

Emergency care units and dimensions of accessibility to health care for the elderly

Unidades de pronto atendimento e as dimensões de acesso à saúde do idoso
Unidades de pronta atención y las dimensiones de acceso a la salud del anciano

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ABSTRACT

Objective: to understand the conception of the elderly and their caregivers about the accessibility to health mediated by the service in Emergency Care Units. **Methodo:** a qualitative study conducted with 25 elderly patients and caregivers at Emergency Care Units in a city of Paraná, using Grounded Theory as a methodological reference. **Results:** According to the participants, the resources available in these services guarantee medical consultation and provide access to exams and medicines. Such resources have attracted patients and caused excess demand, which implies a set of compromising factors for the quality of care in these services. **Final considerations:** Investments in the restructuring of the care network, especially in primary care, with an increase in the number of consultations and the creation of a bond, can contribute to the emergency care units achieving the goal of access to qualified assistance to the elderly population.

Descriptors: Health Services Accessibility; Emergency Medical Services; Health Services for the Aged; Comprehensive Health Care; Quality of Health Care.

RESUMO

Objetivo: compreender a concepção dos idosos e seus cuidadores sobre o acesso à saúde mediado pelo atendimento em Unidades de Pronto Atendimento. **Método:** estudo qualitativo conduzido com 25 usuários idosos e cuidadores atendidos em Unidades de Pronto Atendimento de um município paranaense, tendo a Teoria Fundamentada nos Dados como referencial metodológico. **Resultados:** segundo os participantes, os recursos disponibilizados nesses serviços garantem consulta médica e possibilitam acesso a exames e a medicamentos. Tais recursos tem atraído os usuários e causado excesso de demanda, o que implica um conjunto de fatores comprometedores para a qualidade do cuidado nesses serviços. **Considerações finais:** investimentos na reestruturação da rede de atenção, principalmente na atenção primária, com ampliação do número de consultas e criação de vínculo, podem contribuir para as unidades de pronto atendimento atingirem o objetivo de acesso à assistência qualificada da população idosa.

Descritores: Acesso aos Serviços de Saúde; Serviços Médicos de Emergência; Serviços de Saúde para Idosos; Assistência Integral à Saúde; Qualidade da Assistência à Saúde.

RESUMEN

Objetivo: comprender la concepción de los ancianos y sus cuidadores sobre el acceso a la salud mediado por la atención en Unidades de Pronta Atención. **Método:** estudio cualitativo conducido con 25 usuarios ancianos y cuidadores atendidos en Unidades de Pronta Atención de un municipio paranaense, teniendo la Teoría Fundamentada en los Datos como referencial metodológico. **Resultados:** según los participantes, los recursos hechos disponibles en esos servicios garantizan consulta médica y posibilitan el acceso a análisis y a medicamentos. Tales recursos están atrayendo a los usuarios y causando exceso de demanda, lo que implica un conjunto de factores comprometedores para la cualidad del cuidado en esos servicios. **Consideraciones finales:** inversiones en la reestructuración de la red

de atención, principalmente en la atención primaria, con ampliación del número de consultas y creación de vínculo, pueden contribuir para las unidades de pronta atención alcanzar el objetivo de acceso a la asistencia cualificada de la población anciana.

Descritores: Accesibilidad a los Servicios de Salud; Servicios Médicos de Urgencia; Servicios de Salud para Ancianos; Atención Integral de Salud; Calidad de la Asistencia de Salud.

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INTRODUCTION

Demographic projections indicate that the world's elderly population will increase from 841 million in 2013 to 2 billion in 2050⁽¹⁻²⁾. For developing countries such as Brazil, this demographic transition has been accelerating. According to estimates by the Brazilian Institute of Geography and Statistics (IBGE), in 2013 there were just over 22 million elderly people, representing 10.9% of the population, by 2050 more than 73 million of these individuals will be part of the national structure, to 33%⁽³⁾.

