ABSTRACT
Objective: to describe the profile of users who stay for more than 24 hours in the red room of the 24h ECU. Method: an exploratory-descriptive study, with a quantitative approach, using data extracted from a Computerized System for the Simple Frequency Analysis of the results. Results: ECU 2, at age 18 to 35 years had a presentation of 18%. ECU 2 presented a prevalence of trauma in 14.4%. The outputs in ECU 2 and 3 were 36% and death was 44% in ECU 1 only. Conclusion: this study can demonstrate the need to review the outflow of users served at 24h ECU, and that these outputs can only be performed from the regulatory system for rear, in hospitals so that there is no deficiency in the transfers. As can be observed, there were transfers being performed between ECU's with a percentage of 5%. Descriptors: Emergencies; Humanization of Assistance; Emergency Nursing.

RESUMO
Objetivo: descrever o perfil dos usuários que permanecem por mais de 24h na sala vermelha das UPA 24h. Método: estudo exploratório-descritivo, de abordagem quantitativa, que utilizou dados extraídos de um Sistema Informatizado para a Análise Frequencial Simples dos resultados. Resultados: na UPA 2, a idade de 18 a 35 anos teve uma apresentação de 18%. A UPA 2 apresentou uma prevalência de trauma em 14,4%. A UPA 2 e 3 foram de 36% e o óbito foi de 44% somente na UPA 1. Conclusão: este estudo pode demonstrar a necessidade de rever o fluxo de saída dos usuários atendidos na UPA 24h, e que estas saídas só podem ser realizadas a partir do sistema de regulação para hospitais de retaguarda, de modo que não haja deficiência nas transferências. Como pode ser observado, houve transferências sendo realizadas entre UPAs com porcentagem de 5%. Descriptores: Emergências; Humanização da Assistência; Enfermagem em Emergência.

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INTRODUCTION

The 24-hour Emergency Care Unit (ECU) is a health unit that works with users in the medical and pediatric clinic specialties, characterized as a fixed pre-hospital service “ambulance without wheels”, specific for small and medium emergencies and dental emergencies, as well as being prepared for the care of serious patients, until they are removed to a referral hospital. It is a concept of an intermediate health unit between the health post and the hospital.1

The ECU can be considered a component of the fixed prehospital care, it is part of a complex health network, where it is a reference to the treatment of chest pain in the State of Rio de Janeiro (RJ), Brazil, in the Metropolitan Region I, including the episodes attended by the Rio de Janeiro State Fire Brigade and Mobile Emergency Response Service (CBMERJ / SAMU).1 It has, as a striking feature, a visual standardization guided by the light of Humanization, which means that the service is performed with host and following the logic of risk classification. The protocol of Reception with Risk Classification (RRC) is institutional and computerized. We have the computerized dengue protocol as well. The flow of care is fully computerized, and after its completion by the physician, through the electronic service bulletin (BAM), the user receives the complete medication treatment, totally free, for home use for up to seven days.

In order to reorient and improve the model of Health Services Administration, the State Department of State Health of Rio de Janeiro (SES/RJ) started to count on Shared Management, under the Social Health Organization (SHO) model. With this, the ECUs were grouped into unit batches according to regional criteria, where each belongs to an SHO.1

The ECU is divided into two axes, Blue and Red, where users can access. The blue axis has access to users who seek service by spontaneous demand. This is initiated by the Reception with Risk Classification, whose risk is stratified by the nurse, allowing the prioritization of severe cases or with the possibility of aggravation. On the red axis, there are the yellow, adult and pediatric observation rooms and as in the red room, the users are received or transferred through hospital medical transport. In a serious situation they may remain for 24 hours in observation.1,2

The Ministry of Health foresees that the flow of a care in the red room, depending on the health problem, begins with the attempt to stabilize the user to later return it to the yellow room until later discharge or, in case there is no success in the user should be referred to the Intensive Care Unit (ICU) in a back hospital.1,2 Usually, these users need to continue in intensive care, with appropriate drug therapy, nutritional therapy, transfusion therapy, respiratory therapy and ventilatory support, to achieve any chance of survival. Often, because there are no vacancies in the back hospitals, they remain for more than 24 hours in the unit, despite the ordinance no. 342, dated March 4, 2013, to provide that they should be kept under observation for a maximum period of 24 hours, since the 24-hour ECU is considered a non-hospital component.1,3

The State Department of Health had a group of nurse monitors in its management who made daily visits to the ECUs. These monitors perceived that the permanence of users for more than 24 hours in the red room generated overcrowding, in addition to limiting the service to other users who need this unit. This fact can lead to several factors that hinder the administrative progress of the ECU, such as adequate planning of material and human resources and possible lawsuits.

