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Urgency and emergency in primary care: perceptions of health professionals

Atendimento de urgência e emergência na atenção primária: percepções de profissionais de saúde

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RESUMO

Analisar a percepção de profissionais de saúde da atenção primária referente aos desafios vivenciados diante das demandas de urgência e emergência nas Unidades Básicas de Saúde. Pesquisa qualitativa, realizada com 23 profissionais de saúde, de julho a novembro de 2021, por entrevista semiestruturada e analisadas por Análise de Conteúdo Temática. Identificou-se que os profissionais possuem conhecimento relativo sobre a temática, apresentando como perfil de atendimento crises hipertensivas e asmáticas, convulsões, hipoglicemias e outras. Quanto ao fluxo de assistência, perpassa desde o acolhimento até a regulação, não obtendo contrarreferência do paciente e apresentando como dificuldades para a assistência a falta de recursos básicos e educação permanente. A atenção básica se mostra importante na rede de atenção às urgências e emergências e seu papel nos atendimentos à população carece de melhoria de infraestrutura, capacitação profissional, planejamento estratégico das ações e avaliação das atividades desenvolvidas.

Palavras-chave: Acolhimento. Atenção Primária à Saúde. Educação Continuada. Emergências. Pessoal de Saúde.

ABSTRACT

Analyze the perception of primary care health professionals regarding the challenges experienced in the face of urgency and emergency demands in Basic Health Units. A qualitative research carried out with 23 health professionals, from July to November 2021, through semi-structured interviews and analyzed by Thematic Content Analysis. It was identified that professionals have relative knowledge on the subject, presenting as a care profile hypertensive and asthmatic crises, seizures, hypoglycemia and others. As for the flow of assistance, it goes from reception to regulation, without obtaining counter-referral from the patient and presenting difficulties for assistance as the lack of basic resources and continuing education. Primary care is important in the urgency and emergency care network and its role in serving the population requires improving infrastructure, professional training, strategic planning of actions and evaluation of the activities carried out.

Keywords: Continuing Education, Primary Health Care, User Embracement, Emergencies, Health Personnel.

INTRODUCTION

Most of the Brazilian population depends exclusively on the Unified Health System (SUS) for health care, especially about Primary Health Care (PHC). Through this assistance modality, individual, family and collective actions are developed that range from promotion and prevention to rehabilitation, and that also helps on demand, which according to the health needs of the user, may be characterized by emergencies and emergencies.[1]

According to the National Policy of Urgency and Emergency (NPUE),[2] PHC is classified as a fixed pre-hospital component of care, being the main gateway to the Emergency Care Network. These strategies seek primary emergency care, providing first aid and attending low-risk cases according to the prerogative of the risk classification provided by NPUE. Thus, it is understood by emergencies the situations and aggravations that lead to the imminent risk of death, and emergencies the occurrences that have or not potential risk of life.[2, 3]

Currently, most urgencies and emergencies (UE) that reach PHC are caused by complications of chronic non-communicable diseases.[4] In this sense, prevention, promotion and rehabilitation actions are essential for maintaining health, especially when, statistically, cardiovascular diseases are still the main cause of death among Brazilians.[5] In addition, Ischemic Heart Disease, Stroke and Chronic Obstructive Pulmonary Disease are among the major causes of death worldwide.[6]

Thus, there is a need to prepare PHC professionals to approach UE situations, since PHC is a component of the Urgency and Emergency Network (UEN), and that due to the accumulation of unresolved demands, applicable to this level of attention, a process of overcrowding of highly complex services.[7] For effectiveness of care, health care, focusing on the UE by the PHC, should be performed with the reception of acute or chronic cases through qualified listening, risk classification and evaluation of the user's need.[2]

In the meantime, based on user demand, PHC receives several demands that if they are inadequately assisted can lead the individual to seek another reference service to solve their needs. This context warns of the lack of Permanent Health Education (PHE) protocols aimed at primary care professionals about UE care, leaving them insecure in the conduct of situations that require accurate and immediate care.(3)

Thus, considering the information listed, it was justified to conduct this research considering the need to investigate how PHC professionals direct UE cases that enter primary care services, unpreparedness of these professionals in assisting and conducting these patients. Thus, the study has as a guiding question "What is the perception of health professionals in relation to emergency care in PHC?" The objective of this study was to analyze the perception of primary health care professionals regarding the challenges faced by the demands of urgency and emergency in Basic Health Units.

