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CARDIOVASCULAR EMERGENCY: REFLECTIONS ON THE EXPERIENCE OF SOCIAL SERVICES

EMERGÊNCIA CARDIOVASCULAR: REFLEXÕES SOBRE A EXPERIÊNCIA DO SERVIÇO SOCIAL

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ABSTRACT

This article aims to share the professional experience of social worker in the area of occupational health, more specifically in a reference Emergency Unit of a public cardiology hospital. The Social worker is a professional who is part of the Health Team and who works in hospitals. The method adopted was daily observation of the Social Worker in the professional locus, i.e. in the emergency unit, as well as bibliographic research, based on scientific articles on the subject.

Keywords: Social Work; Emergency; Cardiovascular Diseases.

RESUMO

Este artigo apresenta como objetivo compartilhar a experiência profissional do assistente social em espaço sócio ocupacional da saúde, mais especificamente em Unidade de Emergência referenciada em cardiologia de hospital publico. O assistente social é um profissional que integra a equipe de saúde e atua em hospitais. O método adotado consistiu na observação diária do assistente social no lócus profissional, ou seja, na unidade de emergência, assim como a pesquisa bibliográfica, com base em artigos científicos referentes ao assunto.

Descritores: *Serviço Social; Emergência; Doenças Cardiovasculares.*

INTRODUCTION

Despite technological advancement in the identification and treatment of diseases, medicine has yet to find cures for many heart diseases. Cardiovascular disease is the leading cause of death in the world, reaching 17.7 million in 2015, which constituted 31% of deaths according to the World Health Organization.[1] Adoption of healthy habits (e.g., a healthy diet) and cessation of practices that harm the body (e.g., reduction in smoking and consumption of alcoholic beverages) can aid in prevention. The social determinants of health also influence all aspects of the health process of the population, affecting both the individual and the community in which he/she lives. Social, economic, cultural, ethnic-racial, psychological, and behavioral factors are also associated with health, including population risk factors such as inadequate housing, education, income, and employment.

Brazil's Constitution of 1988 restructured the country's health sector. Health care was recognized as a social right, and it became the responsibility of the State to provide universal, integral, and equal care, regardless of contribution or other requirements.[2] Arouca writes the following:

Health is not just not being sick; it is more: it is a social welfare, it is the right to work, a decent salary; it is the right to access to clean water, clothing, education, and even information on how to rule the world and transform it. It is the right to an environment that is not aggressive, but which, on the contrary, allows the existence of a dignified and decent life, to a political system that respects the opinions, the possibility of organization and the self-determination of people. It is not to be always fearing violence, both violence resulting from misery, such as a robbery or an attack, and violence by a government against its own people to maintain interests other than those of the people.[3]

In Brazil, the public health management model employed by the Unified Health System (Sistema Unico de Saude [SUS]) as a strategy to improve care is organized into three levels of care: primary, secondary, and tertiary care. Primary care, as the start of the medical treatment, or the patient's entrance door, consists of the basic health units and a family health team, with consultation appointments or cases without serious symptoms, such as vaccination and dressing change. The intermediate level of care, secondary care, is the responsibility of the mobile emergency care service (SAMU 192), which handles rescues, and the emergency care units (UPA 24h), which provide the structure for responding to most urgencies and emergencies such as high blood pressure and fever, fractures, cuts, infarction, and stroke. The system is designed to provide medical care, control the

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problem, and detail the diagnosis, and to refer the patient to a hospital or keep the patient under observation for 24 hours when necessary.[4]

The existence of sufficient high-quality secondary care services also promotes a cohesive care network. As cohesion is one of the principles of SUS, a set of actions should be defined to assist in health care for the population in an integrated manner and at various levels, from basic care to high-complexity services.[5]

Hospitals and other specialized or medium-complexity care units that provide care in urgencies and emergencies are also included in this level. High-complexity (or tertiary-level) care is performed in large hospitals that have a competent, specialized team of health professionals that can use advanced technology to handle complex or rare situations that do not fall under other care levels.