The diagnosis of the demand for this service can establish criteria for care, assistance, staff training and feedback, both for the population, and for the health system. It should be noted that the timely acquisition, of reliable information, both at the consultative, and decision-making levels, is a strategic condition for the health system to operate,2 therefore, based on the above, the purpose of this study is:

- To describe the profile of users who remain for more than 24 hours in the red room of the ECUs.

METHOD

Explanatory-descriptive study, using a quantitative approach, using data extracted from a computerized system for analysis and discussion. It was extracted from a masters study, whose scenario was the red room of three ECUs 24h of the same Social Health Organization (SHO), in the State of Rio de Janeiro, Brazil.

Three of the five 24-hour Emergency Care Units (ECU) were chosen because they had the same characteristics and because they were included in the same Program Area Coordination 3.1 (CAP), under the same shared management of Social Health Organization (OSS) with State Secretary of Health.
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State Health of Rio de Janeiro (SES / RJ), being located in the metropolitan region I of the Municipality of Rio de Janeiro.

The 24h ECU (Emergency Care Unit) is constituted by modular structure, air-conditioned environment and is fully computerized. In order to preserve the confidentiality of the units involved, the ECUs of the study were named by numbers 1, 2 and 3.

The data provided for the construction of this work was extracted from a Computerized System used by ECU, known as 24h® ECU - version: 5.5.3.18, and worked in conjunction with the statistical sector of the SHO and the State Department of Health (SES / RJ). The variables selected for this study were: gender, age, unit, international code of disease (ICD), length of stay, death and withdrawal or discharge. The period in which the variables were consulted was from March 2013 to March 2014.

Each ECU participating in the study has a red room with two beds that are composed of: two multiparameter monitors (heart rate, noninvasive blood pressure; respiratory rate, oxygen saturation), six infusion pumps; one biphasic defibrillator; one resuscitation cart; one long board; one neck brace in each size (S, M, L and pediatric); two microprocessed mechanical fans for transport; two individual thermometers; two beds with grids; two oxygen networks; two compressed airs; two vacuum; two portable secretion aspirators; two ventilator bags with reservoir masks; two serum supports, materials and medicines for emergency and continuous use.³

A nurse and a nursing technician are scheduled monthly, who work hours of 40 hours per week, with a scale of 24 x 72 hours. The design of the nursing team of the 24h ECU, in the red room, is in accordance with Resolution COFEN 293/2004, which determines the presence of 01 nurse and 01 nursing technician in the red room in the 24h ECU.⁴

Before CFM Resolution 2077/2014, in the scope of urgency and emergency, the design has become a controversial subject, but the resolution shows that it is necessary 1 doctor for every 2 beds of red room.⁵ At the medical scale, a clinical doctor Designated to carry out visits in the yellow and adult rooms. After performing the medical routine, it only meets the intercurrences when requested and fulfills a workload of 12h or 24h a week. It is assumed that the three ECUs have, in common, the profile of clinical care, and one of them does not perform pediatric care due to the physical capacity installed for the demand offered.

From the presentation of the International Code of Diseases (ICD-10), a grouping of diseases was done according to the affected system, highlighting the most prevalent of the three UPAs of the study, where we found diseases of the cardiovascular system (CRP, , Arrhythmias, ACS, AMI, SAH and Shock); Respiratory system (PNM and Acute Respiratory Insufficiency); Renal system (UTI and ARF); Gastrointestinal system (GEA, pancreatitis), Trauma (agression, firearm perforation, head trauma, pain and acute abdomen pain); And acute problems (hypoglycemia, childbirth, hyperglycemia, cancer, dengue and exogenous intoxication).

The inclusion criteria were: users older than 18 years and with observation time in the red room above 24 hours. It is worth considering that some users of the ECUs evaluated had more than one service, so, the ICD variables, death, and discharge or discharge variables presented differences in their total values.

