

RESEARCH

Perception of family health strategy users on emergency service

Percepção do usuário da estratégia saúde da família sobre o atendimento de urgência e emergência

Percepción de usuarios de familia estrategia de salud de emergencia urgencia y emergencia

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ABSTRACT

Objective: To analyze the users' perception of the Family Health Strategy on the urgent and emergency care provided in primary healthcare. **Method:** A qualitative descriptive exploratory study with 30 users. A semi-structured interview was used as a data collection technique. The data were processed using the software Alceste 4.8. **Results:** Four classes were constructed: User satisfaction with the urgent and emergency care; Unit structure for urgent / emergency care; Justifications for seeking urgent and emergency care; Understanding of the meanings of urgent and emergency. **Conclusion:** The study showed that users are satisfied with the care received in the units although they present ambiguity when it comes to their physical structure. The respondents also failed to conceptualize urgent and emergency, and showed that the cause that led them to seek the healthcare units were changes in blood pressure, diabetes and trauma. **Descriptors:** Family health, Healthcare, Emergency, Urgency.

RESUMO

Objetivo: analisar a percepção dos usuários da Estratégia Saúde da Família sobre o atendimento de urgência e emergência na atenção básica. **Método:** Estudo de abordagem qualitativa exploratória descritiva com 30 usuários. Foi utilizada como técnica de obtenção de dados a entrevista semi-estruturada. Os dados foram processados no software Alceste 4.8. **Resultados:** Foram construídas quatro classes: Satisfação do usuário com o atendimento de urgência e emergência; Estrutura da unidade para o atendimento de urgência/emergência; Justificativas para a busca de atendimento de urgência e emergência; Compreensões do significado de urgência e emergência. **Conclusão:** O estudo mostrou que os usuários estão satisfeitos com o atendimento recebido nas unidades embora apresente ambigüidade quando se trata da estrutura física. Os entrevistados ainda não conseguem conceituar urgência e emergência, e mostram que as causas que os levaram a procurar as unidades de saúde foram alteração na pressão arterial, diabetes e traumas. **Descritores:** Saúde da Família, Assistência à saúde, Emergência, Urgências.

RESUMEN

Objetivos: Analizar la percepción de los usuarios de la Estrategia Salud de la Familia en el cuidado de la atención de emergencia en la atención primaria. **Método:** Un estudio descriptivo exploratorio cualitativo con 30 usuarios. Se utilizó como técnica para la obtención de datos a la entrevista semi-estructurada. Los datos fueron procesados con el software Alceste4.8. **Resultados:** Se construyeron cuatro clases: la satisfacción del usuario con la atención urgente y de emergencia, unidad de la estructura para la atención urgente y de emergencia, las justificaciones para la búsqueda de atención urgente y de emergencia; comprensión del significado de urgente y de emergencia. **Conclusión:** El estudio mostró que los usuarios están satisfechos unidades de cuidados recibidos, aunque presente la ambigüedad cuando se trata de la estructura física. Los entrevistados también no logran conceptualizar la atención urgente y de emergencia, y muestra que la causa que les llevó a buscar las unidades de salud fueron los cambios en la presión arterial, la diabetes y el trauma. **Descritores:** Salud de la Familia, Atención de salud, Emergencia, Urgencia.

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INTRODUCTION

Brazil adopts a unified and standardized public health system, and which legally ensures every Brazilian citizen quality, timely and effective healthcare. However, even with these advances, the Brazilian health system has still not succeeded in satisfactorily meeting the needs of the common citizen and this becomes more evident when it comes to urgent and emergency care.

Since the deployment of SUS (Unified Healthcare System), by determination of the Constitution of 1988 and regulations of Laws 8.080 and 8.1420 (1990), the health care in Brazil proposes a model based on the actions of promotion, prevention, protection, recovery and rehabilitation. Additionally, recognizes constraints and determinants of health: food, shelter, sanitation, environment, labor, income, education, transportation, recreation, and access to essential goods and services.

In the 1990s, began the deployment of the Family Health Program (FHP), currently called the Family Health Strategy (FHS), with the objective of contributing to the construction and consolidation of SUS, proposes a reorientation of the care model from primary care.²

The establishment of the FHS has contributed to improve the epidemiological indicators in all regions of Brazil, especially in the North and Northeast, where conditions of life and health are even more precarious.³

This reformulation involves the service to users with urgency and emergency conditions of, provided by all the entry ports in SUS, to allow the resolution of their problems or the forwarding to a service of greater complexity, when necessary. The care for the urgencies should flow at all levels within SUS, organizing care, from primary care, J. res.: fundam. care. online 2013. dec. 5(6):169-186

until the post-hospital care, as well as in convalescence, recovery and rehabilitation.⁴

Thus, the roles and prerogatives of the family healthcare units in relation the care of urgencies of low severity / complexity should be performed by all FHS teams in all the Brazilian municipalities, being that they should be continuously trained to dispense assistance based on caring for acute cases. Faced with this, PHU (Primary Healthcare Unit) needs structuring necessary physical and material resources to meet the urgent and emergency situations.

