

Development, semantic and content validation of the Reception and Screening System for oral health services

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Abstract: This study aimed to develop and validate the semantics and content of the Reception and Screening System for Oral Health Services (SATSB) of the Brazilian Unified Health System (SUS). The instrument guides the reception and emergency risk classification in spontaneous oral health demand in SUS primary health care. The first step of the study was content validation, which included the delimitation of the theoretical model, the allocation of diseases and health conditions in the Manchester Triage System scores validated for use in Brazil and was carried out through focus groups with experts. The second step was to validate the semantics of the Reception and Screening System through focus groups carried out with oral health technicians and assistants, who critically evaluated and applied it to users who sought the emergency dental service. A visual analogue pain scale was administered to test the discrimination power of SATSB. SATSB and the pain scale showed similar results,

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discriminating the problems into urgent, little urgent and non-urgent. It could be observed that about 50% of users sought the service were not urgent cases, which did not require examination or assistance by the dentist. SATSB proved to be valid and useful for reception and risk classification in primary care emergency dental services, being able to be used to organize the demand in a humanized and effective way.

Keywords: Screening. Emergency. Dental health services.

1 INTRODUCTION

Primary Health Care (PHC) is considered the main gateway to the care network, but the emergency dental care service is frequently sought by users as an alternative to solve their oral health problems and enter the health service. This reality may reflect the insufficient supply and capacity of care in the PHC. The use of emergency dental services as a gateway to oral health services reveals fragmented care, disorganized demand and poor access by users to health services. In most cases, care is provided in order of arrival, an organizational problem in which clinical criteria for classifying the needs of users are not established, violating the principle of equity of the Unified Health System (SUS) (BRASIL, 2012).

As a technology capable of improving the health service, it is proposed to organize access through reception with emergency risk assessment and classification, a proposal for changing the health work process. Reception is the expression of humanized and qualified listening and presents itself as an instrument capable of receiving the user and guaranteeing access to health services. Risk/screening classification is the definition of the order of service based on the complaint presented, generating access and safe, responsible and humanized service. Risk /screening classification is a dynamic process of organized inclusion of users in the health system, capable of improving the quality of health care provided to them (BRASIL, 2009).

Screening has emerged as a method to optimize care and minimize the damage caused by overcrowding, identifying patients who need immediate care. Screening is a dynamic classification process that allows patients to be more quickly referred to appropriate care services (AZEREDO *et al.*, 2015).

Urgent care based on the order of arrival of users and not on the severity of the problem is very present in the day-to-day of health services and changing it requires commitment⁴. It is necessary to understand and classify, in spontaneous demand, what is urgent and what is not

urgent, and what can be scheduled for another day. Receiving and classifying users in the service order, based on the risk classification, makes the service more human, more efficient and capable of providing responses to all those who seek it (BRASIL, 2013).

As an alternative to face the problem, the Manchester Triage System (MTS) (MACKWAY-JONES; MARSDEN; WINDLE, 2006) was developed, which adopts priority classification and risk prediction for patients seeking emergency care, widely used in the European Union (AZEREDO *et al.*, 2015; ZACHARIASSE *et al.*, 2017). It has been adopted in several Brazilian states and the Federal District (GBCR, 2021).

MTS classifies patients into priority levels using colors: level 1 – red (emergency); level 2 – orange (very urgent); level 3 – yellow (urgency); Level 4 – green (somewhat urgent); level 5 – blue (not urgent).

The MTS validity in emergency care ranges from moderate to good, with diagnostic odds ratio being lower in younger and older patients (ZACHARIASSE *et al.*, 2017). However, few studies have evaluated the validity and reliability of classifications of instrument used to determine the degree of risk of patients in emergency services (ZACHARIASSE *et al.*, 2017; GBCR, 2021) and, in particular, the MTS application in oral health services. It was translated and validated into Brazilian Portuguese in issues related to dental emergencies. In this study, the inter-observer reliability and the impact of its application in the emergency dentistry sector of the Faculty of Dentistry, University of São Paulo, were evaluated. The translated and validated version of MTS proved to be adequate and useful for the care of patients in this service (KANEGANE, 2011).

