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CLINICAL-EPIDEMIOLOGICAL PROFILE OF A MOBILE EMERGENCY SERVICE

PERFIL CLÍNICO-EPIDEMIOLÓGICO DE UM SERVIÇO DE ATENDIMENTO MÓVEL DE URGÊNCIA

PERFIL CLÍNICO-EPIDEMIOLÓGICO DE UM SERVICIO DE EMERGENCIA MÓVIL

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ABSTRACT

Objective: to characterize the clinical-epidemiological profile of the Mobile Emergency Care Servie of a municipality on the Western Frontier of Rio Grande do Sul/Brazil, referring to 2016 and 2017. **Method**: descriptive, retrospective and quantitative documentar study. 5.957 incident reports from January 2016 to December 2017 were included. Which the relative and absolute frequencies were processed. **Results**: attendance prevailed due to neurological cause (11.9%) and collision (14.3%). Most of the calls were for men (55.7%) and the age group was 60 to 79 years old (26.2%); 98.6% of the activations were for assistance, the basic support unit (57.3%) was the most used, and in 90.1% of the consultations there were no incidents. **Conclusion:** the most prevalent services were neurological causes and collisions. Men and the elderly were the most attended population. The services were performed mostly by the basic support unit, with no incidents occurring.

Descriptor: Emergency Medical Services, Ambulances, Emergency Nursing, Health Profile.

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RESUMO
Objetivo: Caracterizar o perfil clínico-epidemiológico do Serviço de Atendimento Móvel de Urgência de um município da Fronteira Oeste do Rio Grande do Sul/Brasil, referente à 2016 e 2017. **Método:** Estudo descritivo, documental retrospectivo e quantitativo. Incluíram-se 5.957 boletins de ocorrências de janeiro de 2016 até dezembro de 2017. Foram processadas as frequências relativas e absolutas. **Resultados:** Prevaleceram atendimentos por causa neurológica (11,9%) e colisão (14,3%). A maioria dos chamados foi para homens (55,7%) e a faixa etária de 60 a 79 anos (26,2%); 98,6% dos acionamentos foi para prestação de socorro, a unidade de suporte básico (57,3%) foi a mais utilizada, e em 90,1% dos atendimentos não apresentaram incidentes **Conclusão:** Os atendimentos mais prevalentes foram de causas neurológicas e as colisões. Homens e idosos foi a população mais atendida. Os atendimentos foram realizados em sua maioria pela unidade de suporte básico, predominando a não ocorrência de incidentes.
Descritores: Serviços Médicos de Emergência, Ambulâncias, Enfermagem em Emergência, Perfil de Saúde.

RESUMEN
Objetivo: caracterizar el perfil clínico-epidemiológico del Servicio Móvil de Atención de Emergencia de um município de la frontera occidental de Rio Grande do Sul/Brasil. **Método:** Estudio documental descriptivo, retrospectivo y cuantitativo. Se incluyeron 5.957 informes de incidentes de enero de 2016 a diciembre de 2017. Se procesaron las frecuencias relativas y absolutas. **Resultados:** la assistência prevaleció por causa neurológica (11,9%) y colisión (14,3%). La mayoría de las llamadas fueron para hombres (55,7%) y el grupo de edad tenía entre 60 y 79 años (26,2%). El 98,6% de las activaciones fueon por assistência, la unidad básica de apoyo (57,3%) fue la más utilizada, y en el 90,1% de las consultas no hubo incidencias. **Conclusión**: los servicios más prevalentes fueron las causas neurológicas y las colisiones. Los hombres y los ancianos fueron la población más atendida. La mayoría de los casos fueron atendidos por la unidad básica de apoyo, con predomínio de la no ocurrencia de incidentes.
Descriptor: Servicios Médicos de Urgencia, Ambulancias, Enfermería de Urgencia, Perfil de Salud.

