ABSTRACT

Objective: to analyze the Family Health Strategy professionals’ perception on the urgent and emergency attendance. Method: a descriptive study, with a qualitative approach. The participants were 36 doctors and 34 nurses from the FHSs of southeast Teresina/PI, throughout semi-structured guided interviews. The statements were processed by the IRAMUTEQ® software. The research project was approved by the Research Ethics Committee, CAAE nº 20688713.7.0000.5210. Results: the results showed low effectiveness of the urgency and emergency care network for the professional’s lack of knowledge, as well as for the deficit of physical and material resources. Conclusion: it is imperative to adopt public policies aimed at legal compliance and improvement of the basic care urgency and emergency patients, in order to effectively include FHS at the Unified Health System (SUS) care networks to better attend the population. Descriptors: Perception; Family Health; Urgency; Emergency.

RESUMO

Objetivo: analisar a percepção dos profissionais da Estratégia Saúde da Família sobre o atendimento de urgência e emergência. Método: estudo descritivo, com abordagem qualitativa. Participaram 36 médicos e 34 enfermeiros de ESFs da zona sudeste de Teresina/PI, por meio de entrevista com roteiro semiestruturado. Os depoimentos foram processados pelo software IRAMUTEQ®. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE nº 20688713.7.0000.5210. Resultados: os resultados evidenciaram baixa efetividade da rede de atenção às urgências e emergências pelo desconhecimento e o despreparo dos profissionais quanto ao atendimento, bem como pela deficiência de recursos físicos e materiais. Conclusão: é imperativa a adoção de políticas públicas que visem o cumprimento legal e a otimização do acolhimento dos pacientes em urgência e emergência na atenção básica, a fim de concretizar a participação da ESF nas redes de atenção do Sistema Único de Saúde (SUS) na melhoria assistencial da população. Descriptors: Percepção; Saúde da Família; Urgência; Emergência.

RESUMEN

Objetivo: analizar la percepción de los profesionales de la Estrategia Salud de la Familia en la atención urgente y de emergencia. Método: estudio descritivo con enfoque cualitativo. Los participantes fueron 36 médicos y 34 enfermeras de las ESF del sureste de Teresina/PI, a través de entrevistas con guión semiestructurado. Los informes fueron procesados por el software IRAMUTEQ®. El proyecto de investigación fue aprobado por el Comité Ético de Investigación, CAAE nº 20688713.7.0000.5210 Resultados: los resultados mostraron una baja efectividad de la red de salud para la atención de emergencia por la ignorancia y la falta de preparación de los profesionales y de servicios, así como la carencia de recursos físicos y materiales. Conclusión: es imprescindible adoptar políticas públicas encaminadas al cumplimiento legal y para optimizar la recepción de los pacientes en la atención primaria urgente y de emergencia, con el fin de lograr la participación del ESF en las redes de atención del Sistema Único de Salud (SUS) en cuidar mejor de la población. Descriptores: Percepción; Salud; Urgencia; Emergencia.

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INTRODUCTION

The Basic Care is at the urgency care network as an element of the access increment, fortification of the connection with the society, responsibility and first aid until transferance to other healthcare units, after classifying the risks.¹ It is primary component of healthcare as a gateway to enter this network, according to Decree nº 7.508/2011, which regulates Law 8.080/90 of the Ministry of Health (MOH),¹ pre-hospital fixed component, which comprehends the basic (family) health units, community health staff, specialized first aid posts, diagnostic and therapies services, as well as non-hospital urgency attendance units.³

The FHS shall welcome patients with acute or chronic conditions, whose medical history is already known, allowing the therapeutic readjustment within the user’s and healthcare unit availability.⁴ However, there is a divergence of perception and feeling about the urgencies and emergencies, because, for the users, it may be associated with the life course disruption; for professionals, it is related to time and proportional to the patient’s prognosis; and, for health institutions, it is aimed at disruption of the service organization.⁵

At many points of view, we notice first aid services is overcrowded by people with basic care complaints.⁶ This is justified by the staff-patient relationship when reception, connection and accountability with the user fail, besides not including the patient in the service schedule, lack of medications, inability to proceed urgency tests, and non-priority service for non-recognition of an urgency by professionals.⁷

Thus, we emphasize the importance of evaluation standards for effective understanding of the complications at the FHS as well as better definition of its role at this attention network, for it is full of gaps and contradictions, ultimately confusing the staff and their attitudes.⁸ Therefore, an interest arouses in guiding the FHS professionals about their beliefs and values regarding the urgency and emergency attendance at their work place.