For the organization of the data, spreadsheets were used in the Excel® Program, sent by the statistical sector, with the distribution of sociodemographic variables, related to the clinical situation of the user. Data was presented as simple and percentage frequency in graphs and tables. For the analysis of the variables we used the Simple Frequency Analysis.

The study was approved by the Research Ethics Committee of UNIRIO, under the number CAAE (Certificate of Presentation for Ethical Appraisal) 36959714.0.0000.5285, process 842.753, dated October 22, 2014.

**RESULTS**

The results presented correspond to the 342 users who were selected to be part of this study, of a total of 634 that were observed in the red room of the three units, 144 in the ECU 1; 107 in the ECU 2, and 91, in the ECU 3. Table 1 illustrates the sociodemographic variables (age and gender) of the users served in the red room.
Table 1. Distribution of users by gender and age ECU 1, 2, and 3. Rio de Janeiro (RJ), Brazil, 2014.

<table>
<thead>
<tr>
<th>Gender</th>
<th>HAU 1</th>
<th>%</th>
<th>HAU 2</th>
<th>%</th>
<th>HAU 3</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>68</td>
<td>47</td>
<td>56</td>
<td>52</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>Female</td>
<td>76</td>
<td>53</td>
<td>51</td>
<td>48</td>
<td>50</td>
<td>55</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>100</td>
<td>107</td>
<td>100</td>
<td>91</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age group</th>
<th>18–34</th>
<th>35–51</th>
<th>52–68</th>
<th>69–85</th>
<th>86–102</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–34</td>
<td>8</td>
<td>6</td>
<td>19</td>
<td>18</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>35–51</td>
<td>14</td>
<td>10</td>
<td>25</td>
<td>37</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>52–68</td>
<td>37</td>
<td>25</td>
<td>14</td>
<td>29</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>69–85</td>
<td>62</td>
<td>43</td>
<td>52</td>
<td>37</td>
<td>5</td>
<td>43</td>
</tr>
<tr>
<td>86–102</td>
<td>23</td>
<td>16</td>
<td>17</td>
<td>27</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>100</td>
<td>107</td>
<td>100</td>
<td>91</td>
<td>100</td>
</tr>
</tbody>
</table>

The gender distribution per unit was homogeneous. The age group that was most prominent in ECU 1 and 3 was that of 69 to 85 years (43%). At ECU 2, the high percentage of the age group between 18 and 34 years old (34%) came to our attention.

Table 2, we can observe the distribution of diseases, according to the systems affected from the International Code of Diseases (ICD).

Table 2. Distribution of the affected systems ECU 1, 2, and 3. Rio de Janeiro (RJ), Brazil, 2014.

<table>
<thead>
<tr>
<th>Systems</th>
<th>ECU 1</th>
<th>%</th>
<th>ECU 2</th>
<th>%</th>
<th>ECU 3</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>55</td>
<td>39.9</td>
<td>44</td>
<td>45.3</td>
<td>48</td>
<td>55.1</td>
</tr>
<tr>
<td>Respiratory Systems</td>
<td>36</td>
<td>26.1</td>
<td>20</td>
<td>20.6</td>
<td>24</td>
<td>27.5</td>
</tr>
<tr>
<td>Traumas</td>
<td>8</td>
<td>5.8</td>
<td>14</td>
<td>14.4</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Renal System</td>
<td>9</td>
<td>6.5</td>
<td>2</td>
<td>2.1</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>Gastrointestinal Systems</td>
<td>9</td>
<td>6.5</td>
<td>7</td>
<td>7.2</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Accute Problems</td>
<td>21</td>
<td>15.2</td>
<td>10</td>
<td>10.3</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>100</td>
<td>97</td>
<td>100</td>
<td>87</td>
<td>100</td>
</tr>
</tbody>
</table>

In table 2 above, we observed a homogeneity of diseases of the cardiovascular system in the three units. The diseases of the respiratory systems were more prevalent in ECU 1 and 3. ECU 2 presented a prevalence of traumas in relation to the other units.

As for the types of output, we noticed that ECU 1 was the one with the highest percentage of deaths (44%). In ECU 2 and 3 this percentage was for the exits by high, represented by 36%, being the ones that had more exit by discharge.

Table 3. Outcomes and deaths above 24h ECU 1, 2, and 3. Rio de Janeiro (RJ), Brazil, 2014.