INTRODUCTION

The Mobile Emergency Care Service (SAMU) was created on September 29, 2003 through the institution of Ordinance No. 1864, which is included in the National Emergency Care Policy (PNAU). victims in situations that demand greater care and severe cases requiring quick interventions.[1] The SAMU covers 82.2% of the Brazilian population, being 3,533 municipalities, covering a total of 170.6 million inhabitants.[2]

Within the urgency and emergency care network, SAMU has a fundamental role in providing the population with a quick and resolute service. The main types of care provided are cardiorespiratory problems, burns, suicide attempts, violence, accidents and trauma.[3] Studies carried out in other regions of the country show the majority of care for clinical causes, with a sequence for traumatic ones.[4-5]

In this way, the relevance of exploring information contained in the SAMU service bulletins is justified, and

before these, identifying and updating municipal profile data. It is also considered that these data are an essential source of information for the dimensioning and planning of health actions in the area of urgency and emergency, as well as the impact on health services and social support network, thinking about the formulation of public policies and health promotion/prevention.

It was listed as a research question: what is the clinical-epidemiological profile for the years 2016 and 2017 of SAMU care in a municipality on the West Frontier of Rio Grande do Sul/Brazil? This study aims to characterize the clinical-epidemiological profile of the Mobile Emergency Care Service of a municipality in the West Frontier of Rio Grande do Sul/Brazil, referring to 2016 and 2017.

METHOD

Descriptive, retrospective and quantitative documentary study, carried out in a SAMU service base in a municipality in the West Frontier of Rio Grande do Sul/Brazil, component of the 10th Regional Health Coordination (CRS), which performs approximately 300 monthly consultations. During the collection period, 31 professionals worked at the site, being six doctors, six nurses, seven nursing technicians and 12 drivers. The service has a structure of mobile units, providing 24-hour care, which is composed of an Advanced Support Unit (USA) ambulance, a Basic Support Unit (USB) ambulance and a motorcycle, which provides emergency care support from 7 am to 7 pm. In addition to emergency assistance, through telephone calls from the population that are designated by the regulation center,

Data collection took place from November 2017 to March 2018, from Mondays to Fridays, with the collaboration of seven previously trained collectors, using a form previously prepared by the researchers and based on information from the service bulletins used by SAMU. The archived bulletins of SAMU consultations were included in the study for the period from January 2016 to December 2017. These bulletins are filled out manually by the nursing technician at the USB, by the nurse at the USA, and at the assistance of the Motorcycles are responsible for the driver, who can be the nursing technician, nurse or doctor.

Bulletins that were erased, illegible and that did not present at least 80% of the information filled in were excluded. In this study, the following variables were selected: sex, age, year, month, day of the week, time, type of service, unit, location of service, transportation, origin, incidents (canceled and false calls, deaths, refusal to attend and / or hospitalization, victim is no

longer at the scene) and clinical and traumatic reasons.

Data were collected manually for the form and, later, organized and tabulated in a database in Excel. Independent double typing of the data occurred in order to check for errors and inconsistencies. Subsequently, the data were exported to the statistical program Statistical Package for Social Sciences Inc, Chicago, IL (SPSS, version 21.0) and analyzed. Descriptive statistics were used for data analysis, with relative and absolute frequencies.

The research was approved by the Research Ethics Committee at the University to which it is bound by opinion No. 2,328,841.

RESULTS

In the two analyzed years, SAMU carried out a total of 6,174 consultations, 3,253 in 2016 and 2,921 in 2017, and of these 5,957 bulletins were collected, according to the inclusion criteria.

Regarding the sex of the people assisted, there was a prevalence of males with a total of 3,319 (55.7%), compared to females, which was 2,596 (43.6%) in the two years evaluated. The elderly population was the one that demanded the greatest number of assistance. Table 1 shows the comparison of this information and age according to the years investigated.

Table 1 -Services provided by SAMU in the years 2016 and 2017, according to sex and age, Rio Grande do Sul – Brazil, 2020.

Features	Year				Total
	2016		2017		No
	No	%	No	%	
Sex					
Male	1767	53.2	1552	46.8	3319
Feminine	1341	51.7	1255	48.3	2596
In blank	21	50.0	21	50.0	42
Age					
< 1 year	9	42.9	12	57.1	21
1-19 years	277	53.7	239	46.3	516
20-39 years	806	54.1	683	45.9	1489
40-59 years	712	50.0	712	50.0	1424
60-79 years	839	53.9	719	46.1	1558
80 years or older	425	51.8	396	48.2	821
In blank	61	47.7	67	52.3	128

Source: prepared by the authors.