This service is considered as an important link between the different levels of care in the system,⁵ is part of a regionalized and hierarchical service network for urgencies and emergencies and is characterized as attendance seeking to arrive early to the victim after experiencing harm to their health and which can lead to suffering, sequelae or even death.⁶

However, the population is still resorting to healthcare services in situations of suffering and anguish and there is an outline to meet it and give satisfactory response to their acute health problems. Thus just seeking services that meet urgencies and emergencies, revealing the low resolvability in Primary Care.⁷

The main factors that contribute to this situation, are related with the persistence of the hegemonic exercise of the physician-centered clinic, the lack of preparation of Primary Care professionals for the more complex healthcare needs, the lack of organization for the spontaneous demand and the inability to absorb it, the work process dynamics related primarily to health practices directed towards promotion and prevention and service logic, organized for the elective care.⁸

In addition, profile of Primary Care is characterized with small technological innovation,

Moura LRP, Rocha ESB, Moura MEB *et al.* without support diagnosis and appropriate therapy and with restricted composition of human resources.⁹

Based on these it is clear that strengthening of primary healthcare, should be encouraged, since it helps to reduce complications that lead users to the levels of secondary and tertiary care, minimizing, including medium-and long-term costs of these sectors.

Starting from this issue, the object of this study was outlined as, the perception of the Family Health Strategy users on the urgency and emergency care in primary care. In addition, this study led to the following question: How do Primary Care users perceive the urgency and emergency care?

The objective of this study is to analyze the users' perception on the urgency and emergency care in primary care, analyze the perception of the Family Health Strategy users regarding the service structure and material resources used in the treatment of urgencies and emergencies.

METHODOLOGY

This is an exploratory descriptive study with a qualitative approach, based in the municipality of Caxias-MA, Brazil. Study subjects were selected from 30 Family Health Strategy users from the Healthcare Units that received urgent /emergency care in PHUs that receive the study subjects.

For the data production, a technique for obtaining the interview data was used with the Primary Care users regarding the Urgency and Emergency care in the Primary Care Units of Caxias-MA, Brazil. Addressing the user happened after collecting verbal information from FHS staff on the occurrence of the urgency and emergency situations in the community served by them. Afterwards, we sought the individual who experienced the said situation to obtain the

Perception of family health strategy... information under the user's perception.

The data were processed in the software Alceste 4.8, by means of Descending Hierarchical Classification, i.e. the relationship between the Classes formed from the *Corpus*, based on interviews of the research subjects.

The subjects who agreed to participate in the study received information about the interest, background, purpose and the objectives of the study and signed the Free and Informed Consent Term (FICT). In addition, before the completion of the interview, according to the determinations of Resolution 196/96 of the National Health Council after the project was submitted to the Ethics Committee and Research (CEP) of the University Center UNINOVAFAPI, for consideration and approval with CAAE No. 05585312.2.0000.5210.

RESULTS AND DISCUSSION

The corpus analysis or Initial Context Unit consisted of 30 interviews. In characterizing each one of the interviews the following variables were considered: subject (suj) (each interviewee was classified with a number following the numerical order in which the interviews were carried out); Age (age); gender (g); ALCESTE divided the corpus into 117 Elementary Context Units (ECU) and from these were selected 49 ECU, i.e. 41.9% of the material was considered for analysis. From the ECU were constructed 04 Classes (set of ECU with the same word).

The data found in Descending Hierarchical Classification revealed 4 semantic classes that allowed us to understand, during the analysis, the perception of the users in the representation of collective environments, in which they could demonstrate divergent positions in relation to the urgency and emergency situations experienced in the FHS, as shown in Figure 1.

*Perception of family health strategy...
 (...) I thought the service was good, I thought it was great. I was well cared for. I liked it a lot
 (...) the service was good, because I was cared for. I arrive there and make an appointment to get cared for (...)
 the service was wonderful. I think that this is a good clinic. At the time that I need that, I am well cared for (...).*

