

USER'S DEMANDS TO AN EMERGENCY SERVICE AND THEIR WELCOMING IN THE HEALTH SYSTEM¹

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This study aims to identify and analyze users' demands to emergency services, as well as to examine the work organization to welcome them in the health system. We carried out a case study with a qualitative approach. Data were collected through free observation by time sampling. Observation focused on the organization of the work process and on the care given to users who received some kind of care at the emergency service, highlighting their demands and their acceptance in the system. Users who demanded health services displayed different needs, ranging from the simple to the more complex level. The work process was organized to meet some of these needs, aiming, within certain limits, to treat the main complaint and follow the health system hierarchy. Healthcare users were responsible for obtaining integral care. They journeyed alone, at their own risk, through different services, with no guidance or help from the healthcare system, as would be expected.

DESCRIPTORS: health services; quality of health care; health councils (SUS); emergency medical services

DEMANDAS DE LOS USUARIOS A UN SERVICIO DE EMERGENCIA Y LA RECEPCIÓN POR EL SISTEMA DE SALUD

Este estudio tiene por objetivo identificar y analizar las demandas de los usuarios a un servicio de urgencia y la organización del servicio para su acogida en el sistema de salud. Se trata de un estudio de caso, con aproximación cualitativa. La recopilación de datos se realizó a través de la observación libre por muestreo de tiempo. El foco de observación fue la atención prestada a los usuarios que recibieron alguna atención en el servicio, destacándose las demandas y su acogida en el Sistema. Se constató que demandaron el servicio usuarios con diferentes necesidades, desde las simples a las más complejas. El proceso de trabajo estaba organizado para atender algunas de esas necesidades, respondiendo, con límites, a la finalidad de tratar la molestia principal y seguir la jerarquía del sistema. La totalidad del cuidado fue dada por el usuario, que recorría solo, a su criterio y riesgo, los diferentes servicios, cuando esto sería una responsabilidad del sistema como un todo.

DESCRIPTORES: servicios de salud; calidad de la atención de salud; Consejos de Saúde (SUS), servicios médicos de urgencia

DEMANDAS DE USUÁRIOS A UM SERVIÇO DE PRONTO ATENDIMENTO E SEU ACOLHIMENTO AO SISTEMA DE SAÚDE

O estudo tem por objetivo identificar e analisar demandas de usuários a um Serviço de Pronto Atendimento e a organização desse serviço para o seu acolhimento ao Sistema de Saúde. Trata-se de um estudo de caso, com abordagem qualitativa. Os dados foram coletados por meio de observação livre. O foco de observação foi o atendimento prestado aos usuários que obtiveram algum tipo de atendimento no serviço, destacando suas demandas e seu acolhimento ao Sistema. Constatou-se que demandaram o serviço usuários com diferentes necessidades, desde as simples às mais complexas. O processo de trabalho estava organizado para atender a algumas dessas necessidades, respondendo, dentro de limites, à finalidade de tratar a queixa principal e seguir a hierarquia do Sistema. A integralidade do cuidado era dada pelo usuário, que percorria sozinho, a seu critério e risco, os diferentes serviços, quando esta seria uma responsabilidade do Sistema como um todo.

DESCRIPTORES: serviços de saúde; qualidade dos cuidados de saúde; conselho de saúde (SUS); serviços médicos de emergência

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INTRODUCTION

A health service demands can be considered as an explicit request that expresses all of the user's needs. It can occur through a consultation, access to tests, medication intake or procedures, since that is how services organize their offering. Paradoxically, each user can present different needs. These include the search for answers to socioeconomic issues, bad living conditions, violence, solitude, need for bonding with a service/professional or, also, access to some specific technology that can provide quality of life⁽¹⁾.

In all health care situations, welcoming must be present. This presupposes attending to everybody, listening to their demands and assuming an attitude that is capable of providing users with more adequate answers, using the available problem solving resources. This implies delivering care with interest and accountability, advising when this is the case and articulating with other services with a view to the continuity of care, thus guaranteeing the efficacy of this follow-up⁽²⁻³⁾.

Health service demands involve factors that, depending on their order, will define the users' choice. Influencing factors include the severity or urgency of the problem/need, available technology, problem-solving capacity of care, welcoming, access conditions (distance from home, transportation forms, time and cost), care agility, patients'/relatives' experiences, quickness in appointment making or referral to other services, as well as users' bonding with professionals, services and the health system⁽⁴⁻⁸⁾.

