Revista de Enfermagem e Atenção à Saúde
REAS

ORIGINAL ARTICLE
DOI: 10.18554/reas.v11i1.4760
e202139

UNDERSTANDING OF HEALTH PROFESSIONALS ABOUT A MUNICIPAL URGENCY AND EMERGENCY NETWORK

COMPREENSÃO DOS PROFISSIONAIS DE SAÚDE SOBRE UMA REDE DE URGÊNCIA E EMERGÊNCIA MUNICIPAL

COMPRENSIÓN DE LOS PROFESIONALES DE LA SALUD SOBRE UNA RED MUNICIPAL DE EMERGENCIAS Y EMERGENCIAS

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How to cite this article: Santos IN, Silva RML, Silva RKV, Santos AKT, Carvalho MRP, Lopes LASL, Canto MOM, Pinheiro RT. Understanding of health professionals about a municipal urgency and emergency network. Rev Enferm Atenção Saúde [Internet]. 2022 [acesso em:____]; 11(1):e202139. DOI: https://doi.org/ 10.18554/reas.v11i1.4760

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ABSTRACT
Objective: to assess the understanding of health professionals about the urgency and emergency network in the municipality of Camaragibe-PE. **Method:** descriptive, exploratory study of a quantitative nature, carried out at the Centro de Especialidades Médicas de Camaragibe. Sample with 255 professionals. Data collection through a semi-structured questionnaire and descriptive analysis. **Results:** the professional staff had mostly 47.6% nurses and nursing technicians, 63.6% women, aged between 30-39 years (30.1%), length of service from 1 to 5 years (31.6%) and great relationship (48.1%). Regarding knowledge about the health care network, the majority responded that they work at the secondary level (53.9%), that fixed and mobile components (77.7%) are necessary for the emergency service to exist, and that they do not know the plan emergency and emergency municipal services (73.8%). **Conclusion:** the study showed a lack of knowledge of professionals about the municipal plan of urgency and emergency of Camaragibe-PE.
Descriptors: Health Personnel; Emergencies; Emergency Medical Services; Health Policy.

RESUMO
Objetivo: avaliar a compreensão dos profissionais de saúde sobre rede de urgência e emergência no município de Camaragibe-PE. **Método:** estudo descritivo, exploratório, de natureza quantitativa, realizado no Centro de Especialidades Médicas de Camaragibe. Amostra com 255 profissionais. Coleta de dados por meio de questionário semi-estruturado e análise descritiva. **Resultados:** o quadro profissional apresentou, em sua maioria, 47,6% de enfermeiros e técnicos de enfermagem, 63,6% de mulheres, faixa etária entre 30-39 anos (30,1%), tempo de serviço de 1 a 5 anos (31,6%) e relacionamento ótimo (48,1%). Acerca do conhecimento sobre a rede de atenção à saúde, a maioria respondeu atuar no nível secundário (53,9%), serem necessários para existência do serviço de urgência os componentes fixo e móvel (77,7%), e não conhecer o plano municipal de urgência e emergência (73,8%). **Conclusão:** o estudo evidenciou déficit de conhecimento dos profissionais sobre o plano municipal de urgência e emergência de Camaragibe-PE.
Descritores: Pessoal de Saúde; Emergências; Serviços Médicos de Emergência; Política de Saúde.

RESUMEN
Objetivo: evaluar el conocimiento de los profesionales de la salud sobre la red de urgencia y emergencia en el municipio de Camaragibe-PE. **Método:** estudio descriptivo, exploratorio de carácter cuantitativo, realizado en el Centro de Especialidades Médicas de Camaragibe. Muestra con 255 profesionales. Recolección de datos mediante cuestionario semiestructurado y análisis descriptivo. **Resultados:** la plantilla profesional estuvo compuesta en su mayoría por 47,6% enfermeras y técnicos de enfermería, 63,6% mujeres, edad entre 30-39 años (30,1%), antigüedad de 1 a 5 años (31,6%) y gran relación (48,1%). En cuanto al conocimiento sobre la red asistencial, la mayoría respondió que trabaja en el nivel secundario (53,9%), que los componentes fijos y móviles (77,7%) son necesarios para que exista el servicio de emergencia y que desconocen el plan de emergencia. y servicios municipales de emergencia (73,8%). **Conclusión:** el estudio mostró un desconocimiento de los profesionales sobre el plan municipal de urgencia y emergencia de Camaragibe-PE.
Descriptores: Personal de Salud; Urgencias Médicas; Servicios Médicos de Urgencia; Política de Salud.

