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RESEARCH

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ACOLHIMENTO NA ATENÇÃO PRIMÁRIA À SAÚDE NA PERCEPÇÃO DA EQUIPE MULTIPROFISSIONAL

Welcoming in primary health care in the perception of the multidisciplinary team

Acogiendo en la atención primaria de salud en la percepción del equipo multidisciplinario

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ABSTRACT

Objective: to understand the reception in the basic health unit in the perception of the multidisciplinary team. **Methods:** descriptive and qualitative study conducted with a Family Health team using the focus group technique. Data analysis was performed through Content Analysis according in the Thematic Analysis modality. **Results:** it was verified that the actions conceived by the team as welcoming were performed in specific shift and time, by a professional category, considered as screening of acute complaints that would determine medical care. **Conclusion:** most professionals had little understanding or lacked the guidelines of the National Humanization Policy and the expanded conception of welcoming, generating work processes incompatible with the policy, resulting in several challenges to be faced by the team.
DESCRIPTORS: Host; Primary health care; Multiprofessional team.

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RESUMO

Objetivo: compreender o acolhimento na unidade básica de saúde na percepção da equipe multiprofissional. **Métodos:** estudo descritivo e qualitativo conduzido com uma equipe de Saúde da Família por meio da técnica de grupo focal. A análise dos dados foi realizada por meio de Análise de Conteúdo na modalidade Análise Temática. **Resultados:** verificou-se que as ações concebidas pela equipe como acolhimento eram realizadas em turno e horário específicos, por uma categoria profissional, consideradas como triagem de queixas agudas que determinariam atendimento médico. **Conclusão:** a maioria dos profissionais possuía pouco entendimento ou desconhecia as diretrizes da Política Nacional de Humanização e a concepção ampliada do acolhimento, gerando processos de trabalho incompatíveis com a política, resultando-se em vários desafios a serem enfrentados pela equipe.

DESCRITORES: Acolhimento; Atenção primária da saúde; Equipe multiprofissional.

RESUMEN

Objetivo: entender la recepción en la unidad básica de salud en la percepción del equipo multidisciplinar. **Métodos:**estudio descriptivo y cualitativo realizado con un equipo de Salud Familiar utilizando la técnica del grupo de enfoque. El análisis de datos se realizó a través del Análisis de Contenido en la modalidad Análisis Temático. **Resultados:** se verificó que las acciones concebidas por el equipo como bienvenida se realizaron en un turno y tiempo específicos, por una categoría profesional, considerada como cribado de quejas agudas que determinarían la atención médica. **Conclusión:**la mayoría de los profesionales tenían poca comprensión o careceden de las directrices de la Política Nacional de Humanización y la concepción ampliada de la acogida, generando procesos de trabajo incompatibles con la política, lo que resultó en varios desafíos que enfrentar el equipo.

DESCRIPTORES: Host; Atención primaria de salud; Equipo multiprofesional.

INTRODUCTION

The Política Nacional de Humanização, doravante, (PNH) was implemented by the Ministry of Health in Brazil in 2003, and its guidelines include respect for individuality and valuing human subjectivity in health care and management practices. It seeks to strengthen interdisciplinary practices, support networks and intersectoriality, and to build users' autonomy and protagonism in the health system. Moreover, it highlights the importance of providing the ambiance and organization of healthy and welcoming spaces for users, seeking the humanization of care.[1]

The embracement, therefore, is a PNH device that aims to provide adequate spaces for workers to meet, listen to, and welcome users, and to care for the relationship among workers and users themselves in order to guarantee universal access to the Sistema Único de Saúde (SUS), information, resoluteness, construction of bonds, and comprehensive care.[2]

The reception should not be restricted to triage for medical referral, nor should it be restricted to the nurse or doctor, because all professionals on the team should be able to receive the user, and it should occur throughout the service's operation. One of the great difficulties is the understanding of professionals regarding the implementation of humanization and embracement in health services as recommended by the PNH.[3-4]

