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ORIGINAL

Exploring the Management of the Triage System in the Screening of Patients: The Case of Emergency Health Services in Portugal

Exploración de la gestión del sistema de triaje en la selección de pacientes: el caso de los servicios de urgencias sanitarias en Portugal

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ABSTRACT

Introduction: this study examines the effectiveness and management of triage systems, particularly the Manchester Triage System (MTS), in Portuguese emergency services. It explores the extent to which current screening practices align with the goals of prioritising critical patients and managing limited healthcare resources efficiently. Methods: a qualitative research design was adopted, using semi-structured interviews with healthcare professionals working in emergency departments in Portugal. Thematic analysis was conducted to compare frontline experiences with theoretical insights from the existing literature, enabling a contextual assessment of the MTS's operational effectiveness. Results: the Manchester Triage System was generally perceived as valid and functional. However, professionals reported challenges such as delayed diagnostic procedures, lack of material resources, and inconsistent adherence to triage priorities. Key suggestions included refining workflow structures, improving digital systems, and strengthening nurse training in Basic and Advanced Life Support. Conclusions: reorganising emergency departments—by more clearly separating high- and low-priority cases, improving staff allocation, and enhancing IT infrastructure—can reduce waiting times, improve patient flow, and increase clinical safety. These changes may enhance patient satisfaction, reduce inequalities in emergency care delivery, and mitigate burnout among healthcare professionals.

Keywords: Management; Screening; Triage; Emergency Medical Services; Effectiveness; Prioritisation.

RESUMEN

Introducción: este estudio analiza la eficacia y la gestión de los sistemas de triaje, en particular el Manchester Triage System (MTS), en los servicios de urgencias portugueses. Se examina hasta qué punto las prácticas actuales de clasificación se alinean con los objetivos de priorizar a los pacientes críticos y gestionar de forma eficiente los recursos sanitarios limitados. Métodos: se adoptó un diseño cualitativo mediante entrevistas semiestructuradas a profesionales de la salud que trabajan en servicios de urgencias en Portugal. Se realizó un análisis temático para comparar las experiencias de primera línea con los aportes teóricos de la literatura existente, lo que permitió una evaluación contextual de la eficacia operativa del MTS. Resultados: el Manchester Triage System se consideró globalmente válido y funcional. Sin embargo, los profesionales identificaron problemas como retrasos en las pruebas diagnósticas, falta de recursos materiales y una adhesión inconsistente a las prioridades de triaje. Entre las principales sugerencias se incluyeron la optimización de los flujos de trabajo, la mejora de los sistemas digitales y el refuerzo de la formación de enfermería en Soporte Vital Básico y Avanzado. Conclusiones: la mejora de la organización de los servicios de urgencias —incluida la separación más clara entre casos de alta y baja prioridad, una mejor asignación de personal y el fortalecimiento de la infraestructura informática— puede reducir los tiempos de espera, mejorar el flujo de pacientes y aumentar la seguridad clínica. Estos ajustes contribuyen a una mayor satisfacción de los pacientes, a la reducción de inequidades en la atención urgente y a la disminución del desgaste profesional del personal sanitario.

Palabras clave: Gestión; Cribado; Triaje; Servicios de Urgencias; Eficacia; Priorización.

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INTRODUCTION

The management carried out through the screening systems is something that raises several issues, both for health professionals and users. It is therefore an increasingly pertinent topic drawing attention over the year from numerous scholars. Nawata et al.(1)looked into the over-and under-provision of diabetes screening, while Cardona-Morrell et al.(2)presented a framework for identifying patients with the highest likelihood of demising. The lean and sigma methods based on defining, measuring, analysing, improving and controlling processes were investigated by McGrath et al.(3) to establish the best possible approach to structuring patient screening systems. Roaten et al.(4) proposed the creation of a universal suicide risk screening program in a safety-net hospital system catering for uninsured, underinsured, or patients who face financial barriers to accessing healthcare services. Web-based screening systems were tested by Matcham et al.(5)to sort out patients who have suffered from smoking addictions and mental disorders. Based on the abovementioned literature, it is evident that screening systems are widely adopted in the hospital system, therefore creating a need for continuous understanding of their use and management. Emergency Services in Portugal provide care to millions of individuals each year. The constant changes in care are numerous and depend on the nature of care. Change is therefore a constant in the field of medicine, and these changes are increasingly rapid and complex.(6)Screening in the Emergency Services is the starting point of the health care delivery process,(7)and should be a meticulous and demanding process carried out by professionals prepared for it. The Screening System is a process to be used with all users who present themselves at the Emergency Department in order to determine the severity of the clinical picture. The primary objective of screening is, therefore, to place the user in the correct place, to more easily receive the appropriate level of necessary care, facilitating the allocation of adequate resources to meet the needs of the user in medical terms. In Portugal, the most widely used system is the Manchester Screening System. This method consists of identifying the real situation of the user, following a flowchart of decisions as various questions are asked. The use of this system classifies the user on a scale of 5 categories identified through a number, name, colour and predictable time to give the initial medical observation.(8)

The Manchester Screening System

Since its implementation, several researchers have demonstrated that the MTS is a sensitive, reliable and widely validated instrument, including pediatric clients.(8)According to Azeredo et al.(9), the researchers who evaluated the STM report that, in addition to giving priority to the care of the clients, it was able to predict the evolution of the clients during their stay in the institution. Martins et al.(10)also report in their research that the STM is a preponderant instrument to distinguish clients with high risk of life and low risk of life, as well as to distinguish which users will remain in the hospital at least twenty-four hours before being discharged. In a systematic review of the literature by Azeredo et al.(9)on the effectiveness of STM, the researchers concluded that only two of the twenty-two investigations analysed presented unfavourable results for the application of STM.(11,12)

The authors also state that the concept can be expanded to other Emergency Services with different characteristics.(13,14,15,16,17,18)Each SU must develop its own means to deal with the composition of medical teams, the existence of many severe users and overcrowding, as these events can increase waiting times and user dissatisfaction.(19)An important parameter of the MTS is pain assessment, which is difficult because it involves complex and subjective aspects, involving the patient, as well as the triage nurse. The pain scale is numerical, where zero corresponds to no pain and ten corresponds to the worst pain. In adult users, the normal question is asked to know how severe the pain is, while in paediatrics, a version with images of the panda bear was created to be used in younger children.(17,20,21,22)Thus, the Manchester scale can be used to assess pain in children who go to the SU. One of the conditions for using the STM is the evaluation of the risk classification process from the audit, in which two trained and trained professionals evaluate the classification forms obtained by sampling the total number of users screened by the professionals. Incorrect and/or incomplete classification screenings are identified. The results are analysed and compared. A maximum of 5 % of incorrect and incomplete screenings and 95 % agreement between evaluators is expected.(19)An investigation was carried out based on the differences between the nurse and the physician in the triage function. It was found that the doctor, due to his practice being more focused on obtaining a diagnosis, transforms the screening into a consultation. The nurse, in turn, is more disciplined and can maintain an accuracy rate above 95 %.(23,24,25)