Table 2 shows that in terms of the distribution of occurrences per month, the highest prevalence in 2016 was in January, with a total of 306 visits, and in 2017, in December, with 275.

Table 2- Services provided by SAMU in 2016 and 2017, according to month, day of the week and time, Rio Grande do Sul – Brazil, 2020.

Variable	Year				
	2016		2017		Total
	No	%	No	%	No
Month					
January	306	54.7	253	45.3	559
February	246	56.3	191	43.7	437
March	228	48.9	238	51.0	466
April	240	50.6	234	49.4	474
May	271	50.9	261	49.1	532
June	269	60.7	174	39.3	443
July	305	53.7	263	46.3	568
August	287	54.8	237	45.2	524
September	254	53.3	223	46.7	477
October	244	51.3	232	48.7	476
November	249	50.2	247	49.8	496
December	230	45.5	275	54.5	505
Day of the week					
Monday to Friday	2257	53.4	1966	46.6	4223
Saturday to Sunday	869	50.5	853	49.5	1722
In blank	3	25	9	75	12
Service time					
07:00 - 12:59	903	50.3	894	49.7	1797
13:00 - 18:59	1005	53	890	47	1895
19:00 - 00:59	739	52.1	679	47.9	1418
01:00 - 06:59	404	57.6	297	42.4	701
In blank	78	53.4	68	46.6	146

Source: authors.

With regard to information on the type, unit, origin and origin of SAMU care, Table 3 shows the frequencies of these variables and the information compared for the years 2016 and 2017.

Table 3 -Services provided by SAMU in 2016 and 2017, according to type, unit, location, transport and origin, Rio Grande do Sul – Brazil, 2020.

Variable	Year				
	2016		2017		Total
	No	%	No	%	No
Type					
Help	3108	52.9	2767	47.1	5875
Transport	3	4.7	61	95.3	64
Other*	6	100.0	-	-	6
In blank	12	100.0	-	-	12
Unit					
Advanced Support	1312	51.6	1231	48.4	2543
Basic Support	1817	53.3	1597	46.8	3414
Location					
Urban area	2920	52.6	2633	47.4	5553
Rural area	246	49.6	183	50.4	363
In blank	29	70.7	12	29.3	41
Transport					
Simple	2088	53.3	1826	46.7	3914
medicalized	788	47.4	873	52.6	1661
In blank	253	66.2	129	33.8	382
Origin					
Residence	1831	53.6	1588	46.4	3419
Public highway	874	52	806	48	1680
Health Strategy	42	56.8	32	43.2	74
Workplace	16	51.6	15	48.4	31
Event	15	75.0	5	25.0	20
Highway	102	48.8	107	42.2	209
Emergency care unit	-	-	63	100.0	63
Other**	166	48.5	176	51.5	342
In blank	83	69.7	36	30.3	119

*Presence of a vehicle without the need for regulation; ** Cases such as police station, residence and among others.
Source: prepared by the authors.

The list of clinical and traumatic reasons identified in the bulletins is presented in Table 4, as well as the occurrence of incidents during the consultations.

Table 4- Comparison of the reasons and incidents variables referring to the services provided by the SAMU in the years 2016 and 2017. Rio Grande do Sul – Brazil, 2020.

Variable	Year		
	2016	2017	Total
		No	No
Reason			
Clinical			
Respiratory	290	311	601
Cardiovascular	325	353	678
Neurological	384	325	709
Digestive	96	118	214
Obstetric	47	33	80
Psychiatric	215	230	445
Infectious	34	36	70
Pediatric	1	3	4
Metabolic	197	200	397
exogenous intoxication	31	34	65
Other clinical reasons	405	185	590
Traumatic			
Collision	452	401	853
run over	60	53	113
Fall	354	331	685
Aggression	65	59	124
Gunshot wound	19	13	32
White weapon injury	33	29	62
Burn	4	5	9
Drowning	0	3	3
electropletion	9	7	16
Other traumatic reasons	57	49	106
blank data	51	50	102
incidents			
None	2832	2533	5365
Canceled	4	7	11
False	6	3	9
Death	131	154	285
refused service	62	57	119
refused hospitalization	29	26	55
is no longer in place	53	45	98
Other*	12	3	15

*Case of accessibility to hard-to-reach places that put the team at risk.
Source: prepared by the authors.