The aging phenomenon brings both challenges and opportunities. For public health, it has been a global concern, as the Global Disease Analysis points out that 23% of the global burden of disease is attributed to the consequences of aging. This situation contributes to the increase in the demand for health services and their resources, requiring responses from health policies and new forms of care, with care models that consider the characteristics of the elderly and that are streamlined and organized in an integral way throughout the care course⁽⁴⁾.

The high frequency of exacerbations of chronic conditions in the elderly has generated a great demand in the urgency and emergency services, especially in the Emergency Care Units (UPA), which is a fundamental reorganization in order to offer adequate assistance to this population⁽⁵⁾, since it is one of the gateways of the Brazilian Unified Health System (SUS).

Accessibility to services is a necessary condition for ensuring health care. For this reason, the term "accessibility", whose definition is complex and comprehensive, is usually used; its the main characteristics are summarized as follows: in the availability dimension, which constitutes the geographic relationship between the physical health institution and the individual who needs them, the time of displacement and the form of its costs; in acceptability, established by how individuals understand the availability of the resources offered; the provision of information and the resolving capacity of the raised demands⁽⁶⁻⁷⁾.

These characteristics of accessibility to care are discussed as one of the main problems associated with care in Brazil⁽⁸⁾. Not unlike the middle-aged and elderly population in Taiwan, it has been shown that the abundance of health facilities and the coverage of services lead these people to seek care in all conditions, even though it is not necessary to resort to health services due to its low complexity and good prognosis, which generates increased treatment time and high costs. The same study also pointed out that the age and number of chronic diseases are the main factors that affect hospitalization⁽⁷⁾, situation also verified in Brazil.

In view of such arguments, research that fosters the accessibility of the elderly to UPA is extremely relevant to the improvement of the health conditions of this population group. The subject of accessibility and the elderly have been

investigated only in Primary Health Care (PHC)⁽⁹⁾ and in the hospital emergency services⁽¹⁰⁻¹¹⁾, and there is a lack of information that addresses this issue in medium complexity emergency services, such as UPA.

OBJECTIVE

Faced with this gap in the knowledge about the accessibility of the elderly to UPA and believing in the relevance of the theme for the improvement of care for the elderly, this research is justified to understand the conception of the elderly and their caregivers about the access to care mediated by the service in emergency care units.

METHOD

Ethical aspects

The study was developed after approval by the Standing Committee on Ethics in Research with Human Beings of the State University of Maringá. All participants signed the Consent Form in two copies.

For the differentiation of the participants, as well as for the preservation of their identities, they were coded by Arabic numerals corresponding to the interview, preceded by the letter "I" for the Elderly and "C" for the Caregivers, followed by identification by the letter "F" for the Female sex and "M" for the Male sex, besides the age, the classification of risk obtained and the unit in which the patient was attended to. The anonymity of the site and study scenario was also maintained.

Type of study

The study is descriptive, exploratory, with qualitative approach.

Methodological References

The Grounded Theory was adopted as a methodological reference. It aims to understand reality from the individual's perception and to extract the most significant aspects from the experiences, through the comparison, codification and extraction of the regularities of the utterances of each individual⁽¹²⁾.

Methodological procedures

Study scenario

The study was conducted in the two UPAs of a municipality in the interior of Paraná, with the last demographic census pointing to it as having the highest index of elderly among the eight municipalities with more than 200 thousand inhabitants. Currently, there are 43,716 thousand elderly people, who represent 12,2% of the general population, which consists of 357.077 inhabitants⁽³⁾.

The implantation of UPA is fairly recent in Brazil and the state of Paraná currently has 27 units, two of them implanted five years ago in the studied municipality⁽¹³⁾. The UPA Zona Norte, listed as port II by the Ministry of Health, has a coverage of approximately 200 thousand inhabitants, with a rest/observation room with 12 beds, including two isolation beds. UPA Zona Sul serves the rest of the population of the municipality and is classified as size III, with 31 observation beds and three isolation beds⁽¹³⁾.

