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PERCEPTION OF FAMILY HEALTH TEAMS REGARDING PRIMARY CARE PROVIDED IN THE URGENCY NETWORK

PERCEPÇÃO DE EQUIPES DE SAÚDE DA FAMÍLIA SOBRE A ATENÇÃO BÁSICA NA REDE DE URGÊNCIA

PERCEPCIÓN DE EQUIPOS DE SALUD DE LA FAMILIA SOBRE LA ATENCIÓN BÁSICA EN LA RED DE URGENCIA

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ABSTRACT

Objective: to learn the perception that Family Health teams have about the primary health care provided in the Urgency Network. **Method:** qualitative, descriptive and exploratory study carried out through semi-structured interviews of professionals from Health Centers in a municipality of Santa Catarina/SC. We used the Collective Subject Discourse in order to analyze the data. **Results:** four discourses emerged with the Central Ideas: primary care as a reference to urgency and emergency care; flow of care; capabilities; and difficulties of the service offered to situations of urgency and emergency in the primary care. Among the capabilities, the dedication of professionals in assisting users and the classification for defining the service stand out; and as for the difficulties, the lack of equipment, transportation, physical space and little training of teams stand out. **Conclusion:** improvements are needed in primary care, mainly those related to structural aspect and human resources, in order to offer a safe service that meet the urgency demand. **Descriptors:** Primary Health Care; Family Health Strategy; Health services; Emergency Medical Services; Nursing. **Descriptors:** Atención Primaria de Salud; Estrategia de Salud Familiar; Servicios de Salud; Servicios Doctors Urgencia; Enfermería.

RESUMO

Objetivo: conhecer a percepção de equipes de Saúde da Família sobre a atenção básica na Rede de Urgência. **Método:** estudo descritivo-exploratório e qualitativo, realizado com entrevista semiestruturada a profissionais de Centros de Saúde de um município de Santa Catarina/SC. Para analisar os dados, utilizou-se o Discurso do Sujeito Coletivo. **Resultados:** emergiram quatro discursos com as Ideias Centrais: a atenção básica como referência à urgência e emergência; fluxo do atendimento; potencialidades; e dificuldades do atendimento de urgência e emergência na atenção básica. Dentre as potencialidades, aponta-se a dedicação dos profissionais no acolhimento do usuário e a classificação para definição do atendimento; e como dificuldades, a falta de equipamentos, transporte, espaço físico e pouca capacitação das equipes. **Conclusão:** são necessárias melhorias na atenção básica, principalmente estruturais e de recursos humanos para uma assistência segura e de fato pactuada às urgências. **Descritores:** Atenção Primária à Saúde; Estratégia Saúde da Família; Serviços de Saúde; Serviços Médicos de Emergência; Enfermagem. **Descriptors:** Primary Health Care; Family Health Strategy; Health Services; Emergency Medical Services; Nursing.

RESUMEN

Objetivo: conocer la percepción de equipos de Salud de la Familia sobre la atención básica en la Red de Urgencia. **Método:** estudio descriptivo-exploratorio y cualitativo, realizado con entrevista semi-estructurada a profesionales de Centros de Salud de un municipio de Santa Catarina/SC. Para analizar los datos, se utilizó el Discurso del Sujeto Colectivo. **Resultados:** surgieron cuatro discursos con las Ideas Centrales: la atención básica como referencia a la urgencia y emergencia; flujo del atendimento; potencialidades; y dificultades del atendimento de urgencia y emergencia en la atención básica. Dentro de las potencialidades, se muestra la dedicación de los profesionales en la acogida del usuario y la clasificación para definición del atendimento; y como dificultades, la falta de equipamientos, transporte, espacio físico y poca capacitación de los equipos. **Conclusión:** son necesarias mejoras en la atención básica, principalmente estructurales y de recursos humanos para una asistencia segura y de hecho pactada a las urgencias. **Descriptor:** Atención Primaria de Salud; Estrategia de Salud Familiar; Servicios de Salud; Servicios Médicos de Urgencia; Enfermería.

