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RESEARCH

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MOTIVATIONS OF USER ACCESS IN SITUATIONS CHARACTERIZED AS NON-URGENT READY

Motivações do acesso de usuários em situações caracterizadas como não urgência em pronto atendimento

Motivaciones de acceso del usuario en situaciones caracterizadas como listo no urgente

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ABSTRACT

Objective: to identify the reasons why users in situations characterized as non-urgent access the Emergency Service in a municipality in the state of Rio Grande do Sul. **Method:** this is a descriptive and exploratory study, developed from a qualitative approach. Data were collected through semi-structured interviews with 21 users of an Emergency Department in a municipality in the state of Rio Grande do Sul (RS), in November 2016, and submitted to content analysis, thematic modality. **Results:** they point out that Primary Care has not been effective as a gateway to the health system. The justifications for seeking emergency services were: lack of medical professionals in health units; Basic Health Unit with little resolution; inadequate opening hours for users; queues; greater demand than supply in relation to medical consultations; ease in performing exams and receiving medication. **Conclusion:** users' access to health services must permeate health planning, preferably at the local level, in order to allow the definition of actions that are applicable in accordance with the reality of the community.

DESCRIPTORS: Health services; Health services needs and demand; Emergency medical services; Nursing; Emergencies.

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RESUMO

Objetivo: identificar os motivos pelos quais os usuários em situações caracterizadas como não urgentes acessam o Pronto Atendimento em um município do estado do Rio Grande do Sul. **Método:** trata-se de um estudo descritivo e exploratório, desenvolvido a partir de uma abordagem qualitativa. Os dados foram coletados mediante entrevista semiestruturada com 21 usuários de um Pronto Atendimento em um município do estado do Rio Grande do Sul (RS), em novembro de 2016, e submetidos à análise de discurso. **Resultados:** apontam que a Atenção Primária não tem sido efetiva como porta de entrada para o sistema de saúde. As justificativas pela busca ao serviço de urgência foram: falta de profissional médico nas unidades de saúde; Unidade Básica de Saúde com pouca resolutividade; horário de funcionamento inadequado aos usuários; filas; demanda maior que a oferta em relação às consultas médicas; facilidade em realizar exames e receber medicação. **Conclusão:** o acesso dos usuários aos serviços de saúde deve permear os planejamentos em saúde, preferencialmente a nível local, de modo a permitir a definição de ações que sejam aplicáveis em conformidade com a realidade da comunidade.

DESCRITORES: Serviços de saúde; Necessidades e demandas de serviços de saúde; Serviços médicos de emergência; Enfermagem; Emergências.

RESUMEN

Objetivo: identificar las razones por las cuales los usuarios en situaciones caracterizadas como no urgentes acceden al Servicio de Emergencia en un municipio del estado de Rio Grande do Sul. **Método:** se trata de un estudio descriptivo y exploratorio, desarrollado a partir de un enfoque cualitativo. Los datos fueron recolectados a través de entrevistas semiestructuradas con 21 usuarios de un Servicio de Emergencia en un municipio del estado de Rio Grande do Sul (RS), en noviembre de 2016, y sometidos a análisis de contenido, modalidad temática. **Resultados:** señalan que la Atención Primaria no ha sido eficaz como puerta de entrada al sistema de salud. Las justificaciones para buscar servicios de emergencia fueron: falta de profesionales médicos en las unidades de salud; Unidad Básica de Salud con poca resolución; horarios de apertura inadecuados para los usuarios; colas mayor demanda que oferta en relación a consultas médicas; facilidad para realizar exámenes y recibir medicamentos. **Conclusión:** el acceso de los usuarios a los servicios de salud debe permear la planificación de la salud, preferiblemente a nivel local, para permitir la definición de acciones que sean aplicables de acuerdo con la realidad de la comunidad.

DESCRIPTORES: Servicios de salud; Necesidades y demandas de servicios de salud; Servicios médicos de emergencia; Enfermería; Urgencias médicas.