To welcome means to listen adequately and in a qualified way to the users' demands, assuring them a positive conduct and taking responsibility for the resolution of their problem or suffering. Thus, to welcome means to provide access, producing resoluteness to the needs that lead users to seek health services. Thus, this guideline is directed to the reorganization of health work processes, favoring a better relationship between users and services, considering them as rights holders. In this sense, it seeks humanization, empathy, solidarity, and the exercise of citizenship by users.[5]

Work processes in health care need to subvert the hierarchical logic of care, in order to guarantee resoluteness and humanization of care. To this end, intersubjective care technologies must be valued, betting on the workers' ability to develop therapeutic communication, therapeutic listening, and an expanded clinic that aims at integrality and sees subjects and not objects of care. In this perspective, the technical and assistentialist care with emphasis on the medicalization of health is remodeled.[6]

Therapeutic listening emerges as an important method to ensure the construction of a satisfactory organization, questioning protocols and standardization in the services, so that the services can holistically understand the demands of the community. Thus, the welcoming subsidized by listening is capable of offering the necessary technology and appropriate interventions. The team needs to expand and concern itself with these measures in order to do a quality job guaranteeing the continuity of care.[3]

One of the pillars of this approach is Primary Health Care (PHC). PHC represents the gateway to the health system, and thus, this device strengthens care and can be a guarantor of the principles of SUS.[7] In Brazil, the principles of PHC are to be the first contact, to ensure longitudinality and completeness of care, and to focus its actions on family and community approaches.[8]

PHC determined that the treatment model, previously focused on cure, could be replaced by prevention of diseases, looking at the user as a whole and understanding his or her needs. It is important that the biopsychosocial needs of users are welcomed by means of a broad and active listening, strengthening the conceptions in which the humanization of care is established. [9] Even after the implementation of the welcoming through the PNH, there are still practices that are not consistent with it in PHC services, requiring studies that seek to reflect and learn about these practices. Thus, this study aims to understand the host in the basic health unit in the perception of the multiprofessional team.

METHODS

A descriptive study of qualitative nature, as it allows the deepening of a given object from the perceptions, meanings, and experiences of each individual.[10] The study participants were professionals from a multidisciplinary team of the Family Health Strategy (FHS) of a municipality located in northern Minas Gerais.

The sample was by convenience and the selection of the team was done randomly by simple drawing, considering

teams in which the welcoming was implemented in the work process and which had a minimum Family Health team at the time of data collection, as recommended by the National Primary Care Policy[11]; As an eligibility criterion, it was considered that a team member had been working for less than six months in the Basic Health Unit (BHU), as this period was not enough to satisfactorily experience the phenomena that were the object of the study.

Data collection was carried out from August to September 2018, through the focus group technique. The focus group is a qualitative research technique that aims to provide interaction, communication, questioning, as well as experience reports among the participants, producing information and problematizations about a given theme.[12]

Two focus group sessions were held, lasting an average of 40 minutes each, in a reserved environment in the UBS. Initially, a sociodemographic questionnaire was applied to characterize the group. The sessions were audio recorded. Subsequently, the material was analyzed through thematic coding based on the structure approach[13] with the purpose of knowing the perceptions about the experience of welcoming. From the constructed questions, the object was investigated, and themes that were repeated and referred to the experiences and visions of the professionals emerged. Subsequently, the themes were organized with the construction of categories.

The emerged data were transcribed in full. In addition, the impressions of the moderator and one interviewer were also considered. For data analysis, we used the Content Analysis technique proposed by Bardin[14] in the Thematic Analysis mode, and the professionals' speeches were grouped into themes. The study participants were identified as follows: N (Nurse); NT (Nursing Technician); P (Physician); CHWs (Community Health Workers), with sequential Arabic numerals.

The study respected the ethical precepts for research with human beings contained in resolution 466 of the National Health Council, being approved by the Research Ethics Committee under CAAE: 93401318.2.0000.5141.

