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Family health residents in patient care in the pandemic: an experience report

Residentes em saúde da família na assistência à paciente na pandemia: um relato de experiência
Residentes de salud familiar en atención al paciente en la pandemia: informe de experiencia

RESUMO
OBJETIVO: Relatar a atuação dos residentes do Programa em Saúde da Família na assistência a pacientes no contexto da infecção de Sars-CoV-2. MÉTODOS: Trata-se de um estudo descritivo do tipo relato de experiência, realizado na Unidade Básica de Saúde da Família (UBS) destinada ao atendimento de pacientes sintomáticos respiratórios, delineado do mês de julho a dezembro de 2020. RESULTADOS: A UBS passou a ser referência no município para assistência de pacientes portadores de sintomas respiratórios, promovendo o diagnóstico e tratamento do COVID-19. CONCLUSÃO: Baseado no relato descrito, é possível confirmar que a experiência vivenciada, além de contribuir para o aprendizado dos residentes multiprofissionais, colaborou significativamente com o êxito das ações exercidas.
DESCRITORES: Atenção Primária à Saúde; COVID-19; Residência não Médica.

ABSTRACT
OBJECTIVE: To report the performance of residents of the Family Health Program in patient care in the context of Sars-CoV-2 infection. METHODS: This is a descriptive study of the experience report type, carried out at the Basic Family Health Unit (UBS) for the care of symptomatic respiratory patients, delineated from July to December 2020. RESULTS: The UBS became to be a reference in the city for the care of patients with respiratory symptoms, promoting the diagnosis and treatment of COVID-19. CONCLUSION: Based on the report described, it is possible to confirm that the lived experience, in addition to contributing to the learning of multidisciplinary residents, significantly contributed to the success of the actions performed.
DESCRIPTORS: Primary Health Care; COVID-19; Non-Medical Residence

RESUMEN
Objetivo:Identificar la representación social de métodos no farmacológicos para el alivio del dolor durante el trabajo de parto. Método: Estudio descriptivo, con abordaje cuantitativo y cualitativo, realizado en una unidad de maternidad de Colatina / ES. Las entrevistas se realizaron mediante la aplicación de un formulario semiestructurado y se extrajo la transcripción completa para el análisis semántico de la información y las evocaciones. Resultado: Para los participantes, las representaciones sociales sobre el término "método no farmacológico (NFM)" se estructuraron en un tronco principal representado por los términos "Confort", "Relajante", "Bien", "Alivio" y "Cuidado". , demostrando el reconocimiento de los beneficios de usar los métodos y provocando sentimientos positivos durante el parto. Conclusión: Queda por admitir que las MNF tienen un gran potencial para asistir a las parturientas, ya que los beneficios logrados se evidencian en el estudio y comprender su importancia en las salas de parto es fundamental para la calidad de la atención de salud de la mujer.
DESCRIPTORES: Atención Primaria de Salud; COVID-19; Residencia no médica

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INTRODUCTION

Manifested at the end of 2019, the new coronavirus, the causative agent of a collection of pneumonia cases in China, was named SARS-CoV-2. However, there is no full information about the natural history of the disease. It was shown that the virus is highly transmissible and causes a Severe Acute Respiratory Syndrome (SARS) that can range from mild cases, about 80% of cases, to very severe, between 5% and 10%, which can progress to respiratory failure. (1) Although the pandemic started in China in December 2019, in Brazil, the first episode was evidenced and reported in March 2020. (2)

In view of this, the World Health Organization (WHO) announced on March 11th that the world would be in a pandemic situation. (3) Due to this reality, measures were established in order to reduce viral transmission. These safety measures include: adherence to masks, hand hygiene, abundant cleaning of surfaces, respiratory etiquette, border surveillance and cessation of operation of businesses deemed non-essential, being examples of non-pharmacological measures that have been proposed to control the high contamination rates. (4)

The speed of transmission between countries resulted in a pandemic, attributed to the close communication of infected individuals, symptom manifestations, and people's path in environments without air circulation. (5) Regrettably, there was no standardized global approach to confronting COVID-19. Each country dealt with the pandemic according to the competences, alternatives and hypotheses evidenced by their respective epidemiological surveillance. As an outcome of the lack of resolution, the countries showed different speeds in relation to the transmission of the disease. Some showed considerable success in managing the disease in their population, while others, although with correct practices, had little resolution. (6)

