Emergencies and emergencies in primary care: nursing vision

Urgências e emergências na atenção básica: visão da enfermagem

Urgencias y emergencias en atención primaria: visión de enfermeira

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RESUMO

Objetivo: Analisar a capacidade de atendimento de casos de Urgência e Emergência pelos enfermeiros da Atenção Básica do Guará/DF. **Método:** Abordagem qualitativa e método descritivo, de acordo com os pressupostos de Gil, no qual todos os dados utilizados foram adquiridos por meio de entrevista realizada nas UBS do Guará-DF com enfermeiros da equipe da ESF. **Resultados:** Foram obtidos por meio de entrevistas realizadas com 07 enfermeiros identificados neste estudo com indicadores alfanuméricos (E1 a E7) para salvaguardar a identificação dos mesmos. **Conclusão:** Esta pesquisa buscou entender como ocorre o atendimento aos casos de urgência e emergência na AB sob o ponto de vista do enfermeiro. Baseado nas informações coletadas considera-se que apesar existir demanda de urgência e emergência na AB, o treinamento dos profissionais e o fornecimento de infraestrutura básica não são realidade. O enfermeiro como sujeito principal neste cenário de tantas controvérsias, fica de fato instável e muito vulnerável em cada um dos atendimentos. Cabe ao SUS repensar onde de fato deve ser feito o serviço de atendimento de urgências e emergências, prover recursos humanos capacitados e caso decida que será também na UBS esse tipo de atendimento, deverá rever a estrutura física e recursos materiais para tal.

Descritores: Emergências; Atenção Básica; Enfermagem.

ABSTRACT

Objective: To analyze the ability to care for Urgency and Emergency cases by nurses from the Primary Care of Guará/DF.**Method:** Qualitative approach and descriptive method, according to Gil's assumptions, in which all the data used were acquired through an interview carried out in the UBS of Guará-DF with nurses from the FHS team.**Results:** They were obtained through interviews with 07 nurses identified in this study with alphanumeric indicators (E1 to E7) to safeguard their identification**. Conclusion:** This research sought to understand how urgent and emergency care occurs in AB from the nurse's point of view. Based on the information collected, it is considered that although there is a demand for urgency and emergency in PC, the training of professionals and the provision of basic infrastructure are not reality. The nurse, as the main subject in this scenario of so many controversies, is in fact unstable and very vulnerable in each of the consultations. It is up to the SUS to rethink where the urgent and emergency service should actually be provided, provide trained human resources and if it decides that this type of service will also be provided at the UBS, it should review the physical structure and material resources for this.

Descriptors: Emergencies; Primary Care; Nursing

RESUMEN

Objetivo: Analizar la capacidad de atención a los casos de Urgencia y Emergencia de los enfermeros de la Atención Primaria de Guará/DF.**Método:** Enfoque cualitativo y método descriptivo, según los supuestos de Gil, en el que todos los datos utilizados fueron adquiridos a través de una entrevista realizada en la UBS de Guará-DF con enfermeros del equipo de la ESF.**Resultados:**Fueron obtenidos a través de entrevistas con 07 enfermeros identificados en este estudio con indicadores alfanuméricos (E1 a E7) para salvaguardar su identificación.**Conclusión:** Esta investigación buscó comprender cómo ocurre la atención de urgencia y emergencia en AB desde el punto de vista del enfermero. Con base en la información recabada, se considera que si bien existe una demanda de urgencia y emergencia en AP, la formación de profesionales y la dotación de infraestructura básica no son una realidad. El enfermero, como sujeto principal en este escenario de tantas controversias, es en realidad inestable y muy vulnerable en cada una de las consultas. Corresponde al SUS repensar dónde realmente debe prestarse el servicio de urgencia y emergencia, dotar de recursos humanos capacitados y si decide que ese tipo de servicio también será prestado en la UBS, debe revisar la estructura física y los recursos materiales para este.

Descriptores: Emergencias; Atención primaria; Enfermería.