Literature Review

According to Choi et al.(26), an investigation was conducted that describes the implementation of three health professionals in screening. This trio consists of an experienced doctor, a nurse and an assistant. This team works together and simultaneously in the screening. The nurse performs the triage as usual, the physician evaluates and treats the patient, and the assistant is in charge of the referral of the same to the SU. This investigation was carried out for eight hours over seven days in an SU. The results obtained were compared with a screening only composed of a triage nurse. It was concluded that there were improvements in waiting times and medical care in categories four and five, and few improvements in the time of completion of medical care. However, there were no improvements in waiting time for users in categories two and three. This process demonstrated a high level of tension and wear and tear of the medical team, and a greater number of errors may occur.(19)In 2003, a debate was published on the relevance of the existence of the blue category, corresponding to non-urgent users, questioning the screening process, especially of the STM, stating that it was introduced with little evaluation, recommending that this category be abandoned, since these users are not suitable for the SU and may be referred to primary health care, these services being of less complexity. Experienced teams ready to treat more severe cases should not occupy their time with this type of user.(20)This research draws attention to the long waiting times for this level of priority. In these cases, it would not be necessary to perform the screening, but rather the use of well-trained nursing professionals to complete very simple treatments, indicating the “See and Treat” model as an alternative to obtain better results.(22)

Screening was the first formalised clinical risk management system, designed to ensure that whenever demand outstrips existing resources, these should be directed to clients with the greatest clinical need. In this sense, the problem is not the screening or the system used for clinical decision-making, but the lack of resources available to meet all the demand.(19)Another important point to mention will be the waiting time for the screening. Many services have been shown to have times longer than forty minutes, which can be dangerous. These delays should not happen because no one is aware of the user until he performs the screening. Risk classification will only be dispensable when the available resources match the demand, something that is impossible to happen these days. There will always be an imbalance between the supply and the capacity to respond to the needs of the population, and it is therefore necessary to adopt new organisational measures in health care.(19)The waiting time can be used as a marker of quality and available infrastructure,(21)recommending that one should never lose the safety and rigour that screening offers, both for users and for health professionals.(18)An investigation was carried out in the Intensive Care Unit (ICU). The first analysis included ninety-one inpatients from the SU; 67 % of the clients were admitted to the ICUs, classified as high priorities (red and orange). Eighteen clients were poorly screened, and six clients were screened correctly, but worsened upon arrival. A critical user was screened with priority level three, corresponding to the yellow bracelet.(27)The research concluded that the Manchester Screening System is a sensitive tool for detecting clients who need intensive care, while also failing to detect clients who have worsened their clinical condition upon arrival at the SU. It is necessary to conduct training for triage nurses in order to be able to increase sensitivity.(19)

Another source of investigation was chest pain. This study evaluated patients with chest pain in the SU, submitted to STM screening. Using the STM, the triage nurses demonstrated the ability to recognise clients with this typology, and an Electrocardiogram (ECG) and a medical evaluation were performed in ten minutes, demonstrating a sensitivity of 86,8 % and a specificity of 72,4 %. Among the fourteen nurses present in the study, thirteen think they need more training, which may be a determining factor to improve sensitivity, and the result found is already positive.(28)According to Trigo et al.(29), in Portugal the capacity of STM to classify clients with coronary syndrome was investigated. Two hundred and seventy-eight patients with ST-segment elevation in acute myocardial infarction were evaluated; 79 % of clients were classified as urgent and very urgent, while 21 % were classified as urgent. The number of clients screened with urgent priority was too high, and may be related to both screening errors and STM failures, because it is not possible to incorporate variability, and this does not include the performance of ECG as a discriminator in the chest pain flowchart. The incorrect classification of these patients by the Manchester Screening System has resulted in an increase in waiting times, limiting the possibility of access to the necessary therapies.

An investigation was carried out analysing the implementation of STM in a paediatric emergency health unit in the UK. The waiting times for users classified as emerging priority were 1,3 minutes, very urgent 30 minutes, urgent 37,9 minutes and a little urgent 37,6 minutes. The audit provided information in order to improve and expand the practice of nurses, also helping to define care protocols before medical evaluation. It was concluded that the STM is suitable to be used in the Paediatrics unit.(30)In the Netherlands, two investigations were carried out. The first tests the validity of the MTS by correlating the categories of urgency with information on vital signs, use of resources, predefined referral and hospitalisation for true urgency. The sensitivity obtained was 63 % for very urgent and emerging cases, with 15 % of underestimated screening. The percentage of hospitalisation for emergent clients was 53,5 %, very urgent 28,6 %, urgent 16,2 %, a little urgent 6 % and non-urgent 0,9 %. The specificity obtained was 78 % and an overestimated screening of 40 % in categories two and three. This research concluded that the MTS needs to undergo modifications to increase specificity.(31)

The second investigation evaluates the use of STM in pediatric SU. Sensitivity was also 63 % and specificity was 79 %. However, the Manchester Screening System is less sensitive in children aged zero to three months. Screening was underestimated in 12 % and overestimated in 54 % of patients. The investigation concluded that the validity is moderate, and it is necessary to carry out investigations on specific flowcharts for which the STM demonstrates low validity. Despite failing in this regard, overestimated screening is superior to underestimated, which provides safety.(32) According to Van Veen et al.(33), it was possible to evaluate some of the most used Triage Systems in pediatric urgency. This suggests that the STM obtained good reliability, the ESI moderate to good, the paedCTAS moderate, and the ATS weak to moderate, demonstrating that the STM seems to be valid to screen children who present to the SU, and it is necessary to carry out further investigations on its validity and reliability in certain parameters. In Sweden, an investigation was carried out based on the evaluation of the reliability between screeners and the accuracy of the MTS in the SU. One thousand and twenty-seven cases were analysed by seventy-nine nurses from seven Emergency Services. The accuracy of the screening was 92 % for emerging cases and 91 % for very urgent cases, very positive. In less urgent cases, the agreement and accuracy were lower, with cases of underestimated and overestimated screening, concluding that the resources of the SU may be being heavily consumed by so-called non-urgent clients.(34)Referring to a last investigation carried out in 2009, nine hundred evaluations were performed by twelve nurses in three different hospitals. The first used an informal system, the second the ESI and the third the STM. The objective was to compare the agreement of the different systems. The agreement demonstrated by the STM was very good and that of the ESI was moderate to good. Comparing the systems, 5 % of the screenings were underestimated for the STM and 13 % for the ESI, while the overestimated screenings were 6,1 % for the STM and 29,5 % for the ESI.(25)These investigations allowed to demonstrate that the STM has scientific production to prove that it is considered a valid and reliable system, and can be used safely in the Emergency Services.(19)

METHODS

Prior to conducting interviews, ethics clearance was secured due to the involvement of human participants. The research adopted a qualitative approach to investigate of meanings, psychic representations, social representations, symbolizations, perceptions, points of view, perspectives, experiences, life experiences and analogies. It has addressed, among other topics, adaptation mechanisms; adherence and non-adherence to treatments; stigma; Care; reactions and roles of professional and family caregivers; facilitating factors and difficulties in the face of the profession / in the face of treatment / in the face of working conditions.(35)In this context of this study, qualitative research was particularly useful in situations where relevant variables and/or their effects were not apparent or when the number of subjects and/or data obtained are insufficient for statistical analysis. Subjects can vary in number, from an individual to large groups, and the focus of inquiry can vary from a particular action of a person or small group to the function of a complex institution. Research methods include interviews (structured, semi-structured and open), observation (external or participant) and analysis of written material.