In the 1990's, Brazilian cities adopted the pyramidal health care model. This model still has not achieved a result that attends to the population's needs, although it has brought about significant changes in health service structures and work processes. Care production, coverage and the complementariness and integration among actions at health units and with the system have been insufficient. Moreover, the relation between service supply and demand is inadequate.

The lack of political definitions, low problem-solving capacity and service quality, in combination with difficulties to change the population's cultural habits and beliefs, have made users seek medical care where they find an open door.

As a result of the restricted service offering, the excessive public seeks care at sites that concentrate a greater possibility of entry doors. In

this sense, urgency and emergency hospital services correspond to the profile of complying with demands in a more agile and concentrated way. Although overcrowded, impersonal and acting on the main complaint, these sites join a series of resources, whether appointments, drugs, nursing procedures, laboratory tests and hospitalizations, while basic care units only offer medical appointments.

We observed at the Emergency Care Service of a large Health Center that the user population frequently used the emergency door, not only for acute cases but also, electively, to complement care delivered by Basic Health Units (BHU) and Specialized Units (SU). Moreover, workers' discourse frequently mentioned that, in elective cases, the improper use removed the mission of providing the emergency care mission, which put users in a situation where they had to justify their needs to obtain care.

Based on the described situation, this study aims to identify and analyze user demands in an Emergency Care Service and the organization of this service for welcoming in the health system.

METHODOLOGY

This qualitative study observes reality and attempts to understand phenomena and social processes manifested in daily work which directly and indirectly affect the lives of people seeking and receiving health care. Various elements are observed simultaneously, with a view to understanding and describing the context the phenomenon occurs in⁽⁹⁾.

The methodological research design is a case study, which allows for an in-depth look on the study unit, considered in its singularity⁽¹⁰⁾.

Data were collected through free observation by time sampling⁽¹¹⁾ at an Emergency Care Service of a Health Center, managed according to the strategic guidelines by the Porto Alegre Municipal Health Secretary (SMS/POA). Observation focused on user care, highlighting their demands and the organization of the work process, between August and December 2003.

Observations were made in the waiting room, at the reception desk, in the preconsultation area, in the waiting corridor, in front of the consultation rooms, in the observation and procedure rooms. Most observations were concentrated in the preconsultation area and the observation room. As these sites are

open and large, they offer a view of other care areas and their functioning. Almost all nursing and medical procedures were carried out at the observation room. Observation periods were intentionally scheduled on weekdays and covered the three work shifts.

The project was approved by the SMS/POA Research Ethics Committee. Health workers received the Free and Informed Consent Term, which guaranteed compliance with ethical aspects as determined by National Health Council resolution 196⁽¹²⁾.

Data were analyzed according to qualitative method guidelines: data ordering, classification in relevant structure, data synthesis and interpretation⁽⁹⁾.

RESULTS AND DISCUSSION

User Demands at an Emergency Service

The following Emergency Service (ES) demands were identified: care in severe and risk situations for patients, acute complaints, punctual needs characterized as non-urgent and care to complement care received in other health services, as well as bonding with the emergency care service. Users attended this service to solve their urgent and non-urgent needs, sometimes expressed unspecifically through complaints, which was the way the doors of health care opened to them.

We identified that patients in risk or severe situations who lived close to the physical area of the Health Unit were taken to the ES for evaluation and, when their problem was not solved there, they were transferred to technologically more complex services. These cases included patients with suspected Cerebrovascular Accident (CVA), heart problems, convulsive crises, sudden illness, mental disorders, among others.

In these situations, patients received first care at the ES and were transferred to municipal hospitals for continued care. In most cases, they were referred to emergency services without previous communication. Physicians advised the relatives and sent the care summary together with the request for a more detailed case assessment. In more severe situations, hospital emergency services served as an entry door for users, who were referred to hospitalization units or other services, according to hospital criteria.

Users who attended the ES to solve acute situations presented complaints related to hypertensive crises, pain, respiratory dysfunctions, diarrhea and vomiting. At the Pediatrics sector, the most common problems requiring care were respiratory problems in the winter and gastroenteritis during warmer months. This specialty attended children until 12 years old; after this age, they were referred to the clinic, which increased demands on these professionals, as they attended all ages from the start of adolescence onwards. Little pressure resulted from pediatric demands. During the data collection period, few patients were attended at the observation room, and care was mostly delivered through consultations.

