

Profile of adult care classified as non-urgent in emergency care unit

Perfil dos atendimentos de adultos classificados como não urgentes em unidade de pronto atendimento

Perfil de atención de adultos clasificados como no urgentes en la unidad de atención de emergencia

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Abstract

Objective: To identify the profile of care classified as non-urgent in the Emergency Care Unit (ECU). **Methods:** This is a descriptive, retrospective, documentary study with a quantitative approach, carried out in an ECU located in the city of Curitiba, PR, with users from 18 years of age and blue priority in the risk classification. Data were tabulated in Excel® and analyzed in SPSS® to obtain descriptive statistics, inferences and perform the chi-square test. **Results:** 213 medical records were analyzed, predominantly looking for young adults, with a mean age of 39 years, female. The main clinical complaints/demands reported ($p<0.001$) by users were: respiratory and flu problems (36%), followed by medication administration (14%) and unprotected sexual exposure (8%). Morning calls (39%) were more frequent ($p<0.001$), with Monday and Wednesday being the days with the highest demand ($p=0.026$). The most common outcome of the consultations was discharge from the unit (61%; $p<0.001$). **Conclusion:** The care of adults up to 39 years old predominated, with greater demand during the day. The clinical complaints and demands presented were not compatible with the profile and complexity intended for an urgent and emergency service.

Descriptors: Patient Care; Health Services Needs and Demands; Emergency Health Services.

Whats is already known on this?

The search for resolution of non-urgent demands in Urgency and Emergency Units entails long periods for the effectiveness of care, overload of the units and weariness of the care team.

What this study adds?

It presents the profile of the care analyzed and demonstrates that the clinical complaints and outcomes are not compatible with the complexity destined to the Emergency Care Units.



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Resumo

Objetivo: Identificar o perfil dos atendimentos classificados como não urgentes em Unidade de Pronto Atendimento. **Métodos:** Estudo descritivo, retrospectivo, de caráter documental e abordagem quantitativa, realizado em uma UPA localizada na cidade de Curitiba/PR, com usuários a partir de 18 anos e prioridade azul na classificação de risco. Os dados foram tabulados no Excel® e analisados no SPSS® para obtenção de estatísticas descritivas, inferências e realização do teste qui-quadrado. **Resultados:** Analisou-se 213 prontuários, predominando a procura de adultos jovens, com média de idade de 39 anos, do sexo feminino. As principais queixas clínicas/demandas referidas ($p < 0,001$) pelos usuários foram: problemas respiratórios e gripais (36%), administração de medicação (14%) e exposição sexual desprotegida (8%). Os atendimentos pela manhã (39%) foram mais frequentes ($p < 0,001$), sendo a segunda-feira e quarta-feira os dias de maior procura ($p = 0,026$). O desfecho mais comum dos atendimentos foi a alta da unidade (61%; $p < 0,001$). **Conclusão:** O atendimento de adultos com até 39 anos predominou, com maior procura no período diurno. As queixas clínicas e demandas apresentadas não eram compatíveis com o perfil e a complexidade destinados a um serviço de urgência e emergência.

Descritores: Assistência ao Paciente; Necessidades e Demandas de Serviços de Saúde; Serviços de Saúde de Emergência.

Resumen

Objetivo: Identificar el perfil de atención clasificada como no urgente en una Unidad de Atención de Emergencia. **Métodos:** Estudio documental, descriptivo, retrospectivo, con enfoque cuantitativo, realizado en una UAE ubicada en la ciudad de Curitiba, PR, con usuarios de 18 y más años con prioridad azul en la clasificación de riesgo. Los datos fueron tabulados en Excel® y analizados en SPSS® para obtener estadística descriptiva, inferencias y realizar la prueba de chi cuadrado. **Resultados:** Se analizaron 213 historias clínicas, con predominio de adultos jóvenes, con edad promedio de 39 años, del sexo femenino. Las principales quejas/demandas clínicas reportadas ($p < 0,001$) por los usuarios fueron: problemas respiratorios y gripe (36%), seguidas de la administración de medicamentos (14%) y la exposición sexual sin protección (8%). Los servicios en horario de mañana (39%) fueron más frecuentes ($p < 0,001$), siendo lunes y miércoles los días de mayor demanda ($p = 0,026$). El resultado más común de la atención fue dar el alta de la unidad (61%; $p < 0,001$). **Conclusión:** Predominó la atención a adultos hasta 39 años, con mayor demanda durante el día. Las quejas y demandas clínicas presentadas no eran compatibles con el perfil y complejidad previstos para un servicio de urgencia y emergencia.