There is still a need to validate the MTS for public oral health services, considering that its validation for Portuguese was carried out in a service located within a higher education institution. In addition, the classification and nomenclature of oral diseases and conditions listed as urgency and emergency, recommended by the Ministry of Health (BRASIL, 2013) are not fully in accordance with the International Classification of Diseases (ICD-10) and this is essential to guide dentists for the correct prioritization of care.

The aim of this study was to develop and validate the Reception and Screening System for Oral Health Services instrument (SATSB) in the spontaneous demand of the PHC, aiming to define priorities for care of emergency and urgency cases in SUS and organize the demand in a more adequate way.

2 METHODS

This is a theoretical-methodological (LIMA, 2011) study of content construction and SATSB validation by a group of experts, who classified dental urgency and emergency diseases and conditions in the MTS based on the application of validated flowcharts. Semantic validation was also carried out (HERDMAN; FOX-RUSHBY; BADIA, 1997; PAIVA; FIRMINO; ABREU, 2018) with SUS users.

Focus groups (MORGAN, 2019) with experts (GRANT; DAVIS; 1997; ALEXANDRE, COLUCI; 2011) were performed at the Faculty of Dentistry of the Federal University of Minas Gerais (FAO UFMG), in 2019, and involved researchers experienced in construction and validation of instruments and SUS professionals.

The study was carried out in a medium-sized city (CALVO *et al.*, 2016) in the state of Minas Gerais, and had as target population spontaneous demand users who sought oral health service in the PHC of a SUS Basic Health Unit. This municipality follows the precepts of the National Oral Health Policy (PNSB) (BRASIL, 2004) and was chosen by the reception of the management team as well as the availability of professionals to participate in the research.

The project was approved by the Ethics Committee of the Federal University of Minas Gerais (Protocol No. 3.082.686) and was carried out in accordance with guidelines established by the Declaration of Helsinki. All participants signed the Informed Consent Form.

Step 1: Instrument construction

The development of the preliminary version of SATSB was based on the concept of reception with risk assessment and classification, considering MTS (MACKWAY-JONES; MARSDEN; WINDLE, 2006), PHC (BRASIL, 2012) and the National Oral Health Policy (PNSB) (BRASIL, 2004). This version was discussed and improved in the focus groups. Health conditions were selected from the document of the Ministry of Health (MS) on Reception to Spontaneous Demand (BRASIL, 2013).

Two focus groups (MORGAN, 2019) were performed to discuss oral diseases and problems listed as dental emergency by the Ministry of Health (BRASIL, 2013), the time required for care and allocation in color scores. These focus groups were composed of eight participants, in addition to the moderator and two reporters, which intention was to carry out the SATSB content validation. These two focus groups with experts (GRANT; DAVIS; 1997;

ALEXANDRE, COLUCI; 2011) were composed of professors and SUS professionals, all dentists, with experience in the topic addressed and qualified as follows:

Expert A: Specialist in Endodontics, coordinator of a dental trauma project and professor of endodontics;

Expert B: Specialist in Oral and Maxillofacial Surgery, one of the coordinators of the emergency dental service of a public hospital and professor of surgery;

Expert C: Specialist in Periodontics and Professor of Periodontics;

Expert D: Specialist in Public Health and Professor of Public Health Internship;

Expert E: Specialist in Endodontics, working at SUS;

Expert F: Specialist in Periodontics, working at SUS;

Expert G: Specialist in Public Health, working in the SUS

Expert H: Oral Health Municipal Coordinator.

Step 2: Performance of the focus group with Oral Health Assistants and Technicians

This focus group was used in the municipality involved in the research with six Oral Health Assistants (OHA), two Oral Health Technicians (OHT), the oral health municipal coordinator, in addition to the moderator and the reporter. At this time, the semantic validation of SATSB was performed, whose objective was to verify if the items were understandable and if questions were clear to subjects who would apply it (Fig 1).

