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USERS' PERCEPTION OF THE RISK ASSESSMENT SCREENING IN AN EMERGENCY CARE SERVICE IN CAPE VERDE

Percepção dos usuários sobre a triagem com classificação de risco em um serviço de urgência de Cabo Verde

Percepción de los usuarios sobre la selección de pacientes con clasificación de riesgo de un servicio de urgencia de Cabo Verde

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ABSTRACT

Objective: To reveal users' perception of the risk assessment screening in an emergency service. **Methods:** Qualitative case study of 17 users of the Adult Emergency Department (AED) of the Agostinho Neto Hospital located in Cape Verde, Africa. Open interviews were carried out from August to October 2012 and the data were analyzed using the thematic content analysis. **Results:** Three thematic categories emerged: 1) "Prior screening by nurses"; 2) "Emergency service: quick response to save lives"; 3) "Unawareness of the purpose of risk assessment". **Conclusion:** Users have little knowledge of the risk assessment screening, which may contribute to overcrowding and affect the care of cases considered urgent.

Descriptors: Emergencies; Hospital Services; User Embracement.

RESUMO

Objetivo: *Objetivou-se desvelar as concepções dos usuários acerca da triagem com classificação de risco em um serviço de urgência.* ***Métodos:*** *Trata-se de uma pesquisa qualitativa, alicerçada no método "estudo de caso", realizada com 17 usuários do Serviço de Urgência do Adulto (SUA) do Hospital Agostinho Neto, na ilha de Cabo Verde, África. Foram realizadas entrevistas abertas de agosto a outubro de 2012, e os dados analisados à luz da análise de conteúdo representacional temática.* ***Resultados:*** *Revelaram-se três categorias temáticas: 1) "Triagem prévia pelo enfermeiro"; 2) "Serviço de urgência: atendimento rápido para salvar vidas" 3) "Desconhecimento do propósito de classificação de risco".* ***Conclusão:*** *Concluiu-se que os usuários possuem pouco conhecimento sobre a triagem com classificação de risco, o que pode contribuir para a superlotação e prejudicar o atendimento dos casos considerados urgentes.*

Descritores: *Emergências; Serviços Hospitalares; Acolhimento.*

RESUMEN

Objetivo: *Desvelar las concepciones de los usuarios sobre la selección de pacientes con clasificación de riesgo de un servicio público de urgencias.* ***Métodos:*** *Se trata de una investigación cualitativa con el método de "estudio de caso" realizada con 17 usuarios del Servicio de Urgencias del Adulto (SUA) del Hospital Agostinho Neto en la isla de Cabo Verde, África. Fueron realizadas entrevistas abiertas entre agosto y octubre de 2012 y los datos fueron analizados a la luz del análisis de contenido por temáticas.* ***Resultados:*** *Se revelaron tres categorías temáticas: 1) "Selección previa del enfermero"; 2) "Servicio de urgencias: atención rápida para salvar vidas" 3) "Desconocimiento del propósito de la clasificación de riesgo".* ***Conclusión:*** *Se concluye que los usuarios tienen poco conocimiento sobre la selección de pacientes con clasificación de riesgo lo que puede contribuir para la superlotación y perjudicar la atención de los casos que son considerados urgentes.*

Descriptores: *Urgencias Médicas; Servicios Hospitalarios; Acogimiento.*

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INTRODUCTION

Risk assessment screening is understood as a way of operating the work processes in health, assuming a posture capable of embracing, listening and giving adequate answers to the patients, that is, it requires rendering a service with accountability and response capability, and, when appropriate, guiding them, as well as their family, to the continuity of care in other services. For that, it requires the establishment of referral and counter-referral processes with these services in order to ensure the effectiveness of these referrals[1].

Risk classification is a selection method that aims to redirect the client according to the priority for care, in a humanized way, informing the waiting time, organizing the flow of patients in the health system, selecting the appropriate means for the diagnosis and treatment of the health issue presented[2].

Embracement with risk classification is a process adapted as a synonym of screening, and should be dynamic, continuous, and include activities that soothe the patients and their families, offering them emotional support and safety[3].