The interviews allowed access to data that are difficult to obtain through direct observation, such as feelings, thoughts and intentions. In this research, the researchers focused on conducting interviews with various health professionals, which is their main objective, with the scope of finding out what they think of the Screening System and the management of their Hospital Center.

The interviews conducted with health professionals are the focus of the investigation. During the process, the researchers found it pertinent to formulate some questions to interview users present in the SU, in order to find out what they think of the service and the work done by the health teams, thus interconnecting some questions that are common to the interviews of health professionals. In this way, it is possible to investigate the vision of those who provide the services, as well as those who receive them. In this way, the questions to which researchers wish to acquire answers are:

Table 1. Healthcare professionals

Triage in national hospitals is performed by nurses. What is your opinion on this?
A large percentage of users who go to SU (Emergency Services) do not need to do so, as we all know. In your opinion, should screening have a doctor? If that doctor evaluated the patient at the time and prescribed the In your opinion, what are the biggest benefits that screening brings to an SU?
The monitoring of a user from the moment he enters the emergency room is important. How is the control carried out to know how long it is waiting to be observed? What computer system is used by doctors/nurses to monitor users who are in the SU?
In the investigation it was mentioned the existence of users who misrepresent their true state of health, exaggerating their condition to obtain faster care. Triage nurses have the capacity to perform vital signs tests. Why are these tests not carried out on users in the screening, instead of relying only on a dialogue following a flowchart, without a single analysis? I mention this because one of the problems discovered in the investigation is precisely overtriage (overvaluing the case) and undertriage (undervaluing the case). As we know, the latter is more serious, putting the lives of users at risk. Don't you think that performing these tests would be an advantage, both to reduce screening errors and to find users who try to misrepresent the system to get faster care?
Waiting times are rarely met in emergencies and users who have low priority wristbands wait a long time. Do many of these delays happen due to a lack of health professionals, material resources, both, or lack of organization with regard to management?
In your view, what are the biggest flaws in SUs in relation to user management?
A practice that could be a solution to the reduction of waiting times would be the creation of a team directed to critical users and another team for non-critical users, triage sections divided for these two groups. Do you think this would be a good method to implement in the Screening System?
Do you know other Screening Systems?
In the research it was found that 25 % of clients change doctors in the SU. Does the fact that this happens not cause problems in the management of users by doctors?
Most national hospitals operate under the Manchester Triage System. Do you think this system is correct as it stands at the moment?
COVID-19 has also brought some flexibility in terms of management, teleconsultations. Will the implementation of teleconsultations be favourable for the management of users? Would it be an added value to continue with this practice in the future, or should we use only the face-to-face method?

Intepretation of Findings

Continuing this investigation, in this chapter we will proceed to the analysis of the results obtained in the interviews. Triage in national hospitals is performed by nurses. What is your opinion on this? / -When he enters the emergency room he is directed to the triage, where he is provided with a bracelet. What do you think of this process, do you think they do this work well? Only one of the ten health professionals does not have an opinion on the matter, stating that a screening can be performed by nurses, as well as by doctors, because they are qualified health professionals to do so. The rest agree with this methodology, because nurses have the training, skills and knowledge to perform it. The purpose of screening from their perspective is to be a quick process, because it is the first contact that SU have with users, that is, they can give entry to high priority users, who have to be screened as soon as possible, in order to be referred directly to the SU for a more in-depth diagnosis of their clinical case. Once they arrive at this location, a more detailed observation of the respective case by the medical teams should be carried out. Some users agree that it is a job well done, others not so much, indicating that they have already gone to different hospitals with the same problem and that they have obtained bracelets of different color, something they cannot understand. They state that it is up to the nurse to give or not a bracelet with reduced or moderate priority. Some users think that they will always be screened with yellow or green bracelets, because most screeners always think that it is never anything serious. One patient also mentioned that the triers should be allowed to refer non-urgent patients to the Health Center. In this way, it would be possible to avoid the concentration of non-critical users in the SU, reducing overcrowding in them, because primary health care must have all the necessary mechanisms and tools to support non-urgent cases.

Thus, the opinion of users does not fully corroborate the opinion of health professionals. While some believe that the screening is well performed and that nurses are professionals able to perform the screening, others believe that the screening is sometimes very vague and poorly performed, without giving due value to the word of the user.

Table 2. Users

Do you have any idea which professional performs the screening? Will it be a doctor or nurse?
How often do you go to the Emergency Room? When you feel something different, some pain, do you immediately go to the SU or try other alternatives?
When you enter the emergency room you are directed to the triage, where you are provided with a bracelet. What do you think of this process, do you think they do this work well?
When you go to the emergency room, do you wait a long time to be observed or do you think you wait for the appropriate time?
Have you left the emergency room without being observed, that is, have you left because you have been waiting a long time and do not get any observation from the medical teams?
Are you always serious about what you truly feel or have you given some purposeful emphasis to get a faster service, since there is so much delay in being called?
Do you think that many of these delays are due to lack of health professionals, material resources, both, or lack of organization with regard to management?
The creation of a team for critical users and another team for non-critical users, triage sections divided for these two groups. Do you think it could be an advantage?
Do you think it is an asset to be observed by several doctors or do you think it should be only one to observe you?
When you are observed and perform tests, do you think you wait a long time for the results of the tests, or do you think it is a quick process?
Do you know how the screening system works?
Do you think there is disorganization in emergencies or do you think that good management of the service is carried out?
Did the onset of COVID-19 in 2020 give rise to any fears about going to the emergency room to get medical care? If so, what other method did you choose to choose? Did you carry out any teleconsultations?
Do you consider that teleconsultation is a method to be maintained in the future or do you prefer to go to the Health/Hospital in person?

A large percentage of users who go to the SU (Emergency Services) do not need to do so, as we all know. In your opinion, should screening have a doctor? If this doctor evaluated the patient at the time and prescribed the necessary medications, would it decrease the existing overcrowding?