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INTRODUCTION

The theme of this study assumes an understanding of Health Care Networks (HCNs) and, for this, a brief approach to the subject is presented. Proposals for HCNs are recent. Their origin is linked to the experiences of integrated health systems that emerged in the United States in the first half of the 90s and advanced to the public systems of Western Europe and Canada, until reach, later, some developing countries. Brazil is among these nations that have launched the theme recently, but with increasing evolution. This universal movement that focuses on the construction of HCNs, is supported by evidence from several countries in the sense that these networks are an escape for the contemporary crisis of health systems.¹

Health Care Networks can be defined as polyarchic organizations of health service sets linked between themselves by one mission, common goals and a cooperative and interdependent action, able to provide continuous and comprehensive care to a given population, with coordination of primary health care - given at the right time and place, with proper cost and right quality in a humane way and with equity - and with sanitary and economic responsibilities, creating value for the population.¹

In this view, these services are structured in a network of health care points with equipment of different technological densities that must be distributed properly in space. Some foundations are the basis for organizing HCNs with effectiveness, efficiency and quality: economy of scale, availability of resources, quality and access; horizontal and vertical integration; substitution processes; sanitary territories; and levels of care. Notably, HCNs have as dominant logic the overcoming the fragmentation of actions and health services and qualification of care management.¹

The Primary Care (PC) is one of the structural components of the HCN that, understood as the center of communication, has the key role of organizing the network and coordinating the care, according to the Ordinance GM/MOH nº 4,279/2010.² A study indicates that the organization of health systems in HCNs coordinated by PC may have significant impact on the health of the community with affordable costs, being engendered in the legal and political framework of the Unified Health System (SUS). Specifically, health systems organized in this way can contribute to clinical quality,

with sanitary outcomes of positive impact on users' satisfaction due to improved access and solvability and reduced costs of local health systems. However, there are several challenges to ensure PC as coordinator of HCNs.³

A research conducted to understand the organization of the HCN in the perception of health professionals revealed difficulties and opportunities of building a networking and revealed that strategies are needed in order to minimize or overcome these difficulties of consolidating the HCN and the completeness of health, given the need for continuity and accountability of the assistance.⁴

Priority Health Care Networks in the HCNs were established in the country in 2011. The Emergency Care Network is among these, as established by Ordinance GM/MOH nº 1600/2011. The PC, as a component of this network, aims to assure the first care to emergencies in adequate environment until the transference/referral to other points of attention, if necessary, is carried out, in order to implement the hosting with assessment of risks and vulnerabilities.⁵ It is noteworthy that this gateway to SUS, in the case of patients in urgent and emergency situations, may be the only access available to users very often in the Brazilian reality. This fact adds to this gateway great importance and responsibility.

A research that aimed to identify the tasks of the PC in the emergency service, from national health policies, indicates that the interface between emergency policies and PC deserves to be valued in new studies.⁶

Given the above, the development of the present research presents as guiding question: *How do Family Health Teams (FHT) perceive the primary care in the emergency network?* This study, carried out by the Study Group on the Care offered to People under Acute Health Situations (SGAHS), aimed to know the perception of Family Health teams of primary care in the emergency network of a municipality in the region of Grande Florianópolis - SC. It is believed that the importance of this research comes from the possibility of point out subsidies to improve the care provided to urgencies and emergencies in the PC.

METHOD

Descriptive and exploratory study with qualitative approach carried out in three Health Centers (HC) in the municipality of Palhoça, Santa Catarina. There were 19 HC and 25 FHT in the city during the research period. Three HC, one from each region

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(center, north and south), were randomly selected for data collection taking into account the criterion of having a FHS active there.

Among the 61 professionals working in the selected HC, 22 participated in the study, from the following categories: nurse, physician, dentist, nursing technician and community health agent. The principle of the data saturation was used to determine the number of participants. For inclusion of professionals, the following criteria were considered: possess professional bond with the Municipal Department of Health; be in exercise of work activities in the period of data collection, and have at least six months of working in the FHT, a length of time considered necessary for the professional to get familiar with the PC in the emergency network.

Data were collected from August to October 2011, in the private HC environment, through semi-structured interview that lasted an average of 30 minutes, recorded in MP3 format and later transcribed.