Descriptorios: Atención al Paciente; Necesidades y Demandas de Servicios de Salud; Servicios de Salud de Emergencia.

INTRODUCTION

The Health Care Network (HCN), established by Ordinance number 4,279, of December 30, 2010, is defined as a set of health actions and services, organized in different technological densities, which are integrated by technical, logistical and management support systems seeking to ensure comprehensive care to the users. The HCN aims to promote systemic interconnection of health actions and services with the provision of continuous, quality, responsible and humanized care to improve the functioning of the system.⁽¹⁻²⁾

One of the components that integrates HCN is the Emergency Care Network (ECN) that was implemented in Brazil in 2011, after the Ministry of Health reformulated the National Policy for Emergency Care. Its objective was to reorder care and attend to the health problems of users in the area of urgency and emergency in a coordinated manner, through the different points of attention that compose it, to define flows and redirection of users in an appropriate way.⁽³⁻⁴⁾

As a component of the ECN, the Emergency Care Units (ECU) stand out, health establishments with an intermediate complexity structure, which operate 24 hours a day, every day of the week, intended to meet urgent and emergency situations in acute chronic cases or acute cases of clinical, surgical or trauma character. In addition, the ECU performs the initial stabilization and diagnostic investigation, to later assess the need or not for referral to more complex hospital services.⁽³⁻⁵⁾

In the ECU, users are categorized according to the risk they present, through Risk Classification (RC), which is an instrument, in the protocol format, used to support the clinical decision, in order to identify the severity of the users and allow rapid care, according to the potential risk that it presents. Among the different RC systems, the Manchester Triage System (MTS) stands out, which, based on the main complaint of the individual, defines the time and priority of care through colors: red (emergency, immediate care); orange (very urgent, service within 10 minutes); yellow (urgency, service within 60 minutes); green (little urgency, service up to 120 minutes); blue (non-urgent, service within 240 minutes).⁽⁶⁻⁷⁾

The increasingly accentuated demand of users with clinical complaints classified as non-urgent leads to the mischaracterization of the real attributions that the ECU performs, as it absorbs demands that could be solved in less complex units, such as the Basic Health Unit (BHU). This contributes to the overcrowding of these establishments, interferes with the quality of care provided, generates long waiting

periods, causes the wear and tear of professionals, compromises the quantity of human and material resources to meet greater demand and results in surplus financial expenses to health systems⁽⁷⁻⁸⁾

Knowing the reasons that lead users to seek the ECU is essential to improve the management of urgency and emergency services, assist in the execution of a more accurate and personalized screening, allow better administration of available resources, ensure efficiency and resoluteness in care, enable appropriate referrals to the demands brought and contribute to the improvement of care flows within health care networks. In addition, the results can provide valuable information to support the construction of strategies to strengthen Primary Health Care.⁽⁷⁾

Considering the Emergency Care Network and the different points of health care, as well as the purpose of the Emergency Care Units and how users are categorized within this service, we seek to identify the profile and demands that lead users with non-urgent complaints to seek services for urgent and emergency care. Thus, the objective of this study is to identify the profile of care classified as non-urgent in the Emergency Care Unit.

METHODS

This is a descriptive and retrospective study, with a quantitative approach, carried out in an Emergency Care Unit (ECU) located in the city of Curitiba - PR. The unit offers urgent and emergency medical and nursing care to adults and children by spontaneous demand or referral from other services, to all users of the Unified Health System (SUS).