Given the theme, the purpose of this study is to analyze the Family Health Strategy professionals’ perception on urgency and emergency attendance.

MÉTHOD

Article drawn from the dissertation << Strategy Family Health Professional’s...
ESF Professional's Perception on the Urgency and Emergency Attendance along Text Segments Classes

**CLASS 1**
23.8%
209 Text Segments
Urgency and Emergency Attendance at ESF

**CLASS 3**
16.29%
143 Text Segments
Legislation and Permanent Education for Urgency and Emergency Attendance at ESF

**CLASS 2**
24.03%
211 Text Segments
Coping Forms of ESF Professionals to Urgency and Emergency Attendance

**CLASS 4**
16.29%
143 Text Segments
ESF Organizational Structure for Urgency and Emergency Care

**CLASS 5**
19.59%
172 Text Segments
Most Common Urgencies and Emergencies at ESF

**WORD**
**x²**

Health 124.35
Family 73.34
To work (job) 54.94
To find 54.38
Good 48.89
All 41.59
Strategy 40.79
Professional 39.08
PSF 33.91
To work (functionate) 32.46
World 22.59
Place 22.33
Prepare 20.67
Equipment 20.67
New 20.53
Reality 19.15
Community 17.89
Important 17.87
Teresina 16.10
Prepared 14.70

**WORDS**
**x²**

Legislation 287.6
To know 162.53
None 120.99
Leprosy 109.11
Tuberculosis 93.00
Course 81.71
To remember 70.81
To receive 69.12
Law 66.44
Year 54.82
Prenatal 45.50
Program 44.51
Practice 40.11
Never 33.02
To participate 31.05
Ordinance 30.03
College 25.85
Specialization 21.39
To pass along 20.65

**WORD**
**x²**

Hospital 67.12
To come 49.96
Over there 42.32
To take 39.61
To send 38.78
Samu 38.21
To call (for s.o.) 31.61
To arrive 29.82
To delay 26.53
Ambulance 25.52
There 25.44
Patient 25.22
To route 24.84
To call (to s.o.) 23.69
Here 23.18
People 22.38
Cut 22.31
To ask 20.96
C.Reference 20.95
Car 19.39

**WORDS**
**x²**

Possible 55.93
Demand 50.44
Appointment 40.48
Quality 31.05
Measure 30.76
Structure 30.40
Complicated 28.04
Marking 25.85
Less 24.29
To believe 22.65
To attend 21.83
To stay 21.06
Spontaneous 20.05
Limitation 19.92
Manners 19.92
Interesting 14.97
Wrong 14.97
To disturb 14.97
Appropriate 12.65
Material 12.21

Figure 2. FHS Professional’s Perception on the Urgency and Emergency Attendance along Text Segments classes, according to the Hierarchical Classification Descending (CHD) method.

**DISCUSSION**

- **Class 1 - Urgency and Emergency Attendance at FHS**

Compound by 209 Text Segments, 23.8% of UCEs, class 1 is directly related to class 3 and associated with 5. At this class, words like good, to function, place, equipment, reality, community, important and prepare represent the urgency and emergency attendance at FHS, and reveal it as good and important for its professionals, but, in order to be well actualized, it needs from adequate working hours, to good physical structure of the unit, materials, equipment and staff preparing.

