BASIC LIFE SUPPORT IN PRIMARY HEALTH CARE: INTEGRATIVE LITERATURE REVIEW

SUPORTE BÁSICO DE VIDA NA ATENÇÃO PRIMÁRIA À SAÚDE: REVISÃO INTEGRATIVA DA LITERATURA

SOPORTE VITAL BÁSICO EN LA ATENCIÓN PRIMARIA DE SALUD: REVISIÓN INTEGRADORA DE LA LITERATURA

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ABSTRACT
Objective: To know the scientific production on Basic Life Support in Primary Health Care. **Method:** Integrative literature review, including articles published in national and international journals that addressed the theme Basic Support of Life in Primary Health Care, available in Portuguese, English or Spanish, published between the years 2000 and 2020, available online in the databases: LILACS, BDENF and MEDLINE. **Results:** The searches led to 14 articles. The articles showed the unsatisfactory knowledge of Primary Health Care professionals, in addition to a lack of practical skills for assistance. Several studies have pointed to the need to provide permanent education in Cardiopulmonary Resuscitation. There was a lack of various materials and equipment for Basic Life Support. **Conclusion:** It is necessary to train health professionals, in addition to better supply and adequate storage of the necessary supplies for cardiopulmonary resuscitation.
Descriptors: Basic Life Support; Cardiopulmonary resuscitation; Primary Health Care.

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RESUMO
Objetivo: Conhecer a produção científica sobre o Suporte Básico de Vida na Atenção Primária à Saúde. **Método:** Revisão integrativa da literatura; foram incluídos artigos publicados em periódicos nacionais e internacionais, que abordassem a temática Suporte Básico de Vida na Atenção Primária à Saúde, disponíveis em português, inglês ou espanhol, publicados entre os anos de 2000 e 2020, disponíveis online nas bases de dados: LILACS, BDENF e MEDLINE. **Resultados:** As buscas levaram ao encontro de 14 artigos. Os artigos evidenciaram o conhecimento insatisfatório dos profissionais da Atenção Primária à Saúde, além de falta de habilidade prática para a assistência. Vários estudos apontaram para a necessidade de disponibilização de educação permanente em Reanimação Cardiopulmonar. Constatou-se a falta de vários materiais e equipamentos para o Suporte Básico de Vida. **Conclusões:** É necessária a capacitação dos profissionais da saúde, além de melhor fornecimento e adequado armazenamento dos insumos necessários para a reanimação cardiopulmonar.
Descritores: Suporte Básico de Vida; Reanimação Cardiopulmonar; Atenção Primária à Saúde.

RESUMEN
Objetivo: Conocer la producción científica sobre Soporte Vital Básico en Atención Primaria de Salud. **Método:** Revisión integrativa de la literatura, se incluyeron artículos publicados en revistas científicas nacionales e internacionales que abordaron el tema Soporte Vital Básico en Atención Primaria de Salud., Disponible en Portugués, Inglés o español, publicado entre 2000 y 2020, disponible online en las bases de datos: LILACS, BDENF y MEDLINE. **Resultados:** Las búsquedas dieron lugar a 14 artículos. Los artículos evidenciaron el conocimiento insatisfactorio de los profesionales de Atención Primaria de Salud, además de una falta de habilidades prácticas para la asistencia. Diversos estudios han señalado la necesidad de impartir formación permanente en Reanimación Cardiopulmonar. Faltaban varios materiales y equipos para el soporte vital básico. **Conclusión:** Es necesario capacitar a los profesionales de la salud, además de un mejor suministro y almacenamiento adecuado de los insumos necesarios para la reanimación cardiopulmonar.
Descriptores: Apoyo Vital Básico; Reanimación Cardiopulmonar; Atención Primaria de Salud.

