

FACTORS INTERVENING IN THE WELCOMING OF PATIENTS SUSPECTED OF CEREBROVASCULAR DISEASE

FATORES INTERVENIENTES NO ACOLHIMENTO À PESSOA COM SUSPEITA DE DOENÇA CEREBROVASCULAR

FACTORES INTERVINIENTES EN EL ACOGIMIENTO DE LA PERSONA CON POSIBLE ENFERMEDAD CEREBROVASCULAR

Alice de Andrade Santos¹
Larissa Chaves Pedreira²
Nadirlene Pereira Gomes³
Juliana Costa Ribeiro-Barbosa¹
Nildete Pereira Gomes⁴
Catia Maria Costa Romano⁵

How to cite this article: Santos AA, Pedreira LC, Gomes NP, Ribeiro-Barbosa JC, Gomes NP, Romano CMC. Factors intervening in the welcoming of patients suspected of cerebrovascular disease. Rev baiana enferm. 2019;33:e28018.

Objective: to identify intervening factors in the welcoming of patients suspected of cerebrovascular disease. **Method:** qualitative research involving 16 nurses working in the welcoming at a referral hospital for cerebrovascular disease in the state of Bahia, Brazil. Data collection was carried out using the Focus Group technique; for analysis, Matus' Strategic Situational Planning was used. **Results:** access to technologies and the implementation of the risk classification protocol were positively intervening factors in the welcoming. Deficits in the hospital infrastructure, lack of support staff at the door, lack of professional training, disinformation of the companions and fragilities in the Health Care Network compromised the welcoming. **Conclusion:** the factors that intervene in the reception of the person with suspected cerebrovascular disease required strategic management based on Strategic Situational Planning capable of intervening in optimizing the administration of available resources, both to invest and to value the strengths and to prioritize the resolution of those points considered as compromising and aggravating.

Descriptors: Stroke. User Embrace. Strategic Planning. Nursing Service. Hospital.

Objetivo: identificar fatores intervenientes no acolhimento à pessoa com suspeita de doença cerebrovascular. *Método:* pesquisa qualitativa com 16 enfermeiros atuantes no acolhimento de um hospital referência para doença cerebrovascular do estado da Bahia, Brasil. Para coleta de dados realizou-se Grupo Focal; para análise, o Planejamento Estratégico Situacional de Matus. *Resultados:* o acesso às tecnologias e a implantação do protocolo de classificação de risco foram fatores positivamente intervenientes no acolhimento. Contudo, déficits na infraestrutura hospitalar,

¹ RN. M.Sc. in Nursing. Secretaria Municipal de Saúde de Salvador. Salvador, Bahia, Brazil. lice_andrade1@hotmail.com

² RN. Ph.D. in Nursing. Associate Professor at the Universidade Federal da Bahia. Salvador, Bahia, Brazil.

³ RN. Ph.D. in Nursing. Adjunct Professor at the Universidade Federal da Bahia. Salvador, Bahia, Brazil.

⁴ Physiotherapist. M.Sc. in Nursing. Universidade Federal da Bahia. Salvador, Bahia, Brazil.

⁵ RN. Ph.D. in Health Sciences. Associate Professor at the Universidade Federal da Bahia. Salvador, Bahia, Brazil.

inexistência de equipe de apoio na porta de entrada, ausência de capacitação profissional, desinformação dos acompanhantes e fragilidades na Rede de Atenção à Saúde comprometeram o acolhimento. Conclusão: os fatores intervenientes no acolhimento à pessoa com suspeita de doença cerebrovascular exigiam uma gestão estratégica com base no Planejamento Estratégico Situacional capaz de intervir na otimização da administração dos recursos disponíveis, tanto para investir e valorizar os pontos fortes quanto para priorizar a resolução dos pontos considerados comprometedores e agravantes.

Descritores: Acidente Vascular Cerebral. Acolhimento. Planejamento Estratégico. Serviço Hospitalar de Enfermagem.