METHOD

This is a descriptive and exploratory study, with a qualitative approach, carried out with 23 health professionals, including nurses, doctors and nursing technicians, who are distributed in seven Basic Health Units in the city of Petrolina, Pernambuco. The municipality is in the mesoregion of São Francisco Pernambucano, has a territorial extension of 4,561.870km² and 386,791 inhabitants, has 151 establishments linked to the SUS, 56 Basic Health Units[8].

The inclusion criteria involved professionals who worked in the Basic Health Unit for at least six months. And the exclusion criteria were professionals who were on vacation or on leave and medical certificate in the period of research. In the context of data collection,

four professionals refused to participate in the research.

Data were collected from July to November 2021. The interviews took place in the BHU, according to the availability of professionals and lasted on average 15 to 40 minutes, through a portable voice recorder, upon authorization of the participants when signing the Informed Consent Form (ICF). For its execution, the biosecurity standards against COVID-19 were obeyed.

The guiding instrument for the interviews was a script, which was subdivided to collect sociodemographic data (age, gender, professional category, degree of training, time of training, time working in BHU, work in emergency and emergency services, and continuing education course) and guiding questions according to the objective of the study: 1. Understanding of urgency and emergency; 2. Knowledge of urgent and emergency situations that could be attended at the BHU; 3. Emergency situations witnessed at the BHU and how the team acts; 4. Preparation for urgent or emergent situations in its context of action; 5. Complementary training in urgency and emergency within or outside the context of Primary Care; 6. Perception of the physical structure and material resources to act in emergency situations at the BHU; 8. Communication barriers and the process of reference and counter-reference between health services.

The data were transcribed after all the interviews and to maintain the anonymity of the participants, reference codes were used for identification in the speeches according to the professional category and order of the interviews, obtaining the acronym NT for the technical category of nursing, N for nurse and M for medical, followed by numbers, for example, NT1, NT2, N1... N2.

After transcription, the data were analyzed based on the Thematic Content Analysis method. For this type of analysis, three stages were performed: pre-analysis, exploration of the material and treatment of the results with inference and interpretation[9].

In the pre-analysis, it was possible to organize the information, formulate hypotheses and draw them according to the objective of the study. In the exploration phase, there was a coding of the data, determining the key points according to the systematization initiated in the pre-analysis. In the interpretation of the data, it was possible to define the points based on the inferences of the interviews, formulating grouping patterns for the construction of categories.

The research respected all the ethical and legal aspects presented by Resolution n. 466/12 and was approved by the Ethics Committee on Research in Human Beings of the Institute of Integral Medicine Professor Fernando Figueira - IMIP/PE, under CAAE 45812321.1.0000.5201, and opinion N 4.707.343 on May 12, 2021.

RESULTS

Table 1. General characteristics of the participants.

PROFESSION	
Nurse	08
Medical	05
Nursing Technician	10
GENDER	
Female	22
Male	01
AGE GROUP	
26 to 35 years	11
36 to 45 years	06
Over 45 years	06
TRAINING TIME	
Between 1 and 5 years	07
Between 6 and 10 years	07
Above 10 years	09
TIME OF OPERATION IN APS	
Between 6 months and 1 year	01
Between 1 and 5 years	14
Above 05 years	08

Source: The authors.

In addition, six interviewees work in another service, 10 have already worked in some service in the UE and only four people have not taken courses complementary to their training.