We included electronic medical record data of users treated at the ECU, aged eighteen years or older, of both sexes, categorized with the blue priority (non-urgent) in the risk classification, treated from July 1 to December 31, 2022. The medical records of users whose access to care information was not available were excluded.

For the sample calculation, the total number of users treated at the ECU classified as blue (non-urgent) in the period from July 1, 2022 to December 31, 2022 (1569 visits) was considered, in a stratified manner, calculated from the total number of visits, with 95% confidence and a margin of error equal to 5%, reaching a sample of 213 (13.6% of the population).

Based on the information provided in the municipality's health system, a structured instrument was used to collect data containing the following information: sex; age; date and time of care; vital signs; flowchart (protocol service flow defined by the municipal management); main medical diagnosis and ICD (International Classification of Disease); complaints referred by the users in the risk classification; main complaint referred by the users; conduct/outcome of care. Access to this information was made through the electronic medical record of the municipality of Curitiba, used in the institution. To extract the data present in the medical records, the participants were named with the letter "P" followed by an ordinal numeral referring to the established collection sequence (P1, P2, P3,...).

Data were collected between May and July 2023 and tabulated in Microsoft Excel® software spreadsheets. For the descriptive analysis, categorical variables were presented according to their frequencies and percentages of occurrence. For continuous variables, the Shapiro-Wilk test was used to test normality. In the variables with normal distribution (systolic and diastolic blood pressure; $p > 0.123$) the data were presented as mean and standard deviation, while in the variables with violated normality (heart and respiratory rate, oxygen saturation and body temperature; $p < 0.001$) the data were presented as median and interquartile range 1 and 3 (25th and 75th percentiles).

The presentation of this information was done in tables, formatted in Microsoft Word®. For the inferential analyses, the data tabulated in Excel were transferred to the Statistical Package for the Social Sciences (SPSS) software, version 23/2015. In order to compare the characteristics of the care (shift, day of the week, flowchart, main complaint, conduct), the chi-square test was used. The same test was also applied to compare the days of the week and the main complaint of the consultations between the different age groups. The significance of all analyses was determined at 5% ($p < 0.05$).

This research was evaluated by the Ethics and Research Committee of the Municipal Health Department of Curitiba (SMS/Curitiba), receiving a favorable opinion under number 5.905.706 on February 22, 2023, in compliance with the guidelines of the National Health Council established by Resolution 466/12 for the execution of research involving human beings.⁽⁹⁾

RESULTS

We analyzed 213 medical records of care provided in the ECU; the highest demand was for young adult users in the first two age groups (mean=39 ±15), with ages ranging from 18 to 86 years and predominance of females. The demand for care was mainly concentrated in the morning and afternoon shifts, with no significant difference in demand during the opening hours of the BHU (similar distribution). The days with the highest number of visits were Monday and Wednesday. The general characteristics of the care are presented in Table 1.

Table 1. General characteristics of users and care (n = 213). Curitiba, PR, Brazil, 2023

Variable	n	Percentage	X ²	p
Age group (years)			113.90	<0.001
18 to 29	63	30%		
30 to 39	61	29%		
40 to 49	37	17%		
50 to 59	24	11%		
60 to 69	14	6%		
70 to 79	10	5%		
80 and above	4	2%		
Sex			0.12	0.732
Female	109	51%		
Male	104	49%		
Service Shift			76.75	<0.001
Morning (7am to 1pm)	84	39%		
Afternoon (1pm-7pm)	79	37%		
Evening (7pm to 1am)	46	22%		
Late at night (1am to 7am)	4	2%		
Open BHU			1.69	0.193
Yes	116	55%		
No	97	45%		
Week Day			14.32	0.026
Monday	42	20%		
Tuesday	27	13%		
Wednesday	42	20%		
Thursday	23	10%		
Friday	21	10%		
Saturday	27	13%		
Sunday	31	14%		

Note: Bold banknotes represent a significant difference.

