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Organization of health care during a coronavirus pandemic: the reflection of collaborative work

Organización de la asistencia sanitaria durante una pandemia de coronavirus: el reflejo del trabajo colaborativo

Organização do atendimento em saúde durante pandemia do coronavírus: o reflexo do trabalho colaborativo

ABSTRACT

Despite the changes brought about by COVID-19, primary health care needs to ensure access and coverage of the territory in a comprehensive and universal manner. Objective: To report the experience of a family health resident about the reorganization of the flow of care in a family health unit during the Coronavirus pandemic. Method: This is a descriptive study, of the experience report type, about the experience of a resident inserted in the family health strategy of the José Adelino da Silva unit, in the city of Porto Velho, Rondônia. Results: The care flow was structured in order to reduce agglomerations and maintain access and resolution. The spontaneous, programmed demands and procedures of the USF service portfolio were organized. Conclusion: The reorganization of the service flows showed the potential of collaborative work. It was possible to implement the reception, qualified listening, programmed agenda and no agglomerations and queues were observed.
DESCRIPTORS: Coronavirus infections; Primary Health Care; Health planning. Interdisciplinary practices.

RESUMEN

A pesar de los cambios provocados por el COVID-19, la atención primaria de salud necesita asegurar el acceso y cobertura del territorio de manera integral y universal. Objetivo: Informar la experiencia de un residente de salud familiar sobre la reorganización del flujo de atención en una unidad de salud familiar durante la pandemia de Coronavirus. Método: Se trata de un estudio descriptivo, del tipo relato de experiencia, sobre la experiencia de un residente inserto en la estrategia de salud familiar de la unidad José Adelino da Silva, en la ciudad de Porto Velho, Rondônia. Resultados: El flujo de atención se estructuró con el fin de reducir las aglomeraciones y mantener el acceso y la resolución. Se organizaron las demandas y procedimientos espontáneos y programados de la cartera de servicios de la USF. Conclusión: La reorganización de los flujos de servicios mostró el potencial del trabajo colaborativo. Se logró implementar la recepción, escucha calificada, agenda programada y no se observaron aglomeraciones y colas.
DESCRIPTORES: Infecciones por Coronavirus; Atención Primaria de Salud. Planificación sanitária. Practicas interdisciplinariais.

RESUMO

Apesar das mudanças trazidas pela COVID-19, a atenção primária à saúde precisa assegurar o acesso e cobertura do território de forma integral e universal. Objetivo: Relatar a experiência de uma residente em saúde da família acerca da reorganização do fluxo de atendimento em uma unidade de saúde da família durante a pandemia do Coronavírus. Método: Trata-se de um estudo descritivo, do tipo relato de experiência, acerca da vivência de uma residente inserida na estratégia de saúde da família da unidade José Adelino da Silva, no município de Porto Velho, Rondônia. Resultados: O fluxo de cuidado foi estruturado visando reduzir aglomerações e manter o acesso e resolutividade. Organizou-se as demandas espontâneas, programadas e procedimentos da carteira de serviço da USF. Conclusão: A reorganização dos fluxos de atendimento evidenciou a potencialidade do trabalho colaborativo. Foi possível implantar o acolhimento, escuta qualificada, agenda programada e não foram observados aglomerações e filas.
DESCRITORES: Infecções por Coronavirus; Atenção Primária à Saúde; Planejamento em saúde. Práticas interdisciplinares.

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INTRODUCTION

Primary Health Care (PHC) is considered a gateway for users and an important strategy to reduce health inequities. It is understood as the guiding axis of the Health Care Network (HCN) in the Unified Health System (SUS) and responsible for ordering universal access. In this context, the basic health units (UBS - Unidades Básicas de Saúde) must guarantee mechanisms that ensure the accessibility and reception of users with an organizational logic. [1]

Coronavirus 2019 disease (COVID-19), caused by the SARS-COV-2 virus, has spread rapidly globally, declared a pandemic by the World Health Organization (WHO) on March 11th, 2020. [2] In this scenario, the actions of the PHC must resolve the health needs of users and the work processes organized, to face emerging diseases with a high power of infection.

It is necessary to discuss the role of PHC in fighting the pandemic, since, according to studies, around 80% of cases are mild and most of the moderate cases seek PHC as their first access to care. [3] Thus, despite the changes brought about by COVID-19, PHC needs to ensure access to health care and coverage of the territory's population in an integral and universal manner. [4]

In this scenario, the actions of the PHC must resolve the health needs of users and the work processes organized, to face emerging diseases with a high power of infection.