INTRODUCTION

Redes de Atenção à Saúde (RAS) are defined as a set of health services linked from a single mission, with common objectives and a cooperative and interdependent action, coordinated by primary care and provided in a humanized manner and with health and economic responsibilities, being fundamental that the different levels of care are integrated. From this perspective, emergency care should be organized in networks through organizational arrangements of health actions and services, with different technological densities, which, integrated by technical, logistic and management support systems, aim at guaranteeing integral care to users.[1]

To this end, on December 30, 2010, Ordinance No. 4279 was launched in Brazil by the Ministry of Health (MS), which outlines the guidelines for structuring the RAS, which aims to promote the integration of health actions and services through continuous, comprehensive, responsible, humanized and quality care, as well as to increase the performance of the Unified Health System (SUS) in terms of access, equity and clinical, health and economic effectiveness.[2]

In 2011, through Ordinance No. 1600/2011, the MS reformulated the National Policy for Emergency Care and established the Emergency Care Network (RAU) in the SUS. The RAU is then organized by the following elements: promotion, protection, and surveillance; Primary Health Care (PHC); Serviço Móvel de Atendimento às Urgências (SAMU) and Regulation Centres; Stabilization Room; National Health Force of the SUS; Unidade de Pronto Atendimento (UPA); and set of 24-hour hospital and home emergency services.[3]

In this context, the Emergency Room (PA) is recognized as a service of intermediate complexity between the PHC and the hospital network, established with the purpose of attending to emergencies and emergencies as a support network for PHC, attending the population on weekends and at night, due to the fact that the basic units are closed, articulating with the PHC, SAMU, hospital units, diagnostic and therapeutic support units and with other RAS services by means of flows and counter flows.[3]

However, emergency services have provided an increasing amount of care, often classified as non-urgent. Because of this, the RAS proposal is uncharacterized and fragmented, in addition to dissociating the user from the reference team with regard to Primary Care.

From this perspective, this study aimed to identify the reasons why users in situations characterized as non-urgent access the Emergency Room in a city in the state of Rio Grande do Sul.

METHODS

It is a descriptive and exploratory study, developed from a qualitative approach. The scenario of this investigation was the Ready Attendance of a municipality in the state of Rio Grande do Sul (RS), Brazil, geographically located in the central region of the state. This scenario has a well-distributed physical structure and is composed of a multiprofessional team, counting on nurses, doctors, pharmacists, nursing technicians, assistance agents and receptionists.

In 2014, the implementation of the Manchester Risk Classification Hosting Protocol, as well as the Sistema de Informação (SIGSS), including the electronic record, through which monthly data is updated by means of reports sent to the management of the Health Department of the municipality and monitoring by the Municipal Health Council.

For this purpose, a semi-structured interview composed of closed and open questions, previously established and according to the proposed objectives, was used as a tool for

data collection. This instrument enabled the characterization of the research subjects and presented the following guiding question: "What is the reason that brought you to the Municipal Emergency Room?

The criteria for selecting the interviewees were: users present in the waiting room who had registered for service and were waiting for reception or who had already been received, not having been classified in the reception due to urgency and emergency situation. As exclusion criteria, users with cognitive/mental limitation and under 18 years old. Still, there was no delimitation of the sample, and data collection was interrupted when there was saturation of information. The collection period was November 2016.

After data collection, they were submitted to discourse analysis.[4] The ethical aspects ensured confidentiality, anonymity, voluntariness, and protection of subjects regarding their rights to information. Participants were identified by pre-established codes, with the letter U followed by a number, the letter "U" being the representation of the word User, thus ensuring the anonymity and confidentiality of participants.

The study followed all the recommendations contained in Resolution 466/12 of the National Health Council, approved on November 9, 2016, by means of Certificate of Presentation for Ethical Appreciation (CAAE) No. 61368516.8.0000.5346, from the Federal University of Santa Maria and Opinion No. 1.812.332.

RESULTS AND DISCUSSION

After the data analysis, the Registration Units that were detached from the text corpus were used to describe and present the results.

Twenty-one users were interviewed, nine (42.85%) men and 12 (57.14%) women aged between 18 and 70. The fact that most of the interviewees were female may be related to the cultural issue of caring for women who seek health services more often. This occurs because of the stereotype of women as "fragile sex", as opposed to "strong" men.[5] In society in general, there is a production of intense self-care practices for women from a very early age, since their bodies are seen as vulnerable and future reproducers.[6]

Regarding schooling, 18 (85.71%) participants have completed high school and three (14.20%) elementary school. In relation to occupation, 15 (71.40%) are trade workers in general, three (14.20%) self-employed and three (14.20%) unemployed at the moment. The question of the greater number of interviewees working on the commerce can be justified by the equivalence of their working hours and health unit working hours and by the fact that there is no alternative to the attendance, except for the search for the service which works 24 hours, as the PA. Thus, the attendance of Basic Health Units (BHU) in extended hours is seen as a possibility of expanding the access.