Source: the authors (2024).

Table 2 presents specific characteristics about the flowchart, the main complaint referred by the user, the ICD assigned and the conduct/outcome of the service. There was a significant difference in the distribution of all analyses. Regarding the flowchart, the most prevalent was malaise in adults (n=143; 67%), followed by COVID (n=27; 13%). The main clinical complaints reported by users were respiratory and flu-like problems (n=76; 36%), followed by medication administration (n=29; 14%) and unprotected sexual exposure (n=18; 8%). The predominant ICDs observed in these consultations were: U07.2 (clinical or epidemiological diagnosis of COVID-19, when laboratory confirmation is inconclusive or not available), Z00.0 (general medical examination) and Z53.2 (procedure not performed due to the user's decision for other reasons and not specified). Regarding the conduct/outcome of care, most users were discharged (n=131; 61%), followed by medication (n=42; 20%) and evasion from the establishment (n=24; 11%).

Table 2. Specific characteristics of the care (n = 213). Curitiba, PR, Brazil, 2023

Variable	n	Percentage	X ²	p
Flowchart			1396.8	<0.001
Malaise in adults	143	67%		
COVID-19	27	13%		
Wounds	11	5%		
Sore Throat	8	4%		
Sexually transmitted disease	5	2%		

Bites and stings	4	2%		
Abdominal pain in adults	3	1%		
Backache	2	1%		
Allergy	2	1%		
Extremity problems	2	1%		
Others	6	3%		
Main complaint			478.2	<0.001
Respiratory and flu	76	36%		
Administration of Medication	29	14%		
Unprotected sexual exposure	18	8%		
Extremity problems	17	8%		
Wounds	12	6%		
Sore throat	8	4%		
Headache	7	3%		
Face/eyepiece problems	6	3%		
Abdominal pain	5	2%		
Diarrhea	5	2%		
Back pain	4	2%		
Bites and stings	4	2%		
Earache	3	1%		
Others	19	9%		
ICD (International Classification of Disease)			509.9	<0.001
U07.2 (clinical or epidemiological diagnosis of COVID 19, when laboratory confirmation is inconclusive or unavailable)	27	13%		
Z00.0 (general medical examination)	15	7%		
Z53.2 (procedure not performed due to patient decision for other and unspecified reasons)	15	7%		
J06.9 (acute upper airway infection not specified)	10	5%		
R05 (coughs)	10	5%		
Z20.2 (contact with and exposure to predominantly sexually transmitted infection)	7	3%		
J03.9 (unspecified acute tonsillitis)	5	2%		
J11.8 (influenza [flu] with other manifestations, due to unidentified virus)	5	2%		
Conduct/Outcome			340.2	<0.001
Discharge	131	61%		
Medication	42	20%		
Evasion	24	11%		
Referrals	11	5%		
Observation	4	2%		
Hospitalization	1	1%		

Note: Bold banknotes represent a significant difference.

Source: the authors (2024).

In addition to these care characteristics, some vital signs were measured in users, such as: systolic (SBP) and diastolic (DBP) blood pressure; heart rate (HR) and respiratory (RF); body temperature and oxygen saturation. For each variable, a descriptive analysis was conducted. Descriptive values of vital signs are found below in Table 3. The data indicate, on mean, normality in the categorization of measures for all variables. Users with extreme values are outside the normal parameters for all measurements.

Table 3. Descriptive analysis of the vital signs measured in the consultations. Curitiba, PR, Brazil

Vital signal	Mean \pm SD	Median (IQR 1 and 3)	Maximum	Minimum
Systolic blood pressure (mmHg)	131 (17)	-	216	94
Diastolic blood pressure (mmHg)	82	-	114	45
Heart Rate (BPM)	-	83 (76. 95)	131	19
Respiratory rate (BRPM)	-	20 (19. 20)	22	15
Saturation (% O ₂)	-	98 (97. 98)	100	83
Body temperature (°C)	-	36.3 (36. 36.6)	37.9	33.6

Note: SD = standard deviation; IQR = interquartile range; BPM = beats per minute; BRPM = breaths per minute; O₂ = oxygen; °C = degrees Celsius.