INTRODUCTION

Emergency is understood to be cases that require immediate care because there is an imminent risk of death. Urgency, on the other hand, presents itself in situations in which health is compromised, but without immediate risks, if not treated, it can progress to more serious or even fatal complications. Normally, situations can sometimes be urgencies or emergencies, varying according to the care and the initial approach to stabilize the condition.[1]

In the health care network, the Urgency and Emergency Services (SUE) are essential and act as "open doors". However, these units deal with a complex and unstable scenario, which involves several operating problems, such as: inadequate physical structure, high patient demand, lack of material and personnel, overload and long working hours, which can negatively impact health and interfere in the performance of the work provided by professionals.[2.3]

According to the Ministry of Health, the National Policy for Urgent Care and Emergencies (PNAUeE) was standardized and later reformulated into the Emergency Care Network of the Unified Health System (SUS) by Ordinance No. 1,600 of July 7, 2011, in which the structuring concept to be used is the expansion of access and reception to acute cases through risk classification, enabling the resolution of your problem or transporting it to a more complex service, within a hierarchical and regulated system, being links of a network for sustaining life at increasing levels of complexity and responsibility.[4]

In this flowchart conception in the integrality of care, the delay in care and the non-acceptance of spontaneous demand are factors for low user satisfaction, especially the lack of knowledge of the service flow, as they lead to high demands and waiting time in some locations, representing complicating factors for the operation of emergency units in general.[5] The identification of these obstacles and the development of strategies in order to minimize the obstacles in the consolidation of the Urgent and Emergency Care Network (RAUE) of the Unified Health System (SUS) from the perspective of health professionals allows changes to be implemented in for a holistic assistance and aimed at improving the population's quality of life. However, publications related to the theme and secondary health care are still scarce.[6]

Thus, the objective was to assess the understanding of health professionals about urgency and emergency network in the city of Camaragibe-PE. Also, characterize and identify the relationship of health workers,

verify the knowledge of professionals about the RAUE of the Unified Health System (SUS) and Emergency Care Plan (PAE), how to characterize the structure, the practice model and the work conditions. This research was developed by the Education Program through Work for Health (PET-Saúde) Redes de Atenção, associated with the National Program for Reorientation of Professional Training in Health (Pró-Saúde) in partnership with the Ministry of Health.

METHOD

This is a descriptive and exploratory study, of a quantitative nature, carried out in the three units that make up the public Urgency and Emergency network of the municipality of Camaragibe-PE, namely: Centro de Especialidades Médicas de Camaragibe - CEMEC, Centro units, Tabatinga and Vera Cruz. Data were collected in the second half of 2015.

A total of 255 health professionals from CEMECs, active and registered with the Health Department, participated in the study. This number was obtained from the formula for determining the sample based on the estimate of the population proportion and considering a confidence level of 95%. The proportion of CEMECs employees represented 21% of the civil service, considering the 1393 employees of the Health Department. The inclusion criteria were: being working in the unit referenced in the project and performing their work activities during the data collection period. While the exclusion criteria were: being away for health reasons, be involved in the production and be the author, co-author or advisor of this research.

Health professionals self-completed a quiz semi-structured study developed by the researchers and based on the foundations recommended by the scientific literature on the subject. It was divided into two sessions: the first contained a variable referring to the sociodemographic profile of the professionals (gender, age, profession, length of service, professional training, title and place of work); and the second session was relevant to the urgent and emergency service support network, to inter-professional relationships, to the professional's relationship with the user, to the perception of SUS, PAE, risk factors in the work environment, and occupational diseases.