The measures taken to control the virus reflected in different instances of society, especially in the health sphere, which focused on the assistance provided to suspected or confirmed cases, as well as the need for human resources, materials and beds available in the Intensive Care Unit. (7) However, in addition to medical care, it was necessary to

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concentrate attempts to effectively control the pandemic, through actions targeted at the population, in order to protect them from transmission, with early identification of signs and symptoms, social isolation , monitoring the case and household contacts, treatment and rehabilitation of those affected. (8)

Combating the current pandemic requires community, promotional, territorial and inclusive health surveillance. (8) In this sense, Primary Health Care stands out as a gateway to the Health Care Network, with the establishment of strategies aimed at achieving effective results during the pandemic, in the construction of resolving and effective interventions in mild and moderate cases of COVID-19, as well as in the recognition and directing of severe cases to the most complex levels of care. (7)

In light of the above, this paper aims to report the performance of multidisciplinary residents of the Basic Care in Care program in the context of SARS-CoV-2 infection.

METHODS

This is a descriptive study, of the type of experience report, which aims to describe the characteristics of a certain scenario, event or population. (9) The setting was a Basic Family Health Unit (UBSF) in a municipality located in the northwest of São Paulo, a field of multidisciplinary residents' practices. The unit covers an estimated population of 15.898.000 users, has three family health teams and included in them, three nurses, two obstetricians, three clinicians and two pediatricians.

The activities were developed in a UBSF, carried out from the experience of multidisciplinary residents in primary care with an emphasis on the family health strategy, delineated between July and December 2020. Among the professionals involved, nurses stand out, nursing technicians, multidisciplinary residents and physicians.

The unit refers to a service aimed at providing family health care in the community which, following the city's regulations, became a reference unit for respiratory syndrome, whose care became exclusively for those suspected and confirmed of COVID-19.

As inclusion criteria, the reports, observations, experiences lived by residents in family health in view of their actions and activities were used, considering the role in care, people, materials and flows in the face of the COVID-19 pandemic, as well as their experiences associated with changes in the work process and the challenges of a new routine.

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ASSISTANCE SCHEDULE

The pandemic scenario required adaptation and assistance and structural reorganization in institutions and services of all levels of complexity, creation of isolation wards, organization of assistance flows, elaboration of protocols, relocation of professionals, development of permanent education, in addition to the necessary actions to serve the population. (10,11)

On July 14, 2020, the Basic Health Unit, which until now was a service for family health care in the community, became a reference in the city for the care of patients with respiratory symptoms, whose activities focused on promoting the diagnosis and treatment of COVID-19. Therefore, due to the demand of the population, the extension of working hours, as well as the fact that professionals belonging to the risk group are transferred to services not referred to the care of respiratory symptoms, there was a need to insert new employees in the unit, among them, nurses, nursing technicians, administrative assistants and physicians.

Initially, a meeting was held with the professionals and residents of the unit, in order to clarify the protocols, define the organization of the internal flow of care and division of employees with their proper functions. Therefore, a routine of permanent education was established with health professionals in accordance with the approval of municipal decrees.

In primary health care, a flow of care was established, in which the user, before entering the unit, was received at the entrance by a properly trained health professional, in order to clarify possible doubts, identify the presence of respiratory complaints (cough , fever, runny nose, odynophagia, among others), direct the patient to an appropriate unit in case of absence of symptoms, organize the waiting list and lead the patient to care, then performing the screening early. Soon after the patient was admitted, care was continued by the Resident Nurse and Nursing Technician to carry out the reception and verification of vital signs. In the reception, the user was approached about their complaints, symptoms, onset of the condition, comorbidities, drug and food allergies, workplace and function, home contacts, updated telephone numbers, immunization against influenza in 2020 and if the patient had contact with confirmed cases for COVID-19, in addition to providing guidance related to home isolation, mask use and hygiene.