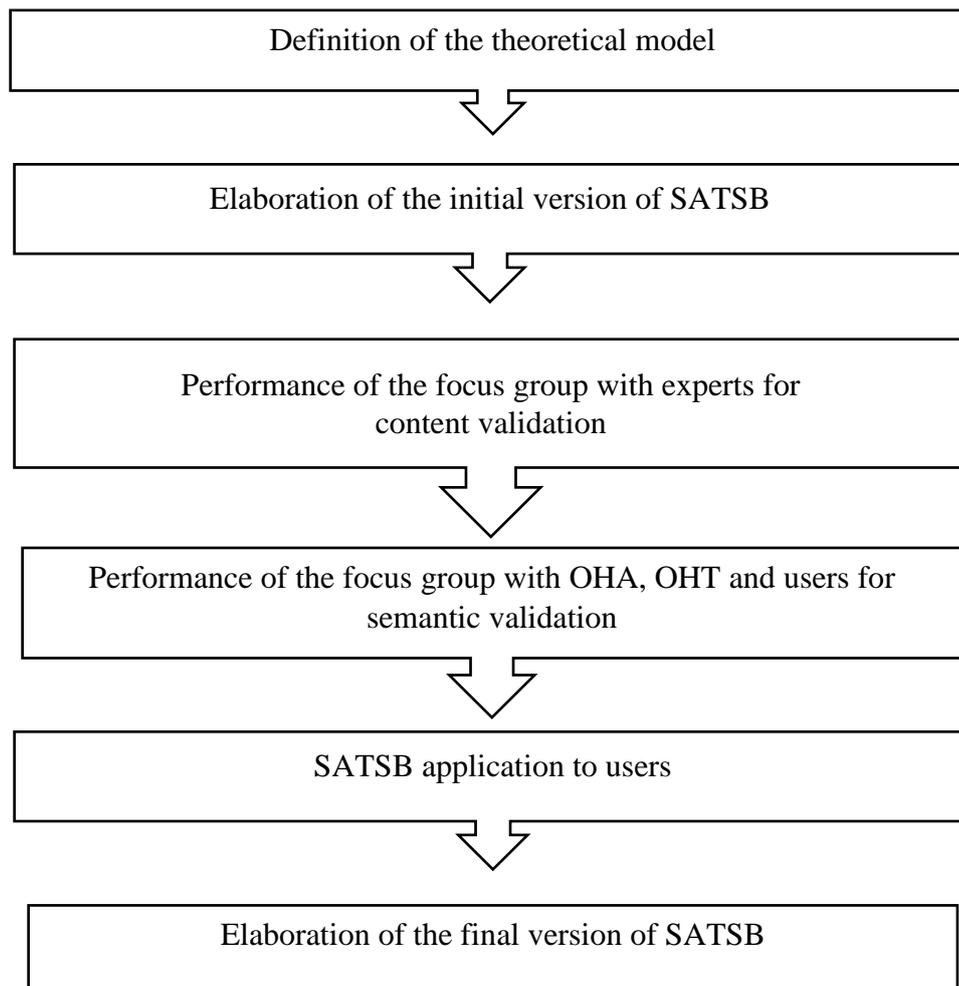


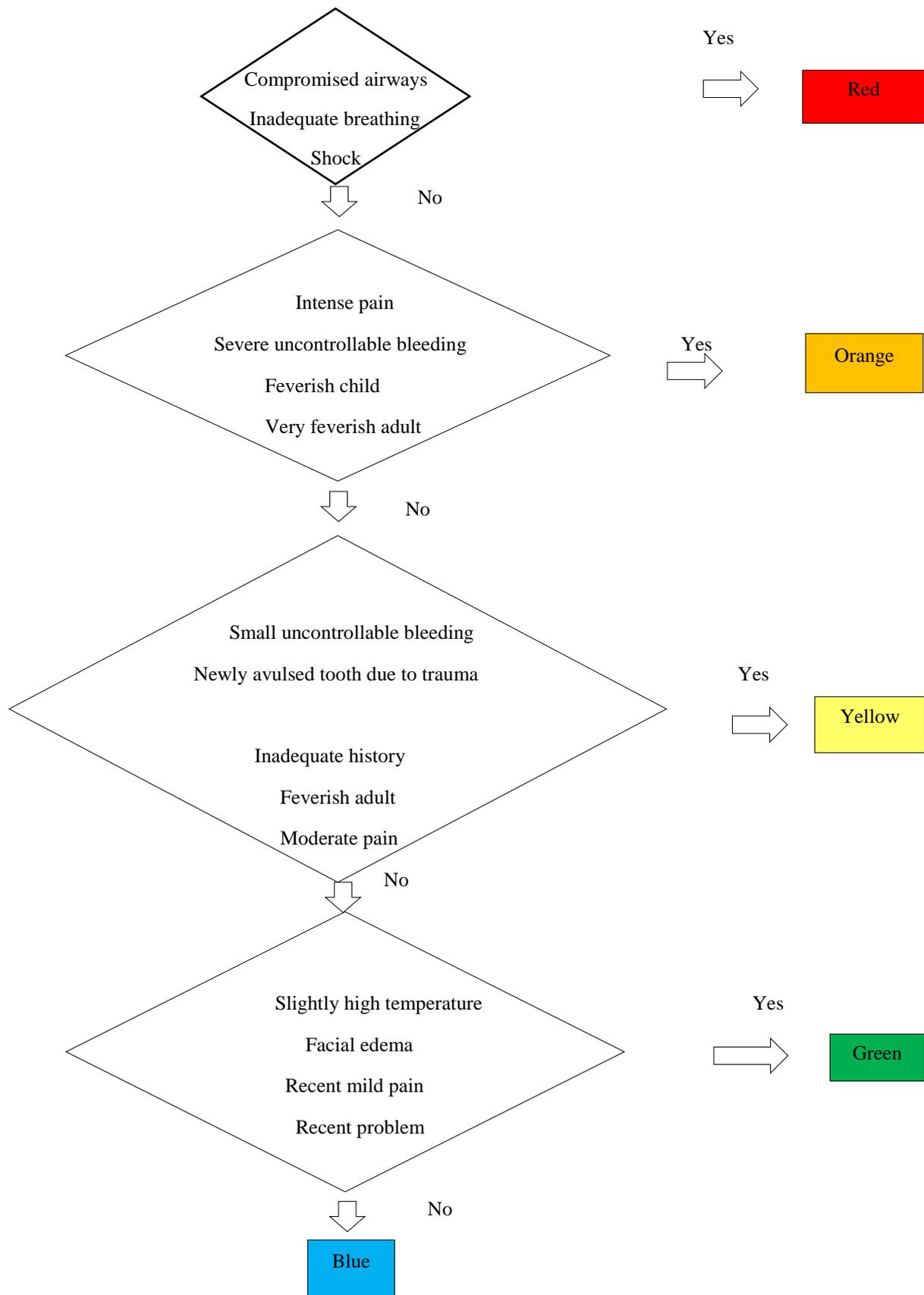
Figure 1- SATSB construction, semantic and content validation flowchart

Step 3: SATSB application to users

The previously validated instrument (KANEGANE, 2011) was applied to users who arrived at the PHC unit complaining of pain (Figures 2 and 3), together with the pain scale. Initially, the visual pain scale was shown to the user who indicated the level of pain; however, it was observed that even talking normally, smiling, playing and eating, they tended to choose the worst degrees of pain on the scale to “ensure ” care. Therefore, OHA and OHT observation was also used in the pain classification. In measuring pain, both adults and children's pain rulers were used to measure pain intensity and its effects on normal body functions, combining verbal descriptions with a visual analogue scale, which makes it broader (BOTTEGA; FONTANA,

2010; VALERA; CAREZZATO; VALE, 2014). Users were approached by OHA or OHT, in the reception room. Then, the dentist would carry out the clinical evaluation, whose complaints were part of urgency demands, diagnose the problem according to ICD-10 (OMS, 2008) and decide on care priorities according to the proposed instrument. It is noteworthy that the dentist was in clinical care of users scheduled for sequential treatment.