Source: the authors (2024).

The five most frequent clinical complaints (Table 2), in a total of 152 visits, were compared between groups of different ages. The result of the chi-square test showed no significant difference in the frequency of occurrence of complaints between the ages ($X^2=33.04$; $df=24$; $p=0.103$). The descriptive analysis of the findings is presented below in Table 4. The findings point to more cases of respiratory or flu-like problems in young adults, as well as unprotected sexual exposure – there are no cases after the age of 50. A higher percentage of older adults complained about medication administration, however, these comparisons were not statistically significant.

Table 4. Description of the main complaint of care among the different age groups. Curitiba, PR, Brazil, 2023

Complaint	18 to 29 (n=50)	30 to 39 (n=45)	40 to 49 (n=24)	50 to 59 (n=15)	60 to 69 (n=9)	70 to 79 (n=6)	80 or + (n=3)
Respiratory or flu	29 (58%)	23 (51%)	12 (50%)	6 (40%)	3 (33%)	2 (33%)	1 (33%)
Extremity problems	5 (10%)	3 (7%)	3 (12%)	4 (27%)	2 (22%)	0 (0%)	0 (0%)
Wounds	5 (10%)	3 (6%)	2 (9%)	2 (13%)	0 (0%)	0 (0%)	0 (0%)
Expo. unprotected sex	7 (14%)	7 (16%)	4 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Medication administration	4 (8%)	9 (20%)	3 (12%)	3 (20%)	4 (45%)	4 (67%)	2 (67%)

Note: Data presented as frequency of occurrence and percentage within the group.

Source: the authors (2024).

DISCUSSION

The present study showed that the age group with the highest demand for care in the ECU was young adults aged between 18 and 39 years. This finding is in line with other studies that presented the same age profile, demonstrating that the search for care is predominantly of individuals of productive age, and, therefore, may face difficulties in obtaining assistance in the BHU due to work shifts, thus contributing to increasingly frequent searches for ECU services. In addition, it is worth considering that in this age group the population is more susceptible to accidents at work, in traffic, acute diseases and other external causes, which consequently often leads to seeking these services as a first option.⁽⁸⁻¹⁰⁾

There was a slight predominance of demand for the service by female users. Although small, the greater demand for women is in line with studies that point to greater longevity of this population and a more frequent search for health services. However, male users tend to access services in cases of acute situations, as they often feel shame, impatience, fear and carelessness with their own health, in addition to cultural, socioeconomic and social issues that influence this search.⁽¹¹⁻¹⁴⁾

Regarding opening hours, the highest demand occurred in the morning period (from 7 am to 1 pm), from Monday to Friday, with the highest demand on Monday and Wednesday. These findings are particularly relevant, since during the morning period and on working days (Monday to Friday) the BHU are in opening hours, and can provide care to users in non-urgent situations, since this service is preferably recommended as a gateway to the health system.⁽¹⁵⁻¹⁷⁾

National studies carried out in the municipalities of Vitória (ES) and Piracicaba (SP) and international studies carried out in the Netherlands revealed that users prefer to seek assistance from urgent and emergency services rather than primary care. They report that urgent and emergency services provide immediate care, without the need to make an appointment in advance; they have medical care at any day and time of the week; they provide better resolution of their problems; they offer better quality care; they have more technologies and resources, such as access to exams and medications, in addition to being close to their homes.^(11,18-21)

In addition, the lack of clear and accessible information about which health service to seek in the face of a clinical or traumatic complication is a significant issue that influences the decision of users to seek care in urgent and emergency services, especially those who are unfamiliar with the functioning of the health care network. Often, this lack of guidance leads to unnecessary demand for units intended for more severe cases, contributing to overcrowding and impacting the efficiency of the health system.^(8,21-22)