After screening, the user who was stable, with no apparent signs of seriousness, was taken to the waiting room to wait for medical care. After the medical consultation and request for tests, the user with mild symptoms was referred to the care room for the resident nurse and unit nurse to report the case on the e-SUS platform to then proceed with the collection of RT-PCR for confirmation of SARS-CoV-2 infection.

During case notification, the nurse was responsible for registering the test request in the laboratory network and filling out the spreadsheet used to control collections with the patient's data (full name, workplace, updated telephone numbers, date of onset of symptoms and criteria for monitoring) and the test result. For user monitoring, the attached spreadsheet was used in order to communicate the test results, maintain the investigation, user

monitoring and household contacts, with emphasis on patients with comorbidities (Hypertension, Diabetes Mellitus, Decompensated Respiratory Diseases, Immunosuppression, among others).

The user with changes in vital signs, with decreased oxygen saturation, the value less than or equal to 94%, was referred to the emergency room of the unit, in order to briefly stabilize this change. The emergency room had a medical care team, a nursing team and essential equipment to provide care to critically ill patients.

With an increase in unstable users, those who remained accommodated in the emergency care unit under the care of the nursing staff and residents. During this period of recovery of the condition, the user was submitted to laboratory tests and prescribed medications as needed and, when necessary, oxygen therapy was installed with a volume determined according to the saturation presented. In cases of patients whose condition worsened, they were referred to an inpatient unit through the Mobile Emergency Care Service (SAMU). However, due to the increased demand for COVID-19 cases, the SAMU could not readily respond to patient regulation, and the user remained monitored in the unit with assistance and guidance, waiting for the arrival of the ambulance for transport to a hospital unit.

In cases where the patient came to the unit with complaints that had started for 14 days or more, the procedure was to perform a rapid test to detect SARS-CoV-2. After completion of the test, the report was granted, as well as the provision of appropriate guidance given by nurses and residents. After releasing the result, it was also the responsibility of the service to update the notification, with information on whether the suspected case had been confirmed or not.

DISCUSSION

Given the above, the attributions of the residents contributed to meeting the needs of users, in addition to direct assistance, reception, notification of cases, PCR test collections, daily updating of the COVID-19 case sheet, monitoring of confirmed cases, evaluation of the actions taken and the outcomes, daily telephone contact to monitor users, communication of test results, contact with reference individuals at home and the necessary guidance. This provided monitoring and identification of mild, moderate and severe cases of the disease, guidance on the worsening of symptoms and immediate return to the health service for reassessment, when necessary.

The carrying out of activities help the well-being of users' lives from a multidisciplinary practice, favoring collaborative action between health professionals and promoting comprehensive care, which is essential for strengthening the SUS.

There was an active role of residents in the care unit for suspected and confirmed patients of COVID-19 and the experience of learning about urgent and emergency situations in primary health care.

The adhesion of residents to the implementation of the new flow of care, assistance to users, the use of personal protective equipment and the resolution of other demands made, with knowledge and a sense of responsibility, was evidenced. The carrying out of activities help the well-being of users' lives from a multidisciplinary practice, favoring collaborative action between health professionals and promoting comprehensive care, which is essential for strengthening the SUS. (12)

Residents had the support of nurses, the family health team and managers in constant supervision, which provided autonomy and the development of training for the exercise of activity and function based on scientific knowledge. Thus, when working in multidisciplinary teams, the role of each professional is valued, thus favoring qualified assistance, collective work and the opportunity for new knowledge about other areas. (13,14)

Thus, since the work of residents together with health professionals at the UBS favored the work process, the quality of care and patient safety.

CONCLUSION

When reporting the experience lived in the current pandemic scenario, we saw the diversity existing in them and their potencies, recognized through the adopted strategies, such as planning, in which the

protagonist is the family health team, which together with the multidisciplinary residents had partnerships with management and society.

Based on the described report, it is possible to confirm that the lived experience contributed to the training of residents, significantly collaborated with the success of the practices, provided work with a multidisciplinary team and provided safe and quality care to the user. Therefore, the bond established between all professionals, who included residents in the service routine through the program, was a fundamental foundation for the implementation of new strategies and care flows, especially in a pandemic period, as currently experienced.

The professionals' capacity for resilience and reinvention and the importance of this workforce for the community are considered.

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