In the search for solutions to the overcrowding of these services and in the expectation of ensuring care for the critically ill patients in view of the reduced efficiency and difficulty to assist the population in their needs, several countries have implemented systems or protocols for risk assessment and stratification[4].

Urgency is defined as "a medical condition, with or without potential risk to life, whose patient depends on medical care"[5]. Emergency services should be organized to provide proper assistance to individuals in situations of urgency and emergency, which are respectively characterized as situations where there is no imminent risk of death, but require rapid care, and situations that require immediate care and involve risk of death[6].

It is known that emergency services are important pillars of health care in Cape Verde and are still used as gateways to the health system. Cape Verde is a young country, located in the Atlantic Ocean and constituted by 10 islands that lie off the Northwest coast of Africa. It has a population of approximately 500 thousand inhabitants, of which 54.4% are under 25 years old. It is one of the countries with the best health indicators, as a result of a governmental effort and international partnerships agreed since its recent independence, which have provided infrastructure improvement, human resources training and structuring of services[7].

In recent years, the country's health services have undergone remarkable transformations, conditioned by changes in the management and organization models of health care networks, which has made it possible to increase the quality of care provided to the population and improved access as well[7,8].

Nevertheless, Cape Verdean citizens remain "dissatisfied with the National Health Service, with the situations of care in public institutions at different levels and with the quality and effectiveness of the care provided"[9].

The screening in the adult emergency department - AED (locally called *SUA)* of the Agostinho Neto Hospital, the only one in Santiago Island, Praia city (capital), Cape Verde, has been practiced for several years by physicians and nurses, but without any specific clinical criterion liable to sustain an organized, quality care, especially with regard to humanization and embracement. Faced with this problem, the implementation of a five-color gravity risk screening protocol was proposed in 2012, supported by the Manchester triage system[10], being: red for category I, orange for category II, yellow for category III, green for category IV and blue for category V. It is worth noting that the first three categories represent the most urgent and priority ones for care, with decreasing waiting time from category I[10,11].

In view of this scenario, we aimed to unveil the users' perception of the risk assessment screening in an emergency service.

METHODS

This is a qualitative, descriptive study, based on the "case study" method, carried out with users of the Adult Emergency Department (AED) of the Agostinho Neto Hospital in the city of Praia, Santiago Island, Cape Verde, Africa.

The hospital that was the scene of the research, characterized as general, located in the historic center of the capital, is considered a reference hospital for the population that requires clinical and surgical care. It is a public institution, under the supervision of the Ministry of Health, bearing 348 beds and being backed up by the Trindade Hospital, where care and hospitalization are provided to psychiatric users. It should be clarified that, in Cape Verde, access to health services is taxed by means of a fee called "coparticipation", which represents a payment for the required assistance.

The study participants were adult emergency service users, from the municipality of Praia, Santiago Island, Cape Verde, Africa, who agreed to participate in the study and signed the Informed Consent Term (ICF).

Data collection took place in the period from July to October of 2012, in the morning, evening and night periods, aiming to cover different moments and users' perceptions. The following inclusion criteria were adopted: users over the age of 18 who sought the AED and who had been classified as risk patients "yellow", "green" or "blue". Exclusion criteria were users presenting the screening categories "red" or "orange". The present study was performed during the implantation process of the Risk Classification Protocol at the Agostinho Neto Hospital.

As a strategy, open-ended interviews were conducted with questions: Tell me, what do you understand by screening? For you, what is emergency care?

The open interview is used when the researcher intends to obtain as much information as possible about a subject according to the interviewee's vision, as well as to achieve greater detailing of the subject in question. It is usually used in the description of individual cases, in the understanding of cultural specificities for certain groups, and for comparability of several cases[12]. The interviews were audio recorded, transcribed and later eliminated.

Sampling was by established theoretical saturation in the 17th interview, at which point the participants' narratives became repetitive. It is understood by theoretical saturation the suspension of new interviews when, for the researcher, there is a repetition of sufficient and redundant material in the speeches, enabling the collection to be interrupted as new data cease to arise[13]. For this study, no pilot project was carried out.