In adults, high tension levels and pain (abdominal, pelvic, thoracic and headache) were the most frequent complaints motivating the search for emergency services.

A significant number of adult patients went through consultations or were assessed directly in the observation room, attended by the service and discharged. These patients had acute complaints, which were selected and treated. The service had the conditions and ability to attend these patients; we found that the delivered care solved momentary needs. In situations requiring continued care, patients were verbally advised to turn to basic care services for examination or follow-up, or for access to secondary care. As this access was not always easy and sometimes took time, acute symptoms made users turn to services with an open door, which could take the form of a return to the emergency care service to treat the same complaint.

Agility to schedule appointments, on the same day as they attended the service, made some users seek emergency care to obtain answers to their needs. This search occurred independently of any bond with the service and seemed to be related to the solution of their complaint/need.

We found that concern about waiting time to receive care started well before users accessed the health services. It started at home, as soon as the need emerged and the subject imagined the possibility of "there's no place". This imaginary waiting line is hidden by the way services are structured, as well as by the number of times workers ask users to come back another day to try and get a place. This waiting line, which sometimes takes many days, at home, represents the contradiction in the exercise and practice of SUS principles⁽¹³⁾.

In practice, when delivering care, workers do not have much view on users' before and after, on their trajectory through the system and the difficulties they faced or will face for their needs to be attended to. In most cases, users submit to what workers say or do in the name of the system, of knowledge, standards and institutional policies.

In addition to the idea that patients using emergency care services have a bond with professionals/services, we observed that this happens to complement the care they receive at the unit of origin. This search occurred in three ways: to pick up medication prescriptions and get the drugs from the SUS pharmacy, to complement care started in other services and to realize nursing procedures.

At SUS pharmacies, medication was only provided on a medical prescription, which should contain the date and the professional's stamp and signature. After receiving the pharmacy stamp and mention that the drugs had been delivered, they could no longer be obtained with the same prescription, unless the physician wrote 'for continuous use' on the prescription. When the validity of the prescription expired, users could either: return to their doctor and get another prescription; try different services to obtain the prescription and/or not take the medication until they managed to get the drugs. Depending on their purchasing power, users could also buy the medication, which did not apply to a significant number of SUS users.

We could identify patient demands coming from the Health Center itself and from other municipal network services. As they did not achieve the integral solution of their problems, these patients turned to emergency care to complement what had already been started. These demands were observed for medical as well as nursing care (capillary glucose, nebulizations, application of injectable drugs and nasoenteral and urinary catheters).

The above reinforces the idea that outpatient services, whether at primary or secondary care level, were not structured for care delivery in acute cases and referred users to emergency care services. It was also observed that, in elective cases, when medical appointments could not be scheduled in the short term, users preferred emergency care to waiting in line to schedule an appointment. The same fact was described in an article⁽⁴⁾ where the authors mentioned that patients from hospital outpatient clinics and Specialized Units turned to the emergency unit

for acute cases, problems and/or hospitalizations. In basic care too, the way services are organized, prioritizing previously scheduled appointments, leads to the informal referral of users to urgency/emergency care services when demands exceed programmed levels or does not correspond to what is offered by the service^(5, 6, 14).

The organization of work processes at different Health Units made workers prioritize the problems to be treated, according to a set of knowledge that determined a given service organization. Hence, basic or specialized units did not acknowledge acute complaints as a priority because they considered this profile as emergency care. At emergency care services, in turn, non-urgent complaints, called elective, were characterized as and referred to outpatient clinics.

Besides causing user dissatisfaction, as they were sent from one side to the other, without having their needs attended to, left workers with the feeling that patients were in the wrong place and came to the service to seek unnecessary care, thus distorting that service's mission.

Users turn to health services to get their needs solved; if they do not manage, they move to another service until they obtain a solution. Their manifestation of a need can express the solution they imagine to what represents a problem. The problem definition takes into account the health-disease concept they apprehend in social relations and daily reality. We, workers/manager are responsible for understanding and characterizing these problems in order to turn care more welcoming, using an approach that leads to a competent solution and satisfies users.