Currently, emergency room visits follow emergency care procedures. In September 2003, the National Policy of Urgency and Emergency was created under Ordinance 1863 and aimed at structuring and organizing the urgency and emergency network in Brazil in a humanized way, integrating urgency care.[6] Care is immediately provided to the patient in emergency situations and in a period not exceeding 2 hours in cases of urgency.[7] In an effort to enhance care in emergency units, the National Humanization Policy was implemented to use patient reception as a humanization strategy in health care practices and screening/risk assessment as a classification system for patients according to severity, similar to the Manchester/England, own protocol or reference, used in the Clinics Hospital complex.[8]

Emergency room care should only be sought in an emergency situation, when a person needs immediate care due to imminent risk of death. The cardiac emergency unit is a dynamic space that will respond to threatening and sudden situations in which immediate care is required for patients with cardiovascular disease. The dynamic nature of the environment is shown by the readiness of the multidisciplinary team, which is always prepared to provide immediate and qualified assistance to any patient who arrives demanding immediate medical attention. These professionals should have a global view of the patient, possess clinical/scientific knowledge, and be competent and skilled, ensuring efficacy with a lower stress index.

The health system in general is precarious, with few options in primary or secondary care and too many patients who end up seeking care in the emergency room to solve low-complexity problems, especially in teaching hospitals that have knowledge and advanced technology, not respecting the hierarchy of the decentralized SUS, where the patient should be treated in his or her neighborhood for later referral to high-complexity units, if necessary. Therefore, the reference cardiology emergency units of public hospitals provide access to the high-complexity services of SUS, often used by the population that seeks prompt consultation, as it is hard to access the basic network. Thus, the cardiology emergency service remains a challenge for managers of public and private services, as it is highly complex, uses advanced equipment and technology, and requires trained professionals. In addition to these factors, the work performed by the various professionals of the multidisciplinary teams in these hospitals is affected by the health and disease conditions of the population served, concomitant with increased care in reference cardiology emergency units.

THE FOUNDATIONS OF THE ROLE OF THE SOCIAL WORKER IN REFERENCE EMERGENCY HEALTH UNITS

The National Health Council and resolution CFESS N.° 389/99[8] recognize the social worker as a professional that integrates multi-professional teams and their professional action focuses on all levels of health care. The social worker acts as a "frontline intellectual agent" and mediates the communication between the institution (social service provider) and the service user to meet the emerging social demands of the population served.[9]

Health care is also the institutional social space that most uses the social worker, whose job it is to understand both the specific living conditions of service users and the relevant policies, for health promotion, prevention, and care.

Today's society needs professionals with different intellectual backgrounds who are able to perform their duties in a wide range of social settings. Health care, professionals are required to have competence not only in health care but in health promotion. In addition to skills to perform the practical work, the process of providing care, in the context of SUS, assumes the need for a constant scientific and technological apparatus and a humanistic and social knowledge, with an understanding of the service user in his or her daily life.[10]

The role of the social worker is divided into three fundamental dimensions that guide his or her daily schedule: theoretical-methodological, technical-operative, and political ethics. These three dimensions are also applied in health care and are complementary to each other.

In teaching hospitals, the social worker's work is performed in three areas: assistance, teaching, and research. With regard to assistance, the social worker works in outpatient units, infirmaries, intensive care units, and emergency rooms, where he or she provides care to patients, families, and, caregivers, complying with the assistance policy that provides, in its principles, respect for the dignity of the citizen, patient autonomy, the right to have benefits and high-quality services, and equal rights in access to care, without discrimination of any kind.