[...] for a PSF to work in a manner that also contemplates the urgency and emergency along with the elective attendance, with integrity only at the wonderful environment of 40 hours and that I think it’d work if we were well paid. But we don’t have no condition at all to do it, because for the local PSFs to work, they’d have to
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literally double the number of constructed Basic Health Units because there’s no place for this […] (Suj. 9)

Complaints about the working hours and excessive assignments at FHS were frequent in the statements of the participants that, actually, have to work 20 hours per week. According to MOH, the working hours of the FHS staff are 40 hours per week, except for the physician class, that can work half of the stated. 11

It is noticed inconsistency at the units’ structure. Many of them, recently built or under renovation, bore, under minimum conditions, half of the teams for only one shift. It is an obstacle the managers’ perception on basic care as holder of simple actions, deviating the focus that the FHS works with great complexity, under extensive knowledge and planned actions. 11 This encumbers the implementation of new public policies, attending new health paradigms.

If I have to attend urgency and emergency at FHS, I can’t work at the current conditions: I don’t have autoclave, a box to collect perforating and cutting objects, I can’t bandage, remove stitches […] I need to have structure… It’s not to place the professional and tell him that, from today on, he’ll be doing urgency and emergency, because, even though I’m willing to do it, even though I’m prepared, I won’t be able to solve the patient’s problem […] I think this situation is impracticable […] (Suj. 32)

This statement reveals the antagonism between the health worker obligations and what he really receives. We should think over the overwork and the lack of structural conditions, for instance, to adjust the staff and the USF to technical and assistance plans to improve the offered services. 12

The following statements show the rejection as perception of the lack of knowledge of basic care as part of care networks, as well as the concern about the agglutination of the proposed actions, and the consequent essence loss for the work family health, which aims to promote , protect and prevent the health to the people.

[…] this ain’t the PSF philosophy. Here, what you do is to avoid the patient to sicken and not to attend urgency […] So, I think this research is not focused at the PSF; I don’t see it the way you see it… If the policy has changed, many things have to change. If needed, I do it, but what we need is the people to well evaluate and guide the patients. So, they are things to be reviewed (Suj. 19)

[…] If this is a new theme, it has to be reformulated and uniformed to match PSF with urgency and emergency, because it

Family health strategy professional’s perception…
doesn’t work like this; you have a sudden illness, like angina, a heart attack; how do you, inside PSF, will make this attendance? You’ll have to summon a doctor, a nurse, a 24 hours nursing technician to do that, because urgency and emergency evolve from time to time. (Suj. 10)

The Primary Care represents promotion, prevention, diagnosis, treatment and health rehabilitation, individual and collective, actions. 13 However, it tries to solve the elementary needs of the user or their guidance to other services that compose the care network, and it is the basic care that orders and coordinates the health care by the connection with the community. 14 FHS will, then, try to solve the problems that came to her and refer those that are more complex. 15

It can count on an observation room, which shall work during UBSs attendance time, to attend, humanly, some first need of the population, avoiding the user to go directly to the emergency room and providing a family atmosphere, with known and trustful people. 16

◆ Class 3 - Legislation And Permanent Education For Urgency And Emergency Care at FHS

Composed by 143 Text Segments, 16,29% of UCEs, class 3 is directly related to class 1 and also associated with class 5, representing the professional’s perception on legislation and permanent education for the urgency and emergency care at FHS. At this class, the words legislation, training, to know, none, course, to remember, to receive, practice, never and to participate reveal the lack of focused training and the lack of knowledge about specific laws.

At this area I don’t remember […] . We always receive lot of training and, sometimes, I even make a joke when comes a convocation for one, saying: - the same thing again! [laughs] It seems we are always doing the same trainings...As for legislation, I don’t even know how to tell you, I mean, because I’m kind of a laywoman, I’m not so aware of it. (Suj. 34)

The solution capacity of urgency services in primary care is directly linked to professional training, technological support and the ability to evaluate and treat cases. 17 However, at the subjects’ perception, the training offered didn’t add approaches and behaviors regarding urgencies and emergencies, as they are focused on prevention, protection and health promotion.

