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PROFILE OF USERS SERVED IN THE TRIAGEM SECTOR OF A 24 HOUR EMERGENCY SERVICE UNIT

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ABSTRACT

Objective was to draw the profile of the users served in the in the triagem sector of a 24 hour emergency service unit.

Method: descriptive quantitative study with application of semi-structured form to 417 users in screening sector from January to July 2015.

Results: it was evidenced: 63.1% were female, the age group 20-30 was predominant (24.9%), the night shift (34.6%) stood out in the visits and 80.6% came of Campina Grande. The main complaint of a headache 12.3%. As for the history of chronic diseases, 21.1% were hypertensive and 10.1% were diabetic. Self-medication was reported by 51.1% of the sample. According to the Manchester protocol, 80.3% of the green classification.

Conclusion: knowledge of the profile of the patients contributed to the planning and execution of educational actions for users on the operation of the network of attention to urgency and emergencies in the municipality, in order to find the health services according to the severity of the care.

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INTRODUCTION

The 24-Hour Emergency Care Unit (UPA 24h) is one of the fixed pre-hospital components, considered as an intermediate complexity health facility, between the Basic Family Health Units (UBSF) and the Hospital Network (http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1600_07_07_2011.html).

The Ministry of Health proposed as the main objective admitting for the purpose of these units to enable the resolution of acute or exacerbated conditions of clinical origin, as well as surgical procedures and traumas, besides stabilizing the patient and/or initiating the diagnostic hypothesis of the case, clarifying the necessity of referral or not to hospital

service of greater complexity, in this context, Brazil presents an increasing number of UPAs 24h (http://www.campinas.sp.gov.br/arquivos/administracao/convenios/2013/ms-port-342-04mar2013.pdf and Konder, 2015). In order to better organize the service, during the reception process in the screening sector, the UPA 24h adopted the risk classification system. This has the objective of organizing the flow of care in urgency and emergency health services. In this way, the implementation of the Reception with Evaluation and Risk Classification (AACR) aims to accommodate and meet the demand according to gravity and refer to other levels of assistance (Rossaneis, 2011 and Goulart, 2013). The Manchester protocol is the most adopted in the UPA screening section (Diniz, 2014). This allows classifying the level of risk that the patient presents based on apparent and described signs and symptoms. The risk assessment and measurement are done by the unit's nurse and recorded on the attendance sheet. After evaluation, the user receives the classification, prioritizing the level of severity/risk: red - immediate care; yellow-urgent service; green - can wait; blue - it is not a matter of urgency or emergency - it should be referred to the Basic Health Unit or another locality (Rossaneis, 2011). Understanding that the unit aims to provide effective reception and prompt service, knowing the user who seeks the UPA 24h will subsidize the profile of the patients assisted in the unit, in order to facilitate the elaboration of targeted protocols, agility in actions directed to the main complaints services and guidelines to users about the UPA 24h, as well as the type of assistance provided by the service. The present study had the objective of tracing the profile of the users served in the screening room of a 24-hour Emergency Care Unit in the city of Campina Grande/PB.

and unaccompanied persons were not included in the study and the most serious cases in which there was no time available to respond to the form. Data collection began after the consent of the heads of the units involved and after approval by the research ethics committee (No. 872,633). The data were transcribed in Excel spreadsheet version 2010 and submitted to descriptive and inferential statistical analysis in the statistical program SPSS 21.0.