Collective Subject Discourse (CSD) was adopted for data analysis, because this does not reflect the individual thinking of study participants, but the collective thinking, making it an instrument for intervention in reality. The CSD consists of four methodological approaches: Key Expressions (KEs); Central Ideas (CIs); Anchoring (AC); and CSD itself.⁷

The KEs are excerpts that highlight the essence of the content of speeches about a central idea. The CI is an expression that describes briefly the direction of the set of KEs originating the CSD. The AC is the foundation that the subject uses to prepare his speech and which may be based on an

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ideology or belief. The CSD is a speech synthesis written in the first singular person, structured by KEs that have the same CI.⁷

The procedures for construction of CSD were: reading the speech of each participant and extraction of KEs and CIs thereof; and grouping of KEs of different individual speeches with the same CI, thus creating different CSD. It is worth mentioning that ACs were not found in the individual speeches.

The project was authorized by the Municipal Department of Health and approved by the Ethics Committee of the Federal University of Santa Catarina, under Protocol n° 2026/12. The professionals were given a Informed Consent form with the ethical aspects recommended by Resolution n° 196/96 of the National Health Council. Interviews were coded with the letter N (Nurse); NT (Nursing Technician); P (Physician); D (Dentist) and CA (Community Agent), followed by numbers that correspond to the sequence of the interviews (N1, N2, NT1, NT2, ...).

RESULTS AND DISCUSSION

Among the 22 professionals who participated in the study, there were three physicians, four nurses, four nursing technicians, 10 community health agents and one dentist. The age of professionals ranged from 22 to 55 years and the time working in the unit was between seven months to nine years: six subjects had six to 11 months of operation; 10 had one to four years; and six of them, had five to nine years.

The results reveal four discourses that emerged from the perception of professionals FHT relating to Primary Care in emergency network. These discourses and their central ideas (CI) are shown in Figure 1.

Central idea		Collective Subject Discourse 1
The PC as reference to urgency and emergency	Central idea	The service in the unit has spontaneous demand, we never know what will come next. The place is far from first-aid posts and hospitals, the population is poor and has difficulty to go to another health service. Even though our service is of primary care, which is not supposed to be directed to emergency care, we are a reference for the population, because this is a place with a health team. They can bring someone with a grievance and we have to be able to meet and stabilize the patient until this engages the service that would be indicated to his situation. You need to have a whole reference and counter-reference with respect to this. We are the gateway of this type of situation. (N2, N4, P1, NT1)
Flow of service in Urgencies and emergencies	Central idea	Collective Subject Discourse 2
Difficulties of urgency and emergency care in PC	Central idea	When the patient is identified in an urgent situation, an emergency, it is evaluated first by the nurse and then by the doctor, and usually the nurse calls the ambulance, because even with the patient stabilized, there is still life-threatening risk, and this needs a better structure for assistance. In situations of urgency, we try to use the municipal government transportation and make the counter-reference with the first-aid post of the municipality, sending professionals in the ambulance, and in situations of emergency we call the SAMU, and sometimes even the police, so that we may have a car. (N1, N2, N3, N4, P1, P2, P3, D1, NT1, NT2, NT3, NT4)
Capabilities of urgency and emergency care in PC	Central idea	Collective Subject Discourse 3
	Central idea	The basic unit has no structure to assist an emergency, there are no supplies, equipment, space, and we do not have training to meet this kind of situation. The person should not come to the health center when he has a life-threatening problem, because this will risk the patient's life. He will come here just to waste his time, that could be used to go straight to the hospital, and we have a very great difficulty to transport the patient. Sometimes we have even gone to the house of the patient using private cars, bus and we have even paid so they could come to the health center. (N1, N2, N3, P2, P3, NT2, CAS3, CAS4, CAS5)
	Central idea	Collective Subject Discourse 4
	Central idea	First, all strive to welcome the person in the post, and although we do not have the right material, we see what is urgent, emergency and if we can make an appointment. The team provides the first care, the person is medicated and this avoid the person to be crowding the emergency rooms of hospitals. This even helps people who may not have conditions to reach another service. We fight against time and do what is within our possibilities. (N3, N4, P1, P2, CAS5, CAS6)

Figure 1. Collective Subject Discourses and their Central Ideas on Primary Care in the emergency network. Palhoça, SC, Brazil, 2011.