ORIGINAL

Introduction

Primary Care is the main gateway to the Unified Health System (SUS), and should act as a filter capable of organizing health demands, from the simplest to the most complex.[1] It is characterized by the combination of individual actions and/or collective practices designed by democratic and participatory management and health practices that encompass health promotion, protection, maintenance and rehabilitation, as well as the prevention, diagnosis and treatment of diseases.[2]

Considered as the main focus in the search for social rights and as responsible for generating responses regarding the needs and expectations of the population, Primary Care (AB) is responsible for promoting improvements in behaviors and lifestyles and for reducing social and environmental impacts. environmental in health.[3]

Primary Care (AB) is a system composed of professionals with knowledge of the health history of its enrolled population, capable of solving more than 80% of the demands of its public, without the need to refer to another service. In Brazil, AB is also known as Primary Health Care (PHC).[4]

In addition to other tasks, Ordinance GM/MS nº 2.048/023 of November 5, 2002, regulates the responsibility of Primary Care to carry out the reception of urgencies and emergencies of low severity, providing initial health care that allows the reduction of greater damage to the user until he is referred to the emergency hospital network[5]. The term Emergency is defined as a health problem with the potential to cause intense suffering or imminent risk of death, therefore requiring immediate medical treatment; and urgency characterized by unpredictable health impairment, with or without potential risk to life, where there is also a need for immediate medical attention.

Therefore, in its routine work, the Family Health team may encounter health situations where there is a need to attend to imbalances in vital functions, with or without risk of progression to immediate or mediate death. Such demands may require the action of the entire team or of a professional in isolation, depending on the circumstances of the moment[5]. However, AB does not have sufficient structure to meet such demands due to the fact that care is not provided in an organized and effective manner[6]. The likely low professional training also appears as one of the reasons that explain the low effectiveness of PC in urgent and emergency care.[7]

This fact is evidenced by studies on the overcrowding of urgency and emergency units that point out that several demands met in emergency rooms could be welcomed and resolved in AB.[6,8]

In addition to the evidence previously described, this study originated from the following research problem: Do nursing professionals who work in Primary Care feel able to perform urgent and emergency care?

This study becomes relevant, as it will allow to know the urgency and emergency care in the Basic Care of the Unified Health System of Guará - DF from the perspective of the nurse and will also contribute to the reflection of training bodies, managers and professionals of Primary Care, regarding the promotion or improvement of the necessary conditions for the success of assistance to urgent and emergency cases, regarding the adequacy of the physical

structure and the mechanisms of professional qualification, and may also contribute to the resolution of the difficulties presented.

The objective of this study was to analyze the capacity of attending Urgent and Emergency cases by nurses of Primary Care in Guará/DF.

Method

This research was carried out using a qualitative approach and a descriptive method, according to Gil's[9] assumptions.

All the data used were acquired through interviews carried out in the basic health units of Guará-DF with nurses from the Family Health Strategy team.

As a way of preserving the dignity and autonomy of the interviewees, anonymity, confidentiality, respect for individual, ethical, moral, social, cultural and religious values, as well as all other provisions contained in Resolution No. 2016, which deals with ethical specificities in human and social research.

The transcription of the collected data preserved the reliability of the narrative, the confidentiality, secrecy and anonymity of the information.

The research was developed in basic health units located in the administrative region of Guará.

Founded on May 5, 1969, with the initial objective of housing public servants of the Government of the Federal District10, the administrative region was consolidated and achieved great socioeconomic development and currently contains 3 UBSs that serve an estimated population of 140,560 inhabitants, according to data prepared by the Federal District Planning Company[11].

To carry out the research, authorization was first requested from the legal guardians of each unit and then the project was forwarded to the Research Ethics Committee (CEP).

The research subjects were nurses who are part of the Family Health Strategy team of the three basic health units in Guará, who were guaranteed confidentiality, anonymity, confidentiality and data reliability.

The research started after issuing authorization through the embodied opinion No. 5,180,582, and participants were invited to participate through a quick explanation of the purpose of the research.

After acceptance, the nurses informed which day and time were most favorable for the interview. At the time of data collection, the Free and Informed Consent Term (FICT) and the authorization term for the use of sound and image were presented to the nurses, both in two copies, so that, after the signature, the collection was authorized, the dissemination and publication of narratives.

Nurses received an alphanumeric identifier (E1 to E7) in the order in which the interviews were carried out in order to preserve the ethical criteria of the research.

The nurses participating in the research met the following inclusion criteria: being a primary health care nurse for at least one year; enjoy full mental health; be willing to participate in the research; sign the TCLE and the authorization term for the use of image and sound for research purposes.

No cultural, ethnic, economic, social or sexual criteria were considered as an exclusion factor in this research.

The interviews began after authorization from the CEP and signature of the TCLE and the authorization term for the use of image and sound for research purposes, both in two copies, one of which was in the possession of the researcher and the other was delivered to the participant.

The interviews took place in person at a place, date and time chosen by the participants. The narratives were recorded on a cell phone and later transcribed for data analysis where, as a collection instrument, a questionnaire with 10 discursive questions was used.