The data collection instrument was self-completed in approximately 30 minutes at the health services during working hours, placed in a sealed and unidentified envelope, while the informed consent was returned in another unsealed envelope to ensure the confidentiality and anonymity of

the participants. Each worker was approached in turn by the authors of this research, so that the answers were not influenced, so the questionnaire was answered in a reserved environment, in an office without attendance or rest area, which would guarantee comfort and confidentiality.

Data were systematically organized in an electronic spreadsheet, paired and presented in tables with relative and absolute frequency. For this purpose, descriptive statistics and Microsoft Excel software were used.

All ethical and legal principles that govern research in human beings were complied with, recommended in the Resolution of the National Health Council No. 466/12, upon submission and approval by the ethics committee of the University of Pernambuco, CAAE number 47225615.4.0000.5192.

RESULTS

When characterizing the sociodemographic profile of those surveyed, it was found that the majority of health professionals at CEMECs perform positions of receptionist, security, cook and general services (41.3%), followed by nursing technicians (31.1%), nurses (16.5%), doctors (8.3%) and dentists (2.4%). With a predominance of the female population (63.6%), aged between 30 and 39 years (30.1%) and length of service from 1 to 5 years (31.6%). Table 1 presents the main sociodemographic characteristics of the population studied.

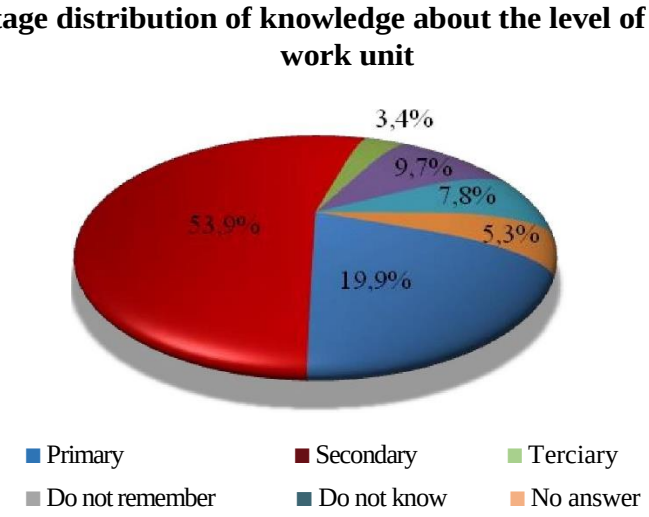
Table 1- Sociodemographic variables of health professionals from Medical Specialty Centers. Camaragibe, Pernambuco.

Variable	%
Professions	
Physician	8.3
Dental surgeon	2.4
Nurse	16.5
Nursing technician	31.1
Others	41.3
Did not answer	0.4
Gender	
Male	36.4
Feminine	63.6
Age group	
20 to 29 years	16.5
30 to 39 years	30.1
40 to 49 years	23.3
50 to 59 years	18.9
> 60 years	4.9
Did not answer	6.3
Service time	
< 1 year	30
1 to 5 years	31.6
6 to 10 years	6.8
11 to 15 years	3.9
16 to 20 years	6.8
> 20 years	3.9
Did not answer	17

Source: Survey data, 2015.

Regarding the distribution of knowledge about the level of care in the unit where they work, the secondary level (53.9%) represented the highest percentage of responses from the participants, followed by the primary (19.9%) and I do not remember (9.7%) (Graphic 1). In addition, about the components necessary for the existence of the emergency service, 77.7% answered the fixed and mobile components, 10.2% fixed, 1.5% mobile, and the rest (10.4%) did not remember, did not know, or did not respond. Moreover, with regard to knowledge about the Municipal Urgency and Emergency Plan, 73.8% responded negatively.