Data collection

The inclusion criterion was as follows: patients aged 60 years or older who were attended at one of the UPA, Zona Norte or Zona Sul in November 2015, who obtained a minimum score of 20 points in the Mini Mental State Examination (MMSE)⁽¹⁴⁾, or be the primary caregiver of the elderly who did not reach such a score. Initially telephone calls were made, previous invitations to participate in the study and schedules were arranged with the participants for the interviews.

At the scheduled meeting, participants were given explanations about the research and its objectives, the volunteer nature and the need to record interviews. These occurred at the participants' residence, between the months of December 2015 and April 2016. The interviews were recorded in digital media and had an average duration of 26 minutes.

Initially the non-structured interview was applied and, from the second sample participant, it was adapted to direct the collection of new data⁽¹²⁾, then to the semi-structured interview. This became more pertinent for the continuation of the steps, as the researcher used a guide of topics described in order to ensure that all the questions of interest of the research were contemplated. Firstly, the guiding question was: "Tell me, how has accessibility to UPA been?" And, when it was necessary, other questions were introduced during the statements, according to the adopted methodology⁽¹²⁾.

When performing the constant comparative method proposed by Grounded Theory⁽¹²⁾, it was possible to verify that the clinical condition of the individual interfered with the conception regarding accessibility to care, and it was necessary to establish the Sample Groups (GA) according to the risk classification obtained in the UPAs studied according to the Manchester Protocol used in these units. Therefore, four GAs comprised the survey, three of them of elderly patients and one of caregivers. The first GA was consisted of eight elderly individuals classified as green; the second, established by seven elders classified by yellow; the third, consisting of five people who received blue classification; and the fourth GA, composed of five caregivers responsible for elderly individuals who presented cognitive impairment classified by the red color. The fact that all the elderly people selected for the red group presented cognitive impairment was expected, considering the association of the red classification, which lists the individuals with the highest health risk and the vulnerabilities added to the cognitive decline.

Data analysis

The data collection and analysis occurred concurrently, being fundamental to guide the selection of the next participants,

so that the GA composition was interrupted when theoretical saturation was observed⁽¹²⁾.

The data collected were analyzed based on the systematic analysis of Grounded Theory, which was based on the constant comparison of the responses of the different participants. Grounded Theory is a qualitative technique in which the data collected are systematically organized and analyzed during the course of the research, with open coding and axial coding. In the open coding, the data were analyzed line by line in order to identify each incident, forming the preliminary codes. In the axial coding, the data were grouped aiming to relate categories to the subcategories⁽¹²⁾.

RESULTS

Out of the 20 elderly participants of the research, those in the 60-69 age group (14) prevailed. The majority were female (14), married (13), had up to four years of schooling (17) and were retired (09). The complaints that led to UPA were diseases of the musculoskeletal and connective system (9), cardiovascular diseases (2), respiratory diseases (4), genitourinary diseases (3), collection of laboratory exams and the administration of medications (1).

As for the five main caregivers of the elderly, all were female (5), most were daughters (3), one was the wife and one was the former daughter-in-law. The majority were over 60 years (3), had up to eight years of schooling (3) and the main activity was elderly care and housework (3). The elderly patients, they were in charge of, were referred to UPA due to the following causes: cardiovascular diseases (3), respiratory diseases (1) and lowering of the level of consciousness (1).

According to the adopted framework, the subjects' conception of accessibility to care in UPA was represented by three categories: "Availability, resolution and acceptability: dimensions of access positively experienced by the elderly and caregivers in the emergency care units", "Dissatisfaction of the elderly and caregivers about the dimensions of accessibility in emergency care units" and "The emergency care unit as the first access option: the fragility of primary care", which began to be discussed.

Availability, resolution and acceptability: dimensions of accessibility positively experienced by the elderly and caregivers in the emergency care units

Among the factors related to access, regarding the availability of resources and services, the geographic relationship was mentioned by the elderly as an obstacle in access to the search for care in the UPA, a problem intensified when associated with the need of collective transportation for the displacement to the location.