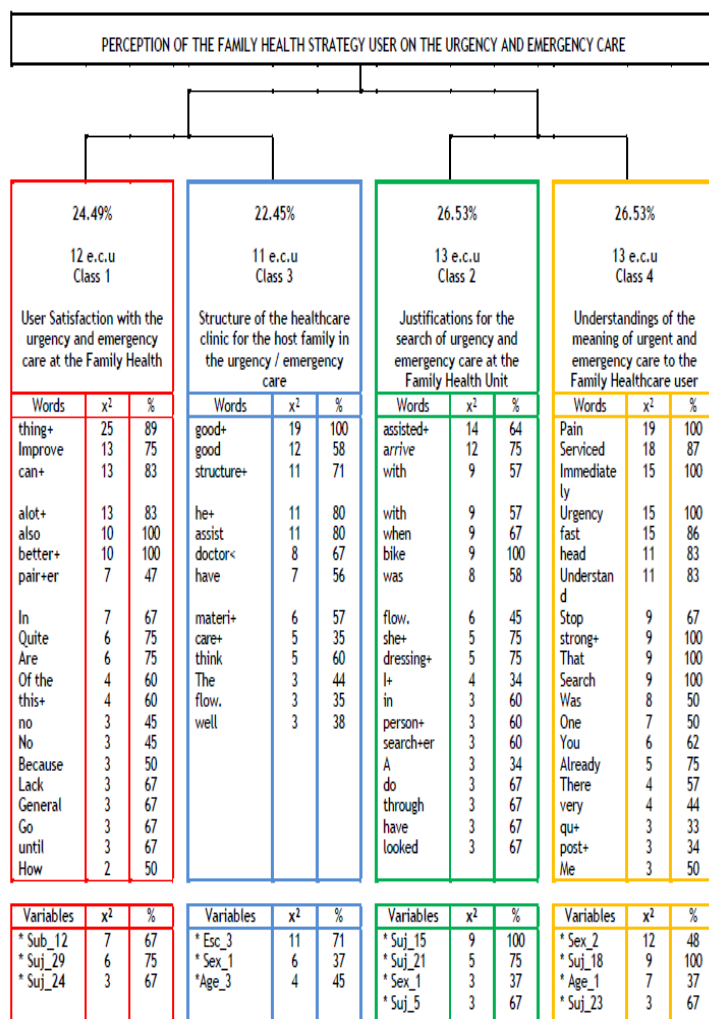


Figure 1: Classes formed by ALCESTE from the interview data. Teresina, Piauí, Brazil, 2013, Source: Direct research

The effectiveness of the users' access to healthcare units and commitment from professionals in promoting a holistic, humane and resolute care are essential for strengthening primary care as the base model of reorientation of the healthcare system.¹⁰

Other users refer to a good urgency and emergency care in FH (Family Health), however, it is perceived that the value judgment describes the setbacks experienced in the daily lives of users in public healthcare system and desire improvements in the quality of urgency and emergency services in PC (Primary Care), considering the principles of SUS.

Class 1 - User Satisfaction with the urgency and emergency care at the Family Health

Class 1, directly associated with class 3, and indirectly associated classes 2 and 4 consists of 12 ECUs, representing 24.49% of the classified ECUs. Here, the words (nurse, professional, patient and work), were selected by frequency and by values of x² higher in class, as shown in Figure 1.

The users have indicated their satisfaction with the care produced by FHS professionals in urgency and emergency care as good, meeting the needs of users at the time of service, in accordance with the following UCEs:

In my case I do not think that they should improve anything, because there I was cared for very well, I have no complaints

*For this care I received normally, but for other care there were failures (...)
 the service was good, but a lot needs to be done so that it can improve, in fact, public healthcare as the law says (...).*

It is from this informal daily assessment made and related to one everyday life and reflective learning that the images on the different service of the care network are configured. This is an evaluation not perceived by the user at the discursive level, although it is at the level of their practical consciousness. The users in their daily lives, conduct a reflexive monitoring of their experiences, establishing value judgments about the various services that are presented to them in the healthcare system, namely, on the daily basis the user reviews the healthcare services this

Moura LRP, Rocha ESB, Moura MEB *et al.* assessment is not only based on their own experiences, but also on experiences referred by other users.¹¹

To comply with the actions relating to Public Healthcare, especially in PC, it is essential for the preparation of pre-planning, ruled in the main concerns of the population, considering their everyday experiences in healthcare services, since the satisfaction expressed by the user is one of the more useful instruments in orientation of corrective measures for the provision of healthcare services.¹²

On the other hand, some users have highlighted some points of dissatisfaction in relation to the production of the care by health professionals in urgency and emergency care, evidencing that the service was terminated by the formal organization established in the FHS and that makes the user seek the other levels of care within the healthcare system. Thus, PC cannot be resolute to accommodate the community's desires.

I was poorly serviced, because the doctor would only see the 16 patients who already had scheduled appointments, it is the Unit rule (...) I believe that this service could be improved, because sometimes you need to travel from your neighborhood, to go to the general hospital, and sometimes they are things that can be addressed at the clinic (...) Regarding the service it is so bad, I have been very poorly cared for (...) I think that the emergency care, can improve and do more things to meet the needs of the community (...).

The resolvability of healthcare services is a way to evaluate the healthcare services based on the results obtained from the user customer service. The researchers report that resoluteness of services in the hierarchical model by care levels, which can be evaluated by two aspects. The first, within the service itself, as the ability to meet

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Perception of family health strategy... their demand and to forward those cases that require care that is more specialized and the second, within the healthcare system, which extends from the initial consultation of the user at the primary healthcare service until the solution to their problem in other healthcare levels.¹³

The statements show that in PCU that the urgency and emergency care consultations are treated as outpatient consultations, i.e. pre-scheduled, which can harm the user's health, since it is a heightened unpredictable situation.

Corroborating with these statements, the literature suggests that users generally show higher levels of satisfaction in relation to doctors and lesser in relation to exams; usually, the dissatisfaction relates to the delay in care, the waiting time in service, the deficient reception, having to move to other services and the difficulties in relationships with the professionals.¹⁴

The contradictions identified in these reports have demonstrated that there can be a certain distancing between the team and some users. This can have negative repercussions on their state of health, a time that unhappy users tend not to adhere to the prescribed treatment and do not continue using the PC healthcare services, due to several established organizational weaknesses in the FHU, however users demonstrate expectations for improvements, as described below.

The service was as I previously mentioned, it was pretty ineffective, has to improve a lot, I was not cared for, that is why it has get better (...) I was not cared for, they asked me to return another day at 6am to make an appointment for the following week. They didn't treated me badly, they treated well, but they had this problem (...).