This issue has been discussed in different ways. Seven out of ten health professionals do not think it is beneficial for various reasons, since the goal of screening is to be a quick process to prioritize clients according to their health status. In this sense, on the one hand, having the presence of a doctor to investigate the less serious cases would not be efficient, because it would be delaying this process; on the other hand, it would be good because it allowed better control, reducing the overcrowding existing in the SU. In the area of screening there should be no long waiting lines, since at this time the first contact of the user with the SU is made and no one is aware of their state of health. Between overcrowding and waiting time in the SU before or after the screening, it becomes more acceptable to exist after the screening, since its prognosis has already been made. Health professionals also state that it would not be beneficial because users would request the Emergency Services in order to obtain a quick service in a short time. In this sense, non-urgent cases would go to this place for ease and speed of service, this not being the most appropriate place. All non-urgent clients should go to primary health care first. However, if the family doctor so wishes, he may refer the clients to the SU. Health professionals believe that there is a lack of knowledge for users to know when to go to an SU. Three of the ten health professionals believe it would decrease overcrowding in the SU but would delay the screening process.

In your opinion, what are the biggest benefits that screening brings to an SU?

The ten health professionals report that the greatest benefit of screening is obviously the speed and prioritization of users, that is, providing medical services more quickly to those who need them. It is necessary to have a rapid screening, because we never know the degree of severity of the user until he is screened, so it has to be a fast and effective process. With this basis of response, we also conclude that the triage is the basis of the management of the users, it is it that allows to organize the service, making the health professionals able to have an overview of all the users present in the SU, thus managing their time and resources. Who in his initial prognosis does not appear to have an urgent case, should wait.

The monitoring of a user from the moment he enters the emergency room is important. How is the control carried out to know how long it is waiting to be observed? What computer system is used by doctors/nurses to monitor users who are in the SU?

Six health professionals mentioned that their hospital uses SCLÍNICA. This programme provides information on the waiting time of clients who are to be screened, such as clients who are already screened. Only the Hospital of Coimbra has this functionality, the demonstration of the users who are to be triaged. All other professionals who use the SCLINIC, claim to have only information from the users after performing the screening. These appear on a first-come, first-served basis and by the color they are screened.

Two healthcare professionals report that their hospital uses MEDTRIX. This computer system presents the users who are waiting to be observed after performing the screening, not knowing the number of users in the service waiting to perform it. One of the health professionals states that they do not give importance to the time that users are waiting, which reinforces the idea that it is possible for a person to be "forgotten" in emergencies because some professionals or hospital centers do not give due attention to the times stipulated by the Triage System. It also states that the computer system is not intuitive. Users are identified in order of waiting and the severity with which they were screened.

A healthcare professional reports that their hospital uses HCIS: It shows times from the time patients are screened, not showing those who are about to screen. Users appear in the system in order of waiting and the severity with which they were screened.

Two health professionals report that their hospital uses ALERT: It presents times from the moment that users are screened, not demonstrating those who are about to screen. Users appear in order of waiting and their severity.

A healthcare professional states that their hospital uses GlINT: It shows times from the moment users are screened, not showing those who are about to screen. Users appear in order of waiting and by their severity.

Important points

Whatever the SU, clients should be screened again when their clinical situation worsens, or after two hours of the first screening. It is impossible to carry out this task because there are too many users for too few health professionals. As a result, it is not feasible to meet all the waiting times stipulated by the Manchester Screening.

In Coimbra, there are delays in carrying out the screening. A health professional reported that there are delays of more than an hour of waiting for users to perform the same, which can put lives at risk. Health professionals in Coimbra have this knowledge because their computer system indicates this parameter. These delays may occur in more national hospitals, but as their computer system does not have this control, it is not something that can be managed. It is important that all computer systems achieve this functionality, so that another sorting section can be added if necessary.

The organization of the emergency, the choice of computer system and management are carried out by the hospital manager. Currently, there are many problems in the SU, and it is necessary to implement new measures to try to solve the existing problems.

A health professional says he does not know how to answer the question, having to ask for help to perform tasks in computer systems. Thus, it was concluded that there is a lack of training of health professionals in certain services, delaying it even further.

The use of two different computer systems in the same hospital becomes confusing for doctors to work with, as is the case of doctors who start to work, the interns of the common year (IACS). Hospital Centers should have only one computer system, which is fast, easy to understand and accessible. Many professionals complain about their systems being not intuitive, noting that it is necessary to open many secondary programs to have access to certain user information. All this causes a great waste of time, time that could be channeled into other types of situations.

In the investigation it was mentioned the existence of users who misrepresent their true state of health, exaggerating their condition to obtain faster care. Triage nurses have the capacity to perform vital signs tests. Why are these tests not carried out on users in the screening, instead of relying only on a dialogue following a flowchart, without a single analysis? I mention this because one of the problems discovered in the investigation is precisely overtriage (overvaluing the case) and undertriage (undervaluing the case). As we know, the latter is more serious, putting the lives of users at risk. Don't you think that performing these tests would be an advantage, both to reduce screening errors and to find users who try to misrepresent the system to get faster care?

The health professional must always take the word of the user, trusting that he will not lie.

Pain is a subjective parameter to assess and the Manchester Screening System assigns it great relevance. Its level of evaluation is complex, because each patient has different pain tolerance, and may mention that the same pain in two users can be perceived in different ways. All health professionals indicate that vital signs tests are performed, but only on clients they deem necessary. In this way, many clients perform the triage through a dialogue, without any performance of vital signs, because the nurse does not think it necessary. Thus, it is possible to increase the speed of the screening, this being its main objective. On the other hand, the prognosis becomes more vague, causing possible cases of overestimated screening or underestimated screening to occur more regularly.

Several health professionals know of cases of clients who distort what they feel to try to get a faster observation, thinking that specific questions should be asked in order to try to control these cases. For example, if a patient claims to have a very strong pain, it will be beneficial to question how long they have been in pain. If you claim to have had this pain for days or weeks, you are probably misrepresenting what you feel. The aim would be to train screening professionals with this type of question or to create a specific document for these cases, thus achieving greater control. This practice would decrease the existing overestimated and underestimated screening percentages. One of the gaps in the SU mentioned by a triage professional concerns the worsening of the health status of the users. When the screening was performed, if the screener assigned a yellow bracelet, after two hours, which did not show seriousness, it changed, since the clinical status of a patient can change from one moment to the next. In this way, it would be beneficial to implement a nursing team to triage waiting clients if necessary. According to the testimonies of all health professionals in this investigation, this practice is not performed in any of the ten hospitals, thus demonstrating a lack of rigor in these aspects, given that there are few health professionals or, possibly, that there are no nurses or doctors with information to perform this type of work.

Waiting times are rarely met in emergencies and users who have low-priority wristbands wait a long time. Do many of these delays happen due to a lack of health professionals, material resources, both, or lack of organization with regard to management? / -Thinks that many of these delays are due to lack of health professionals, material resources, both, or lack of organization with regard to management

All the health professionals mention aspects, failures in the management of the service, in the management of health professionals and in the management of users.