The role of the social worker in a cardiac emergency unit involves direct interaction with the patient, family/companion, and multidisciplinary team. The social worker formulates social responses to the different demands brought by the patient and/or family, as speed is essential in the care provided. The social worker is responsible for identifying the vicissitudes and social conditions of the social network in which the patient operates, providing explanations to the team on the importance of social factors as an integral aspect of the health situation to ensure total care of the patient's needs. Thus, a social worker who works in a reference cardiac emergency unit

must, along with the multidisciplinary team, possess the competence and ability to provide all types of care and face the unforeseen. Initial contact with the patient takes place, if possible, immediately after care has been provided by the nursing and medical staff. The social worker performs his or her work together with the health care team and also assesses the patient's social reality. Understanding the patient as a whole and not only at the level of the sick organ is an integral part of the social worker's professional training. When the social worker is integrated into the health care team, he or she brings a specific background and point of view to interpret the health status of the patient and a different competence for the referral of actions, which distinguishes him or her from the physician, nurse, nutritionist, and other health care workers.[11]

The social demands addressed by the social worker are the most varied, whether they are spontaneous or whether the patient has been referred by health professionals from the cardiac emergency unit. These demands include explicit cases of social vulnerability, cases where the patient arrives alone and suddenly dies without having any documentation, elderly patients who live alone, patients who remain hospitalized and are unable to return home as the companion is an elderly person or a minor, patients who are homeless, patients who suffer from mental disorders and do not have any documentation, patients who live alone and need to be transferred because of another acute disease, patients who have private insurance that does not cover the current situation, and the many occurrences requiring continuation of treatment at home or in the basic care network for access to specifically required equipment. Therefore, these are assistive actions related to the basic needs of the patients and/or families (e.g., obtaining transportation, lodging/support home, orthoses and prostheses, and referral to social assistance network), socio-educational actions related to the exchange of information/alternatives to solve social demands based on changes (e.g., individual and/or group approaches, institutional dynamics/norms and routines, labor/social security orientation, guidelines to access services and social rights), and planning and advisory services (e.g., specific care programs, strategic planning). It is also important to consider the care provided to the family of the patient, who usually arrives at the unit in a critical moment really distressed. Socio-therapeutic actions are implemented for the family in situations where they experience suffering. Socio-institutional support and lodging are also care measures provided to the family through social services.[12]

The social worker in a cardiac emergency unit must initially carry out the social interview with the patient to assess socioeconomic, family, working, and social security conditions. The social interview is a technical operational tool that allows the social worker to determine the living conditions of subjects who are assisted in health services, based on the theoretical-critical perspective, to provide information that allows him or her to apprehend and reveal the new social challenges of his or her daily professional performance.[13] Other operational technical instruments are also used, allowing professional actions to take effect in the intervention. These actions include observation, home visit, reports, study, social assessment and opinion, social report.

Some of the assistance activities performed by the social worker in a cardiac emergency unit include the following:

- Welcome and support the patient and his or her family in meeting their emergency needs.
- Conduct a social interview to assess social, family, working, and social security conditions.
- Identify the social demands that are present in the emergency unit to formulate responses to the needs of the patient, family, multidisciplinary team, and institution.
- Mediate and refer to the social assistance resources network.
- Participate in and perform actions with the health care team.
- Prepare and propose actions aimed at promoting changes and meeting the needs of the population served.
- Provide guidance to the patient, family, and companion on institutional norms, certificates, and post-discharge reports on health (e.g., Basic Health Units, Reference and Counter-reference Program) and socio-assistance resources (e.g., Regional Council of Social Assistance).
- Clarify and guide patients on the functioning of the public health network, specifying the function of the services provided at each level of care.
- Accompany families and/or patients who present social risks or require care.
- Identify support groups to meet the demands of patients and/or families.

FINAL CONSIDERATIONS

The role of the social worker in health care and, more specifically, in a cardiac emergency unit, includes direct patient care actions that promote awareness of the presented reality.

Professional intervention is carried out by a multi-professional team and contributes to the accomplishment of collective and democratic practices, providing the necessary information to promote and prevent diseases. Moreover, this work creates a favorable setting for the globalization and expansion of social rights by interfering with the institutional routine to facilitate access and ensure quality of the services provided.[14]

The findings of this study shed light on the role of the social worker in an emergency unit and can raise awareness among health care teams regarding the reality of cardiac patients, planning and implementation of care and education programs, and provision of better professional interventions.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest in conducting this study.

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