Here it is evident that in addition to not obtaining equal access (the right to have equal

Moura LRP, Rocha ESB, Moura MEB *et al.* rights), this law overrides the principle of equity that corresponds to justice creating opportunities in the distribution of health care and its benefits among the population, recognizing the right of each individual.¹⁵

The definition of fairness must understand not only the restricted sense of the quantity of material and human resources (such as doctors, nurses, hospital beds, clinics, among others), but also the quality of the services provided.¹⁶

The spontaneous demand, without scheduling, leaves some users without care. The reception and screening of surpluses could indicate which ones could be rescheduled and which would have a greater urgency to receive care.

This measure would serve to check would check who could be referred to other services or dispensed to return at another time, and establish justice in the distribution of healthcare and its benefits among the population. Thus fulfilling the principle not only the reception, but of equity provided by the system, mentioned above, and that is one of the seven pillars of quality in health.¹⁷

This study shows the inconsistencies in relation to the guarantee of acceptance in services for users, in accordance with the technological complexity, which should be organized in such a way as regionalized, hierarchical and regulated, because there are many weaknesses in the organization.¹⁸ The author also mentions that the ideal, at different levels of care, is the formation of a healthcare network so that each service complements the action of another by means of organized and agreed upon mechanisms. This only occurs if the services are recognize this as an integral part of the emergency system, adequately serving the patient in that which corresponds to their solving capacity.

The dissatisfaction of users still permeates by aspects that involve the technical competence

Perception of family health strategy... of health professionals in the care in situations that require daily at FHU this factor emerged in the study as seen in the following statements:

For emergency services, professionals need to improve a lot (...) The service left something to be desired, I was looking to have a more detailed guidance on my problem and was unable to (...) The competence of the technique is ineffective, the competence of the clinic in general leaves much to be desired (...).

The competence, as one of the variables that influence the human behavior, understands innate intellectual dimensions and acquired, knowledge, skills, experience and maturity. A competent person develops and performs appropriate and skillful actions in their work, in their area of expertise.¹⁹

The professionals working in the primary healthcare field are not sufficiently qualified for emergency care and emergencies, which explains the professionals from the primary care units they yearn for an immediate transfer without even performing a preliminary evaluation and stabilization of the patient by their insecurity and lack of knowledge on how to proceed.²⁰

In this regard, a study was carried out aiming to verify the knowledge of healthcare providers in Primary Life Support, in which after their completion, in the post-test, although with a growth of 19.79% in the percentage of correct answers after the completion of the training. The professionals still showed lack of knowledge about the location of the cardiac compression and difficulties in the recognition of signs and symptoms of cardiovascular diseases impairing the early access to emergency services.²¹

The lack of health professional preparation may be a reflection of their own difficulty to teach pre-hospital care (PHC) in the learning. Since this

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 type of service has characteristics that are not always capable of adaptation in laboratories such as: care in places of difficult access and care in vehicles, these existing gaps between theory and practice will certainly hinder the preparation of the student in such a skill.²² This new area of activity seems not to have been fully incorporated by the schools and universities in the country. This leads to no attention on the part of educational institutions for the preparation of future healthcare professionals in the area of urgency and emergency care and in particular in Pre-hospital Care, leaving gaps in their training.

Thus, the emergency situation within primary care leads to the assumption that investment in FH by managers and professionals themselves is extremely important in view of the need of living well of the patient and the good service of the professionals.²³

Class 3 - Structure of the healthcare clinic for the host family in the urgency / emergency care

In this class, the contents of the 11 UCE's, which corresponds to 22.45% of the information, directly associated with the class 1. The expressions (good structure, good, material, care) grouped, which are shown in Figure 1 and associated with the most prominent elements in the ECUs, reinforce the perception of the users about the structure of the family healthcare clinic for the reception in the urgent / emergency care.

When addressing the structure in Family Health it is important to remember that this is not limited to space and its facilities when evaluating structure, such as: human resources, materials and equipment available, the range of coverage of the program and its demands, to ensure continuity of care in the community and households when necessary.²⁴

Based on this assumption and based on the

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 statements of the subjects, it could be seen concerning the structure aspects, including physical environment, human resources, materials, equipment and demand. In this approach, we found that subjects showed good structural conditions in relation to the physical facilities of the FHU for urgent and emergency care, highlighting the importance of the FHU to the community with the establishment of the link between the FHS and the users. However, in the statements there was no evidence that the physical space of the FHU is suitable for performing the interventions according to the stratification of the user needs, through risk assessment and vulnerability, as noted below.

I think the structure is very good, clean, organized, and is close to home (...) today everything was great there. I cannot complain about the material, I had medication that I was given to me; I soon after I had injection and they have the professionals to service (...) it is apparently the structure is good, everyone sees that everything is clean and organized all the material (...).