Service organization to welcome health system users

The Emergency Care Service was administratively connected to the BHU and delivered Nursing, Pediatric, Clinical, observation room and reanimation care. Nursing procedures to apply injectable drugs, nebulizations and capillary glucose were performed on the doctor's prescription. Other procedures were part of care dynamics (blood pressure, electrocardiogram, pulse oximetry, serotherapy, medication administration, urinary and enteral catheters, etc). This service only functioned on weekdays, with nursing and outpatient services being delivered from 7h to 20h and medical-pediatric care from 7h to 18h.

The emergency care service consisted of a guard, driver, administrative clerk who worked at the reception desk, nursing, nursing auxiliaries/ technicians, clinicians, pediatricians, cleaning aids and the service coordinator, who was part of the schedule of physicians on duty.

The physical area consisted of a large waiting room for ES users and their companions only, with a TV; one men's and one ladies' room; a preconsultation area; a small interview room; an observation room with beds for adults and padded chairs with armrests; another room equipped for urgency care (reanimation), with an exclusive entry; an area for the application of injectable drugs, adapted next to the reanimation room; a nebulization room; an internal bathroom for patients during care; consultation rooms; an internal corridor in front of the consultation rooms, with chairs for patients awaiting medical consultations; a kitchen equipped for meals; a living room; a clothes deposit; material deposit; coordination room, toilets and a dressing room for employees.

The service had urgency care equipment, except for laboratory and radiology services. In some situations and depending on the severity of cases, this was a problem. The ES did not have any strong support bonds either for hospitalizations. Severe patients were referred to hospitals through the respective emergency services, for examination as well as for hospitalization.

The system's organization as a hierarchized pyramid, with the main access through basic care, had given the ES the condition to attend to the main complaint and return the user to the system, without guaranteeing access to internal or external referrals, even in acute cases that needed reassessment within a short period of time, such as in hypertensive crises or medication readjustments for example.

We followed care delivery to a hypertensive patient who had been referred by BHU nursing auxiliaries for the second time to assess a hypertensive crisis. He was medicated and stayed at the observation room for the second time until the end of the crisis, after which he was discharged and returned home. The patient was verbally advised to make an appointment at the BHU for a new assessment.

Care focused on the main complaint, without deviating from the emergency care condition. However, this did not guarantee the sequence of the action started at the service. It was the users' task to fight

for the continuity of their care, whether at the BHU or at a specialized service. A long period could pass between urgency care and the scheduling of the elective appointment, as workers did not always perceive severity and risk in the same way as users, for whom the rapid scheduling of this care was not always clear, without mentioning their possible lack of knowledge about system functioning.

The SUS has established public policies that qualified health actions in comparison with what was practiced 20 or 30 years ago, but still faces the fragmentation of work processes and relations among professionals and the service network, besides bureaucratizing and verticalizing the system⁽¹⁵⁾. Investments in worker qualification are still low, with a view to their understanding of SUS guidelines and action planning in compliance with users' health needs, turning them into the center of care, which will be the responsibility of all workers and the system.

One patient was assessed by a nursing auxiliary in the preconsultation room; she complained of intense headache and had already consulted with a gynecologist, who authorized the use of an analgesic; as the pain did not stop, she came to the ES. At the preconsultation room, she was informed that she would only get pain relief at the ES and that she should make an appointment with a clinician at the BHU to get her case examined. She mentioned that she had already received information for scheduling the consultation, but that one had to arrive at the waiting line very early and that, until now, she had not managed. The nursing auxiliary emphasized the need to schedule the appointment. She waited in the lobby for the elective consultation, which was made sequentially, in order of arrival, with four appointments per hour.

The ES was organized to attend to punctual and urgent complaints, but did not serve as an entry door to the system in situations considered as elective. Most conducts taken there strengthened the idea that emergency care only relieved symptoms, as the "correct" way to start examining and treating elective cases was at the BHU.

Starting from the premise that BHU do not manage to deliver all care that arrives at the units, considering their need to perform continued and surveillance actions, we confirm the proposal to achieve care integrality through good articulation among services, each of which should comply with its part of care⁽¹⁾. When attended at a urgency service, a

hypertensive patient associated with an outpatient service could not leave without orientation and without having a consultation scheduled at the service of origin, within the shortest possible time period.

The ES had a referral instrument, which informed that the patient had been attended and the need for reassessment within a period established by the professional, but which was not used, as a powerful resource to guarantee system access, in acute as well as elective cases.