The interviews lasted approximately 15 minutes each, and each interviewee received an identification code with the intention of preserving their privacy and individuality. Each code consists of a combination of two characters, each separated by a dot: the first character consists in the letter U, meaning that the respondent is a user of the AED, and the second character consists in a numeric variable showing the sequence of the interviews (U1, U2 etc.). For data treatment and analysis, the categorical content analysis was used[14].

The study was approved by the country's only Ethics Committee (Ministry of Health of Cape Verde), obtaining favorable opinion no. 11, of Decree-Law no. 26/2007, of Deliberation no. 31/2012.

The International Research and Teaching Support Program, by means of the international teacher and student mobility program between universities in Portuguese-speaking countries, aimed to implement a Master of Public Health program and research lines at the University of Cape Verde, with participation of Brazilian university professors and local health professionals as students, leading to the present research as a result of this process. .

RESULTS

Of the 17 participants, seven were male and 10 were female, with ages ranging from 14 to 64 years.

From the analysis of the testimonies, three thematic categories emerged: 1) "Prior screening by the nurse"; 2) "Emergency service: quick response to save lives"; 3) "Unawareness of the purpose of risk assessment".

Regarding the results of category 1, users of the AED of Agostinho Neto Hospital, understand that screening means going through nursing care prior to undergoing medical care. At the occasion, vital signs are verified, the current complaints are collected, registered in the medical record and referred to the doctor, according to the fragments of the speeches below:

> *"Screening is going through the nurse before the doctor, telling the nurse about how one feels, and he writes it down and sends it to the doctor" (U1).*
>
> *"To be seen by the nurse before going to the doctor" (U4).*
>
> *"I understand that it is an intervention made before reaching the doctor, which can be carried out by a nurse or health agent" (U6).*

For the participants, screening has been understood as a pre-consultation, in which nurses ask questions and take notes for later medical care, as if it resulted in an activity developed in order to assist in the medical care.

With regard to category 2, the participants consider that every user who enters the physical space of the hospital emergency room is in a life-threatening situation and needs immediate care. The physical space of an emergency service has an important representation in the users' imagination, that is, the emergency care is an integral part of a physical structure where the biochemical parameters and vital signs are initially evaluated in order to be classified, or not, as urgent cases that are referred to the proposed service according to the risk classification.

> *"[...] it is when someone is feeling close to dying, then they have to go through the emergency room, to receive a fast service" (U1).*
>
> *"This is where I am now, the place with faster service" (U3).*
>
> *"When someone has, for example, an injury, a fall, and must be treated quicker" (U4).*
>
> *"I understand that it is the emergency room, where the pressure and temperature are checked, if it is not serious, and they request examinations. I think anyone who goes to the emergency is because they need to be seen urgently in that place" (U7)*
>
> *"When the patient presents a serious condition, and that is meant for priority care" (U12).*
>
> *"It's quickness, cases of greater urgency (...)." (U14).*

The results of category 3 revealed that the risk assessment screening is still unknown to the population, that is, the participants of the research claim lack of information when the colors are assigned and distributed, for example:

"I was assigned the blue color, I gave up the consultation and left, I didn't know what it was about" (U7).

"If the nurse had had the screening properly explained, I would not have awaited from 8:00 am to 1:30 pm, added that I was then referred by the doctor for consultation at the health center" (U17).

DISCUSSION

In the field of health, the embracement with risk assessment screening is understood as a technical-assistance action, which presupposes in advance a change in the relationship between the user and the professional, placing the former as an active participant in the health production process[15].

In the context of urgency and emergency services, where they are faced with large queues and lack of criteria, except for the time of arrival, the distinction of risks or degrees of suffering is necessary for everyone to be embraced. The adoption of a risk classification system at the embracement ensures care according to the health status, presented in the initial evaluation performed by the nurse professional during the screening. In addition, the patient who is not at immediate risk, as well as their family members, are informed about the probable waiting time. In this activity, screening constitutes an essential work for the correct redirection of patients, with the concomitant purpose of relieving congestion in the urgency and emergency service. However, it must be performed by qualified professionals, increasing the response capability and quality of care[16].