A "Good practice" is that which is expected, designed and operated in a scientific manner and by way of provision of services, that aims not only to meet the expectations of the consumer society. But with political and ethical expectations in the optimization of distribution of the benefit that is health care and advances the right to healthcare as outlined in the Brazilian constitution.²⁵

However, it is worth noting that the MS does not recommend a standardization of the physical reception of these for urgent and emergency care structures, while offering suggestions to better define the structural issues of the FHU for better patient care in emergency situations.³³ The ideal is that the Primary Care Unit has adequate physical and specifies for

Moura LRP, Rocha ESB, Moura MEB *et al.* observation for up to eight hours, according to Decree GM/MS no. 2048, November 05, 2002.²⁶ It is also important that it have equipment, inputs and appropriate medicines for these situations.²⁷

The Decree GM/MS no. 2048, in chapter III recommends that the FHU to carry out the reception / care of urgencies of low severity / complexity, a primary level of care, they should have a properly stocked space with essential drugs and supplies to the first call / emergency stabilization occurring near the clinic or its coverage area and / or to be forwarded to them, to make possible transferring to the larger clinic, when necessary. These recommended resources are:

Medicinal Products: adrenaline, distilled water, aminophylline, amiodarone, atropine, ipatropium bromide, deslanoside, dexamethasone, diazepam, diclofenac sodium, dipyrone, epinephrine, scopolamine (hioscine), phenytoin, phenobarbital, furosemida, hypertonic glucose, haloperidol, hydantoin, hidrocorizona, isosorbide dinitrate, AAS, lidocaine, meperidine, ringer'S lactate, glucose serum, 0.9% sodium chloride - Equipment: portable or fixed aspirator, material for immobilization (pediatric and adult cervical collar, moldable splints and long board with straps and side head protection), oropharyngeal tube, nasopharyngeal mask, ventilation clinic with reservoir. - Supplies: aspiration probe, oxygen, material for venous puncture, dressing materials, material for small sutures.²⁶

Regarding the structure of the FHU, with emphasis on providing material resources and equipment, subjects demonstrate that the realities of emergency room care to the users are divergent, although one perceives the FHU to have improvements, especially in relation to the physical environment and providing medicines.

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Perception of family health strategy... However, some FHU still coexist in a daily life permeated by the scarcity of supplies, lack of instruments and equipment to carry out their activities in urgent and emergency care, especially, the lack of material and equipment, shortages in the supply of medicines, where the users recognize the limitations in the urgent and emergency care in the FHU, which for many is a unique feature that has to be used in such situations. The following statements illustrate this problem:

The clinic lacks a lot, it lacks structure, it lacks both in its physical structure, as well as the care of patients (...) In my vision it needs to improve a lot in terms of structure (...) The clinic is actually good, it's beautiful, pretty clean, but it is still missing a lot... It has the professionals to service the client, but sometimes lacks material (...) the unit's structure is good. The service is normally good. They are lacking materials and equipment, such as gloves and medication (...).

It is a common deficiency in the physical structure of the primary healthcare units. This statement can be corroborated by a study that evaluated the quality of support services from two FHU. This study revealed that one of the units did not have adequate physical infrastructure to provide the basic services.^{28 - 29}

It is noteworthy that this reality is also displayed in a city in northeastern Maranhao, Brazil, which focused on the conditions of the structure of FHU after expansion of FH, evidencing insufficient provision of means and tools ranging from inadequate physical plant to lack of forms, materials and equipment. In addition to material resources, such as insufficient to deal with the constraints, generate stress and worry in the face of demands placed by healthcare model, thus limiting user

Moura LRP, Rocha ESB, Moura MEB *et al.* the FH assistance.³⁸ There needs to be investment in the physical structures of the PHU, which will enable professionals to work better and greater comfort for users.³⁰

Thus, it is inferred that this context does not meet the guidelines recommended by the National Policy of Primary Care - PNAB, guiding the current FH, which refers in his series of standards that it is incumbent upon the Municipal Health Departments ensure infrastructure necessary for the operation of Primary Health Units, providing them with material resources, equipment and supplies sufficient for the set of proposed actions.³¹

Some users perceive that curing the conditions of physical space, with the supply of equipment, materials and medicines, better care can be offered, especially in emergency, aiming at the needs of the community, with the needs of the enrolled community, as shown by the following statements:

In terms of material, they can also be improving so that they can offer more quality, better care for the population (...) I think that the emergency care, can improve and do more things to meet the needs of the community (...).

The facts verified in this study, involving perception and reception, show the need for a special attention to the physical structures and ambiance of basic units, ensuring comfort, appropriate conditions of work for the professionals and hopes, as well as care for the users and spaces suited for meetings and exchanges among healthcare professionals and users.

The non-availability of materials in quantity and quality appropriate to carry out the work directly interferes in the quality of care provided to the client in an urgent and emergency care situation. It is an important fact because it allows professionals to perform their activities in a

Perception of family health strategy... continuous and safe manner. It is also reported that, in an emergency care, of any health service, which it proposes to carry out this type of care, the importance of adequate materials is potentized, having in view that time is a determining factor in the support, and the lack of a material can cause irreversible damage to the patient.³²

Another aspect observed in users' statements in relation to human resources was the lack of medical professionals in the physical space of the FHU for provision of emergency assistance and emergency, demonstrating that patients do not always have their needs met adequately generating dissatisfaction, as mentioned by the subjects:

Whenever I go to the clinic, I never see the doctor (...) They lack much, lacking doctors, because unfortunately they are not able to continue like this (...) They may have material and it is clean, but they do not have doctors (...) They lack physical structure (space) for the care of patients. Lack doctors (...).