The exceeding demand and/or lack of problem-solving capacity in some cases of care delivery, at different points in the system, obliged users to seek other services or submit to further care to get their needs attended to. Turning to emergency care could apparently be the easiest and fastest way of getting their health problems solved.

One user who complained of back pain and spinal problems attended the ES to obtain medical assessment, access to injectable analgesic medication and a continued use prescription. When asked about her relation with a doctor, she responded affirmatively but mentioned that, in the winter, due to the pain and the cold, it was difficult to get up early and wait in the line without having the guarantee of getting the clinical appointment at the BHU of origin, mainly because at that time, there was only one clinician at the unit.

Another user came to the service and complained she was feeling sickness, weakness and breathing difficulties. She informed that she had visited the BHU some days earlier and that the doctor who attended did not examine her, but merely listened to her complaints while writing and, without looking her in the face, requested tests. Dissatisfied, she went to another, this time emergency care, service, in the hope of getting rapid access to a judicious assessment.

The large number of patients, repeated complaints and care routine made some professionals at the BHU, specialized services and emergency care bureaucratize actions and procedures, losing the sense of the person's (citizen's) needs, of system potentials and the possibility to establish care networks.

The practice of SUS principles, i.e. universality, equity, accessibility and integrality, in one way or another, is directly related to access and welcome forms. These will be present in workers' availability to deliver care. This willingness can be expressed by starting a conversation, acknowledging a problem and seeking creative solutions to other people's needs.

In their relations with workers, users seek a welcoming that can interfere in their problem; if they do not achieve this, they will attempt to overcome the obstacles imposed during reception as well as care, with a view to solving their needs⁽³⁾.

Users came from far-off regions for the realization of nursing procedures, such as catheter implantation for example, only because of the guaranteed access they did not always obtain in units close to their home. After exchanging the urinary catheter, the nurse informed the patient that he did not have to travel across town to exchange the catheter, as there were services closer to his home which could do this. He insisted that he had already tried different places and that nobody had changed the catheter. The nurse talked to the patient's relatives, advised about care and insisted that they should attend a service closer to home. They reinforced the idea of coming back, saying that they preferred the security of the ES to having to wander through different units.

Thus, we identified that users came to the service not only because of its geographical location, but also due to service quality, guaranteed access and agility, positive experiences and the way they were welcomed. Other authors have verified the same aspects⁽⁴⁻⁷⁾.

In most cases, ES care delivery was directed at and focused on the action that had to be performed, not leaving much room to expand the care focus beyond the main complaint and the realization of the doctor's order. Patients got an entry door into the system in severe cases and were referred for hospitalization in case of hospital emergencies; in other cases, users had to fight for the integrality of actions and services.

FINAL CONSIDERATIONS

The main ES demands were severe and risk situations, acute complaints involving physical and emotional discomfort, punctual needs characterized as not-urgent and care to complement care received in other health services, as well as bonding with the emergency care service.

Users accessing the ES displayed different needs, ranging from the simple to the more complex level. We also found relations with different health services, in basic care as well as secondary-level

specialties, using emergency care either as a complement, punctually or as a continuation of earlier care.

In most cases, the ES solved users' needs, mainly when these were acute and severe complaints, relieving their symptoms and giving access to different technologies, at the service or externally, like in the case of hospitalizations for example. Thus, the service attended to this population's needs, who did not find a rapid response in other outpatient services.

For elective complaints and to complement actions started in other services, the service's problem-solving capacity depended on users' satisfaction since, as this was a spontaneous search, the service's commitment to cure was expressed by the limits of patients' expectations, and very little by the system's expectations.

The ES demonstrated that its doors were open to incoming demands and that it responded, within certain limits, to its goal of treating the main complaint,

informally referring users to referral services in most cases, at the different complexity levels regulated by public policies (pyramid model).

The users' complaints were molded by the possibilities they apprehended in social relations, which means that their needs were also socially and historically constructed. Users sought emergency care to solve needs that were either acute or not, but that were causing difficulties and discomfort at that time.

The fact that this service did not provide documents for referral to primary and secondary care outpatient services obliged users to submit to the system's hierarchy, even in those cases when they had already received a diagnosis in the emergency care service. In other words, the care they received there had helped very little to get direct access to other system points than basic care or hospitalization. This forced users to fight for their care alone, although care should be guaranteed by the system as a whole.

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