However, this extended hours model, despite guaranteeing assistance by a health professional, seems to favor the break in the continuity of care, because on weekends and night hours, after 7 pm, the user's chance to be assisted by his own family doctor, or by his team, is small. This problem would be reduced if BHU hours were extended to more hours at night or on weekends.[7]

Of the total number of interviewees, 17 (80.90%) were not able to report which was their reference health unit. In view of this, it can be seen that the incorporation of the principle of social participation, co-responsibility, and communication within the SUS in that municipality is quite incipient. The reference unit refers to the regular use of the service by the population, aiming at strengthening the link and continuity of care to the user. Thus, the link between professionals and users promotes conditions to face and solve health problems from the perspective of the responsibility of a certain population, favoring the approximation with families in their territory and resulting in better living conditions.

It is known that the municipality is divided into sanitary regions and that all of them have BHU as reference for users. In this way, the team needs to involve users in the discussions of work processes in the units in the territory that are responsible, since this fact would contribute to extract the user from a position of those who patiently wait for their health needs to be met.

When questioned about the main complaint that had led them to search for the PA, nine (42.85%) cited pain, five (23.80%) mentioned exams, three (14.28%) reported fever, two (9.52%) cited diarrhea, and two (9.52%) cited vomiting. The culture of seeking PA services for situations that should be resolved by PHC is frequent in the Brazilian health system. All these cases could be solved by UBS, considering the organization of the work process to solve 80% of health needs. If the needs are not met, consequently the user is referred to services of higher technological density.[8]

From the point of view of the interviewees, PHC has not effectively been the gateway to the health system, but rather the emergency services, represented by the capacity of these services. The reasons that justified the demand for the PA service, evidenced in this study were: lack of medical professional in the health units; UBS with little resolution; inadequate working hours for users; early lines; demand greater than the offer in relation to medical consultations; ease in performing exams and receiving medication.

In this sense, PHC should perform functions to contribute to the functioning of the RAS, such as being the basis for the health service, being resolute, coordinating care through communication between the various points of attention, ordering the networks recognizing the health needs of users.[9]

However, health care oriented by the biomedical model continues to be strengthened in terms of the organization of health services, with an emphasis on technicalism and specialization, and with a reductionist vision of care focused on the disease. The proposal is that the conception of health be guided by the social determinants of health and disease and that PHC assume a privileged space to consolidate a

model of health care in which the social and family context is considered in an integral way. To this end, the challenge is to transform primary care focused on resolutive care for the user.[10-11]

Similarly, replacing disease-focused care with work focused on health surveillance, the Política Nacional de Atenção Básica (PNAB) created by Ordinance No. 2436 of 2017, establishes that health services must enable universal and continuous quality access and be resolute and, therefore, characterized as an open and preferential gateway to the care network.[9]

However, this fact does not occur in practice due to the limitation of primary care services, resulting in emergency and emergency services being used as entry doors. As a result, the PA environment is marked by the agglomeration of users, causing direct interference on the services.[4]

This study pointed out that the user who accesses the PA understands this service as resolutive and starts to consider it as a preferential entrance door, as illustrated in the following speech:

> [...] *there [Health Unit] doesn't have exams, there's nothing, so we come here, it takes time, but we leave with everything ready, even medicine sometimes*". (U1)

The way in which the attention network is organized and the quality of the service provided to the user are related to the completeness of the care and also to the resolutiveness of the service.[12] Resolutiveness is defined by the final resolution of the problems brought by the users to the service they have accessed and to their satisfaction.

> "*Here the service is faster, even if we have to wait, we leave with everything ready.* (U2)

> *"The service is faster and closer to my service." (U3)*

The performance of certain tests in the service itself, were also related as a reason for users' demand to the PA service and the presence of this offer, consequently, interferes in the choice for accessing this type of service. It is evident that the prescription of medications and exams, in the form of conduct, reinforces the model of care based on complaint-conduct, seeking to meet the health needs brought by the users and that the performance of the exam itself is perceived as an attitude of care by the users. However, these behaviors express "resolution" in the short term, a fact that explains the subsequent returns of the same users to the PA.