At the institution where the research was carried out, it is a fact that this activity, recently implemented, is performed by trained nurses who, together with the physician, constitute the AED team. Several studies have been done with the purpose of understanding whether there are benefits in performing screening by nurses or doctors. However, the literature has shown that the nurse is the health professional considered to be excellent for the conduction of this activity[3].

Nurses have the necessary conditions for screening because they have a clinical language that is oriented to the signs and symptoms, not to the diagnoses, managing to establish an empathic relationship that is key to minimizing feelings such as anxiety, aggression or impatience, and explaining calmly to the patient the purpose of the screening process. Moreover, nurses have a vision of the overall service and the existing resources therein[17].

The distribution and concentration of health professionals in hospitals attract the population to the structures with the greatest number of technological and qualified human resources, leaving the health centers to the margin of the population demand. The demand for urgency services is often motivated by the image built in relation to them, imposing on them the capacity for speed, acceptance and response capability. In this way, for presenting 24-hour access and qualified professionals, it was revealed in the current research that the AED is the gateway for evaluation of vital parameters and complementary tests.

This perception is in line with the concerns expressed in the Cape Verde National Health Plan, which aims to reorganize the basic health care of the national health service, improve and provide access opportunities to the population[9].

Such reality is corroborated by the difficulty in referring to other basic units and in scheduling consultations for the specialties, which contributes to the users' dissatisfaction and overcrowding of the AED. One study pointed out that the users' dissatisfaction with health care is related to the waiting time (51.3%), the shortage of qualified staff (10.2%), and the area of residence of the population, with the inhabitants of the urban center feeling more dissatisfied (62.4%) than those of the rural area (38.6%)[18].

This result agrees with other studies, and one can conclude that care in these services is related to aspects such as satisfaction, speed of care, response capability and humanization. However, some research studies have highlighted dissatisfaction with referrals to other health units and delays in the scheduling of consultations for the specialties[19], that is, the majority of users of these urgency services seek them out for examinations and referrals to specialties as a result of repressed demand for scheduling and consultations in primary health care units[20].

In a study on the evaluation of emergency hospital services in the state of Rio de Janeiro, Brazil, it was observed that the main cause of overcrowding in the 24 urgency and emergency services was the care for patients with outpatient issues. In 60% of these, there was spontaneous reference to the bankruptcy of the primary network as a determinant of overcrowding[21].

This overcrowding also leads the work process to an overload and lack of time for decision-making. The pressures for quick care are frequent, and the division of labor is hindered[22].

The utility of the screening service is based especially on preventing complications and recognizing acute conditions, which cause death risk to users. For the better functioning of this service, the integration with other health services existing in the system is necessary, establishing bonds with them and allowing the appropriate referral of users[19].

The implementation of screening with risk assessment and classification in Cape Verde is a new management strategy in the country, which requires reorganization at the national and municipal levels, as well as new studies that contemplate all the interfaces of this process. The result of the present study was sent to the Ministry of Health of Cape Verde to strengthen the embracement with risk classification in the AED of the Agostinho Neto Hospital and other similar services in Cape Verde, aiming at the reorganization of care. It was also validated by triage nurses in workshops aimed at understanding the users' perceptions of screening and urgency.

CONCLUSION

It was concluded that the users have little knowledge of the risk assessment screening, which can contribute to overcrowding and affect the care of cases considered urgent.

Because of the recent implementation of screening services with risk classification in Cape Verde, the reorganization of the referral and counter-referral system is suggested, as well as the creation of protocols aiming to reduce the users' dissatisfaction with the services.