RESULTS

Five CHWs, one nursing technician, one nurse and one doctor participated in the focus groups, being the multiprofessional team working in the BHU and, therefore, responsible for the embracement, as guided by the PNH.[2] There was a predominance of female professionals (6), the age range ranged between 28 and 45 years; working time in the BHU was from six months to eight years. Only one participant had taken a course on embracement, and the team nurse had a specialization in family health.

In the process of analyzing the professionals' speeches, it was observed that the embracement assumes a defining role in the production of care by the team, and, when conducted in a way that is alien to the conceptions of humanization in health, it results in challenges to be faced in the work process in order to improve the access of users and the resoluteness of the family health teams. In this sense, the following thematic categories were determined: embracement and its conception by the multiprofessional team, work process of embracement from the multiprofessional perspective, work process of embracement from the multiprofessional perspective, embracement as a strategy to improve the work, and challenges experienced by the multiprofessional team when performing the embracement, according to Chart 1.

Chart 1 - Categories and what the professionals said

Reception and its conception by the multiprofessional team
"It's listening to the patient, it's listening to the complaints and trying to resolve it somehow." (CHW01)
"Receiving the patient, he comes to the reception desk and we say good morning, and just by welcoming the person and saying good morning you are already welcoming the patient. You say good morning and ask if everything is ok, what is the person's complaint". (CHW02)
"An opportunity for you to listen and classify what is the user's demand and what is the time I have to meet it. I can classify if it is something I can attend today, if it is something I can attend tomorrow, if it is something I can attend in the short term or in the long term [...].". (N)
"You listen to the patient, about the complaint he has during the day and try to help him, in the case of Primary Care, both the doctor, the health agent and the nurse, in the case of the team itself, to help him with the demands he brings during the day". (P)
"[...] when you go there to make an appointment, so it is still a form of welcoming, sometimes not with the person at the reception, who wants to talk to us or with the nurse". (CHW04)
The work process of the reception from a multidisciplinary perspective
"[...] But sometimes the patient arrives at the last minute and wants to be seen on the spot and it is not an emergency, then he will be scheduled, we monitor him beforehand to know." (NT).
"Then they will go to the doctor or nurse and they will do the triage and we will receive them, and the doctor or nurse will define who is an emergency and who is not.". (CHW03)
"[...] At the moment we have a schedule from 7 to 8 am, if he arrives after this time there is no reception at the moment, but we were discussing this. But today I can receive patients at any time, depending on the availability of my schedule, if I am available, or if I am not, I can receive them on a schedule.". (N)
"For me it works as a triage, I as a doctor see it as triage and not as reception". (P)
"Each day one is on duty at the reception, always taking turns, we listen to the patients to see what they want, as they arrive.". (CHW04).
"[...] all the people who arrive at that time are registered on the form, which is the demand of that user and then passes to the doctor and nurse who make the evaluation of what is urgent or scheduled consultation and then we make the classification according to the schedule of the doctor or nurse". (N)
Welcoming as a strategy to improve the work process
"[...] establishes a greater bond, by being closer". (CHW01)
"[...] to be able to solve their problems". (CHW02)

"You can solve what the user is needing in a timely manner at the level of care, so it is an acute case so at that moment I have to attend, different from that person who wants to do a routine exam". (N)
"[...] I kept talking to the patient, at first he didn't want to answer, but I was very gentle until he agreed to go to the hospital, there I saw that he trusted me, because he didn't even listen to his family, so this is gratifying and it is a very positive point of the reception, to develop people's trust, they believe in us, it is very good to help". (CHW05)
Challenges experienced by the multiprofessional team in performing the reception
"There were many people who left dissatisfied. There have been many people swearing, kicking things, slamming the door, talking about calling the police. It is difficult because many come here with a report already saying that it is urgent and wanting priority and we see that it is not true, then the receptionist who can handle the dissatisfaction". (CHW02)
"[...] the CHW has to be there in the front, because it needs knowledge to classify what you are just going to hear and what you are going to refer, for me, the flaw is in this issue, they are not trained for this". (P)
"A negative point is the emotional overload, we try to solve it, but the system doesn't help and we always want to give a positive answer to the patient and this doesn't always happen, sometimes we can't do anything". (CHW04)
"The user wants to be served at the time he came, he doesn't agree that there is a classification. So the person fights, curses and wants to break the unit". (N)