Objetivo: identificar factores intervenientes en el acogimiento de persona con posible enfermedad cerebrovascular. Método: investigación cualitativa, con 16 enfermeros actuantes en acogimiento, en hospital de referencia para enfermedad cerebrovascular de Bahía, Brasil. Datos recolectados por grupo focal; analizados por Planificación Estratégica Situacional de Matus. Resultados: el acceso a tecnologías y la implantación del protocolo de clasificación de riesgo fueron factores positivamente intervenientes en el acogimiento; que resultó comprometido por déficits de infraestructura hospitalaria, carencia de equipo de apoyo en puerta de entrada, capacitación profesional insuficiente, desinformación de acompañantes y debilidades de la red de atención sanitaria. Conclusión: los factores intervenientes en el acogimiento de la persona con posible enfermedad cerebrovascular requerían gestión estratégica basada en la Planificación Estratégica Situacional, capaz de optimizar la administración de los recursos disponibles, tanto para invertir y valorizar los puntos fuertes como para priorizar la resolución de puntos considerados como comprometedores y agravantes.

Descriptores: Accidente Cerebrovascular. Acogimiento. Planificación Estratégica. Servicio de Enfermería en Hospital.

Introduction

Stroke stands out among cerebrovascular diseases and represents one of the main causes of worldwide morbidity and mortality, especially in the elderly population⁽¹⁾. This public health problem requires a hospital management model that prioritizes qualified welcoming.

Stroke causes impairment of neurological functions due to lack of cerebral blood flow, classified as ischemic when it results from obstruction of the blood vessel, or hemorrhagic, in the face of its rupture. Responsible for about 10% of all global deaths, it is the second largest cause of death. In the Brazilian context, it is the first cause of death and one of the main reasons for hospitalization in the Unified Health System (SUS)⁽²⁾. Complications involve cognitive, sensory, perceptual, communication and physical sequelae with impairment of muscle strength and motor control. Due to these complications, it is one of the major causes of disability, generating difficulties for the performance of daily activities, such as brushing one's teeth and grooming⁽³⁾.

In order to prevent and/or minimize the incidence of sequelae, it is important that emergency services (ES) are able to provide

agile and quality care. These services are complex organizations that interact with three basic characteristics: physical, organizational and symbolic structures. The ES consists of delimited social spaces, where actors (professionals, managers, planners, politicians, etc.) interact to achieve the goals of the health system⁽⁴⁾. In this environment where actors interact in situations of shared power, Situational Strategic Planning (SSP) is a powerful form of management.

SSP is an appropriate method for management challenges because it permits working with the complexity of social problems. In this method, the future is not deterministic and reality is continuously followed or monitored⁽⁵⁾, making it possible to perceive the constant changes that occur in the world, especially in the context of the current health services, marked by countless obstacles to be faced. Thus, management models are needed to ensure quality care to the population.

In order to reorient care and guarantee better access to health services to Brazilian citizens, the Attendance with Risk Classification (ACCR), one of the tools for the consolidation of the National

Humanization Policy (PNH), was implemented throughout Brazil. ACCR is performed by trained nurses, with the purpose of classifying the patients as to the severity of their condition, so as to prioritize their care and organize the flow at the entry door⁽⁶⁾.

Considering ACCR as one of the determinant strategic devices in the problem-solving ability of health services and the relevance of analyzing the services' operating conditions, this study aims to identify intervening factors in the welcoming of patients suspected of cerebrovascular disease.

Method

A qualitative study was carried out involving nurses working in ACCR at the emergency service of a public referral hospital in the state of Bahia, Brazil, in care for stroke patients. The inclusion criteria for participation in the study were: to carry out fixed activities in the ACCR sector and to have at least six months of experience in welcoming. Exclusion criteria were: being on vacation or away from work for any reason.

Of the total of 18 nurses, one was on maternity leave and another refused. Thus, 16 accepted to participate in the research. All signed the Free and Informed Consent Form, in accordance with National Health Council Resolution No. 466/2012.

The data collection took place between May and June 2016. The Focus Group (FG) was used as the technique, guided by a script consisting of the following guiding question: Which factors intervene for the qualified welcoming of patients suspected of cerebrovascular disease? Three meetings were held with distinct groups in a room at the place of study, lasting approximately two hours each.

The researcher served as moderator, with the help of two master's and two undergraduate students, who volunteered to record the statements and provided support in guiding, controlling the time, recording the meetings and developing the final report of each GF activity. In the first meeting, four nurses participated; in the second, five; and in the third, seven. In order to guarantee the criteria that involved the secrecy

of information, the participants were identified by the initial capital letter N succeeded by an Arabic numeral.