INTRODUCTION

The organization of the Unified Health System (SUS) from the perspective of a care network is a strategy to overcome the fragmented model of operating health care and management.[1]

Health Care Networks (RAS) refer to services and actions that intervene in health-disease processes with the help of technological, logistical and management resources to ensure comprehensive care and improve access, equity and effectiveness proposal in SUS.[2]

Therefore, the levels of care are structured through productive arrangements adjusted according to technological densities, ranging from the lowest, intermediate and highest technological density, which consecutively: Primary Health Care

(PHC), Secondary Health Care and Care tertiary to health.[3]

Primary Health Care (PHC) or Basic Care was structured to be the gateway to the Health System, intervening from a set of individual, family and collective health actions that cover promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance. In this context, it is also important to mention that it is responsible for the first assistance to urgencies/emergencies.[4]

The National Emergency Care Policy emerged in 2003 with the aim of organizing local and regional networks of comprehensive emergency care, as links in the life maintenance chain, structuring them into their various components: Fixed Pre-Hospital, Mobile Pre-Hospital, Hospital and Posthospital. The Basic Health Units (UBS) and the Family Health Strategy (ESF), teams of community health agents, specialized outpatient clinics, diagnostic and therapeutic services, and Non-Hospital Emergency Care Units are part of the Fixed Pre-Hospital component.[5]

Professionals working in PHC may, at any time, be faced with the demand for attention from users in situations of imminent risk of death, such as CRA, so it is imperative that the team has the knowledge, attitude and skills to act in this situation.[6]

Cardiorespiratory Arrest (CRA) consists of the sudden interruption of the activities of the cardiac and respiratory system, causing loss of consciousness, with no pulse or signs of circulation, which can result in irreversible brain damage.[6,7]

It is estimated that around 200,000 people experience CRA each year in Brazil and half of the cases are registered in the pre-hospital environment.[7,8]

The highest rate of out-of-hospital CRA has a cardiac etiology, with ischemic heart disease being the main cause, it is estimated that less than 6% of victims survive.[9,8]

Regarding the rhythm of CRA in an out-of-hospital environment, ventricular fibrillation (VF) and pulseless ventricular tachycardia (PVT) are considered the main causes, reaching almost 80% of episodes, with a good rate of success in reversal, if they are treated immediately. When defibrillation is performed within 3 to 5 minutes of the onset of CPA, the survival rate is approximately 50% to 70%.[9]

Cardiopulmonary resuscitation (CPR) refers to the set of standardized actions that aim to artificially sustain blood flow to the brain and other vital organs, until the return of spontaneous circulation through the proper functioning of the cardiac pump. CPR is performed using Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS).[6]

BLS in adults recommends the following actions: immediate recognition of the CRA, activation of the emergency service, initiation of high-quality CPR and use of the automated external defibrillator (AED), as soon as it is available. Effective care for victims also includes ALS and post-CPA care. This care sequence is known as the survival chain, because if all the links work properly, the chance of survival increases significantly.[9,8]

The chance of survival largely results from the period between the occurrence of CRA and the beginning of CPR maneuvers. The rapid recognition of clinical signs and the execution of CPR maneuvers, with the implementation of effective chest compressions, can increase the survival rate of victims in an out-of-hospital environment by two to three times.[6,7] Every minute without CPR a probability of survival reduces from 7 to 10% in a victim with CA.[9,8]

Fixed Pre-Hospital Care (APH) is the assistance provided at the first level of care to users with acute clinical, traumatic or psychiatric conditions that can trigger suffering, sequelae or even death. However, although the PHC is part of the emergency care network, it is often the case that health professionals, when faced with a more serious emergency situation, have the impulse to quickly refer them to a more complex unit, without having least

one prior assessment and stabilization of the situation, due to insecurity and lack of knowledge of how to act.[10]

A study carried out with nurses working in the Primary Care network of a municipality in the northern region of Espírito Santo identified weaknesses in knowledge, skills and attitudes in caring for CRA. Of the participants, 87.5% had difficulties in identifying the correct sequence of care, 70.8% had difficulties in identifying the rhythms indicative of defibrillation, 70.8% did not recognize the techniques used in administering medication in CRA and 62.5% % reported not being sure about all the steps to be performed in the CPA care.[6]

Therefore, it is essential that professionals are trained to deal with this. In addition, all these units must have a space adequately provided with essential materials and medicines for the stabilization of emergencies that occur in their area of coverage and/or are referred to them, until the transfer to a larger unit is feasible, when necessary.[10]

Faced with the performance of the PHC mentioned in the National Policy for Emergency Care, the following problem question emerged: What is the existing scientific production on BLS in Primary Health Care Units?