PROFESSIONALS' KNOWLEDGE OF URGENCY AND EMERGENCY

Considering the knowledge about UE, it was observed that most of the interviewed professionals were able to differentiate the two concepts, bringing that urgency is configured as a more basic intervention, while the emergency must be solved immediately:

> *An urgency is basic, it is pain, [...]. Now emergency is more specific, you must answer immediately.* (NT1)
> *Urgency is an aggravation that can endanger the patient's life, but it is not an imminent risk [...] of death. [...] The emergency is an aggravation that at that moment if not conducted, [...] can cause the death of the patient.* (M4)
> *The emergency must be attended immediately because the patient is at immediate risk of life, the urgency can be resolved in up to 6 hours or more depending on the case.* (N8)

On the other hand, there were professionals who made it clear in their speech that they cannot identify the difference and the other characteristics that involve the two concepts:

> *Emergency is sorted by colors, can be blue and green, and urgency, yellow and red. [...] Blue and green is that emergency you can wait for, it is not instantaneous, really like it is red and yellow, like a heart attack and stroke.* (N1)

Therefore, professionals consider that emergencies and emergencies can be met in PHC, but with some particularities due to the complexity of the demand and the limitations of the service:

> *Emergency only for stabilization of the board and a referral to another service with more structure, emergency cases yes, and we attend daily.* (M3)
> *Emergency, if it is the first care, [...] can stabilize, depending on the situation. [...] Due to its risk character, because here we do not have all the materials to maintain the service [...].* (N3)
> *Emergency case can make an initial care [...] because it has professionals and some injecting medications, [...], what you offer here does not solve the situation of the patient in its entirety but has how to start a care. Some things are solved, and others must forward to UPA or call the SAMU[...].* (N8)

In the meantime, respondents cited that emergency care in PHC is often challenging because there is no oxygen in the basic unit, in addition to the lack of medicines and other ventilatory support devices and cardiopulmonary resuscitation:

> *There is a lack of medicines [...] for bleeding of the woman herself, intense intermenstrual, [...] medicines for pressure control, intravenous. [...] There is no AMBU, I have no immobilizer, [...] you must wait for the SAMU to immobilize it, I have no oxygen, which in some units has already had.* (N2)
> *There is no AMBU, we have no oxygen point, we do not use substances such as adrenaline, we do not have defibrillator.* (NT9)
> *We do not have suture material, we do not have some medications that would be important in an emergency, for example, patient convulsing us does not have diazepam. [...] There is no tramadol.*

> *There was before, now there is no more after COVID, nebulizer, these things for asthmatic crisis. It's missing glucometer here.* (M4)

In addition, considering the demand for urgency and emergency also as part of the work process of primary care, some professionals refer to the reason these situations can be met, reaffirming PHC as an essential component of UEN:

> *We are the gateway, we are the closest place for the patient, so it ends up being the first place he looks. As we have nursing care, we have a doctor too, we have the medications that are necessary there to do now, then via SAMU we regulate the patient, but we always receive, because here is the gateway.* (N4)

PROFILE OF URGENT AND EMERGENCY CARE IN PRIMARY HEALTH CARE

As listed by the interviewees, some demands are likely to solve in PHC. Thus, the most common demands in basic health units ranged from hypertensive and glycemic crises, through respiratory and gastrointestinal.

> *[...] What has a lot here is flu syndrome, in general COVID, influenza, other viruses, asthmatic crisis, furunculosis, injuries, sawdust impacted in the ear canal, [...], dehydration by diarrhea, [...] vomiting, [...], renal lithiasis and the vesicle.* (N2)
>
> *(Here you go) hypertensive emergency, [...], pain crisis, acute abdominal pain, [...], fever, convulsive crisis, severe asthmatic crisis, [...].* (M5)
>
> *[...] The ones that appeared most and that appear now are these cases of hypertensive urgency, diabetes mellitus, women's health and COVID [...]. Usually pregnant patients who come with bleeding, with elevated BP, with urinary infections.* (N6)

However, even less frequently, cases of acute myocardial infarction, deliveries, traumatic injuries, among other emergencies and emergencies are also received:

> *He choked, [...] he arrived choking on an orange.* (NT7)
>
> *Sharp weapon accidents, heart attack, stroke, convulsive crises re-entering labor.* (M1)
>
> *[...] I have had cuts, [...] allergic reactions, anaphylactic crises, fractures [...].* (N3)

FLOW OF URGENT AND EMERGENCY CARE IN PRIMARY HEALTH CARE

According to the demands received in the BHU, it was possible to observe that there are stages connected to the assistance flow to offer a qualified service. Thus, the patient, when entering the unit, goes through a reception with classification of the condition of urgency or emergency, which determines the consequent action to solve the problem.