Firstly, they refer to the failure in the management of the service, stating that it is always chaotic, where users do not have specific places to wait. When they are called to be evaluated, professionals do not know where they are.

Secondly, they mention the failure in the management of health professionals, since they exist, but are not well distributed. In some hospitals, the existence of only one specialist doctor in the overcrowded SU is something that should not happen, since all the information and conclusion of the clinical case of the user has to go through the analysis of the service specialist. As one health professional pointed out, this overcrowding became more intense from the moment in which the number of medical specialists in the SU decreased. Another flaw mentioned by a doctor, is the lack of control over the professionals who are at the service of the SU, namely in the hours of lunch, dinner and in the breaks that occur throughout their shift, since the users continue to enter this service and there is no one to carry out the work during that period, This will continue to lead to greater overcrowding.

Thirdly, it is also important to mention the failure in the management of users, which exists due to the need for a reformulation of the NHS, as indicated by a health professional. An important aspect to highlight is the lack of family doctors, making users who need an appointment have to go directly to the SU of the nearest hospital. The non-urgent cases assigned with blue and green bracelets, should be observed in primary health care and these centers should always be able to provide this support, helping to drain the users of the Hospital Centers that suffer from overcrowding, being necessary to make a greater investment in these places, in order to provide the proper care to the users who use these services. In addition, it is necessary to inform users, reinforcing that emergencies are places for urgent cases. If primary health care is able to help in this regard, clients who first went to the SU and in the screening if it was observed that it was a non-urgent case, they would be redirected to the health center in their area of residence.

It was also concluded the lack of material resources and health professionals in some areas of the country, as is the case of the Algarve, where they report that there is a lack of specialized professionals, with a large number of doctors working in the field.

The lack of material resources is also a determining factor in the occurrence of delays, to the extent that there is only one equipment in a Hospital Center to perform dialysis or to perform a CT scan. The lack of this equipment causes the service to become slower, without being able to create a solution, when it is only solved with the acquisition of material to speed up this process and not create queues for the realization of the same.

Only one health professional reports that the management of your Hospital Center is well carried out.

In this research, the conclusions obtained from the health professionals corroborate the conclusions of the users, and most of them believe that these delays are due to lack of health professionals and other types of resources. Most users believe that in addition, there is also poor management in the SU, which influences the quality of the service. One user also mentioned that Portugal is the third country with more doctors per capita, believing that there is a huge gap in the management of health professionals, which effectively can affect the service.

In your view, what are the biggest flaws in SUs in relation to user management?

Health professionals often refer to non-urgent cases, which are the ones that are most affected due to the long waiting times, leading to overcrowding in the service.

Only two of the ten professionals say that their hospital has differentiated teams to enable faster care for less urgent patients. In the hospitals where the remaining health professionals work, as there is no such division, this speed is not verified, causing users to crowd together.

From the testimony of a triage nurse, we conclude that a major problem is the fact that users are "lost" in the SU. These perform the screening and their prognosis assigns the same to a specialty. When they are observed, health professionals find that it will be beneficial to refer the patient to another specialty. When this re-routing happens, there is no follow-up by an assistant, causing the user to waste a lot of time to get to the site. This change of specialty is sometimes not well performed, since the user is left without a responsible doctor. Thus, the clinical case of the patient is not concluded, causing them to stay, sometimes, more than twenty-four hours in the SU. These cases happen most often with dependent elderly people, since they wait for something to be said or done to them, without anyone noticing them. In these cases, in particular, we do not highlight only the work, but rather the moral and human values of each health professional, demonstrating that the management of the user in the facilities needs to be greatly improved. Another failure already mentioned is the lack of specialist doctors, which is automatically related to the management of users, because without completion of clinical cases and impossible to send clients safely to their homes.

A practice that could be a solution to the reduction of waiting times would be the creation of a team directed to critical users and another team for non-critical users, triage sections divided for these two groups. Do you think this would be a good method to implement in the Screening System? /- The creation of a team directed to critical users and another team to non-critical users, triage sections divided for these two groups. Do you think it could be an advantage?

This methodology is already present in two hospitals of this research, namely the Hospital Pedro Hispano, in Porto and the Hospital do Divino Espírito Santo, in the Azores. By the impressions of the two health professionals is an extremely effective method that allows to improve the waiting times of non-critical users, as well as to relieve the overcrowding existing in the SU that is created by them, which in a management regime are waiting for long periods, not corresponding to the waiting times stipulated by the system, being thus, a bit neglected. Health professionals report that medical teams are divided by severity. The first team is composed of internal medicine specialists, who are directed to more urgent users. The second team is composed of undifferentiated doctors, who are nicknamed junior doctors, and it is up to them to evaluate the less urgent users.

It would be beneficial to try to implement this methodology in hospitals that have not seen it as both users and health professionals believe it could be a good option. In this way, non-critical users would end up not being neglected as sometimes happens in a normal urgency environment, where there is no such division and users with higher priority pass in front of them. It is necessary to try to implement a method capable of also responding to non-critical users, because it is at this level of priority that there are numerous problems and it is the permanence of these users that causes overcrowding in the SU.

Seven of the ten health professionals approached with this methodology would approve its implementation, since it would be possible to obtain a better management of users, reducing their waiting time. It should be noted that both teams should be trained to assist all levels of severity.

Thus, if the non-critical users section was controlled and the critical users section was more worked, one team could assist the other and vice versa. In this way, teams could also rotate, as critical users cause much more stress and exhaustion, both physical and emotional. In this sense, we would be able to create turnover among all health professionals.

Some health professionals who work in hospitals with "regular" SUs, claim to have never thought about this aspect and find this methodology quite interesting. Nevertheless, we must stress that non-critical clients must be instructed to always go to primary health care and that they must have all the capacity to deal with these problems.

Only one of the ten health professionals does not agree with this methodology. It is also concluded that hospital managers do not do the necessary research in order to study new methodologies to try to implement new systems in order to circumvent existing problems. It will be an added value to try to put new practices in place to prove if this improves the management of the SU or not. Only then will they have results. Without changing the system, without evolving, creating and finding solutions, then we will be sure that the SU will always be chaotic and we will never be able to respond to users in good time with the means we have at our disposal. If it is not possible to invest, acquire material, add more health professionals in the NHS, the change has to start in management, evaluating their changes.

As this question is also relevant to users, challenging them to give their opinion on this methodology, only two users said they were not able to give an opinion. The rest consider the attempt to implement this methodology to be quite positive.

Do you know of other Screening Systems?

Only one of the ten health professionals of the various national hospitals is aware of the existence of different Screening Systems, having mentioned that during his academic career he was never presented other than the STM. This conclusion demonstrates that it is difficult to change work methodologies because health professionals have never had contact with other Screening Systems.

For the most part two national hospitals operate as the Manchester Triage System. Acha, this system is correct, how is it found at the moment?