Three aspects stand out in the first discourse: the PC as reference to the population and gateway to the urgent and emergency situations; the understanding that PC must be able to play its role in stabilizing the victim and activation of specialized support services; and the need for the reference and counter-reference.

In this discourse, the PC as reference is related to the ease of access because the community lives away from the emergency care unit and hospitals and has financial difficulties to move to another health service. However, a contradiction is observed in the discourse with respect to determining the National Policy of Attention to Urgencies, that PC is a component of SUS urgencies network. In the perception of professionals, situations of emergency should not be addressed in this health care level, although the service is in fact performed, once the team understands that the assistance to a user even in a critical condition is their responsibility.

It is evident in the discourse that the assistance is given respecting the level of technological complexity of the health unit, and professionals ask support service when needed.

Access to health services has been a subject of research carried out on PC. Studies analyzing the users' perception about the access to the Family Health Strategy (FHS) revealed problems in it, such as the difficulty to schedule an appointment.⁸⁻⁹ The FHS is a narrow gateway to SUS that deserves a different look, taking the needs of individuals as its starting point.⁸

In the evaluation of health system performance, access is defined as the system's ability to provide, in the right place and right time, care and necessary service.¹⁰

PC as gateway to acute situations is also present in the literature. In FH units of São Paulo, 86.8% of the respondents expressed having participated in some kind of urgent/emergency care.¹¹ The percentage of higher level professionals of FHS who reported performing urgent/emergency care was also high in Florianópolis, despite the organizational difficulties identified in the FHS as the preferred and regular gateway.¹²

Research with managers of PC of municipalities of Rio de Janeiro revealed their understanding of the role of PC in urgencies. The service to spontaneous demand should be carried out at this level of care in the opinion

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of most managers, and if there is a case of an urgency, this must be met immediately, stabilized and if necessary, transferred to another point of the HCN.⁶

It is noteworthy that there are still professionals of the PC who do not recognize their responsibility toward emergencies. This shows that the proposed reversal of logic, from fragmented systems toward networks of attention to emergencies vertically integrated, has not reached yet all those involved in the process.¹³

The Ministry of Health recognizes that the risk stratification (producing equity), assurance of access to services for each specific situation and the integration between care units of different profiles (FH Unit, Emergency Care Unit - ECU, the Mobile Urgency Care Service - SAMU, emergency and trauma hospitals) are among the challenges and needs of the attention to urgencies.⁵

In addition to accessibility, the immediate recognition of the severity of cases by professionals is another feature of the quality of the health system in the attention to urgencies.¹⁴ A research with doctors and nurses from FH found that 55.3% of them consider their staff able to provide initial care of urgencies/emergencies; the vast majority (81.6%) claims to have the ability to differentiate between urgent and emergency levels; and the same percentage (81.6%) considers the actions of care taken in these situations as adequate.¹¹

With respect to the fact that the PC must be able to stabilize the victims and activate support services, present in the discourse, the Ministry of Health emphasizes that it is important the health team to be trained to quickly diagnose serious cases, start maneuvers of basic support to life and trigger the removal service for continuity of care.⁵

Regarding the reference and counter-reference, as pointed out by participants, it is recommended that people with acute harm be welcome at any level of the health system, which means that both PC and specialized services should be prepared for reception and referral of patients to other levels of care when the possibilities of complexity of each service are exhausted.¹⁴

A system of reference and counter-reference is essential for the health services operate in an integrated manner, from a perspective of network of services. In this sense, this system is understood as a mechanism of mutual referral for users between the different levels of complexity of services.¹⁵

The second CSD is mainly related to two elements: evaluation of the user in the situation of urgency and emergency and the transport of the patient from PC to the specialized service. The user with needs of attention focused on the urgency/emergency follows a flow of evaluation in the PC service, passing through the nurse to the doctor for stabilization and subsequent referral to the level of specialized care. The evaluation of the patient that allows to classify the situation as urgency or emergency defines the flow on the network of attention to the urgency and the type of transport to be arranged.