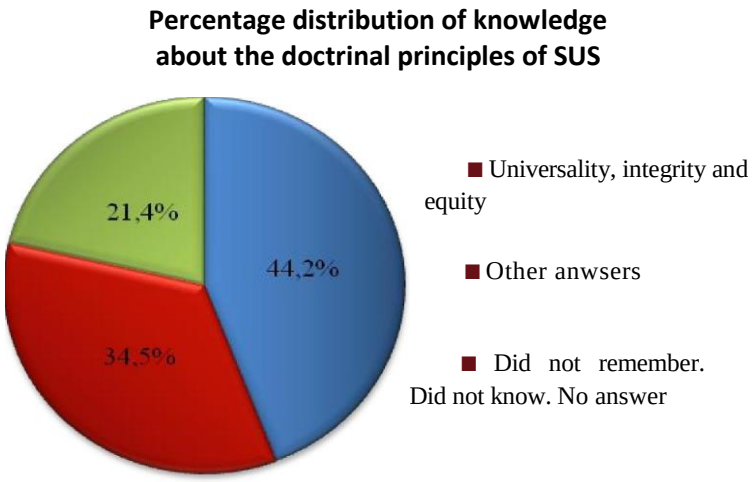
Graphic 1- Percentage distribution of knowledge about the level of care in the work unit. Camaragibe, Pernambuco.



Source: Survey data, 2015.

Finally, regarding knowledge about the law that regulates the SUS, most respondents (59.7%) indicated law 8080 of 1990. Graph 2 shows the percentage distribution of knowledge about the doctrinal principles of the SUS, the most reported that universality, completeness and equity (44.2%), while other responses with each item answered separately (34.5%) also obtained relevant value, and I don't remember or I don't know (21.4%).

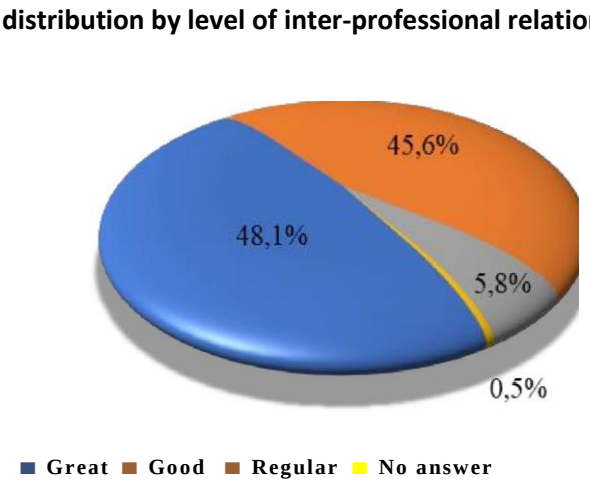
Graph 2 -Percentage distribution on knowledge about the doctrinal principles of the SUS. Camaragibe, Pernambuco.



Source: Survey data, 2015.

With regard to the interpersonal relationship of the health team within the work environment, 48.1% of professionals considered the optimal relationship (Graph 3). As well, 65% of the participants are partially satisfied with the physical conditions of the work environment, 17% totally satisfied, 13.6% dissatisfied and 4.4% did not respond; and 56.8% feel undervalued at work, against 38.8% who did not express the same opinion and 4.4% did not respond.

Graph 3 -Percentage distribution by professional interrelationship level. Camaragibe, Pernambuco.



Source: Survey data, 2015.

Table 2 presents the main diseases/health treatments that led to the departure of health professionals from this study, the diseases of the respiratory system (19%) were the main cause of this absence, right after surgeries (12%) and conjunctivitis (10%).

Table 2 -Diseases/Health treatments that led to the removal of health professionals. Camaragibe, Pernambuco.

Illnesses	**(%)**
Respiratory system diseases	19
Surgeries	12
Conjunctivitis	10
Back pain	6
Dengue	5
Sprain/dislocation/fracture	5
Psychological disorders	5
Diseases of the genitourinary system	5
Repetitive strain injuries/Work-related musculoskeletal disorders	5

Source: Survey data, 2015.