This explains the reaction of others participants when asked about their perceptions of such service; they just were not oriented or trained on the subject by the
contracting institution. Nevertheless, we infer the low demand for new information about the welfare at the FHS by the professionals themselves, who come to treat the work as something unchangeable. Permanent education shall transform the daily services, from obtaining and recycling of knowledge and practices to learning about the social and bureaucratic problems of work.11

In contrast, some participants reported having received training on the care in urgent and emergency situations, but this information was not equally extended to all, compromising the implementation and enforcement of behavior. Moreover, many participants are unaware of the real intention of those trainings and it is neither passed on to them, nor perpetuated to other teams as new health care paradigms.

[...the training we received was how to treat anaphylaxis related to syphilis, the use of penicillin and then were spoken the conducts to anaphylactic shock, pre-eclampsia [...].Legislation I know the protocol not only for the care of anaphylactic reactions, such as pre-eclampsia (which we have a kit as well) and anti-hypertensive urgency. (Suj.69)

The main difficulties perceived by these professionals are related to training; most of them do not know the proposals of the National Urgency Attention Policy and, at most of the UBSSs, there is no activity of Permanent Education to work this theme18. One suggests concepts and differences between urgency and emergency; host and risk classification; signs and symptoms of risk; forms and referencing sites; and first aid.19

♦ Class 2 - Coping Forms of ESF Professionals to Urgency and Emergency Attendance

Includes 211 Text Segments, 24.03% of UCEs, class 2 is directly related to class 4 and constitutes, along with class 4, a subsection of class 5. The words hospital, to take, to send, SAMU, to call, ambulance, patient, to route, to call and counter-reference reveal the perception of referencing the cases as golden pattern in facing the urgencies and emergencies at FHS as a result from the lack of resources and qualified professionals.

[...] sometimes the accompanying has a car and he himself takes. The patient arrives with shortness of breath or other situation and I do not have what to do here, I'll send to the emergency room. Other times it's the medication, if you have edema of glottis [...]; I do routing on a handwriting prescription even when the patient is with a companion and with condition to take to the

hospital [...] or then the SAMU comes; I just tell them and they take [...]. (Suj. 37)

The National Policy of Primary Care provides for scheduled and immediate activities resulting from spontaneous demand, but routing them in cases of hospitalization, retaining responsibility for monitoring the user.11 The impracticality in attendance and referrals reduces the solution of primary care, increasing the costs of the health system and overloading the hospitals that, in turn, also end up failing to provide qualified assistance.18

Perceptions also reveal a service segment, the practice of “Brazilian way” to solve some complications:

[...] when the patient arrives with shortness of breath, sometimes I ask for people chew one tablet of corticosteroid to give an improved and such to not get there without having done anything, but not aerosol we have available. (Suj.2)

[...In our situation, urgency and emergency rooms are few cases we face, is more like a hypoglycemia ... then we try to settle in primary care, giving sugar water or a snack [...]. (Suj.20)

Although illegal, the “Brazilian way” can be justified to resolve legitimate rights of users. In this case, it is increased and perpetuated the reciprocity of benefit to each other, strengthening the bonds of trust and relationship between the parties.20 However, it does not justify the government fails to invest at the service for believing that these attention levels will always find a “Brazilian way” to overcome the problems of the population.

Another way of coping experienced by these professional is simply avoiding the appearance of complications at the unit, or working the health promotion, or guiding the community to look for the reference hospital.

The policy that I and my team have been trying to implement is the education and awareness; that primary care is a level of disease, risk prevention. So, are seeds that we will go planting and its fruits maybe we go only harvest quite a while from here [...]. We will take much of these patients out of the urgency condition, but it all depends on education. (Suj.7)

Generally the people already know: serious case is hospital; and we guide health workers and the general population with education and that urgency and emergency at first is hospital. Then if it does not solve, is to PSF, because there’s no way we attend urgency effectively. Emergency, forget it. In urgency, first we do medical evaluation; in emergency is straight to the hospital, don’t even come here. (Suj.25)
The decrease of hospitalizations for situations inherent to primary care has been significant with the expansion of FHS coverage and qualification. However, it is difficult to educate the public about what to consider an urgency or emergency, considering the immediate character of their needs. It is the user who defines what and where to search, according to his social context, experiences, living conditions and availability of services, and he most looks for the hospital service for the perception that the FHS is only for the healthy control and doesn’t offer exams “on time”, for low infrastructure of UBSs; time limitation and delay of the attendance; unknowing the role of the nurse; and lack of confidence in general physician.