Based on this assumption, the COVID-19 pandemic implied in PHC the demand for effective measures, ensuring infection control and, at the same time, care for pregnant women, children, the elderly, vaccination and drug dispensing in a safe and effective way. Therefore, the elaboration of protocols, flowcharts and technical notes to guide the actions of the services for health professionals is essential, thus preventing users from being left unattended and providing quality follow-up. [4]

In order to strengthen the PHC, together with the need to expand the reorientation in the training of health professionals, the Multiprofessional Residencies in Health (RMS) emerged, created from the enactment of Federal Law No. 11.129/2005. The RMS are guided by SUS principles and guidelines [5] and emerge as a concrete possibility of articulating health services with educational institutions and the community, problematizing the reality of the territory. In this context, PHC has been occupying a prominent place with regard to equity and universal access, ensuring accessibility and quality of health care. [6]

Thus, this study aims to report the experience of a family health resident (Remusf) about the reorganization of the flow of care in a Family Health Unit (USF - Unidade de Saúde da Família) during the Coronavirus pandemic.

METHOD

This is a descriptive study, of the experience report type, about the experience of a resident in family health at the Federal University of Rondônia Foundation (UNIR) inserted in the Family Health Strategy (ESF) of the USF José Adelino da Silva, in municipality of Porto Velho, Rondônia.

The USF is located in the eastern zone of the municipality of Porto Velho-RO. It is made up of five Family Health teams (eSF) that cover the neighborhoods: Ulisses Guimarães, Marcos Freire, Ayrton Senna and Ronaldo Aragão. Furthermore, there are a large number of users who live in areas discovered by eSF and reside in rural areas.

The eSF are composed of physicians, nurses, dentists, nursing technicians, dental assistants and community health agents (CHA). In addition to receiving Remusf professionals, including: a nurse, a physical education professional, a pharmacist, a physiotherapist and a psychologist.

The USF has a reception service (Same), regulation service, pharmacy, laboratory, vaccination room, dressing room, procedure room, triage, three doctors' offices, three nursing offices, three dental offices and a Dental Specialties Center (CEO - Centro de Especialidades Odontológicas). It is noteworthy that in one part of the building, there is an emergency room (ER), however, there is often a shortage of doctors, which implies an increase in the demand for care at the USF.

Thus, the flow of care was disorganized with high spontaneous demand to the detriment of scheduled demand due to the large number of users coming from discovered territories of eSF. The USF was in an attempt to adapt the flow of the programmed schedule and spontaneous demand when the pandemic started, thus needing the urgent organization of care.

RESULTS AND DISCUSSION

The implementation of the flow of care during the pandemic took place through the organization of the types of demands of the USF, divided between spontaneous demands, programmed and procedures of the portfolio of services offered by the USF.

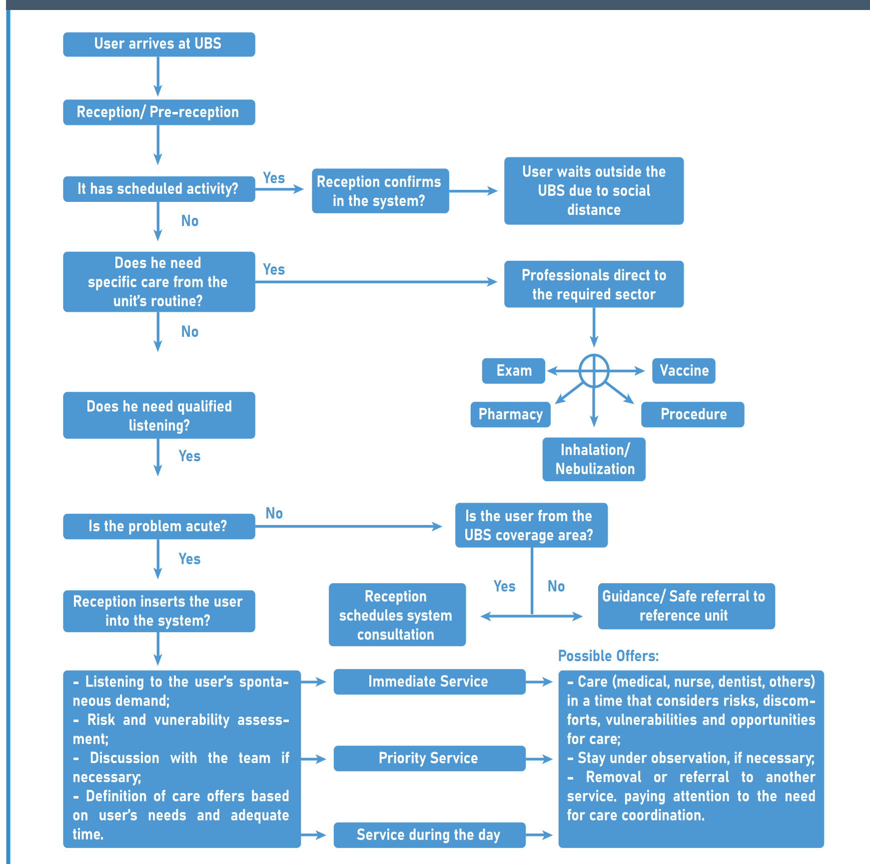
The flow of care (Figure 1) was structured from discussions with USF professionals and residents, considering the contingency plan of the Municipal Health Department (SEMUSA - Secretaria Municipal de Saúde) of Porto Velho-RO. [7]