<table>
<thead>
<tr>
<th>Exits</th>
<th>ECU 1</th>
<th>%</th>
<th>ECU 2</th>
<th>%</th>
<th>ECU 3</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>36</td>
<td>26</td>
<td>35</td>
<td>36</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>Deaths</td>
<td>61</td>
<td>44</td>
<td>35</td>
<td>36</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>97</td>
<td>70</td>
<td>70</td>
<td>72</td>
<td>65</td>
<td>75</td>
</tr>
<tr>
<td>Total of assistances</td>
<td>138</td>
<td>97</td>
<td>87</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With regard to transfers, all had a percentage above 80%. The transfers were made by the units to the hospital beds in the rear, through the state and municipal regulation system. In the ECU 1, 23.9% they had their transfers served by the public network, ECU 2, 24.7% and ECU 3, 23%.
The study also shows that there were transfers above 5% between ECUs from the same SHO from different regions.

**DISCUSSION**

The results allowed to identify a homogeneous distribution between the genders in the three ECUs, as shown in table 1. The findings in studies related to the "profile of users in emergencies" showed variations in gender and age in their care, since some of these studies were analyzed in hours and days of the week.5-8 We observed that, in ECU 1 and ECU 3, the age range between 69 and 85 years was predominant in the group of patients with >24h stay, with ECU 1 with 43% (N = 144) and ECU 3 with 43% (N = 91), which did not meet the findings in the study, 6 which showed the age group of young people aged 20 to 29 years who were attended at the emergency service, representing 23.9% (N = 114) of the sample of patients attended, followed by 23.1% (N = 110) of elderly patients. Corroborating with our findings in this study, the results infer that, the higher the age group, the more severe the health condition. 6

We thus perceive, that the elderly population with critical complications of their health condition end up being larger than the age groups referring to the youths and young adults found in table 1.

Still in table 1, the age group of 18 to 34 years, draws attention to ECU 2, with percentage of 18%, being the largest among the three units. We know that ECU 2, because it is located within a complex with problems of public security and high crime rates, confirmed by the available data, by the Institute of Public Security (IPS), 9 and according to our experience, this is the only reference service for emergency and emergency care to this population. This locality does not have the service of Pacifying Police Unit 10 (PPU) and, due to frequent confrontations between factions and police, the percentage of high trauma is justified, being 14.4% (N = 97) in our study.

For the Brazilian Institute of Geography (IBGE), the older the population, is the greater the likelihood of comorbidity and disability. Another point cited by the Institute is the incidence of violence in large urban centers. This fact causes trauma care. 11

The nurse of the ECU 24h, is appropriately, in an adequate manner, to the institutional protocols available in the unit system, in order to stratify the risk and record necessary and appropriate information to the table presented by the user, minimizing expenses and avoiding waste. Studies 5-9 show the fragility of not having an institutional protocol of risk classification or computerized system, leading to false positive data surveys.

Table 2 shows a homogeneity in the diseases of the cardiovascular system in the three ECUs. Respiratory system diseases are predominant in ECUs 1 and 3, and other studies also point out this prevalence, since they are predominant diseases in the elderly, due to chronicity accompanied by comorbidities. 8,11

Acute problems in this study involved hypoglycemia, hyperglycemia, cancer, dengue, and exogenous intoxication. A percentage of 15.2% (N = 138) is evidenced in the ECU 1, with permanence > 24h, in the ECU 2, with 10.3% (N = 97) and in the ECU 3, with the same permanence > 24h 3% = 87). In the study, some diagnoses, such as hyperglycemia, exogenous intoxication and traumas, such as those of our research, were evidenced, however, the authors believe that hyperglycemia cases may be associated with nonadherence to treatment. For the exogenous intoxications, they call attention to necessity and urgency to promote actions involving mental health. Regarding the traumas, the authors mention other studies that make this point referring to urban violence, also drawing attention to the non-use of protective equipment at work and at home.

The nurse manager is responsible for performing the situational diagnosis of the unit, in order to know which aspects need the most attention, for improvement in the management of care. Therefore, analyzing the epidemiological profile, denotes understanding the insertion location of the units and the causes contributing to the increase of the user's stay in the 24-hour
ready unit, for a better forecasting and provision of materials and human resources, contributing to the Nursing practice.14,5

The types of exits were identified by discharge, death and transfers to hospital beds. It was not possible to confront the selected studies according to the outgoing profile due to the lack of information provided.