In a general way, all health professionals affirm that the Triage System is effective. It performs well its role of quickly prioritizing the users, in order to be able to provide a good service to those who really need it, as well as the entire process of the user giving output to YOUR. It should be noted that it is not because it is well executed in a general spectrum, that it is not necessary to make alterations in order to make it more efficient to obtain a lower percentage of error. There is always margin for improvement in the future. These improvements, which can be projected to be implemented in the near future, such as better evaluating some aspects that triadores normally overvalue, such as pain. A user who already has your data known, cannot be valued in the same way as a user who does not have this background.

The implementation of a triage system tailored to a specific specialty is equally important, as it was reported by a health professional, at the Manchester scale it must be adjusted to the different age groups, children, adults and the elderly, to the extent that The same pathology in the different age groups does not have the same level of severity. Only these small situations have to be evaluated in order to provide a safe Triage System.

COVID-19 also brings some flexibility not concerning management, as teleconsultations. Will the implementation of teleconsultations be something favorable for the management of two users? Is it better to continue with this practice in the future, or should we only use the face-to-face method? / -Do you consider that teleconsultation is a method to keep in the future or do you prefer to go to the Health Center/Hospital in person?

All the health professionals involved in the investigation, will affirm that the teleconsultation is beneficial in many aspects and that it would help to alleviate the overload that exists in our health services, because indeed there are many cases in which a teleconsultation is sufficient. This methodology would help not only in overflow, but also to make the processes faster, cheaper and safer for users. It should be noted, however, that teleconsultation should only be used for cases without any urgency, in which the health professional is already aware of or uses his clinical history. The doctor should always give priority to face-to-face consultation. This method should be implemented in the near future with well-delineated rules, studying its effect in the short term, in order to analyze and verify if it is going to be a well-implemented method and what makes sense to continue. In general, the users agree with the continuation of the teleconsultation, but they also refer that this should not replace the face-to-face consultation, since the majority affirm that they prefer to travel to the health center.

In cases where teleconsultation can work, such as medication, analysis verification, simple consultations, it is more valuable, both in terms of insurance and in monetary terms. It also ends up being a faster process for health professionals, who in this way manage to get better at their time. If the health professional asks for the consultation to be in person, that same will have the responsibility of explaining to the user that it is so that it fears to be carried out.

Do you have any idea of which professional performs the triage? Will it be a doctor or a nurse? All the interviewed users have the notion that he is a nurse who performs

How regularly do you go to the ER? When I feel something different, does someone go to his or try other alternatives?

According to the interviews carried out with the patients, we can verify that they are aware of their clinical situation, as well as demonstrate knowing that the emergencies are directed to urgent cases, dislocating themselves only when there is no other alternative, these being the centers of Health or private hospitals, in case of having health insurance.

When you go to the emergency room, do you wait a long time to be observed or do you wait for adequate time?

Only three to eleven users who will carry out an interview with each other who are attended at the time stipulated by the Manchester Triage System. No meanwhile, possibly we don't know what the times are stipulated by the system, therefore, or more naturally, we will have waited longer than expected, but since they have bracelets with reduced priority and always wait a long time, we consider that it is something normal. The other users will say that they are waiting for a long time.

Did I get out of the ER without being observed, or say, was I drunk because I was waiting for a long time and did not get any observation from the medical teams?

There are indeed proven cases of these events by two clients who conducted an interview, stating that they would never leave emergencies without being observed, these triads being of reduced priority, or that they should not happen. In case of injuries that do not appear to be serious, there should be a link between hospitals and primary health care. The health professionals will be able to know if there are many people in the Emergency Service, they will be displayed in the computer system. It is claimed that we were not able to diagnose or use it in the stipulated time by the Triage System, it was better to approach the same and direct it for primary health care.

Are you always serious in relation to what you truly feel or have you taken any action intended to obtain faster service, since there is so much delay in being called?

Nenhum two utentes tentou ludibriar or health professional present at the triagem to achieve a higher priority than what is truly needed. This problem was analyzed and normally trying to obtain a faster service is users who frequent the SU quite a few times, on the contrary two users who go to the SU sporadically, as the interviewed users.

When you observe and perform exams, do you think you spend a long time waiting for the same results, or do you think it is a quick process?

In a general way, you have no reason to complain. We know that I am afraid of waiting for its turn, want to perform the exam, want the result, once everything or the process takes its time. The users consider, however, that the hospitals that they frequent do not have the necessary material resources and, in this way, it is something impossible to control and apprehend because it is not the fault of the Hospital Center, nor two health professionals. Some refer that as they have the possibility, they prefer to move to the private hospital, since the processes are faster due to having a lower influx of users. Knows how the triage system works?

While there are people who don't know how the Triage System works, others have some knowledge. Those who, indeed, do not understand how the system works, are only told to have less patience to wait. Those of you who have some knowledge, understand that you are all associated with the priority that exists in this place, in that you have the highest priority, you have the legitimacy to pass in front of it.

Do you think that there is disorganization in the emergencies or do you think that a good service management has been carried out?

All the users consider that there is a lack of organization and good management in US SU with the resources that you have available. We believe that new norms are necessary to try to solve these problems, however, if changes are not made, these difficulties will persist. Others believe that the lack of resources is a preponderant factor for not having better service, even more so with an investment in this parameter, we don't know at what point these problems will not prevail.

Has the appearance of COVID-19 in 2020 caused any fear to go to the emergency room to obtain medical care? Yes, what other method did you choose? Did you do any teleconsultation?

The answers to this question are somewhat diverse. Some users will reveal that they had some reluctance to dislocate their years. This suspicion was manifested by the fact that we will not be infected by COVID-19, once initially infected he went to the hospital. The users who reported that they did not make sense, accredit that the management carried out when the pandemic was executed and, therefore, did not compromise their insurance, since there are specific wings for users with, or without COVID-19. We also certify that there is good control over SU, especially the temperature measurement of all users who wish to travel to the Hospital Center. From this sample, few users will need to travel to their SU during the pandemic. Some users will carry out teleconsultations, but the majority do not have the need

The triagem in the national hospitals was carried out by the sick. What is your opinion on this matter?and, A large percentage of users who go to the SU (Emergency Services) do not need to do it, as we all know. In your opinion, should the triage be attended by a doctor? If this doctor evaluates the patient at the moment and prescribes the necessary medications, would it reduce the existing excess?

In the literature review, an investigation was presented based on the implementation of a medical triage service. The researchers reached the conclusion that a nurse is more apt to perform this service because he is less objective. The doctor, in turn, due to his practice, makes a risk classification in a consultation, resulting in a delay in triage, or that it is not completely or intended. Nurses are more generalist professionals, obtaining a high rate of precision. Being a nurse and a doctor simultaneously in the triage service, a small improvement is obtained in less serious cases, notably our waiting times, but this methodology leads to greater wear and tear on medical equipment, which can increase the level of errors.(19)I conclude that it is not beneficial, since the only improvement would be the waiting times for less serious patients, who can wait, thus maintaining the most efficient teams to care for patients who, in effect, need more care.