The study will help PHC professionals to rethink their work within

the BLS. In addition, nurses at the units will be able to base their management practice on health policies and scientific evidence, providing frequent training for employees, supplying material inputs, equipment and structure compatible with emergency care. Managers at the municipal level can be sensitized to improve the supply of resources to the units.

This study aimed to know the scientific production on Basic Life Support in Primary Health Care.

METHOD

This is an integrative literature review that brings together the results obtained in research on the BLS theme in PHC.

The integrative review consists of six steps, in which previous studies on the subject under study are synthesized, with an analysis of the knowledge already produced and notes on questions that can be answered with new studies.[11]

The first stage of the review concerns the identification of the theme and selection of the hypothesis or research question, where the definition of the problem, search strategies, definition of keywords and descriptors takes place. The second step covers the definition of inclusion and exclusion criteria for the study. In the third stage, the identification of the pre-selected studies is carried out by reading the abstracts, keywords and titles of the publications, and organizing the studies. The fourth step comprises the categorization of selected studies. The fifth step performs the analysis and interpretation of the results. The sixth and final step represents the presentation of the review and synthesis of knowledge through the preparation of a document that details the review and proposals for new studies.[11]

The question that guided this research was: What is the existing scientific production on BLS in PHC units?

For the refinement of the research, the following inclusion criteria were used: articles published in English, Portuguese and Spanish. Exclusion criteria were: studies defined as case reports and clinical cases; studies defined as experience reports; dissertations; theses; articles repeated in the Databases and articles not available in full, as priority was given to maintaining methodological rigor for this type of study.

Articles published in national and international scientific journals that addressed the BLS theme in PHC, found in full and published between the years 2000 and 2020, were included. The publications should be available online in the Databases

of Latin American Literature and Caribbean in Health Sciences (LILACS), Base Data in Nursing (BDENF) and Medical Literature Analysis and Retrieval System Online (MEDLINE).

For the location of the publications, the criterion of two searches was used to answer the research question through the Health Sciences Descriptors (DeCs) followed by boleando and: Basic Life Support and Primary Health Care and Cardiopulmonary Resuscitation and Primary Care to Health, as they were the ones that best suited the objectives.

Data collection took place in April 2020 and was supported by a form called the Data Collection Instrument of the selected studies. The instrument includes the following items: identification of the original article, methodological characteristics of the study, assessment of methodological rigor, measured interventions and results found.[12,13]

For the analysis of the articles that met the inclusion criteria, a synoptic table specially constructed for this purpose was used using the Microsoft Excel 2010 program, containing variables that answer the guiding question of the study, covering the following aspects considered relevant: title, year, authors, objectives, results and level of evidence.

The level of evidence consists of a classification based on the type of methodology that answers a research question with the least amount of error and generates the most reliable findings. The articles were classified according to the following levels of evidence[14]:

a) Level 1: systematic reviews or meta-analysis of relevant clinical trials;

b) Level 2: evidence derived from at least one well-designed randomized controlled clinical trial;

c) Level 3: well-designed clinical trials without randomization;

d) Level 4: well-designed cohort and case-control studies;

e) Level 5: systematic review of descriptive and qualitative studies;

f) Level 6: evidence derived from a single descriptive or qualitative study;

g) Level 7: opinion of authorities or report of expert committees.

RESULTS

The searches led to 122 articles (100%), 100 (82%) for the following descriptors "Basic Life Support and Primary Health Care" and 22 (18%) for the following descriptors "Cardiopulmonary

Resuscitation and Primary Care à Saúde", which underwent an initial analysis, with the reading of titles and abstracts, for the selection of studies that responded to the objective. After the first reading, the selected articles were read in full, 19 (15.6%) articles appeared in both search criteria, 89 (72.9%) did not meet the work criteria and 14 (11.5%) composed the final sample, as shown in Table 1 and 2.