> *"[...] there [health unit] doesn't have a doctor, there's no medicine, there's a lot missing there, there's no pediatrician, I've been waiting for my son's appointment for a month and a half [...] there they asked for X-ray, and for the post, it takes 4 months for SUS, there's a queue of people*". (U6)

> "*[...] because here they do RX and exams, so I don't have to move from home again*". (U15)

The delay for the service, due to the fact that the consultation is scheduled in certain BHU, as an attempt to reorder the demand, seems to be unclear to the user:

> *[...] "how are we going to guess when you are going to get sick? They want us to schedule it. It takes a long time here, but we'll be taken care of".* (U16)

Users understand that access in the context of APS is time-consuming, considering the waiting time from scheduling to the day of the consultation and attribute these difficulties to the lack of medical professionals. Reception is a device to operate work processes and is considered a space to listen to problems and guide users, but is criticized by them for controlling what is most expected, the consultation with the doctor.[13] The demands of users are linked to individual or specific criteria, which, through the perception of urgency, define the type of service that will be sought. Therefore, users adjust the PA service offer to their vital, family or work context, structuring, from then on, their demands. In a study developed in the same municipality in 2015, it was found that most individuals consider their clinical condition as a situation of urgency or emergency, although the predominant reason for consultations in the PA is not compatible with a situation of aggravation to health.[14]

> [...]" *at the post there is no doctor, I have a headache and fever, so you get a chart to be seen next week, but I can't wait, my pain is today*". (U9)

> [...] *"in PA the service is faster, I know that here is an emergency, but in my case when I give these crises of stronger column I come here [...] the service, even if it takes an hour, an hour and a half, I leave attended.* (U7)

Users demonstrate that the search for the service is motivated by the speed and promptness of the service offered, being able to transport the user to a service that corresponds to the person's health need. From this perspective, it is understood that it is necessary to organize the work process in the services with greater responsibility on the part of the professionals to facilitate access and welcome all users who seek care in PHC, prioritizing those in situations of frequent search for emergency services in non-urgent situations.8

In this study, it was also found that there is an association between quality of care and speed with which the user is served in the PA, as expressed in the following speech:

> [...] *"The service here is better, we get there fast, there is very long, the service is good here, I don't go there at the station, me and mother try to come here, no matter how long it takes, it solves*". (U9)

[...] *"I look more for prompt service, many people complain about the service, but I don't have a complaint, at least I've always been well attended, it can take a while, but I am attended"*.(U12)

It was noticed in the above reports that user satisfaction is directly related to the guarantee of care, even if the waiting time for care represents a difficulty to be faced. The following statements reveal that the users consider themselves dissatisfied with the quality of the service provided in Primary Care.

"Because there [Health Unit] is a fight to be served, it is horrible, very poorly served. (U10)

[...]" *they seem to have a bad will to serve us"*.(U4)

It is clear that the quality of assistance represents one of the most important principles of primary care in Brazil. It is noticeable that many studies dealing with quality in PHC come from evaluations of the Programa Nacional de Melhoria do Acesso e Qualidade da Atenção Básica (PMAQ-AB), and they bring several approaches of quality of health care in the scope of the Estratégia Saúde da Família (ESF), and there is a consensus that access is quality and quality is a process. Quality verifies the capacity of the SUS to respond to users' health needs.[15]

In this bias, it is important to consider that although the user evidences that he/she knows the conditions of territorial logic and the concept of doorway to primary care, he/she looks for the service in which he/she perceives his/her health need to be met.

[...] *"what am I going to do there?! Hand has nothing."* (U11)

[...] "*the doctors there [Health Unit] only give us paracetamol to take, here we are very well taken care of..., I have a lot of back pain, and it wasn't going to solve my problem*". (U13)

When discussing access, the users' speeches demonstrate that the logic of service in the PA makes it faster, by the fact that they arrive at the place, make a registration and wait for their service. Differently, the service at UBS requires that users go to the place at dawn to schedule the consultation, and this occurs according to the order of arrival and not by principle of risk classification or equity. In addition, the user mentions certain fear in relation to possible risks in the early morning lines.