UPA is distant and depending on the timetable there are no more buses, we have to turn around, we have to ask a relative or neighbor to take us there [UPA], or we to endure until dawn. (I14; F60 – Yellow, UPA Zona Sul).

Although the geographical aspect presents itself as a limiting factor for the accessibility of some elderly to UPA, it was not considered a barrier to seeking the unit. Some deponents

pointed out that, in the face of necessity, distance is not a problem, since the UPA is resolving their issues.

When you need to go to the doctor, you do not measure the distance. It's not getting on the bus that will make you give up, it gets harder, but what is there to do? We need the service and in the UPA they always manage what I'm feeling. (I7; M67 – Green, UPA Zona Sul)

Regarding the resources offered in the UPA, the acceptability dimension is a recurring fact and motivator of the priority preference for this service by the elderly and their caregivers, mainly by the provision of laboratory exams.

The examinations are all done there and that's very good. When my mother was hospitalized, she would do exams every day, take samples in the morning, go to the municipal service and then give us the result. It was very good, because as she is bedridden, we did not have to mess with her, keep taking her away. (C23; F78 – Red, UPA Zona Norte)

The care in the UPA is marked by factors that, according to the elderly and their caregivers, which aids the achievement of their objectives. The guarantee of consultation by spontaneous demand, accessibility to injectable medications, the release of the patient only after the improvement of his clinical condition and the referral to other services, promoting the continuity of care.

Whenever I needed I was welcomed there in the UPA and their service was very good. There you take the medicines on time, if one gets better one leaves, or stays there hoping to get better, they will not discharge a patient if he is not well. And if they don't find a way there, they send the patients to the hospitals. (I2; F64 – Green, UPA Zona Norte)

The health problem is always solved in the UPA. And then, it's just a emergency care unit, if they think we need another doctor's procedure, then they'll refer you to a specialist. (C21; F78 – Red, UPA Zona Norte)

Dissatisfaction of the elderly and caregivers about the dimensions of accessibility in emergency care units

Although the aspects related to the resources offered by the UPA are reasons for satisfaction among the patients, there is some discontent in the acceptability dimension of the accessibility to the care, mainly by the organization of the human resources in those units.

Once I went to the UPA, things were tough for the nursing girls, because there are nurses who have to get out of there and accompany the patient to the Municipal Hospital to do exams! It is pitiful, because we often saw that it was unprofessional for many patients. (C23; F78 – Red, UPA Zona Norte)

The need to refer patients to other services for the performance of certain exams is notorious, which requires nursing professional's follow-up, generating work overload. In addition, in some moments the conduct of the professional also does not meet the expectations of the patients.

I arrived at the reception, I said that I had a lot of pain in my kidney. It is like that there [UPA], whatever pain you have, they prescribe you "Buscopan". [...] The doctor had the urine examined and the result pointed to an infection. But he did not ask for a kidney X-ray. In UPA, they only ask for radiographies if you are dying. (I15; F69 – Yellow, UPA Zona Sul)

The emergency care unit as the first accessibility option: the fragility of primary care

In regard to the search for the UPA, several setbacks favor the distortion of the demand for adequate service to the elderly. Such distortions are due to limitations of PHC, such as the difficulty in accessibility due to opening hours and limitation of the number of vacancies, with rare occasions when individuals can receive care on the same day.

Sometimes we don't even go to the clinic because, depending on the time, there is no doctor, he does not stay [in the UPA] the whole day. (I10; F67 – Yellow, UPA Zona Norte)

If I'm feeling ill, I'm not at the health center. What would I do there? They will schedule me for after 2 or 3 days. And if I'm in pain at the moment, I cannot wait, I'm going to the UPA. We should organize ourselves and decide where it is best to go. (I12; M76 – Yellow, UPA Zona Sul)

When there are shortcomings in the PHC work process, care for the elderly takes place in a fragmented way, since he seeks care in a service that does not have the characteristic of follow-up.