Table 1 - Distribution of articles by Database according to the first search criterion "Basic Life Support and Primary Health Care", Itajubá, Minas Gerais, Brazil, 2020, N: 100

Data base	Found	Did not meet the inclusion criteria	selected for work
BDENF	12	12	0
LILACS	25	19	6
MEDLINE	63	56	7
Total	**100 (100%)**	**87 (87%)**	**13 (13%)**

Source: from the author

Table 2 - Distribution of articles by Database according to the second search criterion "Cardiopulmonary Resuscitation and Primary Health Care", Itajubá, Minas Gerais, Brazil, 2020, N: 22

Data base	Found	repeated	Did not meet the inclusion criteria	selected for work
BDENF	0	0	0	0
LILACS	6	4	1	1
MEDLINE	16	15	1	0
Total	**22 (100%)**	**19 (86.4%)**	**2 (9.1%)**	**1 (4.5%)**

Source: by the authors

For the analysis of the articles, the following variables were used: title, year, authors, objectives, results, level of evidence and country. The items title, year, authors and level of evidence are described in Table 3.

Table 3 -Distribution of integrative review articles by title, year, authors and level of evidence, Itajubá, Minas Gerais, Brazil, 2020

Title	Year	Authors	Goals	level of evidence
A1. Conocimientos teóricos de los Médicos de Familia sobre reanimación cardiopulmonar	2002	Díaz et al.[15]	To know the theoretical levels of training in CPR among family physicians in the municipality of Quemado de Güines.	6
A2. Preparedness for cardiopulmonary resuscitation in primary care	2004	Nurmi and Castrén[16]	Assess readiness for resuscitation of cardiac arrest patients in primary care.	6
A3. Principles of resuscitation in primary care	2006	Jevon and Halliwell[17]	Describe the action health professionals should take when cardiac arrest occurs in the community.	7
A4. Out-of-hospital cardiac arrests occurring in primary health care facilities in Singapore	2007	Ong et al.[18]	To study out-of-hospital cardiac arrests that occur in basic health facilities in Singapore and compare them with those that occur in the community.	4
A5. Preparedness of Primary Healthcare Centers for Critical Emergency Situations in Southwest Turkey	2008	Yorganci and Yaman[19]	Assess the availability of emergency equipment and the knowledge of personnel working in primary health centers.	6
A6. Test Raval Sud para medir habilidades de soporte vital básico y desfibrilación en médicos y enfermeras de atención primaria.	2010	Abril et al.[20]	To develop and validate an instrument to measure BLS skills and semiautomatic defibrillation adapted to health professionals in primary care teams.	6
A7. Avaliação de treinamento em suporte básico de vida para médicos e enfermeiros da atenção primária	2016	Meira Júnior et al.[21]	To assess knowledge and technical skills in cardiopulmonary resuscitation before and after a BLS training course for physicians and nurses working in the ESF.	6
A8. Enfermeiros da Atenção Primária em suporte básico de vida	2017	Moraes and Paiva[22]	To analyze the theoretical knowledge of nurses working in PHC on	6

			measures of BLS in the care of CPA in adults and its relationship with age and other factors.	
A9. Out of hospital Cardio-pulmonary arrest – Is there a role for the primary healthcare teams?	2017	Vinker[23]	-	7
A10. Self-perceived limitations and difficulties by Primary Health Care Physicians to assist emergencies	2018	Martínez et al.[24]	To identify the training received in emergency medicine by primary health care physicians, and the limitations and difficulties perceived by these physicians in assisting in emergencies.	6
A11. Avaliação dos conhecimentos e habilidades em ressuscitação cardiopulmonar assimilados por profissionais da atenção primária em saúde	2018	Nogueira et al.[25]	Evaluate the retention of theoretical knowledge and skills assimilated by PHC professionals, one year after participating in a training course on BLS.	6
A12. Avaliação da estrutura na atenção primária em saúde para o suporte básico de vida	2019	Cassinelli et al.[26]	Describe the structure of the UBS in serving users for the BLS.	6
A13. Conhecimentos e habilidades dos profissionais da atenção primária à saúde sobre suporte básico de vida	2019	Santos et al.[27]	Evaluate the theoretical knowledge and practical skills of PHC professionals about BLS in the care of adults with CA before and after an educational intervention.	6
A14. Suporte básico de vida: conhecimento de enfermeiras (os) que atuam na estratégia de saúde da família	2020	Santos et al.[28]	To analyze the knowledge of nurses who work in the ESF, about BLS, in face of CRP.	6