DISCUSSION

As for identification data, in this study there was a predominance of women (63.6%). This situation was already predictable due to the progressive increase in women's participation in the labor market, in view of access to education, which led to the simultaneous maintenance of two fronts, one focused on the home and the other for external work[7], which can lead to work overload and health problems. In Brazil, women already represent half of the paid workforce.[8]

Also, according to the Instituto Nacional de Estudos e Pesquisas Educacionais Anísio Teixeira - IPE, in undergraduate courses, while men are the majority in areas related to finance, business and computing, women are the majority in areas related to care and assistance.[9] Furthermore, in 2014, regarding the difference in the percentage of men and women in some of these areas, there was a predominance of women in the fields of health and well-being (76.6%).9 Additionally, the present study identified in the professional staff of the health team in the emergency sector, a prevalence of nursing, 47.6% of nurses and nursing technicians, revealing the predominance of women in professions directed to care, which can be explained by the socially constructed female stereotypes and absorbed by the labor market.

Regarding age, there is a predominance of the age group between 30 and 39 years (30.1%), characterizing a sample of adults. In agreement, a study on the quality of the Mobile Emergency Care Service in Maringá-PR, presented 50% of professionals also between 30 and 39 years old.[10] This worker profile is in its most productive phase of life, and it is common in the health area to accumulate more than one bond and long working hours.

Also, the participants claimed to have, for the most part, 1 and 5 years of service (31.6%). The issues surrounding the relationship between time and employment in the public service, and the structural quality of urgency and emergency units are complex and overlapping. It should be added that, among professionals in hospital environments, there is a fragility of the professional bond in a public institution and with the function they perform in the face of the overcrowding of the units.[11] This type of precariousness of work should not happen in any type of activity, especially in the area of health, as it is a branch of essential services for human life.

After presenting the characterization of the sample, it will be discussed the knowledge of professionals about the RAUE of the Unified Health System (SUS)

and the Emergency Plan. First, regarding the hierarchy of the SUS, although 53.9% of the sample answered at secondary level, it is necessary to provide these professionals with guidance on the subject, as 46.1% had divergent answers. It is important for the health professional to know the level of care at which his unit is inserted and the functioning of the health care networks, because they currently make up the forms of articulation with the various health equipment to provide care to the population in a humanized and integrated way, according to the principles of SUS.[12]

It should be noted that, according to the ordinance that reformulates the National Emergency Care Policy and institutes the Care Network to Emergencies in the SUS[4], the contracting of care points, such as the adoption of municipal plans, has the function of monitoring and regionalizing the flowchart in the emergency networks of each management, in addition to having fixed and mobile components as a guarantee of service and guidance in a hierarchical service and integrated into the SUS. In this sense, 77.7% of the interviewees corrected the components that constitute the emergency service (fixed and mobile), however, 73.9% are unaware of the municipal emergency and emergency plan, so it is necessary to carry out permanent education with the professionals stationed in these units to assess emergency care.

It was found in this article that 59.7% of the participants know the law 8080/90 of SUS regulation.[13] This was regulated in all the national territory through the Federal Constitution (CF) of 1988, with the aim of changing the situation of inequality in the health care of the population, making public service mandatory for any citizen, from the offer of services in primary, secondary and tertiary care.

Still on the knowledge about the SUS, it was found that only 44.2% knew the doctrinal guidelines of universality, equity and integrality, the others answered I do not remember or I don't know (21.4%) or other answers (34.4 %). In this perspective, the results obtained demonstrate an incipient knowledge about the SUS on the part of the servers of the urgency and emergency services of Camaragibe, being relevant the implementation of educational actions related to SUS policies.

From this, the real understanding of what the SUS is and how health care in the network works by health professionals who work at the secondary level of health, from the perspective of a broader view of the subject, from the collective to the individual, considering their health needs and living conditions, it will be possible to have actions and services that respond to the

demands of the population. This professional will also be able to guide the population about their rights; so that there is a defense for a more egalitarian, solidary and participatory society.[14]

Furthermore, equal rights and adequate working conditions are sought for health professionals, as the latter, when precarious, can favor physical and mental illness among workers.