The final version of SATSB was created based on information extracted from the focus groups and its application.

Figure 2 - Manchester Triage System translated into Brazilian Portuguese – Dental problems ⁸.

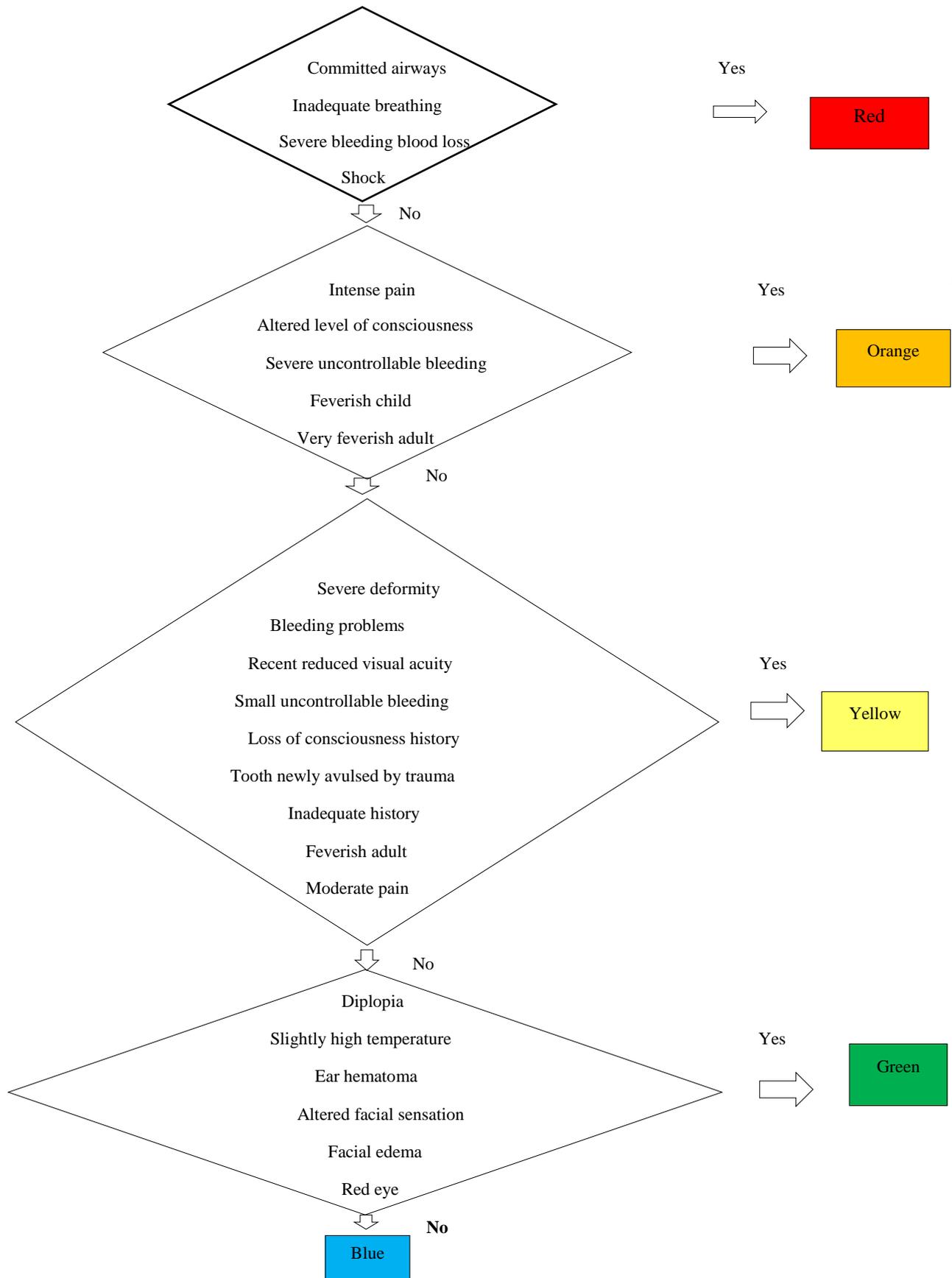


Figure 3 – Manchester Triage System translated into Brazilian Portuguese – Facial problems ⁸.