Source: by the authors

Note: CPR, Cardiopulmonary resuscitation; BLS, Basic Life Support; ESF, Family Health Strategy; APS, Primary Health Care; CRP, cardiac arrest; UBS, Basic Health Unit

Of the articles found, six (42.9%) were developed in Brazil[21,22,25,26,27,28], two (14.3%) in Spain[20,24], one (7.1%) in Turkey[19], one (7.1%) in Cuba[15], one (7.1%) in Finland[16], one (7.1%) in Singapore[18] and two (14.4%) did not involve field research.[17,23]

Regarding the studies developed in Brazil, the regions were: three (50%) in São Paulo[22,25,26], two (33%) in Minas Gerais[21,27] and one (17%) in Bahia.[28]

Regarding the language, six (43%) were published in Portuguese[21,22,25,26,27,28], six (43%) in English[16,27,18,19,20,23] and two (14%) in Spanish.[15,20]

As for the method, eleven (78.6%) studies have level of evidence 6, two (14.3%) have level of evidence 7 and one (7.1%) have level of evidence 4. Of the studies with level of evidence 6, ten (90.9%) are of a quantitative approach[15,16,19,21,22,24,25,26,27,28] and one (9.1%) of measurement instrument validation.[20] The studies with level of evidence 7 refer to the opinion of authority[23] and expert committee report.[17] The study with level of evidence 4 is prospective and observational.[18]

DISCUSSION

The PHC professionals investigated in the studies have knowledge regarding the identification of clinical signs present in a person with CRA in a pre-hospital environment. Satisfactory theoretical knowledge was associated with assessing the victim's level of consciousness and checking the pulse.[22,28]

However, the recognition of a CRA was a difficult item in a study carried out in the interior of Minas Gerais.[27]

There was also sufficient knowledge related to the minimum depth to be applied during the execution of chest compressions

and CPR sequence in adults if it was possible to guarantee ventilations.[28]

In another article, it was found that 70% of professionals know how to point out the importance of performing resuscitation maneuvers.[22] A study carried out in Cuba found that family physicians have an acceptable theoretical level regarding CPR.[15]

On the other hand, unsatisfactory knowledge of professionals was identified more frequently in the analyzed articles. PHC professionals have gaps in the knowledge and skills of CRA patient care. These results show a critical scenario regarding the recovery potential of users assisted during a stop by such teams.[27, 21]

The sequence of the survival chain for CPR in an out-of-hospital environment was the subject of theoretical ignorance. This finding is worrisome, as the implementation of the sequence of actions after the recognition of a CRA is crucial for the survival with a good neurological prognosis of the victims in CRA.[22, 28, 25]

There was scarce knowledge of professionals regarding the handling of the AED and care to be implemented when using the defibrillator in the patient in CRA.[22,27]

A theoretical level below the desired level was also identified in relation to the appropriate place for the position of the hands when performing chest

compressions in adult individuals.[28]

Physicians in Cuba had a low percentage of correct answers to questions related to airway management.[15] Most professionals were unable to distinguish respiratory arrest from CRA.[27]

The professionals working in the ESF showed failures in adequately providing care to the CRA victim, especially regarding the correct positioning of the hands, depth and frequency of compressions, positioning for ventilations and, especially, the handling of the AED.[21]

The professionals did not know how to perform the BLS maneuvers properly before the practical training. The participants had an inadequate assessment of the following items: compression site, posture during compression, compression speed, airway opening, bag-valve-mask positioning, bag-mask-valve handling, effective ventilation and AED handling.[27]

One of the studies that identified the professionals' knowledge and skills as unsatisfactory also found that most participants had never taken any training on the subject.[27]

Research carried out in a rural city in Turkey showed a similar result, as it was identified that the PHC centers were not prepared to offer BLS. The knowledge score indicated that the team needs training, and the same professionals stated that they would be more competent if they could participate in BLS training.[19]

A study carried out in the city of Campinas identified better performance among professionals who had previous contact with the subject, whether through courses, updates, postgraduate studies or recent professional experience (less than five years) in sectors such as Emergency Care, Emergency Help (PS), Intensive Care Unit (ICU) and APH.[22]