The FHS professionals still have to face the realization of reference and counter-reference of referrals at those situations that the FHS cannot solve, within the SUS care networks:

Sometimes you may even have the reference, but not the counter-reference. We will only know what happened to the patient if we go for a visit or ask the health agent to call […] but in the day-to-day we can also forget and if we had a counter-reference, the hospital that received put what was done and sent them to the health unit would be better […]. (Suj.25)

Every network of attention to urgencies and emergencies shall be directed to rapid interventions and to the responsibility of a reception with qualified listening, risk rating, the health needs analysis and vulnerability to fully solving cases.

However, the protocols focused on the healthcare network for urgencies doesn’t describe as counter-reference occurs when patients return to the community, leaving gaps in the health care cycle. Thus, an individual who is referred to a hospital and treated there, do not have to return to the FHS team interventions carried out during the treatment or at least recommendations on how to follow up care as a mandatory standard protocol.

♦ Class 4 - FHS Organizational Structure for Urgency and Emergency Care

Class 4 is directly associated with class 2, with which forms a subsection of class 5; it is compounded by 143 Text Segments (16.29% of UCEs) and represents FHS organizational structure for urgency and emergency care, and defined by the words demand, appointment, quality, measure, structure, complicated, limitation, manners, appropriate and material. The lack of physical structure, materials and equipment, as well as the high demand for first aid support and the various assignments imposed to the team, damage the service quality, preventing the appropriate assistance by the professionals.

[…]. Here, as you see, the limitations are many, both the structure itself as also the medication and to make an urgent care like this, it has to continue; we have nursing technician, but she is only at the appointment schedule. So I had to change a lot to work out urgency care here. (Suj.1)

For MOH, it is unacceptable that the user is not accepted at UBS, especially in case of complications, regardless of whether he is part of the territory, or not, or have to resort to another service without referencing by the FHS. But one must consider the technical capacity of professionals and the availability of materials, supplies and medicine for the most appropriate care.

The Physical Structure Guide of UBSs advocates quantitative equipment, instruments and basic furniture, from outpatient materials to oxygen, nebulizers and surgical instruments. It also establishes that the UBSs must have the reception room for the spontaneous demand, as well as rooms for procedures in complications.

Analyzing the study units, there has been clear inconsistency about the standard structure recommended by MOH. Many units consist of small makeshift homes, inaccessible, and the least necessary for its operation. Some teams were at makeshift sheds, as the head office was under renovation; others worked amid the renovation, without condition to meet the elective or the spontaneous demand. Moreover, the professionals perceive the damaged service quality when they need to reconcile the outpatient, elective and unexpected and immediate action due to the large number of families served.

In our reality complicates very […] patients already go beyond the normal amount of a quiet service and opens for emergency care … clutters. […] The time I have a patient in need of removal to another drive, prevents any other service; we have to stop and accompany the patient, transfer takes time. (Suj.45)

For MOH, each FHS team should be responsible for no more than 4000 people, with an average of 3000 recommended, respecting equality criteria for this definition and the reality of the studied teams counteracts this average. The organizational processes related to welfare improvement require, in addition to public
awareness, changes in the distribution of households by staff.

◆ Class 5 - Most Frequent Urgencies and Emergencies at FHS

Compound by 172 Text Segments (19.59% of UCEs), class 5 is associated with classes 1 and 3, and is subdivided in classes 2 and 4, representing the perception on the most frequent urgencies and emergencies at ESF, suggested by the words crisis, hypertensive, diarrhea, hyperglycemia, hypoglycemia, asthmatic, convulsive, pain, fever; among others related to manners (oral, medicine, insulin, glycaemia, rehydration, sugar, injectable).