> *It is made a classification of this patient, [...] both the reception and the techniques there of the triage already comes, it already reports directly to the professional who is that day in the urgency, to already receive the patient.* (N4)
>
> *[...] When the patient arrives at the reception [...] care is prioritized because it is an urgency [...]. So we usually refer to the procedure room or to the dressing room, if it is a case of trauma, and from there it will be made measurement of vital signs, overall evaluation of the patient,*

general physical examination and the specific conduct of each [...]. (M3)

After receiving and summoning the team, the conducts are directed to each condition to stabilize the patient, considering or not the possibility of regulation for another component of the network.

Each situation has its care, the fracture stabilizes us, tries to keep the alignment, [...], the doctor prescribes some intravenous medication and forwards or calls the SAMU to take the patient [...]. The seizure was stabilized until the patient returned, became conscious again, where she had the sequence of [...]. (N3)

First, try to remain calm, [...] and in case of emergency, contact SAMU immediately to transfer this patient. While we get the transfer do the medication here, depending on the crisis [...]. (M5)

After referral of the patient to a more appropriate unit to attend each case, the basic unit team, as a component of family support and direct follow-up of the user, seeks information about the health status of the referred. However, they report not being usual to counter-reference and only knowing news of the patient referred through family members or contact via telephone to the referred service.

There were few cases we received, we usually know a lot about the patient because we look through the family [...], and in some cases the patient comes with a counter-reference for follow-up. (N5)

It is rare, I picked up very few times, although I also request, in our county file has the counter-reference part below, [...], but never returns filled. (M5)

Considering the reports on the flow of assistance, it is noticeable that teamwork occurs, but there are also reports of insecurity in the conduct of care, which can be compensated with the correct direction by a professional team.

[...] You have had a patient who came here with a nose full of blood, [...], I [...] had no idea how to make that bleeding from his nose stop, so much so that the lady who works with us called SAMU, and the doctor who works there said "no, just put a cold compress that will pass". He passed, then the doctor arrived and answered him. (NT4)

[...] At first I felt insecure, because of my old routine of being restricted to the medical professional, so some things I have doubt, I often turn to the team doctor, who is helpful and always willing to ask questions, [...] if I cannot solve it. (N6)

REFLECTIONS OF THE ABSENCE OF CONTINUING EDUCATION IN HEALTH

In this context, some professionals can act in the best way in emergency situations in PHC, attributing to this the experience acquired in hospital units and the constant search for updates in the area. On the other hand, others are not very prepared to act in these situations and depending on the audience, these difficulties are accentuated:

I feel prepared because I try all the time to catch up on it. So having appropriated, studied about it, helps me in that sense. And I always like to say that a nurse who goes through the urgency, through the work unit, he leaves more qualified to work anywhere. (N2)

No, not today. I do not think it is my profile. I get

> *nervous, some things I go to, I go, I face, but like, if it is aimed at children I have no action, I have a block.* (N7)

In this sense, there are reports that during professional training they did not have sufficient contact with the urgency and emergency that would allow greater autonomy for practical action. Therefore, they showed that knowledge and preparation were the fruits of the experiences lived in the daily work of care.

> *In the stages I have been there in [hospital de] Traumas, only because I am a student, when urgency and emergency arrived they as veterans already take the front of the situation, then we only see more how they act now.* (NT5)
> *I do not think I left college with a good knowledge and experience of urgency and emergency, it was something that I was acquiring with the professional experience and with the courses that we are doing.* (N8)

Considering the context of limited learning in practice and the reports of limited academic and professional training, when asked about complementary training, whether independently or promoted by the management of the municipality of action, some interviewees reported having done training in several areas:

> *Yes. The first-responder training course, I did the BLS, I did the first-responder training, I think about five times the update.* (N3)
> *[...] last week we finished a prenatal course, [...], prenatal care we also experience many cases of urgency and emergency here. (*N6)

On the other hand, about the moments of PHE promoted, most reported that there were few shares and updates of knowledge, being restricted to certain professional categories, and most stated that there was no update in urgency and emergency, time in the PHC.

