLUSION

This study achieved its proposed objective by analyzing the meanings produced by the nursing team, identifying weaknesses, needs, and care-related strengths, in addition to implementing the NP instrument in urgent and emergency care at the MHU.

The study demonstrated positive team receptiveness to the NP implementation, recognizing it as a valuable tool for organizing and planning care, in addition to contributing to improved care and the humanization of care, representing a significant advance in the team's awareness of the importance of this systematization for nursing as a science.

As a scientific contribution, the study strengthens care by making available an instrument aligned with the service demands, enabling a change in the perspective of care provided to patients, and empowering the team to use the NP as its work instrument. In the field of education, it reiterates CHE as an indispensable strategy for professional development, pointing to pathways for curricular updates in nursing programs based on gaps identified in the care setting. In the field of research, it demonstrates the methodological feasibility of combining action research with the analysis of discursive practices, demonstrating that participatory construction ensures greater adherence to and applicability of technologies developed in healthcare services.

CONTRIBUITIONS

Study conception or design: Lins DC, Bezerra STF. Data collection: Lins DC. Data analysis and interpretation: Lins DC, Bezerra STF. Drafting the manuscript or critically revising it: Lins DC, Milhomens RS, Bezerra STF. Final approval of the version to be published: Lins DC, Milhomens RS, Bezerra STF.

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Conflicts of interest: No
Submission: 2026/22/07
Revised: 2026/19/04
Accepted: 2026/29/08
Publication: 2026/09/11

Editor in Chief or Scientific: José Wicto Pereira Borges
Associate Editor: Guilherme Guarino de Moura Sá

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