DISCUSSION

As for the years that made up the sample of the newsletters, it was identified that 2016 had a greater number of visits, showing a decrease of approximately 10.21% (332) between the years 2016 and 2017. The fact of this reduction can be explained by a since, during this period, the family health strategies were (re)organized to meet some urgent and community demands, thus remedying a care failure that occurred previously, when the SAMU was implemented.

However, it is still noticeable that the population continues to use the urgency and emergency service for clinical reasons that could be solved in Primary Care (AB).[6] A study[7] carried out in Botucatu, São Paulo, identified a predominance of the profile of clinical problems treated. by the SAMU in six months, with a total of 2645 attendance records being collected.

The predominance of assistance to men can be characterized as a generalizable profile of occurrences by the SAMU, since converging results were found in a research carried out in the capital of Rio Grande do Sul, in which 63.4% of the occurrences were aimed at sex. masculine.[4] Also, a study8 carried out at SAMU in Rio Grande do Norte detected, in four months of analysis, similar data, in which of the 3,186 consultations, 63.2% were male and 35.8% female. In Bahia, SAMU assistance to men represented 49.9% in relation to women.[9]

In relation to men's health and the reasons for health care in the Urgency and Emergency Network (RUE), the data of the present study are in line with the current literature, in the sense that there is a sociocultural profile among men, focused mainly on alcohol abuse and speeding. These factors contribute to their being more exposed to both car accidents10 and other traumatic reasons.

The predominance of care in the years 2016 and 2017 occurred to the elderly population aged 60 to 79 years (26.2%), followed by young adults from 20 to 39 years (25.0%). The population under one year of age was the one that SAMU provided fewer services (0.4%). The greater number of visits to the age group from 60 to 79 years old can be evidenced by the increase in life expectancy, as well as the health impairment caused by non-communicable chronic diseases.

This fact is in line with the Brazilian Institute of Geography Statistics (IBGE), which reveals that the Brazilian age pyramid is in constant transformation, especially in recent years with the increase in the elderly population.[11] In this light, it is exposed that the rates of hospitalizations in elderly patients due to the worsening of chronic conditions are gradually increasing in Brazil. Based on this, it is necessary to

organize the systematization of care for this group, instituting more frequent home visits in order to identify the vulnerabilities that the elderly are subjected to; developing comprehensive health promotion actions, especially in the primary care setting, in an attempt to reduce chronic complications and that acute injuries can be avoided in the elderly.[12]

The fact that the months of January and December are the most prevalent can be explained by the fact that both are festive months, that is, because January is a month of school holidays, and December is a commemorative month. It was also evident that there is a high number of visits on weekends. Research[13] carried out in Ceará also identified the increase in attendances for car accidents at night and on weekends, relating social behavior and male gender as factors that contribute to this incidence.

It should be noted that the identification of appointments according to the month and day of the week can be used to plan health actions, including appropriate investment strategies and allocation of available resources to better meet the demand. Since these can be contributors to the high rate of attendances in these periods.

According to the type of care, most of the occurrences (98.6%) were for reasons of help. It is noteworthy that in October 2017, a 24-hour UPA was implemented in the municipality where the research was carried out, an aspect that may justify the emergence of the reason for transport by the population served.

As for the units used in the care, the USB with 3,414 (57.3%), followed by the USA with 2,543 (42.7%). This finding is in line with a survey5 that was carried out in the Macroregion Norte de Minas, where 89% of the consultations were performed by the USB.

As for the reasons for the consultations, in the two years there was a prevalence of clinical causes of the neurological type with 709 consultations (11.9%) and the traumatic causes of collision with 853 (14.3%).

It can be inferred a relationship between the highest age group attended by the SAMU and the cause of the occurrences, since according to IBGE data, the Brazilian age pyramid is in constant inversion due to the increase in the elderly population[11], thus justifying the greater number of occurrences per clinical reasons with neurological aspects provided to the age group from 60 to 79 years, which in addition to the increase in life expectancy and the emergence of chronic diseases, it is highlighted that the reduction in the birth rate is constantly heading towards a decline.[7]

Still related to neurological disorders, a study[14] that characterized the epidemiological profile of these victims

assisted by a SAMU pointed out that 59% of the visits were for Cerebral Vascular Accident (CVA), 11% for seizures, 4.1% for low back pain associated with spinal cord injury and 4.1% of other neurological natures.