A study supports the PC as part of the emergency network with the role of welcome spontaneous demand, solve the low complexity urgencies, as well as manage and provide adequate transportation to complex urgencies.⁶

It is noteworthy that the CSD 2 does not clarify whether the evaluation of the user in urgency and emergency, performed by the nurse and the physician, is based on a risk classification protocol, as recommended by the Ministry of Health.

The implementation of the Reception with Risk Rating (RRR) in the FHS is essential to ensure confidence to the staff and equitable access, giving priority to users who require immediate care. The hosting can be understood as the identification of patients of the demand/day that need medical intervention and nursing care, according to the potential risk and health problems, using a qualified hearing process and making protocol-based decision.¹⁶

The organization of PC to through color risk classification (red, yellow, green and blue) can mean an important strategy for overcoming the model of distribution of 'tickets' and 'queues', which allows to identify needs and set priorities in the service.¹⁷

Yet in this speech, it is clear that after the stabilization of the patient in the PC, this is forwarded to the specialized service when there is still risk for life and when the patient's situation demands better service structure, stressing the understanding of the need for a service in network form. In this referral process, the nurse usually takes the role of arranging transportation, whose type will be determined by the user's condition setting as urgent or emerging, which may include the ambulance, SAMU, and even a police car. In the particular situation of urgency, the victim is referred to the

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specialized level in the municipal ambulance with health unit staff.

The participation of nurses is portrayed in two moments of care, both in the evaluation of the user and the transport to another service. However, the autonomy of the professional in the decision of that referral is not clear.

It is noteworthy that in all health care levels, nursing plays a key role as a team member in urgent care through direct patient care, on-site management and management of the entire team.¹⁸

The function performed by the nurse, as revealed in the CSD 2, is in accordance with the nurse's duties in the PC as defined in the Primary Care National Policy - PCNP. This attributes to this professional, among other actions, activities of service to the spontaneous demand and referral when necessary, of users to other services.¹⁹ The result of the nurses' work will depend on how the system of reference and counter-reference is established in the network of attention to urgencies, considered essential for the realization of the SUS principles. Its structure, among other factors, will facilitate the attention flow of users among various levels of care. This requires the integration of services and the establishment of formal customer referrals.²⁰

In the third CSD, related to the CI of difficulties in the PC with respect to urgency and emergency care, two aspects stand out: the lack of structure of the unit and of professional training. According to participants, the lack of conditions (materials, equipment, physical space, transportation and staff training) for assistance in PC is transformed in delays for effective service to users at risk of life.

The literature on the subject confirms the difficulties to meet the urgencies and emergencies in PC identified in this study. A similar reality was observed in Belo Horizonte, where professionals of a Basic Health Unit pointed as difficulties: inadequate physical structure; lack of materials and supplies and complex technology; and unpreparedness of the health team for technical procedures.¹³

A research involving managers of municipalities in the metropolitan region of Rio de Janeiro highlighted among the challenges to ensure the care of emergency in PC: incomplete teams due to difficulties in hiring physicians; structural problems, including lack of adequate equipment and supplies for the management of these situations.⁶

In order to effectively meet the demands of urgencies and even emergencies in PC, it is necessary to consider a number of conditions, including the technical competence of professionals, transportation control system, minimal technological resources and appropriate physical area.²¹ These conditions affected the setting of this study.

The ability of FHT of a municipality in the countryside indicates that the difficulties that professionals meet to assist an urgency and emergency may be related to lack of materials and lack of continuing education activities. The gaps in the local information system and the lack of organization and strategic projects have also been attributed to the difficulties faced by the FH units in attention to urgencies and emergencies.¹¹

Although the very PNAU points as fundamental aspects for the urgency/emergency service in Pre-hospital care component (PC and FHS), training human resources, structuring of physical resources and grid of references, including the adoption of mechanisms for assurance of transportation,²² the aforementioned studies, as well as the present study, show that the difficulties are still real in the attention to urgencies and emergencies in the PC.

It is stressed that health services need to be technically qualified and must have adequate physical infrastructure, personnel, material resources and equipment for the first care or to stabilize the situation of emergency in order to further referral of the victim to more complex units.¹⁴

Enabling an efficient transport system can interfere with the routing of the user among services and outcomes of care in situations of urgency and emergency.