This process in which several health professionals work collectively to positively impact care practices is understood as interprofessional collaborative practice (ICP), which involves systematic negotiation and interaction between professionals, aiming to discuss the actions that will be carried out by the various social actors. [8]

The flow of care was structured to reduce agglomerations and maintain access to and resolvability of care. Thus, the USF organized the following care scenarios: Reception/pre-reception, reception, reception with qualified listening, programmed care and telemonitoring.

According to the flowchart (Figure 1), the first contact between professionals and users takes place in the recep-

Figure 1: Schematic representation of the reorganization of the flow of care at the USF José Adelino da Silva during the coronavirus pandemic.



Source: the authors (2021)

tion/pre-reception. This strategy is organized at the entrance and aims to filter the demand and direct the internal flow of the USF, respecting social distance and a minimum number of people.

Welcoming is an important device in the organization of PHC as a way to enable users' access to health services. [9] It is about the "user reception, since their arrival, taking full responsibility for them, listening to their complaints, allowing them to express their concerns and anxieties and, at the same time, placing the necessary limits, ensuring resolute attention and articulation with others health services for the continuity of care". [10]

Thus, in this sector, users are asked about their complaints and area of residence. Thus, it becomes possible to identify whether it is an acute, chronic or acutely chronic case and these reside in areas covered by eSF, aiming to guarantee the longitudinality of care. Thus, users who are not part of the area covered by the USF are guided and referred to their reference unit. It is worth noting that any user with an acute or acute chronic case will be treated regardless of their referral unit.

At reception, the flow is continued. Once the user's need is identified, the professional present at the reception/pre-reception requests the documents and SUS card and goes to the reception, while the user waits for care outside the USF, considering the wide and well-ventilated environment and thus, avoiding agglomerations.

In order to organize access to the UBS, the classification in: attention to spontaneous demand-urgency/emergency and attention to scheduled demand is proposed. As for the first, situations that are not characterized as urgency or emergency should have the situation/complaint evaluated by the professional who, depending on your need and availability of the service, will be able to: assist you immediately; to schedule an appointment; refer you to another point of attention. In programmed care, we will seek to respect the criteria of adscription of the eSF clientele, that is, the user should preferably be identified by the ACS and assisted by the doctor, nurse or dentist in their area. [9]

Therefore, for access to be successful, it is necessary to organize the reception with qualified listening. Unlike screening, qualified listening aims to welcome the user, taking an approach based on equity, a broader view of the individual and comprehensive care. In this scenario, users' demands with risk classification and vulnerabilities are listened to and, based on that, care offers are defined.

Demands that fall into the colors red, yellow and green must be met on the day according to your needs and adequate time, and demands classified in the color blue will have appointments scheduled through blocks of hours.

Interventions according to the stratification of the user's needs are classified as “Not Acute” (scheduled interventions) and “Acute” (immediate, priority or on-day care). The non-acute situations and the three types of care for acute or chronic acute situations were represented by colors. [11]

Demands that fall into the colors red, yellow and green must be met on the day according to your needs and adequate time, and demands classified in the color blue will have appointments scheduled through blocks of hours. [11] On the other hand, scheduled appointments are scheduled in advance in agreement with users, avoiding the accumulation of people at the same times and long waiting periods. [9]

On the other hand, in the pandemic, many users in the catchment area are not attending the UBS due to social isolation, anguish and fear. This leads to a reflection on the access, longitudinality and responsibility with the ascribed territory. Thus, valuing the objectives and guidelines of the SUS, Telemonitoring was implemented.

Telemonitoring is characterized by remote monitoring of patients, whether for treatment assessment or epidemiological verification. Although this practice was not used on a large scale by the SUS, it constituted an important strategy to promote social distancing and, at the same time, the continuity of care. [12]

Thus, through the search in the territory, the CHAs identify users with SG, as well as other complaints and needs. From this, the FHS carry out monitoring via telephone and, if necessary, interventions in the unit or household.