The lack of human and material resources not only hinder the service but also the relations between workers and users in the FHU.³³ One of the factors that contributes to the lack of doctors in FH is high turnover of these professionals, who attributed the search for better wages and working conditions.^{30,34,35} The remuneration of professionals must be the object of a differentiated policy and adapted to the local characteristics, in order to ensure the dedication and availability necessary for the proper performance of their duties.³⁶

Was shown when users value the specialized medical care, claiming medical experts for caring for the population. The FHU should seek strategies that demonstrate to the population capacity that the family doctor, along with the other members of the multi professional team has to develop healthcare actions at all stages of human development.³⁷

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However, other users justify that the improvement of care in FH will occur if investment to improve the conditions of urgent and emergency care, highlighting the weaknesses of the FH daily care. This situation generates discontent and mistrust regarding the technical capacity of health professionals and the criteria used by these in the provision of care.

I'm thinking that the basic units of health need a recycling of professionals to perform the care, because unfortunately it cannot continue like this (...).

The statements of the subjects denote the need for professional training in FH on Urgent and Emergency care, with the purpose of improving the care provided to users through the qualification of all professionals.³⁵ In this context, it highlights the continuing education as an important element in increasing scientific-technological and efficiency of the work in FH, and that this has been removed from the daily life of their workers.²³ The author also reports the fundamental importance of investment in training of human resources, which induce to interdisciplinary work, the junction teaching/work, the overcoming of practices does not flexible, for there is also the inclusion of the extensions ethical and humanistic guided for citizenship.

With respect to this paradigm, it emphasizes especially the qualification of health workers, who think the educational dimension as constructive work of health means dividing the weight of the responsibility of decision, usually centered, and make the professionals responsible for assessing their own actions. It implies, therefore, to incorporate these responsibilities at all times of healthcare work processes.⁴⁰

It is worth noting that in the FH reality in the municipality of Caxias, Brazil, do not, there is no policy for training human resources for this

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Perception of family health strategy... purpose, and this translates into the everyday practice of its professionals and users. For this, health services should invest in the development of in-service education as a strategic resource for the management of work and education in the area. From this perspective, it becomes possible to overcome the tradition of specific training by a training process that contemplates permanent healthcare education.⁴¹

Class 2 - Justifications for the search of urgency and emergency care at the Family Health Unit

Class 2, directly associated with the class 4, composed by 13 ECUs and 26.53% of the total number of words (assisted, come, seek, dressing and when) grouped together and presented in Figure 1. This thematic analysis category presents the motivations that led the users who have experienced urgent and emergency care situations to seek care in the FHU. These urgent and emergency care situations were varied, and can be classified by situations that involve pain, trauma/injury, arterial hypertension and decompensated diabetes and pediatric emergencies, such as fever, diarrhea and respiratory insufficiency.

The words cited as representative although apparently do not reflect these cases of emergency, referring to the same indirect way as identified in the statements.

It can be said that the users have sought this service with the purpose of solving their needs, be they urgent or not, sometimes expressed by means of the complaint, in a nonspecific way, that was the way in which the doors of care if opened up to them.

However, it is necessary to define the concept with the purpose of better understanding of the contexts in the healthcare services.

The meaning attributed to the disease's symptoms as to its individual and emotional reaction to these symptoms, their influence is not

Moura LRP, Rocha ESB, Moura MEB *et al.* contained only in background of the individual and their personality, but they are intrinsically linked to the cultural, social and economic context in which they occur.⁴¹

In this sense, the PC is an operating space where the interaction user/service/population, and thus it is an active territory and ongoing configuration and, for this reason, it goes beyond the simple definition of geographical space. Only understood as dynamic territory, it will be feasible to search for real and concrete answers that can positively change the framework of health of the population group for which it directs the action.⁴² Thus, the reporting of pain was quite frequent, at the same time that nonspecific described by subjects as main complaint, especially headaches, as noted below:

I was feeling an intense headache, so I went to the clinic (...) I woke up in the morning with dizziness, headache, very strong everything was spinning and I had to seek the health clinic to see what was happening. (...) I started to become ill at home, a strong headache and malaise, I quickly called my parents, they brought me to the nearest health clinic here (...) The headache after kept increasing, already after much time, at around five hours, I thought that I should find a health clinic, to get orientation from a specialist (...).

In these statements it is seen that users are concerned with their symptoms that sometimes persist for a period beyond the expected, which makes them define their problem as an emergency and assess need immediate assistance through the medical consultation (the emergency room type), both in primary healthcare services as well as directly in public hospitals.

Pain is considered a genuinely subjective and personal experience, and there is no standard

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Perception of family health strategy... instrument that allows an external observer, in the case of the healthcare professional to objectively measure this internal and complex experience. According to the same author, pain is considered the fifth vital sign, as important as the others, and should always be evaluated in a clinical setting in order to understand the therapeutic conduct.^{43-44:}

In relation to trauma/injury, some subjects reported as the underlying cause that motivated to seek emergency treatment in the FHU. These trauma/injuries ranging from serious accidents such as the automobile (car and motorcycle) to mild traumas as falls from bicycles and dog bites, as reported below:

I was grazed on the arm in a motorcycle accident. (...) It was a car accident on the road (...) I went to the clinic due to some injuries caused by a bicycle fall (...) I hit my head in a bicycle fall, then I tried the emergency on at a health clinic (...) It was a bite from a dog on the street (...) I had a bike accident and I went to the clinic to dress the wound (...).