[...] "I've been to the station several times, they decide but the schedule has to wake up very early, if there's a way for you to get there and be taken care of, if you get there too late you can't get a chart". (U5)

In health services based on the condition of early risers, the strongest are especially attended and the most needy are excluded. This situation represents an unworthy condition imposed by the health service, and is contrary to the guidelines and principles of the SUS.[16]

[...] "sometimes you have more chips, but you have nowhere to wait you have no cover... and if you arrive at 5 o'clock you have no more chips, it's very dangerous to go at dawn and the villages are dangerous because you have to practically sleep in line". (U20)

[...] "I came first because it is closer to the service, and many times in the units we have to get up early to go, and I have to go to work, sometimes I prefer to go to the service to communicate the boss and I came to PA". (U17)

Some devices have been formulated and implemented to operate health work, such as the reception with risk classification, which presents the inversion of the organization logic and the operation of the health service. The reception makes the service humanized, which presupposes the guarantee of access to all people. It also involves qualified listening to the user's health problems, with responsibility for solving their problem.[17]

It is worth mentioning that the spontaneous demand reception and emergency care in a BHU is different from the care in PA, because PHC directs the work process to the team, knows the population, has records in medical records before the acute complaint, allows the return with the same health team, accompanies the staff and the establishment of a bond, conditions that characterize the continuity of care, and not only a punctual care.[18]

However, the following reports demonstrate the fragility of this device in the Primary Care scenario, both in relation to the work process and the lack of knowledge of the users in relation to the reception proposal.

[...] "there's never anything there, there's no doctor, and when someone comes to pick us up, they don't pay attention to us". (U21)

[...] "so we come here, we are passed on by the pain, we take medication and go away until the next pain comes, they talk here that they can't forward too". (U17)

The reception is a tool in charge of qualifying the health services, enabling the user to have a full and fair service, and

effective the constitutional principles of SUS. However, it is still necessary to qualify the way it operates, since, if used in a disjointed and punctual manner, it can be summarized to the activity of screening and uncharacterized of its first function: humanization.[10]

The results obtained in this survey demonstrate the dissatisfaction of users in relation to various aspects of care, such as the organization of services. Numerous complaints were observed regarding the service, among which the following stand out: demand greater than supply, poor infrastructure, lack of human resources and humanization in the service. Although some users classify health services in general as "slow, but it is attended to", in their reports, the complaint prevails.

Thus, assessing the reason for users' access to a given health service, such as the PA, is a sensitive indicator to monitor the services offered by the public health system. In this sense, it is worth mentioning that the issue of access has to be constantly approached on health stages and that the local manager needs to be the mediator and mobilizer of this discussion, but to overcome the limits, it is necessary to go beyond the discussions. Access should permeate health planning, preferably in a local way, in order to allow the definition of actions that are applicable according to the realities of the communities, but it is up to all players involved in health work to (re)think and establish better ways of access, according to the health needs of users.

CONCLUSION

This study identified that the demand for health services involves factors that, depending on how they are ordered, will define the choice by the user. For the interviewees, the PA concentrates the greatest possibility of door entry, and corresponds to the possibility of meeting the demands in a more agile and concentrated way. Despite being overcrowded, and acting on the main complaint, these services gather a sum of resources, such as consultations, medications, procedures, laboratory exams, and hospitalizations, while the health units have a lack of medical professionals and offer consultations with defined numbers of records or scheduling of non-reception appointments with risk classification.

There was a negative evaluation of the Health Units of the municipality by the users of the public network. As a potentiality of the study, this perception of the user may be useful when dimensioning the actions developed in the health sector, in order to contribute to the planning of services. Therefore, it is expected that this study may contribute to the discussion among workers, users and managers about negative points and redirect alternatives to improve the local health system.