The meetings were audio-recorded, transcribed, systematized and interpreted based on Bardin's thematic content analysis⁽⁷⁾. The grouping of phrases with similar central ideas permitted the organization in six categories, referring to intervening factors for the qualified welcoming of patients suspected of cerebrovascular disease.

In view of the need to understand the results, Matus' Strategic Situational Planning⁽⁸⁾ was adopted as a theoretical framework, focusing on hospital management. Thus, the definition of the situational diagnosis considered the descriptive moment of the SSP, signaling the intervening factors for the sake of effective Risk Classification in patients diagnosed with a stroke. Subsequently, in each category analyzed, the importance was discussed of how the situation should be in comparison with what happened in the scenario studied, considering that the SSP was going through regulation. After this analysis, and in view of the intervening factors, the study discussed the strategic situational feasibility, aiming at the organization of emergency services regarding the effective implementation of the Risk Classification, considered as the strategic and tactical operational moments of the SSP, respectively.

The Research Project received approval from the Research Ethics Committee of the Nursing School at the Federal University of Bahia, under Opinion No. 1.172.310, on 5/5/2015.

Results

The 16 nurses who collaborated were between 24 and 51 years of age. Most were female, single and self-declared mulatto. They reported having multiple activities, working hours exceeding 36 hours per week and monthly income between two and six minimum wages.

Regarding the length of experience in ACCR, 12 professionals reported more than one year, but 10 stated that they were not qualified for this. In addition, 12 nurses did not have a specialization

degree in emergency care. Concerning their familiarity with the theme stroke, only half of the participants claimed to have had earlier contact, through participation in events.

According to the assumptions of SSP, the categories – Hospital Infrastructure, Nursing Training in ACCR, Support Team at the entry door, Information by the companions, Risk classification protocol, Health Care Network – emerged from the relationships and interactions among the factors that support and hinder the welcoming.

Hospital infrastructure

The hospital infrastructure, which the professionals described as the supply of beds, appropriate facilities, human resources, inputs, material and technology, represents a fundamental element for qualified care provision. The study points towards the fragility and shortage of this base though, except concerning the access to technology.

[...] the rooms and corridors are almost always fully occupied [...] there is no oxygen point, bed or place to put a stretcher not even in the corridor. You get powerless! The number of professionals at the welcoming is incompatible with this service's high demand. Only one nurse per shift at the ARCC is complicated. (N16).

Look at the easy access to technology, such as tomography and thrombolysis. That is an outstanding service. (N5).

Admitting an elderly patient with a stroke on the corridor, on an inappropriate stretcher, that's depressing and chaotic. (N2).

Training for nursing work in ARCC

The nurses considered that the professional preparation favored quality in ARCC. Nevertheless, they perceived the lack of preparation for qualified care, as well as the need for service training.

I was hired a year ago and I never took a course. Even feeling insecure I give care. I am learning from the routine and my peers. (N3).

I never got training. I believe that I have made some mistakes and have classified many people wrongly. If I got training using the risk protocol, I would be able to do the screening properly. (N12).

I got a short training on how to work in ARCC, but it was not sufficient to feel secure. (N4).

Support team at the entry door

The existence of a support team at the entry door was appointed as strategic support to enhance care for people suspected of having a stroke.

It would be great to have a health professional at the entry door, for the sake of an active search, because that person would look at the entire movement and would let us know at the welcoming room. (N9).

It helps a lot when the stretcher bearer, receptionist or even the relative tells me there is someone feeling bad, but a health professional would be better [...] continuously classifying. I cannot do the round out there. (N5).

Sometimes the doorman lets me know that the patient is in a bad condition, I speed up the welcoming. (N2).

Information by companions

The study signals the importance of companions providing information on the patients' clinical condition, as this will support and contribute to the welcoming. Nevertheless, the lack of this knowledge affects the quality of care negatively.

[...] the lack of information by the relative is a great source of confusion. (N11).

Some companions are unable to inform what is happening and when. (N13).

Sometimes, at the time of data collection, the relatives are confused, nervous and hardly collaborate. (N8).

Risk classification protocol

The risk classification protocol represents a positive tool for priority-based care classification, as well as to guide the conduct of the classifying nurse.

I think that active risk classification is positive. It guides us. (N6).

Having an organized and functioning welcoming room is very good. It helps us and the patients. (N10).