> *We go in the experience of the day to day, now say that has training for the technicians here, no! When they do training is more for the doctor and nurse.* (NT1)
> *[...] Ask them if someone came here to empower us, you must learn from the stories of life, but they never called.* (NT8)

Thus, when asked about the need for and importance of the process of continuing education, the majority said to feel the lack of knowledge, considering as a basis the interval time between the training of six months to one year as sufficient according to the pre-established flow, suggesting the use of clinical cases that approach the reality and analysis of the main emergency situations experienced in PHC, to serve as a scientific basis.

> *First it should occur with some frequency of updating because urgency and emergency we have protocol update almost frequent, even if it is not annual, but at least every two years, and train the team, from the reception, door attendants, technicians [...].* (N3)
> *It must be in the hall of the themes, in the programs of permanent education, it must have these urgent and emergency training and make it as realistic as possible, [...] it is important to have training that is realistic.* (M1)

DISCUSSION

The UE is an important acute situation that happens routinely. Within UEN, these

demands can be distributed in different levels of assistance according to their complexity. However, the reality is far from the theory, the population tends to seek more complex services, such as the Emergency Care Unit with sensitive demands to PHC, causing overcrowding, which has as main causes failures in basic care.[10]

Thus, considering that UE situations need immediate assistance, health professionals show knowledge about the participation of PHC in UEN, differentiating concepts and correlating them with practice, and pointing out the main problems. According to NPUE, emergencies are health problems that imply intense suffering or imminent risk of death, while emergencies are health problems with or without potential risk to life.[3] From these concepts, most professionals can distinguish them.

Diverging from the results of this study, a survey conducted with professionals from the Family Health Strategy (FHS) of a municipality in Paraiba, showed that they are unaware of UE situations in PHC and their differentiation, demonstrating to be a decisive factor for immediate care, since it generates delay in detecting the need for health of the individual.[11] Regarding UE-related aspects, the colors of the risk classification are cited as a way of differentiating the concepts. Even with contradictions in the report, the same is still valid since it is an element of knowledge of the professional directed to the assistance process in which the severity of the demand is classified.[12]

Regarding the UE care provided by the PHC team, reports by FHS professionals from two municipalities in the interior of Piaui indicate that part of the interviewees do not show refusal regarding the provision of assistance and agree that PHC is an environment for UE care, but they show that some factors, such as work overload and lack of material and structural conditions, are important obstacles to care in the units.[10,13]

A study in three Health Centers of Santa Catarina, showed that these situations should not be met in the places due to lack of conditions and capacity for care and stabilization, but still aid with recognition as an open door to the needs of the population, even while stressing that the public should not be directed to these places in life-threatening situations.[14]

Based on the Self-assessment instrument for Improving Access and Quality of Primary Care (IAQPC), which seeks to assess the determinants for the provision of quality care in PHC, through good planning of actions and material and structural evaluation, A study was conducted in Montes Claros, which revealed a negative assessment of the quality of infrastructure, equipment and materials intended for the first UE care.[15-16]

Thus, it is emphasized that, in order to host UE situations in PHC, an appropriate environment is required with a waiting room, a multiprofessional reception room, offices and an environment for unstable cases in need of regulation to other services.[10] In addition, specific materials should be available for the first visits, such as portable and fixed vacuum cleaner; oxygen cylinder; cervical collar; glucometer; Guedel cannulas; laryngoscope with blade; oxygen mask; otoscope; manual resuscitator and bag-valve-mask.[15]

As in PHC there may be the most diverse demands, it is also necessary the availability of drugs that can be used in the first visits of stabilization of the patient, such as adrenaline; atropine; hydrocortisone; glucose 50%; terbutaline; promethazine; diazepam; haloperidol; ipratropium; phenoterol; potent antihypertensives; hypoglycemic agents; and insulin.[12]

Thus, a survey conducted in two units located in Rio Grande do Sul showed that there is no minimum structure for conducting severe cases in basic units, in addition to not having material for intubation, bag-valve-mask, defibrillator, cardiac arrest cart, emergency medications and others.[17] It is worth mentioning that the reality

is different from what is the ideal scenario for providing good care, as can be seen in this study, that despite obtaining positive results regarding the structure, the inputs and equipment are absent in the BHU, resulting in several health care limitations.