Traumatic injuries are seen and felt by all, the physical, emotional, financial and material damages that trauma causes, has a strong impact on society, both for the victim, family or the family or health team which they belong.⁴⁵

Other users revealed acute crisis of chronic diseases such as Diabetes Mellitus (DM) and Hypertension (HBP), are grievances that have integrated prevention and care actions that occur primarily in FH, being frequent urgencies in the daily life of the FHU, as reported in the following:

I was feeling weak, I have diabetes (...) It was a diabetes crisis (...) It was a high-pressure problem (...) in my case; I think it was pressure, high pressure (...).

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The epidemiological, economic and social analysis of the growing number of people who are living with or at risk of developing hypertension and DM establishes the need to set up programs and public healthcare policies that minimize the difficulties of these people, their families and their friends, and promote maintenance in the quality of their life. This policy works as the Health System port of entry and where the community character actions possibility show themselves as being much more effective and associated with an increase in the prevalence and complications of HBP and DM.⁴⁶

It became evident that the presence of fever and respiratory problems were important factors for mobilizing demand and the urgency and emergency care in Primary Care, as described below.

I went to the health clinic, when my son was ill with diarrhea (...) I tried the clinic because my daughter had an asthma attack and was coughing a lot (...) I went to the health clinic that my granddaughter was had a high fever (...) My daughter had an inflammation in the throat, much pain accompanied by fever and with a tight chest (...).

Other studies on the demand for these services point to fever and respiratory problems as the main complaints for similar results.^{37, 47} Although fever is not always considered by health professionals as a sign of seriousness and technically alone does not justify seeking service as an emergency, for the mothers it is from concern and anxiety.⁴⁸

Class 4 - Understandings of the meaning of urgent and emergency care to the Family Healthcare user

Class 4, directly associated to classes 2 and 3, consisting of 13 ECUs, concentrates 26.53% of the classified ECUs. Here, the words (cared for, J. res.: fundam. care. online 2013. dec. 5(6):169-186

Perception of family health strategy... immediate, emergency, fast and understand), were selected by frequency and by values of χ^2 higher in class, as shown in Figure 1. In this category sought to learn the user's understanding of FH on the "urgent and emergency care" situations. It addresses the knowledge and meaning that the user assigns to these situations in their own words.

However, it is necessary to define the concept of urgent and emergency care that shows to be inaccurate to the point raising doubts about the definition of a meaning with common sense and working with users and service providers

Urgency is an unforeseen occurrence of a health problem with or without potential risk to life, whose bearer needs immediate medical assistance. A medical emergency is the finding of a health condition, which imply in imminent risk of life or intense suffering, thus requiring immediate medical treatment.⁴⁹

For the Ministry of Health Urgencies are situations that present a change in health status, but without imminent risk of life, which by its severity, discomfort or pain, require medical care as soon as possible. The time to resolution can vary from several hours up to a maximum of 24 hours. Emergencies: are situations that present a change in health status, with an imminent life risk. The time to resolution is extremely short, typically quantified in minutes.⁵⁰

Given the diversity of terminology among physicians and the health system, the proposal found in the Medical Regulation of Urgencies is that if one comes to adopt in the country only the term urgency for all the acute cases, which require care. It is also suggested the establishment of a multi factorial assessment which incorporates the degree of urgency the severity of the case, the treatment start time, the resources needed to treat and the social value that involves each case.⁵¹

However, according to Le Coutour, the expanded concept of urgency differs depending on

Moura LRP, Rocha ESB, Moura MEB *et al.* who perceives or feels it: for the users or relatives it can be associated with a disruption in the order of the course of life, related to what is unexpected and that cannot wait. For health professionals, the dimension of urgency relates to vital prognosis at a certain time interval. For institutions, urgency corresponds to a disturbance in their organization, namely, that which cannot be predicted.⁵²

In this regard, the manifestations of subjects allowed identifying several central ideas related to the understanding, which users have on the meaning of “urgency”, giving origin to the collective statements.

The statements of the users indicate different perceptions on the urgency situations, which vary in accordance with the user's health problems. The urgency situations may be related to the need for immediate and fast service as well as the onset of signs and symptoms suddenly are defined as urgent, suggesting the need for immediate assessment by healthcare professionals, seen to the requester as worrying signs.

I understand that urgency is that you're feeling a pain; upon arriving at the clinic you are immediately cared for (...) I understand that an urgency is being quickly care for. Because the situation is serious, I needed faster care (...) I believe that it is when the person arrives at the healthcare clinic and be immediately seen (...) Urgency Care is one that when you arrive you are immediately seen and well received at the health clinic, in the hospital.

Some users believe that urgency is to achieve an “appointment” to consult with the doctor and appropriately conduct an urgency situation at the FHU:

It is that you arrive, sit down, your appointment is scheduled and you will be seen quickly for

Perception of family health strategy... sure (...) This is how you arrive, get care from a doctor, and he is able to meet the entire population (...) It is when we arrive at the clinic when find out if they have space or not (...).

For others, the meaning of urgency can relate to everything that is not good, in this sense, any situation can be an urgency that demands care and may be a routine consultation or even preferential care.