Not only that, but the pressures and physical conditions of work can influence the relational dimension, characterized by the way people perform their activities, since the daily experience of this work, its organization, planning and execution are linked to the relationships established between peers.[15] In this study, most of the participants considered excellent (48.1%) and good (45.6%) interpersonal relationships, as well as being partially (65%) and totally satisfied (17%) with the physical conditions of the work environment.

Despite feeling satisfied in the work environment, 58.4% of the participants feel professionally undervalued. The devaluation, added to the precariousness of work, technological innovations and the imminence of job loss, can have a negative impact on health and, therefore, on absenteeism rates, such as mental illnesses.[16]

When asked about which diseases/health treatments would have motivated absence from work, at any time of work activity, the most cited problems by professionals were: respiratory diseases (19%), surgeries (12%), conjunctivitis (10%), back pain (6%) and dengue, sprain/dislocation/fracture, psychological disorders, diseases of the genitourinary system and musculoskeletal system (5%). Occupational and environmental exposures can contribute to the development and progression of most respiratory diseases, but their impact is poorly recognized in clinical practice, so there is a need to assess occupational and environmental contributing factors and establish measures to prevent exposure of professionals who care for patients with respiratory diseases.[17]

In addition, about having fallen ill because of work, 30.2% of the participants believed that the work environment could be related to some disease that they would have acquired. Therefore, even if the way of production and organization of work incidents on the health of individuals does not necessarily cause accidents or illness, in the face of an intense pace of work, demand for productivity, multifunctionality, loss of autonomy, long working hours, low wages, among others, the dehumanization of the worker is established[18], generating fatigue, demotivation and absence from work.

It is worth noting that, in order to prevent absenteeism and illness, and therefore contribute to the satisfaction of the human needs of health professionals, one must know their occupational risk factors, namely: inadequate working conditions, long working hours , exposure to potentially dangerous agents (chemotherapeutics, antibiotics, disinfectants, sterilants, anesthetic gases, blood and secretions), ergonomic risks (moving and transporting patients and loads, inadequacy of the physical area and instruments for the development of activities, repetitive movements, stereotyped postures), psychological risks (tension, stress, violence, suffering and death of patients), overlapping activities (multiple tasks, ineffective organization of work), in addition to factors external to work.[19]

Also, studies of absences motivated by illness, which are essential in the sphere of public service, due to the growing number of sick leave and days not worked. Health workers are among the professional category most exposed to leave, especially those who work in hospital institutions.[20] Therefore, in view of the above, it is important to foster debates regarding working conditions that affect the health of the nursing team and the medical team, as well as the elaboration of policies aimed at promoting, preventing and rehabilitating the health of this population. It is understood that its analysis and understanding can reduce its organizational impacts and contribute to the quality and effectiveness of care provided in hospitals, positively interfering in the work environment.[20]

CONCLUSION

This study, which evaluated the understanding of Health Professionals from the Urgency and Emergency Network of the Municipality of Camaragibe, revealed, mostly, a female sample, composed of adults, nurses and nursing technicians, and length of service from 1 to 5 years. The short period of time working in the service may justify the workers' lack of knowledge about the municipal health network, since the CEMECs' employees in their entirety did not even know the doctrinal principles of the SUS nor the Municipal Urgency and Emergency Plan.

In this context, it is important to carry out continuing education with health professionals about the health care network in the municipality of Camaragibe, in particular, about urgency and emergency services, in addition to holding team meetings for the planning of actions and the strengthening of professional practice. As

well as implementing policies for valuing municipal civil servants in order to provide improvements in the comprehensive care of workers' health, which will have repercussions on the well-being and quality of the service provided by them, since more than half of the participants of this study feel professionally devalued.

As limiting factors of the study, the representation of the scenario of emergency units in the municipality of Camaragibe is considered, emphasizing the need to carry out new research on the subject, of a qualitative nature, with health personnel at state and national levels.

ACKNOWLEDGEMENT

Thanks to all the subjects participating in the research, as they were of great importance for the accomplishment of this study.

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RECEIVED: 07/06/20
APPROVED: 12/17/21
PUBLISHED: 04/22