

# Is it possible to improve reception in the pandemic? An experience in primary care

É possível melhorar o acolhimento na pandemia? Uma experiência na atenção primária

Es posible mejorar la recepción en la pandemia? Una experiencia en atención primaria

## RESUMO

Objetivo: analisar a qualidade de vida e a presença de dor musculoesquelética em profissionais de um instituto de ensino federal localizado no município de Ipojuca. Método: estudo transversal que analisou 51 profissionais, com coleta de dados entre março e julho de 2021, através dos instrumentos: formulário sociodemográfico; SF-36 (Medical Outcomes Study 36 – Item Short – Form Health Survey) e o questionário nórdico musculoesquelético. Resultados: Os domínios de QV dos participantes apresentaram valores muito próximos para baixo e alto valor, com destaque negativo para os domínios aspecto emocional e capacidade funcional, evidenciando que a capacidade para realizar as atividades cotidianas e o estado emocional foram impactados pela pandemia. Também, dores em pescoço, ombros e costas foram sentidas por grande parte da amostra, independentemente da idade ou da função. Conclusão: Torna-se útil que as instituições invistam na melhoria da qualidade de vida dos trabalhadores, cuja abordagem deve ser subjetiva e multidimensional.

**DESCRIPTORES:** Estratégia de Saúde da Família; Atenção Primária à Saúde; Acolhimento, COVID-19.

## ABSTRACT

Objective: The high demand of users seeking care and the tiring waiting time in the Family Health Units are a reality in Brazil, thus hindering the user's access to the health service. The present report sought to narrate an experience of (re)forming the reception within a context of exception: the pandemic by COVID-19. Objective: To restructure this process, seeking to enhance care from the perspective of a resident in Family and Community Medicine. Methods: Meetings were held every 15 days for 2 years. Results: The workers suggested ideas to reorganize the reception, aiming to expand the clinical and listening capacity of the health team, in addition to fostering a critical sense of self-assessment in everyone. Conclusion: The reception in the Bela Vista 2 team expanded the semantic field and can improve the feeling of belonging and the ability to care by giving time, voice and place to all workers.

**DESCRIPTORS:** Family Health Strategy; Primary Health Care; User Embrace, COVID-19

## RESUMEN

Objetivo: La alta demanda de usuarios en busca de atención y el agotador tiempo de espera en las Unidades de Salud de la Familia son una realidad en Brasil, dificultando el acceso del usuario al servicio de salud. El presente reportaje buscó narrar una experiencia de (re)formar la recepción en un contexto de excepción: la pandemia por COVID-19. Objetivo: Reestructurar este proceso, buscando potenciar el cuidado desde la perspectiva del residente de Medicina Familiar y Comunitaria. Métodos: Las reuniones se realizaron cada 15 días durante 2 años. Resultados: Los trabajadores sugirieron ideas para reorganizar la recepción, con el objetivo de ampliar la capacidad clínica y de escucha del equipo de salud, además de fomentar en todos un sentido crítico de autoevaluación. Conclusión: La acogida en el equipo Bela Vista 2 amplió el campo semántico y puede mejorar el sentimiento de pertenencia y la capacidad de cuidado al dar tiempo, voz y lugar a todos los trabajadores.

**DESCRIPTORES:** Estrategia de Salud Familiar; Atención Primaria de Salud; Acogimiento, COVID-19.

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### Aenne Tavares De Andrade

Resident physician in Family and Community Medicine at the University Center of João Pessoa.

ORCID: 0000-0002-6104-9903

### Denise Mota Araripe Pereira Fernandes

Master in family health, professor and preceptor in Family and Community Medicine at the Municipal Health Department of João Pessoa in partnership with the Faculty of Medical Sciences of Paraíba – FCM/PB-Afya.

ORCID ID: 0000-0001-7804-882X

## INTRODUÇÃO

The Unified Health System (SUS), enacted in the 1988 Constitution, is based on the universal premise of health as a right for all and a duty of the State. However, one of the great challenges is to guarantee such access in an agile, inclusive and resolute way. Primary Health Care (PHC) is the first level of complexity of the SUS, that is, the gateway to the health service. The user, in order to be guaranteed in the search for health care, respect for such ethical principles, must find a strong and well-structured PHC model, offering the best care to the user.<sup>1,2</sup>

In Brazil, the Family Health Strategy (FHS) is the model in which PHC finds to guarantee access and constitutional premises. Thus, great demands and tiring waiting time are a reality in Family Health Units (FHU), and this may be enhanced by the lack of qualified listening, commitment of professionals and difficulties of multi and interdisciplinary work.<sup>1</sup>