This study showed that ECU 1 presented a 44% death rate in relation to the other units. This fact, may be associated with the severity of health of users. This unit has a differential for receiving users of chest pain by the ambulance of the CBMRJ/SAMU. Associating the difficulty of performing tests and vacancy, all indicate that these users aggravate to the point of not being removed due to gravity.

One study showed, in its results, a high death rate, due to the severity of patients with cardiovascular diseases, who progressed to cardiac arrest.18 The association between patients who were prioritized and mortality in the short term [...] This study demonstrated that the nurse of the risk classification is “responsible for the waiting time of the user in the unit and that patients classified with high priority were associated with a 39-fold higher probability of death than those with a low priority.”

Regarding the transfers, there are currently, three systems for regulation of rear beds, and this system is not yet unified, which favors a fragmentation in bureaucratization.

In Rio de Janeiro (RJ), Brazil, we work with two hospital regulation systems, the Regional Emergency Center (REC) being more effective and specific beds for intensive care and “zero vacancy”, when it needs to transfer a polytrauma, for example, while SISREG (National System of Regulation) is more for the provision of beds of infirmary and realization of exams of images and evaluations. In the hospitals of the State network, there is an Internal Regulation Nucleus (IRN). In the IRN, the nurse, doctor and an administrative professional work. In this place, the nurse manages the beds of every hospital, therefore, when a ECU performs the request for a vacancy in the IRN, the active team of the sector, has a deadline to send the requesting unit, besides (re) evaluating the real need of the request.

This study indicates the hospitals of the state and municipal network providing support with their back beds, without distinction of the ECU by territory, ECU beds can also be seen offering such support.

Regarding the transfer between ECU, it was clear that there was no intervention in the regulation of beds and vacancies, because if such necessity existed, it was due to the full occupation of this red room and lack of space in the hospitals for these patients who needed this service.

The information about ECU 1,2 and 3 described in the text above, make us reflect on the role of the prompt service unit in the network, since it is known, that in the design proposal, these units should only meet the small and medium complexity due to its structural limitations. So they should therefore rely on the immediate support of hospital health units through the regulatory tool.

Another point that leads us to reflect on the emergency and emergency network is that ECUs were not designed to remain with severe patients for more than 24 hours and our study indicates that these patients are still with limited assistance in this service, not because of their incompetence Units, but, because of deficiency in the management of beds and places in the regulatory system.

However, if there is an extreme need for studies that can accompany the outcome of these patients when they reach the hospital network, because, regardless of the time of stay in the 24h ECU, it is < or > than 24 hours in the red room, there were investments in this unit that they visibly need to be measured and evaluated if they were sufficient or not for a favorable outcome for the patient and immediate support to the local manager and the authorizing officer, in this case, the Secretary of State for Health of the State of Rio de Janeiro.

According to our experience, the model of bed regulation is fragile and the difficulty of access to the beds of infirmaries and ICUs is aggravated by hospital fragmentation. During our practice, many times it was necessary to resort to the central level of the State Department of Health of Rio de Janeiro, in an attempt to have an intervention in the patient leaving the most severe for the ICU, bed for example. In this way, the workforce was very dense, exhaustive and, above all, incomplete since the resolution did not cover all users.

According to a study, we have, in the city of Rio de Janeiro, today, a network of emergency and emergency faced with a demand above capacity and that is still very fragmented between the spheres of government. Faced with serious governance problems, the network has mechanisms for integration that are still precarious, making it
so that, in daily life, personal contact is a resource for solving prevailing problems.\textsuperscript{15}

It is understood that, the delay in waiting for diagnostic procedures and examinations, being one of the factors that influence the length of stay of this user, since some diagnoses depend on this complementarity.