The re-inauguration of the ARCC represented a gain for the service, the professionals and the patients. (N1).

Health Care Network

The professionals mentioned deficiencies in the organization of the Health Care Network, reflected in the overcrowding of the service, and pointed towards the relevance of a management model that would permit a comprehensive response to the demand.

I see support from management as an issue, because of the very large demand and the deficiency of the network. So we don't cope. (N1).

If there were an organized health network, there would be less overcrowding. (N7).

Being a general referral hospital, our routine is very exhaustive. Sometimes we respond to problems that could be solved in a less complex service, such as the Emergency Care Services. (N3).

Discussion

The study pointed to the hospital infrastructure as an intervening factor whose fragilities compromise the ACCR. This is because it reveals a scenario in which workers and users are faced with a low supply of beds and low turnover, improper physical structure, shortage of nursing professionals and lack of materials.

It should be emphasized that service units need to have sufficient human resources, materials, inputs, and technologies to offer decent and quality care, as recommended by the National Humanization Policy with regard to proper health care facilities. In addition, being a referral hospital for the treatment of cerebrovascular diseases, it is linked to the SOS Emergency Program of the Federal Health Department (MS), which provides financial resources for the reform, expansion of physical space, purchase of high-tech equipment among others, precisely for the sake of efficient response to the demand⁽⁹⁾, which arouses reflections on the management of this resource.

Regarding the physical structure, a study of nurses working in ACCR supports the results of this study, evidencing the deficient infrastructure of the emergency services as one of the factors that influence the care⁽¹⁰⁾. Another study found concerns and difficulties in nursing working,

including the lack of beds in the service⁽¹¹⁾, a situation that triggers stress and frustration among professionals working in emergency services. Essential, therefore, is the organization of resources to ensure less physical and emotional burnout for nurses in their professional practice.

The feeling of frustration generated in the work environment due to overcrowding, high demand and lack of resources was identified as a cause of physical and emotional exhaustion that hindered the professionals' qualified care provision, showing care that is vulnerable to risks and mistaken interventions⁽¹²⁾. Therefore, these situations may impact the nurses' performance in emergency situations, as in the case of stroke, which falls within the 4.5-hour intervention timeline and requires immediate care from the entrance door to the referral of the elderly person affected by this condition.

Specifically concerning access to technologies, in this study, this served as a facilitator for the welcoming of patients suspected of a stroke. The use of technology in nursing care promotes health and qualifies care, assisting in decision making by permitting clinical reasoning⁽¹³⁾. The availability of technology at the place of study is in line with the recommendations for stroke attendance in emergency care. These technological devices should be available in type I, II and III services, being differentiated in the latter due to the availability of the Integral Care Service for CVA (U-AVC Integral), which guarantees user access through the commitment to the following tests: computed tomography-angiography, magnetic resonance imaging, angioresonance, transcranial echocardiography, and interventional neuroradiology⁽¹⁴⁾.

In addition to the provision of appropriate technological resources for the treatment of cerebrovascular diseases, type III hospitals are empowered to train workers. The nurses mentioned that they did not receive the training to act in welcoming and that the form of care had been learned during daily work. This situation is in line with the recommendation of the National Humanization Policy regarding specific training for this purpose⁽⁶⁾. The lack of courses and

training to work in ACCR is a difficult factor for the provision of risk-free care that is harmless to the patient, which corroborates what some participants said about technical unpreparedness as a cause of insecurity and increased probability of errors. In the field of nursing care, studies indicate that, among the most common problems, there is a lack of human resource training⁽¹⁵⁾.

Regarding qualification, it is recognized as a right guaranteed by the Code of Ethics of Nursing Professionals (CEPE). Thus, the referral service should consider specific technical training, indispensable for the purpose of correct classification, as a priority, and the institution should offer conditions for the provision of training courses to its professionals, especially those who work at the entry door⁽¹⁶⁾.

The nurses' working conditions should not be disregarded though, especially regarding the multiple bonds and the exhaustive workdays. This condition of long and exhausting days, associated with the predominance of the female gender in nursing, which implies considering household chores as well, negatively affects the demand for courses⁽¹⁷⁾. Therefore, an operational plan is suggested that includes as many professionals as possible in the training courses.