RESULTS

The sample consisted of 417 users attending the screening service, with the evaluation performed by nurses from the UPA 24h screening section, in the respective service shifts: morning 123 (29.5%), late 134 (32.1%) and night 160 (38.4%). The greatest demand for the service was given by female users, 263 (63.1%). In relation to the age groups served, the following were observed: 0 to 10 years 16 (3.9%), 11 to 20 years 60 (14.4%), 21 to 30 years 104 (24.9%), 31 to 40 (19.5%), 41 to 50 years 49 (11.7%), 51 to 60 years old 38 (9.1%) and over 60 years old 69 (16.5%). As to origin, 336 (80.6%) of the individuals were residents in the city of Campina Grande - PB, 12 (2.9%) in districts of the city, and 69 (16.5%) in adjacent cities to the municipality. During the nurses' care in the screening and risk assessment, the users' vital signs were checked by the professionals. The study looked at the following: Systolic Blood Pressure (SBP), Diastolic Blood Pressure (DBP), Temperature (T), Capillary Glycemia (GC), Oxygen Saturation (SO2%), detailed in Table 1. When questioned about the existence of a previous diagnosis of noncommunicable chronic diseases, 88 (21.1%)

Table 1. Distribution of the values of vital signs measured during the accomplishment of the service in the triage sector of the 24-hour Ready Unit, Dr. Maia. n = 417. Campina Grande, 2015

References	n	Minimum	Maximum	Average	Standard deviation ($\pm$)
SBP (mmHg)	371	80.0	240.0	127.224	21.5
DBP(mmHg)	371	50.0	130.0	80.431	12.7
T (°C)	31	36.0	40.0	37.355	1.2
GP	57	90.0	548.0	182.228	88.9
S0$_2$(%)	48	81.0	99.0	96.542	3.4

Table 2. Distribution of the main complaints reported by users of UPA 24h, Dr. Maia, and respective risk classifications. n = 417. Campina Grande, 2015

Main Complaint	Classification n(%)				
	Blue	Green	Yellow	Red	TOTAL n(%)
Headache	04(0.9)	39(9.4)	08(1.9)	-	51(12.2)
Diarrhea	-	11(2.6)	02(0.5)	-	13(3.1)
Dyspnea	-	04(0.9)	07(1.7)	-	11(2.6)
Pain in limbs or joints	04(0.9)	16(3.8)	07(1.7)	-	27(6.4)
Ear or throat pain	06(1.4)	12(2.9)	01(0.2)	-	19(4.5)

MATERIALS AND METHODS

It was a research of descriptive nature and quantitative approach, carried out in a The 24-Hour Emergency Care Unit (UPA 24h) level III from January to July 2015. The sample was of non-probabilistic type and selected for convenience, within the population that used the UPA 24h services during the collection period. Users were approached upon admission into the screening section. The sample was based on data from the unit, with a confidence level of 95% and a p <0.05; being estimated in 385 subjects. A form developed by the researchers, after a previous approach, was applied to those who underwent the screening and became available to respond to the instrument of data collection, after signing the Informed Consent Term (TCLE). The mentally ill and/or unconscious

stated Systemic Arterial Hypertension (SAH), but only 77 (87.5%) reported taking the medication prescribed for the pathology. The ones that reported Diabetes Mellitus (DM) were 42 (10.1%) and of these 39 (92.5%) self-reported use of the prescribed measurement for pathology. After the anamnesis and physical examination performed by the nurse, the individual received the classification of the risk of their complaint (blue, green, yellow or red), and the user was referred to the most appropriate area. Table 2 presents the main complaints presented at the time of the approach, as well as the classified risk. According to Pearson's Chi-square test, the gender composition of users by the severity of care (risk classification) did not present a significant difference (p = 0.473). Regarding the reason why the service was searched

and the risk classification assessed, we can observe Table 3. There was statistical evidence, according to the Man Whitney test, that the reasons for seeking care in the UPA 24 h were the same for the female and male sex (p = 0.631). Regarding the shift and the evaluated risk, table 4 was elaborated, correlating the shift of attendance and the classification applied by the nurses of the screening sector.

sector. Blood pressure (BP) measurement is the vital signal that immediately reflects changes in cardiac output in patients treated with the urgency and emergency sectors. This measure must be performed on all patients reliably, so that immediate behaviors are taken. A failure of 46 measurements was observed. In the studied population, 88 subjects reported being hypertensive, of whom 11 reported not adhering to the