It is a necessary care when someone needs it. (...) According to your need. I felt bad and wanted to know what was happening. Finally, faced with the situation, I go to the clinic and demand this type of care (...) It is when you arrive and have preferential service, i.e., being one of the first seen (...).

The perception of urgency is formulated by the requester. For users it is linked to the general context in which the symptom or health problem manifests and for professionals is defined based on the severity of the cases and in biomedical knowledge. Sometimes, the conception of the urgency care is distinct in the vision of the users and health professionals. The demands of urgency situations are linked to individual or specific criteria of social groups that, through the sense of urgency, define what care will be sought by the user from the service.⁵²

These aspects indicate that the sense of urgency is grounded in situations, not always consistent with the biological manifestations of greater severity, but are linked to criteria and needs of those requesting the care.³⁷

The perception of symptoms such as loss of health creates anxiety, especially when the user is unaware of what may be happening, so the dialogue with a healthcare professional helps in decision-making and gives them security.⁵³

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In relation to the emergence of the statements of the users are diverse and are linked to problems and health needs that range from the risk to life to situations of low complexity and severity, confused with urgency.

Emergency is this, it is to arrive serious and be seen immediately (...) I believe that urgency, is when the person seeks care and they want to be seen quickly (...) it is the person that is really bad. In the case of an accident, the person arrives all broken, and then they have to have urgent care. This is the emergency (...) an emergency is care that needs to be as quick as possible (...).

The concepts of urgency and emergency care are often confused not only by the laymen public, but also by professionals involved in the healthcare industry. Therefore, their definition is critical for adequate decision making in the organization of this type of care.⁵³

The scope of such interpretations and understanding of the concept of urgency/emergency care by the person who solicits the care (patient or family) should be considered by professionals who work in the area, because successful personal experiences and accurate critical sense are not conditions, that alone are able to solve these cases.

CONCLUSION

This study allowed us to assess and seize the praxis of urgent and emergency care performed in SF, by analyzing the users' perception of the Family Health Strategy in relation to the systematic reception with risk and vulnerability assessment. It can be analyzed from the reports of the subjects of this research the user satisfaction with urgent / emergency care within the FH, the conditions of the J. res.: fundam. care. online 2013. dec. 5(6):169-186

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structure of FHU for the reception this in health care situations which cause them to seek this type of care and the meaning of urgent and emergency care for the FH user.

In relation to the user's satisfaction with the urgency /emergency care in FH, it was found that the satisfaction with the care produced, taking into account their needs. However, it was evident that the organizational aspect of the FHS contribute to the dissatisfaction of users, and may cause a distancing between the team and the users, discontinued service and migration of users to other levels of care. These factors undermine the effectiveness and resolving capacity of FH in the municipality.

When characterizing the conditions the structure of the FHU for the reception of urgency and emergency care, based on the narratives of users, the realities of divergent care are seen. While some FHU have a good physical structure (although it is not adequate for the service according to the stratification of the need of the user, through risk assessment and vulnerability), instruments and adequate equipment, materials and supplies in sufficient quantity to meet the demand and the urgency and emergency care situations. Other FHUs experience the precariousness of physical space, shortage of human resources (doctors) and lack of supplies, materials and equipment to carry out their activities in urgency and emergency care. Thus, these barriers limit the user assistance safely and continues in addition to it is not in line with the guidelines and PNAB of the Decree GM/MS No. 2048.

In addition, it was mentioned the discontent with the technical preparation of healthcare professionals and the criteria used by these in the provision of care, which should be improved. It is believed that it is necessary qualification of professionals who provide care in the primary care network to ensure that they are open to dialog and available to listen to the health needs of users who

Moura LRP, Rocha ESB, Moura MEB *et al.* are seek care within the service. In the sense that even when the medical professional is not available to provide care, the other healthcare staff are able to perform care according to their level of competence, ensuring that all users who seek the FHU are received.

Regarding the health situation that led the user to seek emergency care and emergency at the FHU, the situations were varied. They can be classified by situations that involve pain, trauma/injury, arterial hypertension and decompensated diabetes and pediatric emergencies, such as fever, diarrhea and respiratory insufficiency. It is concluded that the users are concerned with their symptoms that sometimes persist for a period beyond the expected, looking for this urgency and emergency care in the USF and by being close to their residence and with the purpose of solving their needs, even though meeting these needs is not guaranteed because of the weaknesses of the FHU.

The conception of users on the meaning of urgency and emergency care they have different perceptions on the urgency situations, which vary in accordance with the user's health problems. Thus, urgency care situations may be related to the need for immediate and fast service as well as the onset of signs and symptoms suddenly are defined as urgent, suggesting the need for immediate assessment by healthcare professionals, seen to the requester as worrying signs.

This study it is expected to contribute to the development of healthcare actions, because there is still much to be worked out in terms of reception in urgency and emergency care in the FH. Namely, being permanent education, supervision and institutional support, with a view to effectively qualify the care, achieving the completeness and solvability of care, contributing to the achievement of a humanized model idealized by the SUS guidelines, focusing all the actions on user needs. Thus, it is understood that this research does not

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Perception of family health strategy... exhaust the topic on the reception in the emergency care services in the perception of the user, and allows to instigate other researchers to continue the subject in future investigations.

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