In an article by an Israeli specialist, he suggested that the chance of a CRP occurring in an APS unit is very low. Therefore, the impact of the interruptions that occur in primary care on the survival of the general population is low. But, although the impact is small, health professionals should be familiar with the BLS, the Mobile Emergency Care Service (SAMU) telephone number, and handling the AED.[23]

In Singapore, the stoppages that occur in PHC units correspond to 6% of all out-of-hospital CAs throughout the year. The authors consider this as a significant percentage and comment that care providers have an important role in the management of out-of-hospital cardiac arrests.[18]

Studies carried out in Brazil and Finland identified that there is a lack of regular training in BLS for professionals working in PHC.[22,16] Therefore, several authors point to the need to provide

permanent education in CPR.[22, 28,15,20]

Permanent health education is a strategy to increase the continuity of training of health professionals, ensuring access to knowledge, development of skills for practice, updating and strengthening of important skills for work.[29]

The educational intervention was carried out by some authors. In research with the implementation of training in BLS with the PHC health teams, it was found that the professionals classified their own knowledge as poor in the pre-test and as excellent in the post-test.[27]

A study carried out in Montes Claros, Minas Gerais, obtained the positive impact of training. Training using realistic simulations was also suggested to improve the knowledge and skills of professionals.[21]

However, the professionals' retention of knowledge about BLS was analyzed and a considerable drop in the average number of correct answers was observed after one year of training. That is, there was a reduction in knowledge over time.[25]

Faced with the possibility of decline in the theoretical and practical knowledge of professionals over time, the need for permanent training is emphasized, including training that includes theoretical-practical strategies.[25,24]

A study carried out in a municipality in the interior of São Paulo found that most

UBS did not meet the minimum structural requirements for BLS care, 92.3% of the units adapted their rooms for emergency care, using improvised space.[26]

The insufficient amount of materials and equipment is mentioned as a limitation for adequate care for the CRA user in the units.[24] In a rural city in Turkey, only 9.5% of the PHC centers were equipped with all the supplies to care for BLS.[19]

Of the materials considered basic, only procedure gloves and adult bag-valve-mask were found in all units studied in a city in the interior of São Paulo.[26]

There was also a lack of various materials and equipment needed for BLS. The rigid board was observed in only one unit (7.7%). The elements: simple mask, goggles and aprons were also classified as unsatisfactory, as they were not present in all units.[24]

In the analyzed studies, it was identified that the AED was not an item found in all units.[28,18] In addition, the AED is also not usually used in primary health care centers in Finland and Singapore.[16,18] It is recommended to carry out the CPR and the use of the AED by the rescuer for increasing the probability of survival in cases of out-of-hospital CPA.[30]

Early defibrillation is one of the main reasons that influence survival, since ventricular fibrillation is the most common cause of cardiac death and its treatment

consists of fibrillation. When defibrillation is performed within 3 minutes of cardiac arrest, survival rates reach up to 74%. For this reason, defibrillators must be provided in the units and professionals must know how to use them.[18,17]

It was also verified divergence in the storage, standardization and checking of the materials. Most of the materials were ordered in places that presented some obstacle to access, 53.8% did not use protocols for checking materials and 69.2% did not assign a permanent professional to carry out the task of checking materials.[26]

The importance of reviewing the conditions and quantity of materials and equipment more frequently is mentioned, in order to raise the quality of care. The importance of preparing material and equipment protocols is highlighted, as well as the maintenance of the conference and their operation.[24,26]

CONCLUSIONS

The study allowed highlighting the existing scientific production on BLS in PHC. Half of CAs occur in an out-of-hospital environment and primary care units act as a gateway to the unified health system. Therefore, it is extremely important to strengthen primary care, through the qualification and training of the professionals who are part of the team, in addition to the supply of inputs.

The present study triggered some reflections. Gaps in theoretical-practical knowledge, lack of permanent education and lack of material resources, equipment and structure, occur due to municipal managers, nurses from basic health units and other professionals who are part of the team, not seeing CPA care as part of the your role?

It is important to state that PHC, whether ESF and UBS, are part of the emergency care network as a fixed Pre-Hospital component. Therefore, the units must have resolute care when the victim is stabilized until the SAMU arrives.

Therefore, it is suggested that a study be carried out with municipal managers and nurse managers to determine their level of knowledge regarding the National Policy for Emergency Care.

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