DISCUSSION

The speeches revealed a variety of conceptions about what the reception is. Among the meanings pointed out, the following stand out: listening to the patient, hearing his complaints and trying to solve them; properly receiving the user, considering cordiality as something important. Also, listening to the complaint followed by the classification of the demand that will immediately produce a conduct. Another conception was identifying the complaint and directing it to the doctor; or receiving a demand that is directed to a specific professional.

The data produced allow us to understand that most professionals have little understanding or are unaware of the PNH guidelines and the proper definition of welcoming. The PNH broadens the concept of welcoming, not restricting itself to a cordial reception focused on the identification of acute complaints. This device should review the intercessor processes that build relationships in health practices. As a consequence, what we have are humanized relationships structured by different approaches to user care, and transforming practices.[5]

Regardless of the professional category of the research participants, for them the reception is related to properly receiving users in the services. However, the reception needs to transcend "welcoming users" and should be done with an ethical and caring attitude toward the subjects that seek the services.[15]

Thus, it is necessary to receive much more than complaints, which implies the need for risk and vulnerability assessment, establishment of priorities by the subjects in relation to their clinical and psychosocial demands. Actions are glimpsed that are established with the overcoming of a technical and compartmentalized attention.[16]

The data reveal elementary conceptions about the reception. The embracement needs to be understood in its expanded conception, making it possible to conduct planning, health education, and the implementation of actions that meet the fundamentals that determine it.

Broadening this conception, the device is seen as a political strategy that enables the effectiveness of the fundamental principles of SUS, in which the centrality of actions in health services is subverted to programmed activities and focuses on the real needs presented by users, without disregarding health surveillance actions. This logic enhances the encounters between workers and users through the qualification of listening, expands access, stimulates interdisciplinarity, and expands the clinic.[17]

The actions determined as welcoming in this BHU are performed at specific times and restricted to the morning hours by the CHW professional. Then, users are screened by the nurse and the doctor, who will define the need for consultation or other resources or procedures. Some professionals define the reception as this timely moment when triages are performed, including the medical professional reinforces this idea.

Some professionals consider the reception as a triage and base themselves on the modality in which the user presents a complaint and is then given a conduct. This practice turns the reception into a punctual activity, directed to a spontaneous demand and does not privilege a qualified listening.[18]

In this study, the professionals were not able to translate the welcoming as a qualified listening that aims at accountability and commitment to the user's needs. The work processes developed by the team reinforce the conceptions they have about what the welcoming is, and do not corroborate the guidelines proposed by the PNH.

This view, centered on a reception that leads or not to a consultation, impoverishes the work processes, minimizing the reception as an isolated and limiting strategy, not being enough to achieve the necessary quality.[19] The effective implementation of the embracement requires the establishment of significant changes in work processes aiming at reorganizing services based on reflections and problematizations of their actions.[16]

Moreover, it is noteworthy that, in this BHU, the CHWs are the professionals who perform the actions called welcoming. The election of a professional category and the definition of an opportune time to perform the device shows the absence of a multiprofessional proposal and disregards one of the basic principles of this device. Thus, the conceptions and work processes recommended by the PNH are violated.

The great purpose of the reception is to produce decentralization by making it multiprofessional, because

the services still tend to work based on the physician's figure. The predominant embracement performed in BHUs still tends to be summarized in actions of service organization, such as scheduling appointments and procedures on specific days, as this study has shown. However, the reception cannot be restricted to these simplistic processes. The teams should include all professionals in order to favor the offer of interventions.[20]

Regarding the proposal of the reception performed with risk classification for acute diseases, this practice is able to guarantee care based on needs, disregarding impersonality and appointments in order of arrival. However, this practice produces the risk of the reception being restricted to the evaluation of users, focusing only on the complaint-conduct and privileging biological aspects to the detriment of a comprehensive approach. Thus, it is necessary that professionals are able to overcome the protocol procedures and exercise extended listening, ensuring universal access to users' demands.[15]

Despite the fact that professionals have a simplistic view of what the reception is, and that this impacts on practices that are characterized as triages focused on the biomedical model, they state that the practice favors the bond, helps solve users' problems, and stimulates listening.