In the health center, if you schedule an appointment at 4:00 a.m., you stand there waiting. Some nurses who do not collaborate with the service, unwilling attend to people, they are rude, so I do not go there, I go straight to the UPA. (I8; F63 – Green, UPA Zona Sul)

The difficulties faced in PHC reflect directly on the routine of the UPA, since accessibility to this unit is seen as easier. The demand for emergency services due to non-urgent conditions was highlighted by the elderly among the barriers to care in the UPA.

There in the UPA, the disturbances to the service are due to the people not knowing how to separate what is done at the health center from what is done at the UPA. (I10; F67 – Yellow, UPA Zona Norte)

I already went to the UPA for other things, for example, when I had a silly flu. (I9; F67 – Yellow, UPA Zona Norte)

Due to the indiscriminate search for the UPA, patients who really need care at this level of attention are disrupted.

There are people who are not even sick and want the service to get a sick notice. And often this person takes the place of a person who arrives in bad condition at the emergency care unit and cannot enter immediately because the rooms are full (C21; F78 – Red, UPA Zona Norte)

DISCUSSION

The results of the study favor the understanding of the conception of the elderly and caregivers on the dimensions of accessibility to care in the UPA. In this respect, the understanding of conception in the light of public health policies of the elderly, of accessibility to UPAs, supports the understanding of how accessibility is offered to elderly in an emergency situation in these services of medium complexity.

Regarding the availability dimension, it has become clear that many older people need to use some means of transportation to reach the UPA and must adapt to schedules if collective transportation is the option. A survey conducted in Pernambuco corroborates this fact, showing that 13,6% of the population uses buses to access the emergency service⁽¹⁵⁾. However, it is necessary to take into account the complications that may arise for elderly patients if they do not get access to services quickly. The guarantee of accessibility is fundamental in order to make SUS a public policy in the defense of life⁽¹⁶⁾, besides enabling the maintenance of good health conditions in this age group.

In regard to the acceptability dimension of services and resources to intermediate access to care, the dissatisfactions of elderly patients assisted in the UPA is alarming, such as the difficulty in understanding the behavior of some professionals. Such factor deserves attention when considering that the provision of information is located between the dimensions of accessibility, and that elderly patients are subject to specific risk factors for non-adherence to treatment if the guidelines are not adequately offered⁽⁴⁾. Thus, dialogue fosters relationships of trust, expedites the service, promotes understanding of the conduct and even improves the clinical outcome⁽¹⁷⁾. In addition, the cultural factors of the elderly and caregivers need to be considered at the time of the guidelines, in order to demystify behaviors on certain clinical conditions and to empower the population regarding the appropriate resources for each situation⁽⁶⁾.

The attention given by professionals strengthens the main characteristic of accessibility, that is, the capacity of the service to meet the population's health complaints with the resolution of their problems⁽⁸⁾. Although some shortcomings in the UPA are evident, satisfactory reports were reached for the achievement of the goals of the elderly and caregivers, such as the discharge of the patient only after the improvement of the clinical condition. This same finding was obtained in a research conducted in the United States, where elderly patients are discharged from emergency services only after establishing diagnosis and formulating a treatment plan⁽¹⁰⁾.

The resources offered by health units with technological density such as the UPA have attracted attention of patients and had a positive impact on health services, such as performing laboratory exams in the unit's own premises and obtaining the results in a short period⁽⁸⁾. Satisfactory aspects that drive patients to seek the UPA have led to an indiscriminate search. In addition to this, a factor that is detrimental to care is highlighted, especially in emergency services: the search for care by individuals who desire an immediate cure, with the conduct that they think to be the best, which may influence the erroneous demand for the service and cause disorders between patients and professionals⁽¹⁸⁾.