In addition, the professionals themselves need to seek professional qualification. As recommended by CEPE, in its art. 14, nurses need to improve their technical, scientific, ethical and cultural knowledge for the benefit of the individual-family-community and the development of the profession. Therefore, they seek to continuously update their knowledge with a view to ensuring harm-free care⁽¹⁷⁾.

Another intervening in ACCR to patients suspected of stroke, described negatively by the participants, is the absence of a support team at the entry door. The provision of sufficient human resources is one of the critical nodes of public services, as the supply has been outperformed by the high demand⁽¹⁸⁾. In this sense, the proper dimensioning and hiring of personnel needs to be considered a priority, in order to reduce the waiting time and, consequently, the complications of clinical conditions.

The lack of information by the companions was also considered as compromising for the host, as it makes it difficult to understand the patient's condition, both in relation to its onset and duration and to the description of the clinical manifestations. In view of such a reality, popular health education for stroke should be disseminated to gain an understanding of risk factors and clinical manifestations, especially as it has been shown that patients who are victims are rescued by a third person, who does not have information on the condition⁽¹⁹⁾. When it comes to the elderly, this factor is even more complicated, given the existence of comorbidities that, at times, mimic signs of alert to stroke. The importance of health education initiatives such as the Popular Education Campaign is highlighted, which alerts to the control of risk factors, early identification of warning signs and proper emergency response to acute illnesses⁽¹⁴⁾.

Finally, the nurses in this study cited the disorganization of the Health Care Network as an element that also interferes negatively in the reception. In this regard, it is important to emphasize that the precarious integration among health services appears as a characteristic present in most health systems in the Americas for several decades, generating fragmentation and duplication of services. Studies by the Pan American Health Organization and the World Health Organization show that this insufficiency has led to a reduction in the quality and effectiveness of the health care network, unnecessarily increasing the costs of health care, widening inequalities in access and generating great inefficiency throughout the system⁽²⁰⁾.

With regard to the risk classification protocol, its implementation was pointed out as a positive intervening factor for care. It should be noted that the National Humanization Policy itself indicates the use of pre-established protocols, which guide the conduct of the screening process: the main complaint, the degree of risk and the waiting time⁽⁶⁾. The protocol can use countless instruments spread throughout the world. In this service, managers opted for the Manchester Protocol, which defines the severity levels of

each patient and the time it will take to be taken care of. Specifically, in situations of suspected stroke, whose service time is a determinant factor for the reversibility of the condition, the use of the protocol organizes the flow and ensures that the first assistance occurs quickly. Therefore, the adoption of ACCR is an important organizing device⁽¹⁸⁾. Strategically, this aspect needs to be disseminated through continuous education actions in the service.

ACCR is considered to be a potentially decisive intervention for the reorganization of network health promotion though⁽⁴⁾. Considering that having a functioning network facilitates the provision of problem-solving care, ACCR is an important tactic in this context. Studies indicate that the high demand for emergency care in large hospitals could be properly addressed in Primary Health Care Units and Emergency Care Units⁽¹⁴⁻¹⁵⁾.

In the Brazilian context, PHC is the main gateway to high-complexity care, responsible for ordering the need to define flows and counterflows, references and counter-references. Thus, initiatives and actions that seek to increase and enhance the role of PHC are essential for improving the articulation between care levels. As positive repercussions, the reduction of the burden of users affected by chronic diseases who seek tertiary services, continuity of care and user satisfaction can be mentioned⁽²¹⁾.

Considering that the organizational arrangements for actions and services of the Health Care Network aim to ensure the response to health demands and the integrality of care from promotion to rehabilitation, it is urgent to use SSP in the network organization of health services. This favors the definition of articulation strategies among the actors, regulatory mechanisms, monitoring, and evaluation of these services. Thus, the prioritization of actions focused on promotion and prevention, especially for health education, is fundamental for the health sector. These actions constitute important strategies to face the challenges inherent in receiving people with suspected stroke in the health system.

This shortcoming, which represents a limitation of the study, may support management that ensures the functionality of these services and their therapeutic impact on the victims, being referral services with regard to the early assessment of warning signs, treatment, and recovery.

Conclusion

The study pointed out that access to the technologies and the implementation of the risk classification protocol were identified as facilitators for care in the context of stroke victims, enhancing the welcoming. On the other hand, other issues significantly compromise the dynamics, such as deficits in the hospital infrastructure, except for technology, lack of support staff at the entry door, lack of training for nurses in the ACCR, lack of information from the companions and weaknesses of the Health Care Network.