Even with numerous difficulties, health professionals strive to provide the best assistance to users, especially in cases of urgency and emergency, which require more specific attention, providing the first care within the existing possibilities.[13] Thus, the main occurrences of urgency and emergency attended in the units are hypertensive crises, glycemic decompensation, diarrhea, fever, vomiting, seizures, asthmatic crises, choking, fractures, corroborating with the findings of this study.[17,18]

Regarding the pandemic context, it is important to emphasize that the BHU were/are essential in meeting the spontaneous demand for influenza. According to a study conducted in Diadema, the pandemic reformulated all the activities developed in the RAS, especially in PHC, which needed to interrupt the routine and reorganize itself according to the attendance to spontaneous demands. The study showed that PHC had the highest number of respiratory care in approximately 25 days, evidencing the importance of its performance as a gateway to the network.[19]

Thus, when knowing the main demands present in PHC, it is necessary to understand how the assistance is operationalized in the face of emergency cases. In this sense, the Ministry of Health brings that, to provide quality care, it is necessary to welcome the user, implementing the risk classification according to severity and leading to specific care according to the clinical situation, which can be resolved within PHC or need reference.[12]

Welcoming is an indispensable tool that allows the establishment of a link between professional and user, in which qualified listening is extremely essential to identify the individual's health need.[12]

That said, the reality of the perceptions of reception assigns the function to a professional category, perceiving it only as a classification system. A study conducted in the interior of the Taquari Valley addressed that the flow of emergency care in the basic unit begins at the reception, after which the user is directed to screening and sequent conduct, but there is no risk classification, therefore, the patient is evaluated and conducted according to daily demand and clinical picture.[18]

In the high complexity, risk classification is essential for service organization, being even used through manuals, guides and protocols such as the Manchester Sorting System. This protocol can be used in PHC, and it is up to the municipality responsible to choose whether to adopt a specific system. Araújo Moreira and collaborators show that it is possible to make this adoption, but there are still negative points in the use by BHU, such as the lack of knowledge of the user, the work overload attributed to nursing, the increase in waiting time for non-insular cases and others.[20]

Still, the implementation of the Manchester Triage System in PHC represents a breakthrough, in which allows the standardization of evaluation criteria, less time during classification, and consequently, the correct direction of the patient in the correct time, thus ensuring correct conduct for the user.[21]

Knowing that PHC may not cover all the urgent or emerging demand for several factors already brought in this discussion, it is recognized that it is necessary that user regulation for other services occurs. This referral process goes beyond a referral, being a way to ensure continuity of care based on an expanded look at the patient, in which it commonly uses the mobile service for removal and transfer of the patient to the destination unit or if the direction for transfer by own means.[14,22,23]

Thus, the user has access to the network in an integral way, facilitating intersectoral communication and already knowing the need in health, since as a gateway, PHC must provide the necessary care at least for stabilization. The possibility of patient referral to a more complex service is a strategy to optimize user access to the network, not a reason for the service to deny care and anchor the need of the individual in another sector, transferring liability in its entirety, without waiting for counter-referral to occur.[22]

The result of a study conducted with professionals from a UPA in Florianopolis, pointed out that most respondents showed difficulties in performing counter-referral to health services, especially primary care, due to failures in care, the absence of counter-reference flows, in which patient information is obtained only through family contact, fragmenting care network. Still, some professionals reported that the existence of personal contact with professionals working in both locations facilitates counter-reference. In addition to this method, the use of electronic medical records is also cited, due to the individual record of network use.[24]

Based on all the discourse presented, another important point evidenced by the results of this study is the Permanent Education in Health, which is essential in the implementation of a quality care, which helps in the differentiation of concepts, identification of cases and failures in the infrastructure, establishment of care flows, reception to the referral and counter-referral process.