Another factor that hinders the attention given in the UPA is the understanding of the patients that the emergency care unit is an environment conducive to the first contact with the health service, which often leads the patients, in front of the receptionists and the screening team, to reveal their symptoms recognized as urgent to be attended to more quickly or to have their problems resolved^(6,15). Such attitude may hinder the ability of these services to treat patients with real emergencies, safely and in a timely manner⁽¹¹⁾.

The great demand in these units can be justified by the insufficient attendance of the PHC, mainly due to the difficulty of accessibility generated by the working hours and the bureaucratization for scheduling appointments, besides the lack of a bond between health team members and patients, and mainly resolute incapacity. Therefore, it is acceptable that, given the difficulties of accessing these services, patients seek other ways to get the service^(5-6,8-9,11,15,19).

Another permanent disorder in SUS is related to the insufficiency of human resources, especially of medical professionals^(4,6,15-16,20). However, the concept of meeting the demand for PHC should not be confused with the guarantee of medical consultation, since accessibility corresponds to the scope of an operative practice for the health condition of the patient⁽⁶⁾.

Faced with such facts, it is necessary to invest in spaces in the network of specific attention for the elderly, in order to reverse the situation presented in this study, in which neither the PHC nor the UPA meet the needs of this public. The PHC nurse must listen, observe and recognize the needs of elderly care, in order to provide well-being and minimize the demand for services of medium and high complexity due to basic conditions. In order to encourage people to seek care in PHC, bonding and longitudinal strategies should be prioritized, since the coordination of cases at this level of attention would strengthen relations with other levels, allowing for more agile access to exams and procedures with high complexities^(4,6,9,21).

In addition, it is essential to implement tools that enable improvements in access to care in the UPA, especially regarding the decongestion of services and the provision of quality care for the elderly^(11,21).

In this context, the implementation of protocols is promising, such as for the patients to receive, in the PHC, the results of the exams performed in the UPA, allowing adequate monitoring of their health and not just a check of these exams. This strategy would contribute to ordering the flow of elderly patients in the UPA and would promote health care with integrality⁽²²⁾. Another strategy consists in the implantation of units offering exclusive geriatric care, so that the most common diseases of old age would predominate, providing a focus on care for this population⁽⁷⁾, such as the example of the municipality of Canoas, where the elderly UPA was implemented.

These aspects suggest the existence of alternatives to offer quality care to the elderly population, and it is essential to reorganize the work process based on the problems experienced in these services.

Limitations of the study

The data collection is considered a limitation of the study since it was performed only with patients and some caregivers

of elderly people with cognitive impairment. The researchers acknowledge the lack of description of the conception of other individuals involved in the dimension of access to care of the elderly, such as managers, health professionals and the relatives of independent elderly, which should be analyzed in future studies.

Contributions to the area of nursing and public health

The understanding of the conception of the elderly and their caregivers about access to the UPA is an advance for health practice in these services, since it provides professionals with a range of knowledge indispensable for health care. Such information can provide reflections on the behaviors in the service and raise strategies for the restructuring of nursing actions so that access to care encompasses the beliefs and particularities of this age group in order to minimize the biomedical model and the overvaluation of these units.

FINAL CONSIDERATIONS

The UPA adopts the precepts of the Emergency Care Network with regard to equity and universalization of access. In

this research, these precepts were recognized as positive by the patients, with emphasis on the guarantee of care on the same day regardless of severity and the availability of more resources, especially exams and medications that promote the resolution of the health problem.

However, there were situations in which the participants considered the access inadequate, such as the geographic relation, the scarcity in the number of nursing professionals, and also the high demand for the unit for non-urgent causes, denouncing the fragility of access and PHC resolution. These factors, associated with each other, have hindered the effectiveness of access to these emergency services: overcrowding generates delay in care and implies the fragmentation of care, causing, consequently, the inability to solve the demands raised by the elderly.

The high demand of the elderly in UPA demonstrates an emergency in replanning the services of SUS, investing mainly in the monitoring of these individuals in the PHC, so that there is adequate demand for the services of medium and high complexities and consequent improvement in the quality of care for the elderly population.

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