The study also indicates the need for a strategic management model based on SSP that can intervene in optimizing the management of available resources, both for investing and valuing strengths and prioritizing the fast resolution of weaknesses or compromising and aggravating aspects, as reducing difficulties and obstacles is essential to ensure the service quality and universal access. Thus, the identification of these factors permits an important situational diagnosis, supporting central and local management in the search for strategies that guarantee the effective functioning of the referral services for stroke care.

In this sense, studies with managers of other referral services that serve victims of stroke are essential, in order to deepen the understanding of the theme.

Collaborations:

1. conception, design, analysis and interpretation of data: Alice de Andrade Santos, Larissa Chaves Pedreira, Juliana Costa Ribeiro-Barbosa and Nildete Pereira Gomes;

2. writing of the article and relevant critical review of the intellectual content: Alice de Andrade Santos, Larissa Chaves Pedreira, Nadirlene Pereira Gomes and Cátia Maria Costa Romano;

3. final approval of the version to be published: Larissa Chaves Pedreira and Nadirlene Pereira Gomes.

References

- World Health Organization. The top 10 causes of death [Internet]. Geneva; 2014. [cited 2018 May 14]. Available from: <http://www.who.int/mediacentre/factsheets/fs310/em>
- Carmo JF, Oliveira ERA, Morelato RL. Functional disability and associated factors in elderly stroke survivors in Vitória, Brazil. *Rev Bras Geriatr Gerontol* [Internet]. 2016 [cited 2018 May 18];19(5):809-18. Available from: <http://www.scielo.br/pdf/rbgg/v19n5/1809-9823-rbgg-19-05-00809.pdf>
- Damata SRR, Formiga LMF, Araújo AKS, Oliveira EAR, Oliveira AKS, Formiga RCF. Perfil epidemiológico dos idosos acometidos por acidente vascular cerebral. *Rev Interdisc* [Internet]. 2016 [cited 2018 May 18];9(1):107-17. Available from: http://www.revistainterdisciplinar.uninovafapi.edu.br/index.php/revinter/article/view/751/pdf_283
- Dias AC. Depressão no pós acidente vascular cerebral no idoso [dissertação]. [Coimbra]: Faculdade de Medicina da Universidade de Coimbra; 2015 [cited 2017 Apr 3]. Available from: <https://estudogeral.sib.uc.pt/bitstream/10316/30477/1/DEPRESS%C3%83O%20NO%20P%C3%93S%20ACIDENTE%20VASCULAR%20CEREBRAL%20NO%20IDOSO.pdf>
- Tavares APM, Silva AKDO, Fernandes MA. Planejamento estratégico situacional e a aplicabilidade à saúde do trabalhador: um estudo com feirantes. *Rev enferm UFPI*. 2016;5(3):72-5.
- Silva AK, Sousa JP, Rodrigues W, Cançado AC. Planejamento Estratégico Situacional - PES: uma análise bibliométrica da produção científica brasileira. *Rev Serv Público* [Internet]. 2017 [cited 2018 Jun 1];68(2):365-88. Available from: <https://revista.enap.gov.br/index.php/RSP/article/view/1269>
- Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2016.
- Huertas F. O método PES: entrevista com Matus. São Paulo: FUNDAP; 1996.
- Brasil. Ministério da Saúde. Secretaria Executiva. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: acolhimento com avaliação e classificação de risco: um paradigma ético-estético no fazer em saúde [Internet]. Brasília; 2004 [cited 2018 Jun 1]. Available from: http://www.saude.sp.gov.br/resources/humanizacao/biblioteca/pnh/acolhimento_com_avaliacao_e_classificacao_de_risco.pdf
- Brasil. Ministério da Saúde. Protocolo estadual de classificação de risco [Internet]. Brasília; 2014 [cited 2018 Jun 19]. Available from: http://www.saude.ba.gov.br/novoportal/images/stories/PDF/protocolo_classificacaoderisco_cour.pdf
- Prudêncio CPG, Monteiro RAN, Ribeiro BCM, Gomes MSM, Manhães LSP. Perception of nurses on patient admission with risk rating of the emergency care service. *Rev baiana enferm* [Internet]. 2016 abr-jun [cited 2018 Jun 22];30(2):1-10. Available from: https://portalseer.ufba.br/index.php/enfermagem/article/view/14917/pdf_46
- Duarte MDLC, Glanzner CH, Pereira LP. O trabalho em emergência hospitalar: sofrimento e estratégias defensivas dos enfermeiros. *Rev Gaúcha Enferm* [Internet]. 2018 [cited 2018 Jun 22];39:e2017-0255. Available from: <https://seer.ufrgs.br/RevistaGauchadeEnfermagem/article/view/85461/49141>
- Santos JLGD, Lima MADDS, Pestana AL, Colomé ICDS, Erdmann AL. Estratégias utilizadas pelos enfermeiros para promover o trabalho em equipe em um serviço de emergência. *Rev Gaúcha Enferm*. 2016;37(1):76-82.
- Sabino LMM, Brasil DRM, Caetano JA, Santos MCL, Alves MDS. The Use of Soft-Hard Technology in Nursing Practice: Concept Analysis. *Aquichan* [Internet]. 2016 [cited 2018 Jun 25];16(2):230-9. Available from: <http://aquichan.unisabana.edu.co/index.php/aquichan/article/view/4310>
- Brasil. Ministério da Saúde. Linha de Cuidados em Acidente Vascular Cerebral (AVC) na rede de Atenção às Urgências e Emergências [Internet]. Brasília; 2012 [cited 2018 Jun 18]. Available from: http://portal.saude.gov.br/portal/arquivos/pdf/linha_cuidado_avc_rede_urg_emer.pdf
- Duarte SCM, Queiroz ABA, Buscher A, Stipp MAC. Human error in daily intensive nursing care. *Rev Latino-Am Enfermagem* [Internet]. 2015