In total, 07 interviews were carried out, which had data saturation as a criterion for closing the data collection.

The recordings of the interviews were deleted after transcription, and the digitized data will be kept by the researchers for up to 05 years and deleted after this period.

Results e Discussion

The results presented were obtained through interviews with 07 nurses identified in this study with alphanumeric indicators (E1 to E7) to safeguard their identification.

Of the interviewees, three (03) nurses are male and four (04) are female, aged between 28 and 56 years old and time in the profession ranging from 2 to 31 years, as described in the following table:

Table– Profile of the nurses interviewed

IIdentification	Sex	Age	Time Working as a Primary Care Nurse
E1	Feminine	45 years	12 years
E2	Feminine	50 years	20 years
E3	Feminine	33 years	2 years
E4	Male	37 years	2 years
E5	Male	56 years	31 years
E6	Male	28 years	4 years
E7	Feminine	43 years	3 years

The collected data were grouped into seven categories and then transcribed reliably, preserving the anonymity of nurses.

Frequency of calls in urgent and emergency cases

In this category, nurses reported on the demand for urgent and emergency care at the UBS in which they work, and the heterogeneity in the number of frequencies was quite significant. Some units have more and others much less, considering that the latter have a strong relationship with the proximity of the UBS to the Regional Hospital of Guará, as follows:

> We receive few urgent requests, they are more of an emergency. (E 1)
>
> [...] Urgency yes, but emergency is very rare, I don't know if because the Hospital is very close. (E 2)
>
> It's not rare, but it's not frequent either. About once a week, but not very serious cases. Very serious, about once a month. (E 3)
>
> Urgent and emergency care, in primary care, are not routine care. They are more sporadic, more difficult to occur. Approximately one every three months. PCR never seen here. (E 4)
>
> Every day there's a case. (E 5)
>
> Daily, every day, every hour. (E 6)
>
> Never an emergency, because the Guará Regional Hospital is very close. [...] now urgency, it has daily. (E 7)

As it is the gateway to the health care network, the UBS must pay attention to clinical complications of an emergency and/or urgent nature, as it is responsible for the initial reception of all users and their needs.[12]

In their daily work practice, the family health team may be faced with the need to provide care to one or more individuals who present situations with a risk of immediate or mediate death.[5] Therefore, in addition to knowing about the conducts in care to urgencies and emergencies of any nature, attention must be paid to the organization of the service.[13]

Although infrequent in basic health units, circumstances that need immediate care will occur, which makes it mandatory to know where the equipment, medicines and materials to be used are.[14]

Nursing care for urgent and emergency cases in the UBS

In this category, nurses discussed how urgent and emergency care is provided in the UBS where they work, and most professionals mentioned performing risk classification, the first visits performed and the referral of the patient to secondary care, according to reports. Next:

> We do the assessment (risk classification) and the first consultations here. And then, depending on the case, we send them to the hospital together with a nursing technician from our team (E 1)

> In any case that an emergency issue is identified, we are requested to attend. We measure vital signs and assess the general condition of the patient (E 2)
>
> It depends on the case. [...] we provide support and first aid and then we call SAMU or the hospital itself [...] if necessary, we accompany the patient with the ambulance driver (E 3)
>
> The patient is brought by people or even comes on his own after feeling sick near the unit, then first aid and referral to secondary or tertiary care are provided, according to what he needs (E 4)
>
> When they arrive, we welcome this patient, check the main complaint [...] and then we do the shared consultation either with the doctor, or with the nutritionist (E 5)
>
> Patients arrive on demand, the technicians do the screening and then the care proceeds [...] according to the protocols that the Health Department makes available (E 6)
>
> The nursing technician takes care of the demand. [...] and the emergency care itself is all done by the nurse. He performs the initial assessment, sometimes he manages to resolve the demand and sometimes he shares the treatment and conduct with the doctor (E 7)

In addition to being knowledgeable about the organization of the service and having the ability to lead the care of the most diverse cases of urgency and emergency, it is up to the nurse to manage the demand according to the clinical potential of the same. By properly directing patients or providing resolute assistance, nurses collaborate in reducing emergency cases.[15]

Emphasizing the importance of carrying out the effective reception of urgencies and emergencies of users, the assessment of risk and vulnerability is essential to minimize the unsatisfactory evolution of the health problem.[16]