However, it appears that reformulating teams for adequate assistance is not enough to organize the levels of care. It is necessary to invest in innovation and mirror itself in other countries that have already experienced this practice in the aging process.[15]

The data found regarding the traumatic reasons converge with the reality that is increasingly present in everyday life, especially in Brazilian traffic and in emergency care. Collisions also appear as the main cause in a study carried out in Ceará.[13]

Regarding the incidents that occurred during the assistance provided by the SAMU, 5,365 (90%) had no incidents, followed by the option of death with 285 (1.5%) cases and refusal of care with 119. It is noteworthy that in the form to fill in the data, developed for the research, there were other options for incidents, such as false, refusal of care, and absence of the victim at the scene.

Aiming to promote reflections in the population about not carrying out prank calls to emergency services, an extension project carried out in Bahia in municipal schools stands out. From the activities, it was possible, according to data from the general coordination of SAMU, a reduction in prank calls of almost 10%, after a year of project, once the population health education actions were carried out in order to clarify the real need for assistance by SAMU. Therefore, there are weaknesses in the management of urgent and emergency pre-hospital services, which makes health and service managers responsible for solving existing gaps and investing in the provision of a quality service.[17] Furthermore, an integrative review showed that the use of mobile emergency care for demands that do not fit the degree of severity and need for this type of service appears as another limiting factor in the coordination and management of SAMU professionals' activities.[18]

It is reiterated that the knowledge of this information and a mapping of the regions, days and population profile involved in the attendances can help in the management and implementation of strategies for the adequacy and improvement in the structures of the health services to meet these demands, both in the emergency rooms assistance from the coverage municipalities that receive rescued victims as well as from the SAMU itself.[13]

In this sense, managers need knowledge and skills to develop planned

actions for the assistance provided by professionals, in view of the specificities of the population profile served in the service, in order to better meet all life cycles, clinical or traumatic causes and in any established demand. In this way, the responsibilities of management in organizations of mobile health services are identified, and the determination of clinical priorities makes it possible to define the competences of the various health services and the internal flows.

CONCLUSION

When analyzing the clinical-epidemiological profile of a Mobile Emergency Care Service in a municipality in the West Frontier of Rio Grande do Sul/Brazil, referring to the years 2016 and 2017, and comparing them, with it is concluded that in the two years under study there were 6,174 consultations, of which 3,253 were in 2016 and 2,921 in the following year, and of these, 5,957 service bulletins were the subject of this study.

The greatest demand for care related to clinical nature it was of neurological cause(11.9%), and to the traumatic nature, collision (14.3%). Most services were provided to men (55.7%) and the highest number of occurrences was from people aged 60 to 79 years (26.2%), regarding the distribution of occurrences per month, there was a higher incidence in the month of December and January and according to the type of care, most of the occurrences were for reasons of help (98.6%). As for the units used in the care, the USB with 3,414 (57.3%), followed by the USA with 2,543 (42.7%). Regarding the incidents that may arise during the assistance provided by the SAMU, most of the assistance did not present incidents (90.1%), followed by the option of death (4.8%) and refusal of assistance (2.0%).

The limitation during the research occurred due to the erasure and incomplete bulletins, which made it difficult to complete the study of this profile, even though it was an exclusion criterion adopted in the research and it was a retrospective documentary study. Therefore, the importance of adequate and complete filling out during the consultations performed for a more reliable and concrete detailing is highlighted.

The management of the health system has valued the analysis of spatial data for providing new subsidies for the planning and evaluation of actions, based on the analysis of the spatial distribution of diseases, the location of health services and environmental risks. Therefore, it is considered the importance of other studies that aim at the dimensioning of the health need in urgency and emergency, aiming to contribute to the planning of health education activities, management strategies

such as the implementation of guidelines, policies and protocols to systematize care and better organize management according to the profile found.

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