3 RESULTS

The work produced two results. The first, attributed to the focus group held with experts, deals with the allocation of health problems in the MTS scores/colors and represents content validation. The second addresses semantic validation and refers to the SATSB applied to users.

Result of the focus group with experts

The result of the focus groups with experts allowed including oral health conditions listed by the Ministry of Health, into the colors of scores based on MTS, and on the SATSB content validation. The codes for diseases and health conditions were those used by the International Classification of Diseases (ICD 10) (OMS, 2008). An adaptation of scores and length of care in relation to MTS was carried out due to the particularities of Dentistry, as can be observed in Table 1.

Table 1 - Classification of dental problems based on the Manchester Triage System and ICD-10.

Color	Classification	Length of care	Origin	Oral health problem description	ICD 10
Red	Emergency	Immediate	Complications of odontogenic infections	Ludwig's angina	K12.2
			Accident/trauma complications	Hemorrhagic Urgency	R58
			Accidents and traumas	Avulsion (within 15 minutes from the occurrence)	K08.1
Orange	Very urgent	10 min.	Accidents and traumas	Avulsion (between 15 and 60 minutes) in an appropriate storage medium	K08.1
Yellow	Urgent	60 min	Endodontic acute episodes	Irreversible symptomatic pulpitis	K04.2
				Periapical abscess without fistula	K04.7
				Acute Apical Periodontitis	K04.4
			Acute conditions of periodontal origin	Pericoronitis	K05.22
				Periodontal Abscess	K05.2
			Accidents and traumas	Avulsion	K08.1
				Oral mucosa emergencies (traumatic injuries, burns)	K13
	Coronary fractures with pulp involvement	S02.5			
	Temporomandibular joint (TMJ)	Temporomandibular joint dislocation	S03.0		
	Post-surgical complication	Alveolitis	K10.3		
Green	Little urgent	240 min	Periodontal conditions	Necrotizing periodontal disease	K05.4
			Accidents and traumas	Extrusive dislocation	K05.22
				Lateral dislocation	S03.2
				Intrusive dislocation	S03.2
				Subluxation	S03.2
				Root Fracture	S02.5
				Coronoradicular fracture	S02.5
				Fracture without pulp exposure	B00
			Infectious conditions	Infection of fungal origin	B37
Infection of viral origin	S02.5				
Temporomandibular joint (TMJ)	Pain (from TMJ dysfunction)	K07.6			
Blue	Not urgent	Scheduled	Conditions associated with dental processes	Caries	K02
				Reversible Pulpitis	K04.00
				Dentin hypersensitivity	K03.8

Fonte: Os autores

Based on the content of health problems, flowcharts that guided the user in the service were applied during the reception, together with the pain scale, taking into account the main complaint, the pain characteristics and the signs and symptoms presented. After reception, in cases which were initially classified as urgent, users were examined by the dentist and treated according to the priority established by the flowchart of allocation of dental diseases and health conditions based on the Manchester Triage System and ICD-10 (Fig 4).