Table 3. Distribution of the search motives to the 24 hour UPA and the risk classification applied. n = 417. Campina Grande, 2015

Motives	Classification n(%)				TOTAL n(%)
	Blue	Green	Yellow	Red	
Epigastric or abdominal pain	-	25(6.0)	12(2.9)	-	37(8.9)
Fever	02(0.5)	13(3.1)	10(2.4)	01(0.2)	26(6.2)
Skin lesions	19(4.5)	15(3.6)	03(0.7)	-	37(8.8)
Low back pain	03(0.7)	07(1.7)	06(1.4)	-	16(3.8)
Myalgia /Asthenia	04(0.9)	09(2.1)	01(0.2)	-	14(3.2)
Allergic process	01(0.2)	09(2.1)	01(0.2)	-	11(2.5)
Mild orthopedic trauma	02(0.5)	23(5.5)	01(0.2)	-	26(6.2)
Vomit	01(0.2)	17(4.1)	14(3.4)	01(0.2)	33(7.7)
Others	23(5.5)	36(8.6)	36(8.6)	01(0.2)	96(23.0)
TOTAL	69(16.5)	236(56.6)	109(26.2)	03(0.7)	417(100)

Table 4. Distribution of the subjects per shift and classification of the risk assessed. n = 417. Campina Grande, 2015

	Risk classification n(%)				
Shift	Blue	Green	Yellow	Red	TOTAL
Morning	33(8.0)	63(15)	26(6.3)	01(0.2)	123(29.5)
Afternoon	21(5.1)	85(20.3)	28(6.7)	-	134(32.1)
Night	15(3.6)	88(21.1)	55(13.2)	02(0.5)	160(38.4)
TOTAL	69(16.7)	236(56.4)	109(26.2)	03(0.7)	417(100)

When evaluating the age group and the shift sought for service in the service, it was identified that the age group of 21 to 30 years was the one that most sought the unit in the morning shift 34 (8.1%) and night 49 (11.8%); and the afternoon shift was the most sought after by the age groups 11 to 20 years and 31 to 40, both in the same proportion 25 (6%).

DISCUSSION

Mapping the user profile of the UPAs 24h is of fundamental importance to know the flow of care of the urgency and emergency network of the municipality. The collection of these data facilitates the elaboration of strategies that facilitate and modify the scenario of the demand for the care of more complex health, as well as the attendance due to the demands in the unit. There was a greater demand for the service in the evening and by female users, corroborating with other studies (Diniz, 2014 and Silva, 2013), differing from an international study (Sunyoto, 2014) that presented a greater demand for emergency services for males. The age group that sought the service most was from 21 to 30 years, finding that it differed from a similar study (Silva, 2013). These findings may be related to the prevailing insertion of women in the labor market, and it is not possible to access the health system in the daytime, corroborating with the age group presented, since the insertion in the job market happens earlier, and this insertion is related to the culture instituted in the region and local job offer. The search for care in the night and dawn was part of the care profile offered by the service. During the initial care performed by the nurse at the reception, vital signs and initial complaint are paramount. The study showed a gap in the measurement of these signs by professionals who were in the screening room during data collection. This finding is of relevant importance for measures of permanent education to be instituted in the sector, so that professionals reflect on the importance of taking vital signs in all patients attended in the