It appears that the USF, in addition to seeking to serve users during the pandemic, also seeks to implement reflections on specific and common skills

through Interprofessional Education (IPE), which, according to Costa, [13] enhance the development of collaborative skills, as they favor interaction between professionals.

CONCLUSION

The reorganization of care flows in the PHC, added to the efforts to fight the pandemic, evidenced the potential of the work in an interprofessional perspective. It was possible to implement the reception, qualified listening, programmed schedule and there were no crowds and queues during the appointments.

The participation of residents brought a new dynamic to the teaching-learning process and enabled the integration between service and teaching and the development of collaborative practices. In addition, the moments of discussion of the flows between the teams allowed to rescue the role of each professional inserted in the PHC, giving new meaning to and strengthening teamwork, the effectiveness and effectiveness of assistance and health care.

Finally, this study is expected to disseminate the potential of collective construction, considering different perspectives and the interprofessional perspective on themes that cut across the professions and motivate health professionals to invest and apply IPE in different areas of knowledge.

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REFERENCES

1. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Acolhimento à demanda espontânea / Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. – 1. ed.; 1. reimpr. – Brasília: Ministério da Saúde, 2013. 56 p.: il. – (Cadernos de Atenção Básica; n. 28, V. 1).

2. World Health Organization (WHO). WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020 [Internet]. Geneve: WHO; 2020 [cited 2020 Mar 23]. Available from: https://www.who.int/dg/speeches/detail/whodirector-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

3. Dunlop C, Howe A, Li D, Allen LN. The coronavirus outbreak: the central role of primary care in emergency preparedness and response. BJGP Open [Internet]. 2020 Jan [cited 2020 Apr 15]:pii:bjgpopen20X101041. Available from:

https://doi.org/10.3399/bjgpopen20X101041.

4. Andres SC, Carlotto AB, Leão A. A organização e estruturação do serviço de saúde na APS para o enfretamento da Covid-19: relato de experiência. 1 [Internet]. 1o de abril de 2021 [citado 1o de maio de 2021];3(1):09–15. Disponível em: https://apsemrevista.org/aps/article/view/137

5. Brasil. Lei n° 11.129, 30 de junho de 2005. Institui o Programa Nacional de Inclusão de Jovens – Projovem; cria o Conselho Nacional da Juventude (CNJ) e a Secretaria Nacional da Juventude; altera as Leis nº 10.683, de 28 de maio de 2003, e 10.429, de 24 de abril de 2002; e dá outras providências. Diário Oficial da União, Brasília, DF, 30 jun. 2005.

6. Ribeiro JP, Mamed SN, Souza MR, Souza MM, Rosso CFW. Acessibilidade aos serviços de saúde na Atenção Básica do Estado de Goiás. Rev. Eletr. Enf, Goiania, v.17, n.3, p. 1-11, jul./set. 2015.

7. Prefeitura do município de Porto Velho. Secretaria municipal de saúde. Plano municipal de contingência para resposta às emergências em saúde pública coronavírus. Porto Velho, abril, 2020.

8. Reeves S, Pelone F, Harrison R, Goldman J, Zwarenstein M. Interprofessional collaboration to improve professional practice and healthcare. 102 outcomes. Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD000072. DOI: 10.1002/14651858.CD000072.pub3.

9. BRASIL. Conselho Nacional de Secretários de Saúde. Planificação da Atenção Primária à Saúde nos Estados / Conselho Nacional de Secretários de Saúde. – Brasília: CONASS, 2011.

10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS : documento base para gestores e trabalhadores do SUS / Ministério da Saúde, Secretaria de Atenção à Saúde, Núcleo Técnico da Política Nacional de Humanização. – 3. ed. – Brasília: Editora do Ministério da Saúde, 2006.

11. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Acolhimento à demanda espontânea: queixas mais comuns na Atenção Básica / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica. – Brasília: Ministério da Saúde, 2012. 290 p.: il. – (Cadernos de Atenção Básica n. 28, Volume II).

12. Santos GG, Paco JAO. Visão e atuação humanizada de estudante do curso de Especialização em Enfermagem Obstétrica no parto. Glob Acad Nurs. 2020;1(1):e9. https://dx.doi.org/10.5935/2675-5602.20200009.

13. Costa MV. A educação interprofissional no contexto brasileiro: algumas reflexões. Interface (Botucatu), v. 20, no. 56, pp. 97-198, 2016. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832016000100197.