Urgency and emergency services most common in the ubs where they work

In this category, nurses reported which are the most frequent urgent and emergency care that occur in the UBS's where they work and most related the hypertensive peak as the most frequent clinical urgency, according to the following statements:

> Nephrotic crisis, kidney pain, acute pain, severe headache, peak of decompensated diabetes, very high blood pressure. (E 1)
>
> Hypertensive peak, pain and patient with hyperglycemia. (E 2)
>
> Hypertensive peak. I never took a stop here. (E 3)
>
> Abusive use of alcohol and drugs. (E 4)
>
> Now at this moment: fever, suspected dengue and urinary tract infection. (E 5)

> Today they are patients with dengue who cannot get hospital care, urinary tract infection and throat infection. (E 6)
>
> Hypertensive peak, high blood glucose, severe abdominal pain. [...] Sometimes a child arrives with a fever, but it's rare. It is very phased [...] but there is always a hypertensive peak. (E 7)

The excessive spontaneous demand of users due to decompensation of chronic diseases such as Arterial Hypertension and Diabetes Mellitus, in addition to being associated with greater morbidity and mortality, causes damage to the organizational dynamics of care at the basic health unit and evidences care failures. This high demand also reflects the prevalence of the care model centered on the disease and focused on the physician[17-18], which is contrary to the ideal multidisciplinary care for this public.[19]

Service infrastructure

In this category, nurses gave their opinion on whether or not the physical structure of the UBS was adequate for urgent and emergency care in primary care. Of the seven respondents, only one answered yes. The others, in addition to disagreeing, brought the following reports:

> More or less, the infrastructure could improve a bit. But as we are on the side of the hospital, we can stabilize [...] and have this service. Primary care, its previous focus, was left a little aside (with the COVID pandemic), and we are more focused on acute emergency demands, chronic cases and the history of the PSF itself, of prevention and promotion, has fallen a bit. in disuse. [...] in the case of cardiac arrest, we have no structure (E 1).
>
> More urgent (adequate) [...] Emergency we have a deficit [...] not in human resources, but in hospital equipment. (E 2)
>
> Not. We tried to make an emergency room, where the stop cart, the medications, the oxygen, in short, are. But we don't have some hospital facilities. (E 3)
>
> Not suitable even because it is not a unit intended for that. But we can perform the first service and forward it to the competent service. (E 4)
>
> No [...]. We weren't created for this, it's all based on the jeitinho, the improvisation. That primary part was left out. The objective they set for us today is to meet the emergencies that appear, without structure. We don't have a laboratory, staff, pharmacy. We pretend to the patient that everything is fine, that we are solving his problem, but we are not, we are just pretending, deceiving the patient. And for the hospital this is a very comfortable situation. But the problem is that the purpose of the Basic Unit is not to reduce the hospital queue, it is to do preventive work. Consequently, in the long term this will happen, reducing the hospital queue, but that is not our objective. (E 5)
>
> Yup. (E 6)
>
> Not emergency. We don't have a defibrillator, the stop cart doesn't have all the medicines that we've already looked at, there's no reception room

> where, for example, you put the patient on oxygen [...] the unit is not prepared to attend emergencies. (E 7)

The structure of a UBS must be able to meet both the work needs of the Family Health Team and the reception of the spontaneous health demands of the enrolled population, being, therefore, adapted to the local reality, the number of the population served and the specificity of the service.[20]

And although some of the interviewees said that the UBS is not intended for urgent and emergency care, the precepts of the Ministry of Health state that care for acute, traumatic, clinical or psychiatric conditions that may result in suffering, sequelae or death, is the responsibility of all entities that integrate the SUS network, which includes the UBS.[21]

Several studies developed with UBS nurses address the deficit in infrastructure and materials. As one that showed that 100% of nurses reported lack of adequate infrastructure and equipment necessary for urgent and emergency care and also mentioned that this impairs the quality of care[21]. Validating, another research carried out in Rio Grande do Sul with nine professionals from two PHC units in this state, revealed that they did not have the basic supplies for the provision of urgent and emergency care and that nurses considered the units unsuitable for this type of care. attendance.[22]

Still on this topic, a study carried out in 13 UBS attested that the only material needed for urgent and emergency care found in all units were procedure gloves. The automatic defibrillator (AED) was present in only one unit, however the stop cars presented obstacles to access.[23]

Training acquired during nursing graduation for professional performance in urgent and emergency situations

This category deals with theoretical and practical knowledge acquired during nursing graduation for nursing care in urgent and emergency cases. All respondents reported that graduation was insufficient, as follows:

> We don't have that training. [...] We acquire this with practice, with time, [...] with what we propose to learn. But urgency and emergency do not have in college, it has an overview, but the overview does not guarantee assistance, an effective practice. (E 1)

> [...] I didn't have training in urgency and emergency [...] I had training later, working in the basic unit with SAMU, where we had this training. But as he does not have this daily practice, he ends up having difficulty in an emergency. (E 2)

> Graduation did not prepare me, it gave me a foundation. But I think it is not restricted to the area of urgency and emergency. It's a matter of the course as a whole: the college provides support, but it's really everyday life and your studies afterward that will give you the security to act. (E 3)

> I think the graduation is a little weak, even because of the number of higher education courses that exist today of low quality. (E 4)

> It was very low, very small, we almost didn't have it, we didn't leave prepared (E 5)

> Nowadays, in my view, both public and private institutions have the vision of the generalist nurse. They want to teach everything, but at the same time they don't delve into anything. So I think that just the graduation to attend urgent and emergency cases is not enough. (E 6)

> In my training it was zero. [...] 90% of the things I do in my day to day I didn't learn in college [...] It was day to day, even here at UBS I learn with my colleagues, with the doctors, I learn a lot here. In college, like nothing. [...] I did an internship for less than a semester, I rarely went to primary care. [...] It wasn't even from the time of family health, much less urgent and emergency, we didn't even do an internship in it. (E 7)

With advances in the organization of the Brazilian emergency care system regarding the incorporation of new technologies and the definition of concepts, it is expected that professional training will also evolve and thus enable the reception, assistance and referral of users affected by diseases. acute only when the complexity of the service in question makes continuity of care impossible.[24-25]

To this end, the undergraduate Nursing course should guide the teaching of diseases of greater national relevance, covering all levels of care where nursing works through the progressive development of their skills.[26-27]

The national curriculum guidelines for the Undergraduate Nursing Course establish the profile of the graduate/professional student as a nurse with a generalist, humanist, critical and reflective background, able to identify and intervene in the most prevalent cases of health-disease in the national epidemiological profile, with actions based on scientific and intellectual rigor and ethical principles.[28]

Thus, nursing training for the care of patients in critical conditions must cover organic imbalances and facilitating strategies for care practice. Such strategies should make it possible to recognize current clinical conditions in addition to identifying situations in which there is potential for clinical worsening, so that adequate and effective management can be implemented early.[29-30]

Urgent and emergency training course

In this category, nurses were asked if they had training in urgency and emergency and, if so, if the training in question had been provided by the DF health department or carried out through their own resources.

Five of the nurses said they had training in this area, as reported below:

> I did a training a long time ago, it must be about 15 years old. Paid through own resources. (E 1)

> Yes, there's been a while. Funded by the health department itself. (E 2)

> I took some courses, the last one in 2019. All through my own resources. (E3)

> Yes, I did two residencies and all these courses I took were done during the residency. (E 4)
>
> Not. We had CONVERT, by the secretariat, when ubs was transformed into the family health model. But it was something very stuffed down our throats, [...] very imposed. And it was not useful for us to master the subject, we were taking it day by day. (E 5)
>
> Not. (E 6)
>
> I've done it mainly in the child part because I've worked in the ICU in neonatology, and I've also done some SAMU training on my own. [...] Most courses were financed by the service: SAMU, Society of Pediatrics. There is always, but in the hospital part it seems that there was more, for primary care there is very little (courses) or they are not enough for us, I don't know. There is almost no urgency. (E 7)

The need to have agile clinical reasoning to guide the decision-making process in urgent and emergency care reinforces the importance of planning educational training and specialization actions aimed at primary care nurses.[31]

About theoretical knowledge and practical skills in Basic Life Support (BLS), a study whose objective was to evaluate the care of adults in cardiorespiratory arrest before and after an educational intervention concluded that most PHC professionals demonstrated technical incapacity to act in the face of the identification of a PCR. The professionals did not know how to use the defibrillator properly, they were not able to recognize whether the heart rhythm was shockable or not, and most classified their knowledge as poor. Upon evaluation in simulated practice, most did not know how to perform the BLS maneuvers.[32]

A study carried out in the city of Maringá, Paraná, found a deficit in the identification of urgent and emergency situations, with emphasis on the difficulty in the use of essential drugs in the first care[33] and, in the municipality of Cajazeiras, in the state of Paraíba, a similar study showed that primary care professionals health professionals had insufficient professional qualifications for urgent and emergency care, and on the definition of urgency and emergency.[21]

In order to minimize risks to life and enable quality, speed, safety and quality of care, the health team must be able to identify, through initial assessment, the signs and symptoms of severity of each age group. The presence of a professional with insufficient knowledge can contribute to the worsening of the user's clinical condition.[34]

Important topics in urgency and emergency training for primary care nurses

In this category, nurses were able to express their opinion on which topics should be worked on in primary care training.