Based on the welcoming proposals, the users' demands should be received through listening, should not happen at specific times, and should be carried out in a multiprofessional way. The procedures should not be limited to the medical consultation. The FHS needs to implement the first contact with the user, overcoming the curative practices. The reception, exercised effectively, as determined by its guidelines, is a device for this to happen.[18]

The use of soft technologies of care, that is, the focus on intersubjective processes, such as therapeutic listening and therapeutic communication, which allow the object of care to be the person and not the disease. It is important to consider this assumption, which is reaffirmed in the literature by studies on embracement.[18]

It is important to reorganize the work processes of the teams considering what the guidelines determine about the reception. There is a contradiction between the reaffirmation of some important precepts of the device at the same time that the work processes do not correspond to the discourses.[21]

To operationalize the embracement as an operational guideline means replacing the axis of care centered on the physician for the multiprofessional team. The fragmentation of work processes and the lack of involvement of professionals in the development of care proposals contribute to the maintenance of the biomedical model. Thus, the services remain focused on clinical and prescriptive procedures and reinforce individual practices.[15]

The dissatisfaction of users is a point highlighted by several categories regarding the work processes implemented by the team in the reception actions. Some professionals question the fact that the community agent is responsible for the reception. This is a pertinent questioning, since the welcoming actions should be the responsibility of the whole team, but at the same time there was no mobilization of other professionals to take on such responsibility.

As a result, the community health agent reports being psychically overloaded to perform this function in the team. The CHW ends up being responsible for solving the several demands of the users. It is known that there are several difficulties faced by the services to provide answers capable of solving the users' problems. The agent ends up being held responsible when the service does not effectively produce these solutions, damaging their relationship with the users. Another difficulty highlighted is the immediacy required by users to solve their demands. However, the team's work processes reaffirm this immediacy.

Ordinance No. 2436/17, which provides for Primary Care in the national territory, determines the reception as a responsibility of the FHS, recommending that the needs of the population be met in a comprehensive manner. It is the responsibility of the multiprofessional team to understand the diversity and complexity of the population residing in its territory.[11]

This study reinforces the need for the team to implement the welcoming process properly, as recommended by the PNH.[7] The ineffectiveness in the adoption of the embracement in harmony with the PNH produces dissatisfaction among users. Moreover, it implies in high demand for medical consultations, generating waiting lines that are often unnecessary, compromising the quality of the service provided.[22]

Thus, the continuing education of professionals on the proposals of the PNH and embracement can produce changes in the work processes of FHS professionals, because according to this study, the complaint of lack of continuing education on the subject was reported.[23]

CONCLUDING REMARKS

Most professionals on the team had little understanding or were unaware of the PNH guidelines and the proper conception of the reception. In this BHU, the actions conceived as embracement were initially performed at a specific time in the morning shift by the CHWs and not by a multiprofessional team. Most professionals consider the reception as the triage of an acute complaint that will produce a privileged medical conduct. This practice makes the reception a punctual activity, directed to a spontaneous demand, not being developed through qualified listening.

Although the professionals have a simplistic view of what the reception is, they say that the practice favors the bond, helps solve the users' problems, and stimulates listening. The professionals also showed challenges experienced by the multiprofessional team when performing the reception. The dissatisfaction of the users is a point highlighted, and another difficulty highlighted is the immediacy required by users to solve their demands. Reorganizing the team's work processes becomes a requirement so that the precepts of the PNH and PHC are guaranteed. The continuing education of the team can produce changes in the work processes of the teams.

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