- [cited 2018 Jun 3];23(6):1074-81. Available from: <http://www.scielo.br/pdf/rlae/v23n6/0104-1169-rlae-23-06-01074.pdf>
17. Teleb MS, Ver Hage A, Carter J, Jayaraman MV, McTaggart RA. Stroke vision, aphasia, neglect (VAN) assessment-a novel emergent large vessel occlusion screening tool: pilot study and comparison with current clinical severity indices. *J Neurointerv Surg* [Internet]. 2017 [cited 2018 Apr 5];9(2):122-6. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5284468/>
 18. Holland S, Magama M. Evidence based practice translated through global nurse partnerships. *Nurse Educ Pract* [Internet]. 2017 [cited 2018 Jun 27];22:80-2. Available from: [http://www.nurseeducationinpractice.com/article/S1471-5953\(16\)30267-0/pdf](http://www.nurseeducationinpractice.com/article/S1471-5953(16)30267-0/pdf)
 19. Souza CC, Araújo FA, Chianca TCM. Scientific Literature on the Reliability and Validity of the Manchester Triage System (MTS) Protocol: A Integrative Literature Review. *Rev Esc Enferm USP* [Internet]. 2015 [cited 2018 May 1];9(1):144-51. Available from: <http://www.scielo.br/pdf/reeusp/v49n1/0080-6234-reeusp-49-01-0144.pdf>
 20. Feigin VL, Roth GA, Naghavi M, Parmar P, Krishnamurthi R, Chugh S, et al. Global burden of stroke and risk factors in 188 countries, during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet Neurol* [Internet]. 2016 [cited 2018 Jun 12];15(9):913-24. Available from: [http://www.thelancet.com/pdfs/journals/laneur/PIIS1474-4422\(16\)30073-4.pdf](http://www.thelancet.com/pdfs/journals/laneur/PIIS1474-4422(16)30073-4.pdf)
 21. Solla J, Chioro A. Atenção ambulatorial especializada. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI. (Org.). Políticas e sistemas de saúde no Brasil. 2a. ed. Rio de Janeiro: Fiocruz; 2012. p. 547-76.

Received: September 12, 2018

Approved: March 25 2019

Published: June 21, 2019



The *Revista Baiana de Enfermagem* use the Creative Commons license – Attribution -NonComercial 4.0 International. <https://creativecommons.org/licenses/by-nc/4.0/>

This article is an Open Access distributed under the terms of the Creative Commons (CC BY-NC). This license lets others remix, adapt and create upon your work to non-commercial use, and although new works must give its due credit and can not be for comercial purposes, the users do not have to license such derivative works under the same terms.