The answers were very diverse because they reflect the reality of service to the population enrolled in each UBS, according to reports:

> CPA (cardiopulmonary arrest), stroke, delivery. (E 1)
>
> They would be more emergency issues even [...] cardiorespiratory arrest (E 2)
>
> Symptoms of infarction, hypertensive spikes, hyperglycemia. (E 3)
>
> Urgency for trauma, overdose and alcoholic coma. (E 4)
>
> I think this shouldn't be a priority for us. We don't deal with CPA and seizures every day, that would be more useful in the emergency room. [...] if I had answered this question, I would be agreeing with the fact that we accept these demands. [...] in the last two months I have been attending to many chronic patients who were forgotten in the last two years of the pandemic, so they are coming in very decompensated. Decompensated DM, hypertension [...] we needed to focus on these cases [...] (E 5)
>
> The main issue would be the use of protocols. The protocols exist, they are updated, but we do not have the guidance on conduct. So, on our own, we end up seeking (knowledge) to be able to provide better care for the patient. [...] I started to practice [...] I asked questions with older nurses and I managed to assimilate well [...] But I have a colleague who took over with me who felt a lot of difficulty [...] because it came from the attention hospital and primary care is another world. (E 6)
>
> I think there should be courses for these more prevalent cases: hypertensive peaks, children who arrive convulsing. And nobody, and I'm sure of what I'm talking about because I've been through four UBS's, nobody has training or structure if you need to intubate the patient. The doctor will not know how to intubate, he will not know how to ventilate the patient, which medication he will give. If you have a defibrillator, no one will know how to use it. [...] There is no automatic defibrillator here, neither here nor in most UBS's. The Automatic is still telling you what to do, but still I'm wondering, will people know what to do in that ruckus? Will you know how to use it? I would need this training, but this is generally for the nursing area, hospital area as well. (E 7)

The reports presented show interest in primary care nurses in carrying out courses and reveal difficulties that can compromise adequate care for users who arrive at the unit in need of urgent and emergency care.

This fact is corroborated by several studies that demonstrate that updates and training are essential for the provision of quality assistance to the user. Such research evidenced the deficient knowledge of professionals working in primary care in the face of urgent situations, a fact that points to the need to implement permanent education that allows the user to be assisted with appropriate behaviors.[21]

In the urgency and emergency scenario, Cardiopulmonary Arrest (CPA) is one of the most common complications35. The user who is assisted by a health professional who has training in Basic Life Support (BLS) has a considerable increase in the survival rate36. However, professionals often present deficits in

the face of a CRA, such as the difficulty of the situation presented and the ineffective performance of Cardiopulmonary Resuscitation (CPR) sequences.[36-37]

Permanent Education in Health (EPS), implemented by means of ordinance GM/MS nº 1.996, of August 20, 2007, aims at training and qualifying health professionals based on the population's needs so that, by obtaining learning and reflection, there are daily changes in conduct that promote quality service to the user.

Final Consideration

This research sought to understand how urgent and emergency care occurs in primary care from the nurse's point of view. They were asked about various aspects ranging from their academic training, training and even the infrastructure of the UBS where they work.

Based on the information collected, it is considered that although there is a demand for urgency and emergency in primary care, the training of professionals and the provision of basic infrastructure are not reality.

The collected narratives made it possible to achieve the general objective of the research.

The following questions can also be asked: is the search for training on its own capable of guaranteeing the effectiveness of urgent and emergency care in primary care? Is the family health team, with generalist training, prepared to provide assistance in urgent and emergency cases? Wouldn't it be better to have urgent and emergency service available for these units?

Therefore, many questions emerge from this study. In an attempt to find a solution for these services, we are faced with the attributions of primary care and the need it has to promote health, prevent diseases and, as far as possible, promote recovery.

The nurse, as the main subject in this scenario of so many controversies, is in fact unstable and very vulnerable in each of the consultations. It is up to the SUS to rethink where the urgent and emergency service should actually be provided, provide trained human resources and if it decides that this type of service will also be provided at the UBS, it should review the physical structure and material resources for this.

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