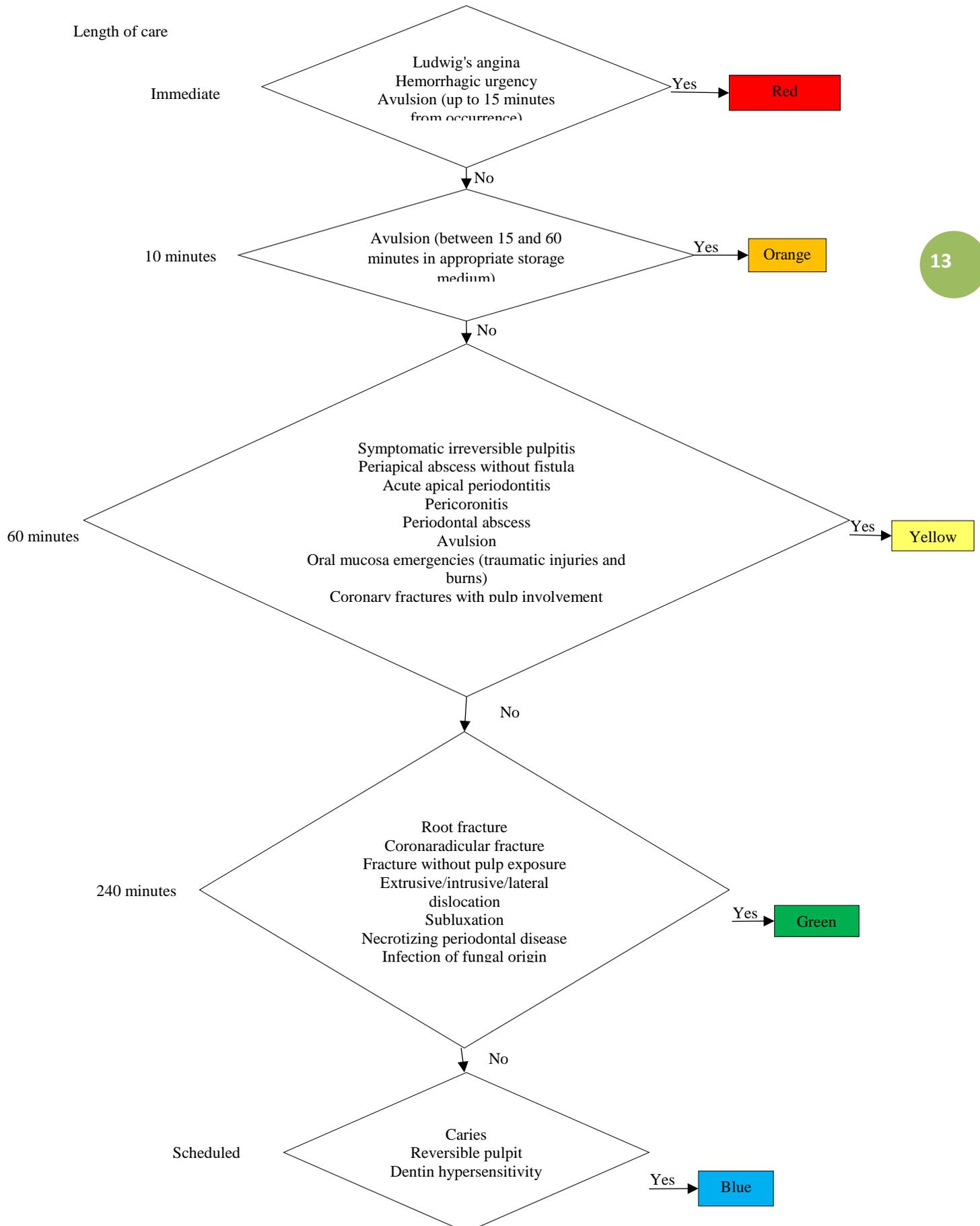


Figure 4 - Flowchart of allocation of dental diseases and health conditions based on the Manchester Triage System and ICD-10.

SATSB test application results

It was considered that, from the biological point of view, there would be no change in the prognosis of some diseases or health conditions if users were treated within 120 or 240 minutes without worsening the prognosis. Therefore, due to the large scheduled demand, it was agreed to exclude the previously existing 120-minute length, leaving colors yellow and green for health problems that can be treated within 60 or 240 minutes, respectively, and the blue color for scheduled demands.

After applying the SATSB to 48 users, it was observed that 26.6% of them needed urgency care with irreversible pulpitis, abscess or alveolitis conditions, 25.4% had less urgent needs such as periodontal conditions, accidents, trauma and infectious conditions, and 48.0% did not need urgent care as they complained of caries or low sensitivity and could therefore have their care scheduled for another day.