Possibilities to improve users' access are given with the establishment of care devices such as reception. This tool is highlighted in the National Humanization Policy (PNH - Política Nacional de Humanização), developed in 2003, and which has been implementing the principles of the SUS, encouraging solidary exchanges between managers, workers and users.<sup>3,4</sup>

The PNH proposes, through the welcoming guideline, a way to expand access based on the reorganization of the work process and qualified listening, which can be performed by any member of the team. In order to guarantee not only the service of all users, but the promotion of continuous care, approximation and rapid response to demands that may be raised through the assessment of vulnerability, severity and risk.<sup>3</sup>

This policy prioritizes that the demands presented by users are heard and accepted without judgment, so that there are no barriers between users and worke-

rs. Thus, all health issues or problems related to the quality of life and well-being of subjects will be important and recognized, legitimizing their voices that seek help directly or indirectly. Qualified listening thus requires the preparation of all professionals to accommodate the unforeseen events that escape any schedule.<sup>4</sup>

In this context, after observing the

**The welcoming process was summarized by the team nurse, resulting in work overload and lack of multiprofessional involvement.**

operation of the access flow of FHU Unindo Vidas users, especially the Bela Vista 2 team, flaws were identified in the reception process that weakened trust relationships and the bond between professionals and users. There was also a prolonged time to resolve the demands brought by users due to the absence of early interventions, leaving them dissatisfied

and discredited in the health service.

The infamous distribution of cards for medical care - controversial for limiting care, placing him in the role of the doctor as a single subject capable of solving the problems presented, but powerful for organizing the flow and generating some security for users - mixed with the very concept of qualified listening by the team in question, since it happened for an hour in each shift, that is, after a given time, how this user who arrived would be welcomed or not was a daily conflict for the workers.

The welcoming process was summarized by the team nurse, resulting in work overload and lack of multiprofessional involvement. In this way, an inefficient reception was perceived, with prolonged listening time, little identified needs and high demand for referral to medical care.

The present research aims to narrate an experience of improving the reception, identifying the possible flaws and overcoming them through the reorganization of the work processes, and finally offering an increasingly adequate, effective and humanized reception to the users.

## METHODS

This is an experience report lived by a resident of Family and Community Medicine, a doctor from the Bela Vista 2 team with approximately 3,400 registered users. This team is part of the Integrated FHU Uniting Lives in João Pessoa (PB). Integrated units are spaces with two or more Family Health teams sharing the same building and strategic space to support care.<sup>5</sup> The aforementioned medical residency lasts for 2 years, the period during which the study in question was carried out.

The report presented was structured according to the SQUIRE 2.0 protocol.<sup>6</sup>

## REPORT DESCRIPTION

During the first month of residency in Family and Community Medicine (MFC - Medicina de Família e Comuni-

dade), it was observed how the reception took place at the USF. This process was performed by a single professional on the team: the nurse, from 7 am to 8 am in the morning shift and from 12 pm to 1 pm in the afternoon. The forms were distributed by the administrative assistant to anyone who arrived between that time. After that, users were instructed to return for the next shift, except in urgent cases, in which the patient was welcomed outside the previously established time.

The experience of the consultations and the learning of the theoretical framework of the MFC led us to the perception that more than 80% of the patients who underwent reception were referred to the doctor and that the removal of the medical records only started after the reception was completed. Thus, users arrived, spoke to the professional listed to receive them, but only after listening to all the patients did they remove the medical records, greatly increasing the waiting time for the beginning of the consultations. This issue became unsustainable in the pandemic, as the waiting time could generate illness and viral spillage. Change was a pressing need, but with the pandemic it has become an unprecedented urgency.

One of the main problems observed and that required a quick intervention was in relation to patients who arrived at the Unit after the time of distribution of the forms. It was inhumane for them to return home without even being heard and welcomed. Therefore, everyone who sought the unit began to be welcomed by any professional from the Unit, usually by a nursing technician. Another change was that the reception was no longer performed exclusively by the nurse. For this, a scale of professionals was created, who were responsible for qualified listening in their respective shifts.