The conclusions of the interlinked literature review were based on the opinion of two health professionals involved in interviews conducted by researchers. These prove that a doctor would increase the time of the triage. The excessive waiting time can be quite serious, because the triagem is the first contact that you have with your SU, not knowing how it is before doing it. I support being a nurse because you have enough training, aptitude and knowledge to allow you to be extremely fast and efficient. Another point that health professionals refer to, being in agreement with Leaman (20) is that non-critical users are unsuitable for the Emergency Service, due to the teams being experienced and prepared to treat more complex cases, I should never occupy time with less serious cases. Non-critical users should always go to primary health care, which is prepared to attend to less complex cases. When referring to the patients who made themselves available to carry out the interviews, it is important to mention that everyone knows that they are nurses to carry out triage, but also that there are some errors that do not respect their practice.

In your opinion, what are the greater benefits than triagem traced to an SU?

According to Silva (8) in the literature review carried out, triagem consists in the separation of people, in function of their prognosis, in which the term triagem means separating the patrons. This separation is based on your gravity. The conclusions that the researchers obtained by conducting the interviews with the health professionals were the same, believing that the greatest benefit of a triage was the separation and prioritization of the patient, providing medical services as quickly as possible to those in need. Thus, in the opinion of two health professionals, it corroborates how the authors present in the reference literature review.

The monitoring of a user from the moment in which emergencies are received is important. How is it done or controlled to know how long this tempo is waiting to be observed? What computer system is used by doctors/nurses will we monitor the users who are in US?

And, I don't know from my point of view, who are the biggest faults in existence that are relatively managed by two users?

According to the information of the two health professionals involved in the interviews, the researchers concluded that we are national hospitals is this long to happen. The health professionals refer that many times their computer systems are not intuitive, occurring various errors, being necessary to open different programs to obtain access to relevant information. Even the simplest resources, such as printers and scanners, present faults, or that will depend on the speed of the service. It was possible to perceive from the interviews that hardly a hospital has a computer system that shows the number of patients that are waiting to carry out triage. The computer systems, in the first place, have to be correctly optimized for the health establishments, being necessary to invest in this aspect, in order to improve the systems.

Another option would be to create a system that manages to be intuitive, efficient, fast and that is all stored in the same database, not being necessary to open a different program for each necessary information. Some health professionals report that to access the user's file, they open a program; To view antecedents, find clinical histories, another program, or see, it is a system that, besides being slow, becomes confusing. Another important story to mention, is the fact that the same hospital uses two different computer systems according to the units. For the interns of the common year, who are not their first year to exercise activities, going through all the specialties, it becomes somewhat unintuitive and complicated to assimilate, because they are afraid to learn to use different systems, when it is possible to use only one of them. all or hospital. Not that it touches computer systems for the realization of management control, it would be necessary to pay great attention to this topic.

Regarding the control of two users in SU, it was also reported that many two health professionals do not pay attention to the time that the users are waiting to be observed, allowing us to conclude that many standards established by the Manchester Triage System are not placed in practice, such as the realization of the second triagem of a patron who is waiting to be observed for more than two hours. In this interval of time, or your clinical condition may worsen, making you need care as quickly as possible. According to Coutinho et al.(19), the STM failed to detect some users who worsen their clinical condition after arriving at the Emergency Service, corroborating also with the observations of some health professionals, who indicate that it is impossible to perform this procedure. task. Not carrying out this control is prejudicial, since this is a medium where incidents can occur at any moment, and there is no team to help quickly if necessary. It would be better to create a team of health professionals to carry out this control, given that in Portugal overfishing is an imminent problem and, in this way, it would be possible to maintain a more effective control by two users, thus creating a better management of the same two way to provide a better security to your health.

The waiting times are rarely met in emergencies and those who have reduced priority wristbands wait a long time. Could it be that many of these delays occur due to lack of health professionals, material resources, both, or lack of organization that does not respect management?

A practice that could be a solution to reduce two waiting times would be to create a team for critical users and another team for non-critical users, triage sections divided for these two groups. Do you consider that this would be a good method to implement the Triage System?

Two health professionals affirm that the use of well-trained nursing professionals is used to initiate and complete simple treatments already in force in their Hospital Center and that it considerably reduces the waiting time of these users, thus combating their negligence. Seven two dozen professionals support this alternative and it seems to be an excellent bet in the near future. Hardly a health professional showed that they did not agree with this methodology. Analyzing the responses, the researchers came to the conclusion that each hospital manager has the power to create methodologies not in his or her health establishment, in order to obtain the best possible results, not that the management has respect. Thus, it can be concluded that in Portugal, many hospital managers do not analyze or understand what they are inserted in. These professionals have to be proactive, innovative, researching and studying new work methods, which allow them to make their service as efficient as possible.

The conclusions that the researchers withdrew from the interviews with the users, are taken as a fact of these, we will accredit that the existing problems are due to a lack of professionals and resources. Subsequently, we refer that the management of YOUR has also not been carried out, because we realize that, while they are waiting to be called, there is a lot of disorganization, or that it does not help to improve the service. Not that it respects the teams differentiated from critical and non-critical users, we consider it quite beneficial to try to implement this measure. When the researchers reported that this practice is already working in other hospitals and they received quite positive feedback, I saw that their opinion was reinforced.

Do you know other Triage Systems?

In the interviews carried out with health professionals, they were barely able to refer to another Triage System. It was also concluded that in Portugal the training system only demonstrates interest in the current Triage System. Studies carried out show that the STM is valid and effective, obtaining a high success rate, being used throughout Europe. It is concluded, however, that the STM is a model that should remain, always receiving updates over time, improving the management of two Hospital Centers in order to create the best possible Triage System.

In the investigation, it was verified that 25 % of two medical trocam users were SU. Could it be that the fact of this occurrence does not cause problems in the management of two users, by two doctors?

According to how the health professionals involved in the interviews, hardly one can prove that this is the real problem, not one that respects the management. It certifies that these trades are not favourable, it is not the fact that the trade occurred in itself, but rather, the fact is that this trade will not be carried out correctly.

A unanimous opinion on the part of all the health professionals is that the users should always be followed by the professional himself, from the moment he enters not HIS at his departure, in this case it is possible, since it is a faster and more rapid process. Effective, I don't lose time with information exchanges. If this is not possible, if you try to be redirected to a more specific area, or if the shift is coming to an end and it is necessary to make a testimonial passage, the health professionals must certify that the passage for the other professional is be done, guaranteeing that there is no information to be transmitted, given that from that moment the person in charge is the professional who renders the turn.

Another aspect that the health professionals will refer to not going through the interview, is that when this exchange occurs and it is carried out under observation by more doctors, most see this parameter as more valuable, since more people can discuss the case of the author, Giving assim new ideas and helping to solve the problem, making the diagnosis faster. For this reason, the Emergency Services work by teams and not by individual doctors.