The types of transportation used by professionals in the service to users in situations of urgency and emergency in PC, present in the discourse, are among the various vehicle options recommended by the Ordinance GM n° 2,048.²³ However, in a situation of urgency, not specified in the discourse of participants, the user is transported in the ambulance with professionals of the PC, which may compromise the care of this health service, depending on their labor demand and its quantitative human resources.

When the user requires transportation from the PC to more complex services, a study suggests the use of an ambulance as an obstacle, since ambulances available in the city to meet this demand do not have

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specialized professionals to carry out more complex care.²⁴

The CSD 4, whose CI is the capabilities in attendance, portrays commitment of professionals to host the user and classify the risk to define the flow of service, which helps to reduce the demands of care in emergency services and benefit the population by assure access to care. This discourse shows that PC is fulfilling, in a way, its role in the network of attention to emergencies, despite the difficulties presented in the CSD 1 and 3.

Unlike this study, the literature points that services of PC are not dedicated to the hosting and assistance of their users, resulting in losses to the population by the difficulty of access and increased demand in emergencies.²⁵⁻⁶ In the state of Rio de Janeiro, the work of the FHS professionals causes the routing of users out of the health unit and increases the demand of emergency services.²⁵

In São Paulo, PC units present difficulties of access to users, since they do not have the resources needed for providing care and, feeling dissatisfied, users seek high complexity services. Thus, the flow becomes complicated, leading to maintenance of overwhelm of service in more complex levels such as ECUs and hospital emergencies.²⁷

The shortcomings found in the hosting and humanization of PC in assisting children bellow five years old with respiratory problems, in Cascavel, Paraná, indicate that the family can schedule an appointment depending on the "will" of who is at the reception.²⁶

In municipalities of Rio de Janeiro, most managers say that it is difficult to absorb the unprogrammed demands and that the most urgent cases that arrive at PC are routed to the most advanced technology services (Emergency Care Units or Hospitals). Thus, the role of PC in the emergency service may permeate the discourse of managers, but it is not accomplished in practice.⁶

Given this reality, we suggest that conditioning factors of PC resoluteness and legitimacy with the population must be discussed in the political scene. This must include the need to review the population coverage by the each Family Health team, since the greater the number of people under the responsibility of a team, the greater the likelihood of spontaneous demand,⁶ include urgencies and emergencies.

The conformation of territories to be assisted by FH teams should be able to relate to urgency and emergency, through risk

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classification and resolution of acute grievances of less complexity. Thus, these territories become care spaces, of assurance of first contact and referral responsible for the consistent use of available technologies in the specialized referral services.²⁸

Primary care units, as coordinators of HCNs, should facilitate access, have infrastructure and trained human resources to assume their role in the stabilization of users under acute conditions and subsequently transfer to medium or high complexity units according to the need of each situation.

FINAL REMARKS

The analysis of the discourses of the Family Health teams about the primary health care in attending the user under a situation of urgency and emergency showed four central ideas: professionals assist the situations of urgency and emergency because they understand they are the reference unit and the gateway to the people with urgent health needs or not; after the initial service is provided, the user is routed to larger units; participants point to weaknesses of the unit to offer the service related to the physical structure, material resources and professional qualifications for the stabilization of patients and, as a potential aspect, service accessibility offered to the user, the commitment of the team to provide care and recognition that primary care makes up the network of attention to emergencies, helping to reduce the demand on hospital emergency services.

Thus, the study indicates a need for improvements in primary care in order that the assistance to users under situations of urgency and emergency be safe and provide the appropriate referral of users. It is up to managers to put into practice the Ordinances of the Ministry of Health/MOH, here, in particular the GM/MOH n° 1600/2011 so that primary care services have an effective role in the emergency network. This should be combined with the commitment of professionals and the demands of the population through discussion forums in municipal health councils.

In this perspective, the present study contributes to show the weaknesses and capabilities of primary care to meet the urgencies and emergencies, allowing a glimpse on the advances and challenges for the network of attention to urgencies and emergencies and subsequent comprehensive care.

The limitation of the present study is related to its potential for generalization, since it was performed in only one municipality of Santa Catarina/SC. In this sense, further research on the subject are required in order to seek to learn the phenomenon investigated.

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