It was found that, an author who states that it is imperative to adopt measures aimed at reducing the “human cluster”, through the implementation of the network of attention with definition of a care flow, as well as greater agility in performing the procedures, whether surgical or of diagnostic exams.\textsuperscript{6}

Another author says, that when care regulation is based on the guidelines of universality, completeness and equity, it may expand or reduce a given offer, since its central objective will be to subsidize the reduction of supply and respond, appropriately, to clinical problems and satisfaction of users. The authors suggest that regulation implies articulations in the technical-political sphere in the scope of care.\textsuperscript{18}

We considered limitations for conducting this study, since our practice demonstrated that, even with the system being 100% computerized, physicians had great difficulties in finalizing their care. This study pointed out that 20 ICD-10s were discarded, without conditions of grouping them in some system due to inconsistency, where some professionals assumed that when finding an open, unevolved medical care bulletin (MCB) without a history commensurate, physicians had great difficulties in finalizing their care. This study pointed out that 20 ICD-10s were discarded, without conditions of grouping them in some system due to inconsistency, where some professionals assumed that when finding an open, unevolved medical care bulletin (MCB) without a history commensurate with the use of one of these ICD-10s. Another point is that the medical coordinator had the assignment to finalize those MCBs that were open. In this way, we can conclude that this fact impaired the real measurement of the days by staying in the red room.

A study\textsuperscript{19} defines as indicators of quality of care indicators that can represent effectiveness, efficiency and optimization of resources, acceptability, legitimacy and equity, and that could be measured by means of operational data of a prompt service unit, the following indicators: (death rate, average length of stay in the unit, non-scheduled return rate, hospitalization rate, unfinished medical care rate, complaints rate and ECG door time rate).\textsuperscript{19} We emphasize that this study was Performed in an advanced emergency care unit of a large private hospital in the state of São Paulo.

This same study pointed out that the results of its indicators are zero death rate, where 22 patients, with immediate need for resuscitation, had their vital functions reestablished. The duration of service within the unit was three hours and seven minutes, depending on the specialty and the level of screening. The rate of return in not programmed consultations was 13.64%. The rate of hospitalization of the 22 patients screened was 13 hospitalized (hospitalization rate of 59.1%), for the 64,891 patients treated, corresponding to, the rate of 1.2%. Complaints rates of 2.8 / 1,000 cases (183 complaints) were observed in the analyzed period. Of these, 53% were related to delayed care or reevaluation. All patients diagnosed with AMI with ST segment elevation were referred to the hemodynamics sector.\textsuperscript{20}

**CONCLUSION**

Knowing the demand profile of the red room strengthens the work carried out daily in the units, for monitoring with the management of the SHO/ECU, however, despite all the difficulties that the ECUs find in its day to day, due to the lack of Basic care support and hospital beds, the hospital tries, to fulfill its role, at all times. This study can demonstrate the need to review the outflow of the users served at the 24h ECU, and that these exits can only be performed by the regulatory system for the rear, of hospitals so that there is no deficiency in the transfers. As it can be observed, there were transfers between ECUs with a percentage of 5%.

The prevalence of the diseases in the systems suggests that, although ECUs are a unit of urgency and emergency, it is more directed to the treatment of chronic cases than to acute cases. This reinforces the importance of the autonomy of the nurse professional in the 24h ECU, since it is responsible for the management of the care, through the reception and classification of risk, having the opportunity to perceive the aggravation or the evolution of this aggravation by every unit and, in that way, make use of the available institutional protocols and apply their technical-scientific knowledge in order to optimize the assistance provided through pro activity, critical reasoning and agility.

The need for intensive care beds to support 24 hour ECUs was clear, but, we know that if we have a patient coming to an aggravation, with this, basic care is needed to also play a part in order to have a better user adherence to the treatment. In this way, it is less bureaucratic because its operation, for some users, is still somewhat distant because of the lack of coverage and the territorial requirement.
The integration of regulatory services in Rio de Janeiro (RJ), Brazil, also needs to improve among them. This study shows the tools that the nurse manager can develop to improve the quality of care provided.

The limitations of the study showed that the 24h® ECU system has rich information to be explored and that there is still human resistance and limitation and that it is up to the manager to demystify this resistance, making the necessary collections and offering training to its employees, Human Resources (HR), at the time of hiring.

The study showed positive aspects, the computerization of the system and the host protocol with risk classification (RC), institutionalized by SES/RJ, which favors a clear and complete database, according to the reality of urgency.

The study pointed out the need for a deepening of the research on UPAs, because there were difficulties in the search strategies performed, because there were no descriptors and no keywords. However, the searches found related to the profile of demand were always related to adult intensive care and neonatal emergencies, as well as emergency and hospital emergencies that address situations of accidents, trauma and mortality. The chronic cases attended to in the case of studies are related to the hospitalization period, similar to the ECU care profile.

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