Users, in general, prefer to be followed by the same doctor if possible, thus corroborating the opinion of two health professionals. Otherwise, we accredit that your passage must be certified by a specialist doctor or your clinical case for more specific. Referem also says that there is no problem in being observed by several doctors, because it is of interest that they find a solution for their problem, regardless of the changes that have been carried out

For the most part two national hospitals operate as the Manchester Triage System. Acha, this system is correct, how is it found at the moment?

The interviwees stated that that it is a triage system that works well, I always have room to improve, affirming that its bases are well executed. I conclude that it is an excellent system to maintain, pois, make the service more fluid, fast and efficient.

A COVID-19 also brings some flexibility not concerning management, as teleconsultations. Will the implementation of teleconsultations be something favorable for the management of two users? Is it better to continue with this practice in the future, or should we only use the face-to-face method?

Observing the analysis according to the responses that the researchers obtained regarding the teleconsultation, or the telephone clinic, all the professionals affirmed that this is beneficial in various aspects and that it can help in the management of two Hospital Centers, thus occupying less time, for those who use , you want health professionals. However, it should be used only in cases of minimal severity or in cases without severity, as a quick check-up, prescription of regular medication or visualization of tests. In the remaining cases, a face-to-face consultation must be carried out. A face-to-face consultation should never be substituted by teleconsultation and whenever the healthcare professional that the person uses should go to a Hospital Center, it should also be done. The investigation verified that these services are useful in various aspects and that they can be used in practice with insurance, without ever compromising the health of two users.

DISCUSSION

Observing the entire research area, one of the techniques that must be implemented to obtain a more effective triage, it may be possible to carry out two sinus vitae tests with greater regularity, in order to reduce the percentages of underestimated triage and overestimated triage.(36) After triage it is essential to exist a separation between what are the objectives of the Emergency Service and those that are not, or it seems, there will be areas that correspond to the emerging state, very urgent and urgent.(37,38,39,40)Likewise, this group will separate the areas destined for low priorities, such as those that are not very urgent and not urgent. In this way, both situations would be evaluated more quickly and the waiting times would be reduced, so that the users do not feel, at some point, neglected, thus improving the management of two SUs. In this way, we would have a better control, not that the management of two users says respect, doing so that these two SAIA would not be observed.(41,42,43,44)

Once this separation was made, the doctors of the various areas were ready to be immediately available, thus reducing the time for the diagnosis of the patient, given that in the investigations carried out, the stipulated waiting times have not been met, something that should not happen. (45,46,47)

According to the health professionals in this investigation, the triage will be carried out in the national hospitals. This priority is given to speed, without ever stinging or rigor and safety.(48,49,50,51)In the event of some type of underestimated triage, the nursing professionals in the Emergency Services should be trained in Basic and Advanced Life Support, in order to quickly help a patient who needs these cares, it is not necessary to wait for medical attention to deal with a situation of emergency.(52,53,54,55)Normally, when these situations occur, it is not a problem of triage, more like what precedes, or it seems, and it is unequivocal the importance of referral after triage for the correct flow of care, and it is local and very important that there is a defined hierarchy , being that there is no problem if it is intended to begin to be observed by a less experienced doctor, to the extent that there is a technical ascendant and an unequivocal support at twenty and four hours a day.(56,57,58)For some research on non-diagnostic delays, it has been studied and demonstrated that these occur due to constraints among health professionals who do not have the ability to act in a useful time, thus adding to their decision regarding triage. However, this lacuna is not only due to health professionals, but also due to the impossibility of the hospital not being able to respond to certain cases.(59,60,61)It is necessary to implement more objective measures and monitor users from the moment they enter the Emergency Service until the moment they leave. These measures may translate into no increase in human resources, or rather, obtain more health professionals for a faster response, trying to meet the deadlines for each scale of triage, as well as no increase in material resources that, as we know, is not Sufficient to give an answer to all the users that go to the SU.

Another point to highlight would be the integration of a full-time team of professionals in the Emergency Services. “As I have already mentioned, other countries will create the specialty of Emergency Medicine, or that in Portugal, despite two numerous defenders of this strategy, it seems that there is still a little long to be possible or the first level of dialogue between the relevant partners”.(36)To help the functionalities of access to information, a more efficient computer system should be implemented in hospitals, where it is possible to control the time that users wait for Emergency Services and the waiting interval between the first diagnosis and the conclusion of their clinical case. As was verified in the investigation, there are programs that increase the efficiency and effectiveness of the Emergency Services, as well as the speed of service to the users and, given that we are in a time when technologies are so simple to use and so autonomous, the Emergency Services

CONCLUSIONS

Despite being effective in many of its aspects, the Manchester Triage System has weaknesses, as we found out by research in the pediatric ward, it has moderate sensitivity and specificity. According to the reports of health professionals, there should be some difference not related to triage and to the attribution of priority according to age, because what child may not present a symptom of risk, a person may be totally different, however that it is necessary to find out the system according to the ities. The health professionals also complain of problems that make the service slower, such as the fact that the material does not function correctly, as in the case of printers, scanners, slow computer systems, among others. It is necessary to assess this situation and guarantee that none of these problems occur in the future. Another aspect that tends to delay the service is the non-existence of a defined location for the patrons, we do not have routing control for them, making them stay in waiting rooms that are not the best suited for your problem, I have you Health professionals have to go to their search, further delaying their diagnosis and, consequently, the service. Relative to the various models, none of them can be considered perfect because they all have weaknesses, it is still important to study or that each item as a strong point and make the necessary adjustments to enhance the optimization of each one. When compared to each other, CTAS is more sensitive and less specific in the detection of certain pathologies, or that it will require more attention than ESI. On the other hand, the CTAS and STM methodology demonstrates good consistency between testers, or that ESI is not verified, since this system has little coverage. Thus, some areas of the Emergency Services tend to be overcrowded, while others are completely empty. O CTAS not respecting the best triage times, since it lacks shorter waiting times for users who will be observed, using different areas for each triage level.

Future Research Direction

To draw conclusions from this investigation, it is imperative to emphasize key facets pertaining to the management of national hospitals and the validation of the triage system:

- Enhance the management of the emergency department to optimize service delivery with existing resources.
- Allocate investments in human and material resources to bolster hospital operations.
- Implement a user-friendly unified computer system across the Hospital Center.
- Ensure consensus among evaluators, thus reinforcing the system's security and validation.
- Attain consistent findings across various health units within the Centro Hospitalar.
- Proactively identify and address critical issues in a timely manner.
- Achieve improved wait times for both patients.
- Provide triage nurses with specialized training for enhanced accuracy.
- Incorporate diagnostic tests for specific clinical scenarios.

Furthermore, with regard to future investigations, it is essential to note that larger sample sizes and additional analytical approaches, such as quantitative analysis, will be necessary. This will allow future researchers to extrapolate and build upon the topics explored in this study.

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