Professionals realize they attend, frequently, minor complications, but emergencies are extremely rare for them as the public is guided to search for the reference hospital.

An elderly with hypertensive crisis or a child with fever we can solve with simple attitudes; prevents them from going to a further place [...] You can attend really calm and as the situations that appear are not so severe, I think we can attend using an oral rehydration serum in cases of diarrhea without important dehydration; adjustment of the doses of the antihypertensive, and sublingual captopril when is with higher blood pressure [...].(Suj. 67)

Other urgent and emergency situations can also occur in primary care and the FHS professionals must be able to conduct them.

I've had patients with hypoglycemia, hypertensive crisis [...]; okay if the patient is still conscious, we can still solve. [...] If not, how do we stabilize a patient only with hand and talk? I've got a child with 40 degrees of fever; what could I do? The doctor prescribed, I did antipyretic, put the child in damp cloths; now it went to urgency. Now if you get a pre-eclampsia, a seizure? I pray every day to God not to happen [...].(Suj. 36)

MOH advocates as medical and nursing procedures at UBS, other actions such as immunization, bandage, drainage of abscesses, suture, administration of oral and injectable drugs, oral rehydration therapy, care in basic urgency and referral of more complex cases of emergencies and urgencies. In addition, the manual of procedures in primary care added excision of cysts, lipomas and nevi; auricular and gastric washing, removal of foreign bodies and contagious clam, and treatment of superficial wounds and ingrown toenail.

Medications are only described in the Book of Basic Care of Spontaneous Demand Reception, along with clinical analysis and conduct in situations such as anaphylaxis; headache; epileptic seizure; decompensating glucose and blood pressure; vomiting; diarrhea; dyspnea; dysuria; skin diseases; pain; intoxication; animal bites; burns; flu-like syndromes; abnormal genital bleeding; dizziness or lightheadedness; Dental emergencies; “red eye” type ophthalmic urgency; cardiopulmonary arrest; violence and ill-treatment and attention to mental health.

One enhances the unavailability of technologies and management that help professionals in the effectiveness of the care network and its actions, creating chaos in the health system. Implantation of information systems, flowcharts, protocols and standards are not satisfactory when there isn't interaction between the various services and their managers, workers and users.

Therefore, it is clear the need to include ideas and joint work not only of FHS teams, but of these workers and municipal health managers, for the strengthening of actions that benefit and apply the network of urgency and emergency care, within the reality of each territory.

CONCLUSION

The FHS professionals deal with urgencies and emergencies daily, as the technologies they have at UBS: equipment, materials, supplies and particular knowledge concerning every situation. Furthermore, the research enhanced a territory demographic and economically important of the capital which policy for urgency and emergency care does not include, effectively, the ESF, as there is no training directed at professionals, or adequate infrastructure at these locations.

Professionals present perception of FHS as a strategy based on health promotion, and disease prevention and protection, which includes educational lectures, home visits and outpatient appointments aimed at the achievement of goals of health care programs. They are unaware of the FHS as part of the network of urgency and emergency care, as well as related support legislation, which shows the need to present new approaches in health to involved professionals, with permanent health education also as a right for all workers and state duty.

The FHS must be rethought by managers as a collaborator to the network of urgency and emergency care in the capital, because for it to be active Indeed, public policies must be implemented to restructure, equip and standardize USFs, as well as empowering all involved professionals, so that they can be
engaged to an appropriate reception of community needs for which they are responsible.

It is expected that this study will contribute to summarize the importance of primary care in the network of urgency and emergency care and its key role in the transformations necessary for population's quality of life, under improvement in infrastructure, job training, improvements in strategic planning actions and evaluation of activities. It is estimated also the intellectual and scientific contribution to the applicability of the appointed actions and incentive to actions to similar researches, in helping other professionals to the perpetuation of care.

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