The administrative assistant enhanced his work, taking responsibility for directing users who arrived with an activity already scheduled to their sectors, thus avoiding unnecessary waits and possible confusion at reception. This resulted in

Table 1. SQUIRE Protocol.	
<b>Problem description</b>	Ineffective reception of a Family Health team
<b>Context</b>	Pandemia pelo COVID-19 diminuindo a tolerância do tempo de espera para o atendimento na USF
<b>Intervention</b>	Conversation circle with workers, rethinking the concept of reception based on their previous knowledge, facilitated by the resident and mediated by the preceptor of the Medical Residency Program and MFC
<b>Measures</b>	Description of the report, process of regaining a more structured reception and with people's needs
<b>Ethical considerations</b>	As it is an experience report, the present study was not submitted to the research ethics committee.
<b>Summary</b>	Dialogued processes in the Family Health team that use light technologies that can be used to facilitate the work process should be stimulated, given the power of such tools
<b>Limitations</b>	The study findings cannot be extrapolated, as it is an experience report.

Source: prepared by the authors (2022).

a decrease in the number of people referred to qualified listening, preventing it from extending and interfering in the programmed activities of that professional. Therefore, patients who, for example, sought the Unit in order to receive a vaccine, collect an exam, receive medication or some secondary level referral did not receive forms and were already directed to solve their needs.

A complaint brought by the users themselves was about the long listening and the difficulty in accessing the doctor. Because, during the listening, the professional wanted to solve demands that were not urgent and required time, causing a delay that only postponed the resolution of the users' needs. Realizing this, a flow was created to renew prescriptions for chronic patients. If they did not complain on the day, they would leave the recipe with a professional on the team and return at the end of the day to pick them

up – in specified folders at reception. Thus, the doctor or nurse analyzed the chart in a timely manner and the patient did not stay in the unit.

### The strategy used

Through the biweekly meetings, a powerful space for exchanges was created where everyone suggested ideas to reorganize the reception process in order to expand the clinical and listening capacity of the health team, in addition to fostering a critical sense of self-assessment in each worker.

In possession of the knowledge that the reception process is not immutable, nor defined only by health professionals, and that several readjustments are needed during the team experience, fortnightly meetings were agreed between the Bela Vista 2 team. In these conversation circles we used the Freirean method of pedagogy of autonomy, so there were no

educators and students, everything was discussed and problematized, extracting knowledge and experiences, for example, about the peculiarities of each situation experienced by workers during the reception and what changes could be made so that there was an increasing strengthening of the relationship of trust and commitment between the patient and the professional.

These moments also served to make each team member feel motivated and willing to actively participate in the reception. It is worth noting that the Community Health Agents (CHA) played a very important role, since they were always in contact with users beyond the Unit, bringing the population's expectations and complaints directly to the discussion.<sup>7</sup>

## DISCUSSION AND RESULTS

Welcoming is essential to user care, as it is a care tool. For effective reception in PHC, qualified listening by workers is necessary, permanently highlighting the demands of users of health services, meeting according to prioritization through a careful assessment of vulnerabilities.<sup>8</sup> Despite the expressive demand, with the organization of the supply of sufficient

and qualified professionals, it is possible to offer efficient and dignified care to all who seek the USF.

It can thus be seen that the guarantee of access and reception is of paramount importance for the consolidation of the population's universal right to the SUS and requires a change in the work process, with a reorganization of the service, in the sense of always offering a positive response to the user's health problem.<sup>9</sup> Access and reception, in turn, articulate and complement each other in the implementation of practices in health services, from the perspective of comprehensive care.<sup>10</sup> To guarantee such access, it is necessary to improve user flows within the service, from reception to departure at the end of the service. The moments of discussion of the flows between the teams allowed rescuing the role of each professional inserted in the PHC, giving new meaning and strengthening teamwork, the effectiveness and effectiveness of care and health care.<sup>11</sup>

In general, the host is recognized as a powerful device to meet the access requirement, providing a link between the team and the population, worker and user, thus questioning the work process and triggering comprehensive care, changing the clinic. For this, it is necessary

to qualify the multidisciplinary team to receive, attend, listen, dialogue, make decisions, support, guide and negotiate. This is a process in which professionals and the unit take responsibility for intervening in a given reality, in their territory of action, from the main health needs, seeking a welcoming and humanized relationship to provide health at the individual and collective levels.<sup>10</sup>

## CONCLUSION

Therefore, even in the midst of a cruel and devastating pandemic, it is possible to remodel users' access to health through the reception of a qualified and committed team. Despite the visible strengthening of the reception process of the FHU in question, it is always necessary to be reassessed according to the responses of users and professionals to the actions implemented. Reception must take place during the entire time the FHU is open and not restrict responsibility for the act of welcoming a worker in isolation, as reception is not reduced to a stage or a place. It is characterized as a humanized relationship, serving as a mainstay to expand access to PHC and other levels of the SUS.

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