Emergencies and emergencies are clinical situations of little approach in graduation, undergraduates and trained professionals reinforce this discourse, showing that in the curriculum of nursing courses there is not enough practice in the area. Alternatives such as practical classes and realistic simulations are important tools for the development of the required skills.[25,26]

Having regard to the difficulties encountered in basic education, It is important to emphasize that reports of health professionals from two BHU were divided between feeling prepared or not and raised the need for periodic scientific updates through continuing education and use of protocols for emergency care.[17]

A study conducted from educational interventions related to Basic Life Support pointed out that PHC professionals have a deficit in previous knowledge about Cardiorespiratory Resuscitation, but that after the intervention, there were improvements in knowledge. It is emphasized that sporadic formations that do not associate theory with the reality of service are not enough to develop the necessary skills and acquire knowledge in the face of possible demands.[27,28]

In this perspective, initiatives such as Permanent Health Education allow the visualization of failures in care during routine activities, leading the team to the recognition of real needs and the modification of strategies, expanding educational spaces continuously.[29] Nurses from PHC in Espírito Santo showed an increase in the level of knowledge in the conducts during the Basic Life Support after educational intervention, which reinforces the need for PHE. Thus, PHC health professionals recognize the need for Permanent Health Education, since the updating of protocols and guidelines for emergency care occurs constantly.[30] Therefore, it is necessary that the training be recurrent and cover all health team professionals.[23]

In the meantime, it is necessary to emphasize that Continuing Education is the basis for quality assistance in the context of urgencies and emergencies, because through it the practices of professionals can become safe and effective, and the understanding of all aspects involving this type of care in PHC are more holistic because they address the centrality in the care of the human being.[29]

LIMITATIONS OF THE STUDY

It is considered as limitations for this research the difficulty of adhesion of some professionals to the participation and the limited time of the professionals to participate due to the accomplishment of the interviews in the working hours. Thus, these factors prevented the expansion of the research to all BHU in the municipality of coverage.

CONTRIBUTIONS TO THE AREA

Thus, the results of this research contribute to improving the quality of emergency care in primary care and the network in general, because it reinforces the importance of care provided by PHC in the face of emergencies and emergencies, in which aspects related to care professionals have more difficulties and facilities, the profile of care for preparation before the identification of the clinic, shows the need for permanent education, adequacy and sufficient inputs to provide care, and reaffirms the importance of alignment of the referral and counter-referral process. It is worth emphasizing the need to carry out other studies on the subject to highlight the reality of other regions, as well as it is essential to know the local reality widely to promote interventions and public policies.

FINAL THOUGHTS

The analysis of the results of this research pointed out that among the interviewed professionals, the majority presents relative knowledge about the urgency and emergency care, knowing how to differentiate the concepts and exemplifying as the exacerbation of the problems. In addition, the majority also agreed with the care in UE situations in PHC, but there were considerations about the limitations of the service, which were evident in relation to material and structural conditions.

It was identified the main occurrences received in the BHU (hypertensive and asthmatic crises, seizures, hypoglycemia, hemorrhages), as well as it was possible to understand how the flow of assistance occurs, based on the reception, stabilization of the patient's condition, and referencing as needed, being also identified difficulties regarding counter-reference. Still, it was found that there is no PHE directed to emergency care, justified both by deficits in basic education and by the need according to the profile of occurrences received. (hemorrhages, seizures, asthma attacks, hypoglycemia)

Having said that, it is emphasized that the PHC, as an orderly of the RAS, is the gateway to the care of urgencies and emergencies, for both, this service requires of the professionals - knowledge, skills and conditions sufficient to conduct immediate care, in order for it to be effective, public policies must be implemented in order to restructure, equip and standardize the BHU, as well as train all professionals involved, so that they can be engaged in the care of the community for which they are responsible.

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