REFERENCES

1. Universidade Federal do Maranhão. Redes de Atenção à Saúde: a atenção à saúde organizada em redes. UNA-SUS/UFMA. [Internet]. 2016 [acesso em 27 de outubro 2020]. Disponível em: https://ares.unasus.gov.br/acervo/handle/ARES/2444?mode=full.
2. BRASIL. Ministério da Saúde. Portaria nº 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União, 31 fev 2010; Brasília; 2010; Seção I, p. 88-93.
3. BRASIL. Portaria nº 1.600, de 7 de julho de 2011. Reformula a Política Nacional de Atenção às Urgências e institui a Rede de Atenção às Urgências no Sistema Único de Saúde (SUS). Diário Oficial da União, 08 jul 2011; Brasília; 2011; Seção I.
4. Cassetari SSR, Mello ALSF. Demanda e tipo de atendimento realizado em unidades de pronto atendimento do município de Florianópolis, Brasil. Texto & contexto enferm. [Internet]. 2017 [acesso em 27 de outubro 2020]; 26(1). Disponível em: http://dx.doi.org/10.1590/0104-07072017003400015.
5. Bardin L. Análise de conteúdo. São Paulo: Edições 70. 2016
6. Botton A, Cúnico SD, Strey MN. Diferenças de gênero no acesso aos serviços de saúde: problematizações necessárias. Mudanças. Psicologia da Saude (Online). [Internet]. 2017 [acesso em 30 de outubro 2020]; 25(1). Disponível em: https://doi.org/10.15603/2176-1019/mud.v25n1p67-72.
7. Pessoa BHS, Gouveia EAH, Correia IB. Funcionamento 24 horas para Unidades de Saúde da Família: uma solução para ampliação de acesso? Um ensaio sobre as "Upinhas" do Recife. Rev. bras. med. fam. comunidade. [Internet]. 2017 [acesso em 30 de outubro 2020]; 12(39). Disponível em: https://doi.org/10.5712/rbmfc12(39)1529.
8. Gomide MFS, Pinto IC, Bulgarelli AF, Santos ALP, Gallardo MPS. User satisfaction with primary health care: an analysis of access and care. Interface (Botucatu, Online). [Internet]. 2018 [cited 2020 oct 30]; 22(65). Available from: https://doi.org/10.1590/1807-57622016.0633.
9. BRASIL. Ministério da Saúde. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União, 22 set 2017; Brasília; 2017; Seção I, p.68.
10. Coutinho LRP, Barbieri AR, Santos MLM. Acolhimento na Atenção Primária à Saúde: revisão integrativa. Saúde debate. [Internet]. 2015 [acesso em 30 de outubro 2020]; 39(105). Disponível em: https://doi.org/10.1590/0103-110420151050002018.
11. Forte ECN, Pires DEP, Scherer MDA, Soratto J. Muda o modelo assistencial, muda o trabalho da enfermeira na Atenção Básica? Tempus (Brasília). [Internet]. 2018 [acesso em 30 de outubro 2020]; 11(2). Disponível em: https://doi.org/10.18569/tempus.v11i2.2338.
12. Costa JP, Jorge MSB, Vasconcelos MGF, Paula ML, Bezerra I C. Resolubilidade do cuidado na atenção primária: articulação multiprofissional e rede de serviços. Saúde debate. [Internet]. 2014 [acesso em 30 de outubro 2020]; 38(103). Disponível em: https://doi.org/10.5935/0103-1104.20140067.
13. Silveira CB, Costa LSP, Jorge MSB. Redes de Atenção à Saúde como produtoras de cuidado em saúde mental: Uma análise reflexiva. Rev. port. enferm. saúde mental. [Internet]. 2018 [acesso em 30 de outubro 2020]; 19. Disponível em: http://dx.doi.org/10.19131/rpesm.0203.
14. Otaviano MDA, Gonçalves KG, Pereira RCC, Felix TA, Dias MAS, Oliveira EN. Tecendo informações sobre o serviço pré-hospitalar: relato de experiência. Sanare (Sobral, Online). [Internet]. 2016 [acesso em 30 de outubro 2020]; 15(1). Dispon[ivel em: https://sanare.emnuvens.com.br/sanare/article/view/934.
15. Facchini LA, Tomasi E, Dilélio AS. Qualidade da Atenção Primária à Saúde no Brasil: avanços, desafios e perspectivas. Saúde debate. [Internet]. 2018 [acesso em 30 de outubro 2020]; 42(n. especial). Disponível em: https://doi.org/10.1590/0103-11042018s114.
16. Nonnenmacher CL, Weiller TH, Oliveira SG. Acesso a saúde: limites vivenciados por usuários do SUS na obtenção do direito. Ciênc. cuid. saúde. [Internet]. 2011 [acesso em 30 de outubro 2020]; 10(2). Disponível em: https://doi.org/10.4025/cienccuidsaude.v10i2.10106.

17. Oliveira JLC, Gatti AP, Barreto MS, Junior JAB, Góes HLF, Matsuda LM. Acolhimento com classificação de risco: percepções de usuários de uma unidade de pronto atendimento. Texto & contexto enferm. [Internet]. 2017 [acesso em 30 de outubro 2020]; 26(1). Disponível em: https://doi.org/10.1590/0104-07072017000960014.

18. Rodrigues JB. O Acolhimento na Atenção Básica: desafios e avanços no Município de São Bernardo do Campo – SP. [Mestrado Profissional em Saúde Coletiva]. São Paulo (Brasil): Coordenadoria de Recursos Humanos da Secretaria de Estado da Saúde de São Paulo; 2018. [acesso em 30 de outubro 2020]. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1008025.

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