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REFERENCES

1. Ministério da Saúde (BR), Secretaria de Atenção à Saúde Política Nacional de Humanização da Atenção e Gestão do SUS. Acolhimento e Classificação de Risco nos Serviços de Urgência. Brasília: Ministério da Saúde; 2009.
2. Moura AC, Lopes AMS, Portela ALF, Sousa ID, Sousa SNS. Implantação do acolhimento com classificação de risco: um relato de experiência. Rev Multop Saúde HSM. 2013;1(2):72-82.
3. Zem KKS, Montezeli JH, Peres AM. Acolhimento com classificação de risco: concepção de enfermeiros de um pronto socorro. Rev RENE. 2012;13(4):899-08.
4. Oliveira GN, Vancini-Campanharo CR, Batista REA. Acolhimento com avaliação e classificação de risco: concordância entre os enfermeiros e o protocolo institucional. Rev Latinoam Enferm. 2013;21(2):500-6.
5. Martins, H, Zamboni V, Velasco IT. Atualização em emergências. São Paulo: Manole; 2009.
6. Oharal R, Melo MRAC, Lausl AM. Caracterização do perfil assistencial dos pacientes adultos de um pronto socorro. Rev Bras Enferm. 2010;63(5):749-54.
7. Ministério de Saúde (CV). Plano Nacional de desenvolvimento sanitário 2012-2016: reformar para uma melhor saúde. Praia; 2012. v. 1
8. Ministério de Saúde (CV). Relatório Estatístico 2011. Praia; 2012.
9. Ministério de Saúde (CV). Politica Nacional de Saúde: reformar para uma melhor saúde. Praia; 2007 [accessed on 2016 June 17]. Available from: %(http://www.governo.cv/documents/POLITINACIONALSAUDE_2020%20%282%29.pdf
10. Coutinho AAP, Cecílio LCO, Mota JAC. Classificação de risco em serviços de emergência: uma discussão da literatura sobre o Sistema de Triagem de Manchester. Rev Méd Minas Gerais. 2012;22(2):188-98.
11. Freitas P. Triagem no serviço de urgência: grupo de triagem de Manchester. 2ª ed. Portugal: BMJ Publishing Group; 2002.
12. Minayo M. O desafio do conhecimento: pesquisa qualitativa em Saúde. 13ª ed. Hucitec: São Paulo; 2014.
13. Fontanella BJ, Ricas J, Turato E. Saturation sampling in qualitative health research: theoretical contributions. Cad Saúde Pública. 2008;24(1):17-27.
14. Bardin L. Análise de conteúdo. 7ª ed. Lisboa: Edições 70; 2011.
15. Bellucci JA Júnior, Matsuda LM. Implantação do sistema acolhimento com classificação e avaliação de risco e uso do fluxograma analisador. Texto & Contexto Enferm. 2012;21(1):217-25.
16. Souza CC, Toledo AD, Tadeu LFR, Chianca TCM. Risk classification in a emergency room: agreement level between a brazilian institucional and the Manchester Protocol. Rev Latinoam Enferm. 2011;19(1):26-33.
17. Caveião C, Hey AP, Montezeli JH, Barros APMM, Sordi JA, Santos SC. Desafios ao enfermeiro na implantação da classificação de risco em unidade mista. Rev Enferm. 2014;4(1):189-96.
18. Valdez TAS. Regionalização e integração sistêmica: cenários para a reforma do Sistema de Saúde de Cabo Verde [dissertação]. Rio de Janeiro: FIOCRUZ; 2007.
19. Azevedo J, Barbosa M. Triagem em serviços de saúde: percepções dos usuários. Rev Enferm. 2012;15(1):33-9.
20. Rossaneis MA, Haddad MCL, Borsato FG, Vannuchi MO, Sentoneet ADD. Caracterização do atendimento após implantação do acolhimento, avaliação e classificação de risco em hospital público. Rev Eletrônica Enferm. 2011;13(4):648-56.

21. O´Dower G, Matta IEA, Pepe VLE. Avaliação dos serviços hospitalares de emergência do Estado do Rio de Janeiro. Ciênc Saúde Coletiva. 2008;13(5):1637-48.

22. Lancman S, Gonçalves RMA, Mângia EF. Organização do trabalho, conflitos e agressões em uma emergência hospitalar na cidade de São Paulo, Brasil. Rev Ter Ocup Univ São Paulo. 2012;23(3):199-07.

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