Regarding the pain scale, 11.0% of users had severe pain, 19.6% had moderate pain, 28.8% had mild pain and 40.6% had no pain complaint. The percentage of occurrence of non-urgent cases in the application of the pain scale and in the SATSB was similar.

4 DISCUSSION

Dental urgency is a major bottleneck in the daily routine of oral health teams. Scheduled daily service can be compromised by the volume of spontaneous demand. It is necessary to reflect on the fact that scheduled demand and spontaneous demand are not independent, and the organization of both cannot take place separately, since one impacts the other. This reading of reality points out the deficient organization and management of health services (BRASIL, 2012; BRASIL, 2009; BRASIL, 2013; LEAL; WERNECK; OLIVEIRA, 2017). The objective is to achieve a network that surpasses the dental-biological specificities and that is capable of developing actions that consider the user in his/her bio-psycho-social integrality (BRASIL,

2004; SILVA; GOTTEMS, 2017). The practice of integrality organizes and articulates work processes and distinct technologies that result in comprehensive interventions.

The content validation performed by the group of experts was an innovation in relation to the work already developed (KANEGANE, 2011) and the recommendations of the Ministry of Health (BRASIL, 2013).

Semantic validation checks whether the items are intelligible to the stratum of the target population with lower skill levels and provides undisputed benefits by generating an instrument that allows for actually valid information to be obtained (JUNIOR; MATSUDA, 2012; TESCH; OLIVEIRA; LEÃO, 2008). Despite the difference in education level among dentists who made up the group of experts and OHA or OHT, there were no difficulties in applying the instrument, demonstrating that they semantically understood all the items of the instrument.

It is believed that the subjective characteristics of the painful phenomenon is responsible for difficulties of assessing pain. It is difficult to establish a diagnosis according to the pain symptom reported by the user, but it is possible to establish priority for care (BRASIL, 2004). Measurement instruments are key elements to refine the relationship and communication between those who feel and those who treat pain (BOTTEGA; FONTANA, 2010; VALERA; CAREZZATO; VALE, 2014; BORGES *et al.*, 2008). What is important for the classification in the scores of the length of care was the intensity and frequency of pain, the possible complications involving the problem presented and not the disease itself.

In the SATSB, users who seek the service without pain complaint were classified as blue color. There are changes that are not associated with pain, but that generate discomfort and concern, affect the individual not only in the biological aspect, but also in the social aspect: aesthetics, self-esteem, the ability to relate or look for a job. This user also needs care.

This study has some limitations. The first refers to the non-validation of the SATSB semantics for diseases and conditions that did not appear during its application. Even so, they were mentioned for being present in the stages of construction and content validation. The second is due to the fact that screening at the MTS is performed by professionals with higher education (MACKWAY-JONES; MARSDEN; WINDLE, 2006) and the level of education of OHA or OHT may have influenced their safety in applying the instrument. Even with good semantic understanding by OHA or OHT, they showed difficulty in interpreting responses in situations where users did not express themselves exactly as it was written in the flowchart.

On the other hand, it must be considered that there is no other study in literature that has developed the MTS content validation for application in oral health services in PHC in Brazil, with a group of experts as adequate as that used in this work. since the validation carried out (KANEGANE, 2011), unlike this one, took place in an outpatient clinic of a Brazilian university.

It is noteworthy that the pain scale and SATSB results indicate large percentage of users without pain, which is in line with other findings (WALDROP; HO; REED, 2000). The MTS version adapted for Dentistry, applied by OHA or OHT contributes to time optimization considering that almost half of cases were not classified as urgent, which would not require clinical examination by the dentist. It also contributes to the service provided to users according to the seriousness of the case, and not by order of arrival. In current times, reception and risk classification in oral health services are not a reality, as professionals and users are not familiar with these proposals.

5 CONCLUSION

The present work presents an alternative for the health service organization, making it more human and in line with the principles of SUS. SATSB proved to be valid for the reception, risk classification and final diagnosis of oral health problems presented by users in the PHC service, being able to be used to organize the demand, improve work processes and problem-solving capacity in a humanized and effective way.

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