prescribed medical treatment. It is estimated that 40% of stroke and about 25% of heart attacks occurring in hypertensive patients could be prevented with adequate antihypertensive therapy and health education. Prevalence is high and increases in older age groups. In the present study, it presented a prevalence of 21.1%, close to 24.4% of the population in Brazil (Iser, 2011). Thus, intervention measures should be thought to be instituted in this sector, since the value of BP is predictive of other cardiovascular problems. Among the individuals interviewed, 56.1% stated that they performed self-medication before seeking the specialized service, which may have favored classification of the same as blue or green. Brazil is one of the world's leading consumers of medicines, with a ratio of 3.3 pharmacies per 10,000 inhabitants, which is three times higher than that recommended by the World Health Organization (WHO), which recommends one for every 10,000 inhabitants. According to the WHO, more than 50.0% of all medicines are incorrectly prescribed, distributed and sold and half of all patients also use them incorrectly (Konder, 2013). The main complaints were headache, followed by epigastric pain and skin lesions. Headache, a complaint that can be treated at the primary care level, was also the most frequent complaint presented by recent studies (Diniz, 2014 and Pícoli, 2016). Diniz et al. (Diniz, 2014), pointed out that the main complaints of users of a county Emergency Room were symptomatic of therapeutic processes of primary care, as well as emotional and non-urgent needs, corroborating the findings of this study. It is observed that the population remains inserted in the hospital-centered model, and even when the primary care units are open, they seek care in the emergency units. In addition, Bittencourt and Hortale (Uchimura, 2015), in a review of the literature, have shown some important strategies to reduce overcrowding of hospital emergency services, such as restructuring the care network with a decrease in hospitals and an increase in the outpatient network.

The UPAs arise in the sense of minimizing spatial inequalities in access to public health. However, UPA although new in the scenario of health care networks, is still a reproductive unit of a fragmented and simplified public health service, focused only on the cure of diseases, which has been sought by the population (Cassettari, 2017). The constant search for the urgency service to attend to problems of resolution in the primary care can demonstrate a failure in the bond of the health system. A study (Silva, 2014) identified that the user seeks his care in the place where he meets his needs, without taking into account the geographical location of the service, corroborating one of the reasons for the study in question, reported by 12.2% of the sample; besides the difficult organizational accessibility in the UBS and the sociocultural question of how the individual understands the health-disease process. In this study, as in Diniz et al (Diniz, 2014), the majority of users presented a green risk classification (56.6%). Risk classification has become an important tool that allows the organization of services and care flows, allowing the prioritization of emergency cases (Gomide, 2012). There is still a great demand for users with a blue classification, which confirms once again that non-urgent cases are responsible for a high demand for emergency services, which is corroborated by a recent study (Duro, 2014). These findings can be related to the failures in the use of the reference system and counter-reference by the professionals involved in the care, making imperative health actions involving all levels of care in relation to the flow of care in the urgency and emergency network of the city. In order to be resolutive, UPAs should be integrated into a Health Care Networks policy with a greater participation of the state in its implementation process, revising and reformulating the criteria of the location of the territories. When asked "what reasons led the subjects to look for UPA 24h", the following was observed: lack of physician in the UBSF, lack of medication in the UBSF, greater ease of access to the doctor and lack of information. These reasons corroborate with other studies (Pícoli, 2016 and Godoi, 2016 and Bittencourt, 2009), which affirm that the majority of the attendances of UPA 24h could have a resolution in primary health care. In spite of the identification of strategies to reduce overcrowding of ready-made care in the literature (Uchimura, 2015), the authors emphasize that we must advance in the production of studies that involve the decision-making of managers of emergency units, in order to provide them with strong evidence to help solve the problem of overcrowding.

Conclusions

The study identified a higher incidence of adult women looking for UPA during the night shift. The reasons for searching stand out those related to the need for care of greater complexity, lack of physicians in the UBSFs, and greater ease of access to medical care in relation to basic units. These findings drew the attention of the researchers to the mistaken functioning of the network of attention to the urgencies and emergencies of the municipality, as well as the lack of information of the users about the operation of the UPA 24h. Defined as units of intermediate action between primary care and the hospital network, UPAs should compose an articulated network of attention to urgencies. However, they have been highlighted by being pressured to respond to a pent-up demand for health systems, which often causes problems of overcrowding in the unit. In view of the above, it is necessary to carry out new studies that address the profile of the clientele served in these services, linked to research that evaluates the

users 'and professionals' knowledge about the functioning of this health sector, as well as health education strategies to inform the population as it gives the health care in the network of attention the urgencies and emergencies of the municipality in question.

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