Regarding the main clinical complaints presented by users, respiratory and flu complaints, medication administration and unprotected sexual exposure predominated. Regarding the search for respiratory and flu complaints, the present study resembles others as one of the main reasons for seeking care, both in adults and children. The justification for this predominance was associated with the cold climate of the region, where the present study was conducted. In addition to the seasonality of the presence of respiratory infections related to cold weather, it is crucial to consider the pandemic context related to the SARS-CoV-2 coronavirus. During the pandemic, attention around respiratory symptoms increased significantly. Symptoms associated with COVID-19, such as cough, fever and difficulty breathing, have become a cause for concern for users and health professionals, leading to a more frequent search for care. This study was conducted during this challenging time, and it is plausible that respiratory complaints gained even greater relevance.^(10,23-24)

The search for the ECU for the administration of intravenous or intramuscular medication, with medical prescriptions from other services, whether from the SUS, health plans or private offices, proved to be a common practice among the users of this study. This dynamic of seeking care for procedures that are not emergency or urgent may have implications for the efficiency and appropriate use of health resources. The application of medications was not mentioned in any study analyzed, showing that this practice, although understandable in certain contexts (cases in which the BHU are closed), is not consistent with urgency and emergency situations, and the users may seek a BHU to perform this procedure.

The significant demand for care related to cases of unprotected sexual exposure, shown in this study, specifically for the performance of Post Exposure Prophylaxis (PEP) and rapid tests (HIV, syphilis and hepatitis B), is a particular characteristic of the local organization of the municipality. The ECU selected to conduct this study is one of the references for the assistance to the population that demands the evaluation and dispensation of medications in order to prevent STIs, outside the conventional operating hours of the other services that operate in the same area.⁽²⁵⁾

As for the outcome of users treated in the ECU, most were discharged after treatment, in line with similar findings in other studies, showing that most of the complaints presented by users are of low complexity or not urgent. This indication reinforces the idea that many cases could be managed effectively in a BHU, avoiding overloading services for urgent and emergency situations.⁽²⁶⁻²⁷⁾

Considering the initial evaluation of users, vital signs are essential to verify changes in clinical status and assist professionals in risk classification, together with the complaint referred to correctly prioritize users, and must be carried out in a reliable and efficient manner. This and other studies revealed that, among the vital signs measured (systolic and diastolic blood pressure, heart and respiratory rate, body temperature and oxygen saturation), most of these presented means within the normal range in all categories. This correspondence between the normality of vital signs and the classification of users as non-urgent is consistent, as users with vital signs within the normal range usually indicate less serious clinical conditions, not requiring immediate care and the users may be directed to seek care in a BHU.^(13,28)

Of the limitations, the study was carried out in a single ECU in the city of Curitiba, making the patterns of search for care and the characteristics of the sample specific to this location, limiting the applicability of the results to other regions. Another issue is the time frame used in the sample, not portraying all the diversity of cases over time and in different contexts. The presence of a pandemic period must be considered, which required reformulations in the organization of the municipality's health system, interfering with the perception and search patterns of users when seeking care.

Studies that use more comprehensive time frames and that are carried out in several Emergency Care Units can generate a greater number of data and enable a higher degree of understanding of the profile of non-urgent care. The identification and mapping of care can provide SUS managers with subsidies in the elaboration of health education strategies, improvement of the processes of the Urgency and Emergency Network and the strengthening of Primary Health Care and BHUs, as a gateway to the public health system.

CONCLUSION

From the identification of the profile of the care of users classified as non-urgent, attended in an Emergency Care Unit, the results showed the predominance of adults up to 39, female, with greater demand in the daytime and with clinical complaints and demands presented compatible with the classification of "non-urgent", demonstrating that their needs would have Primary Care as the most indicated point of care.

Given these particularities of each health service, it is important that professionals are able to clearly communicate to users the specificities of each service and the reasons why certain cases are referred to other points of the Health Care Network. This effective communication contributes to users understanding the service proposal in each unit, favoring the conscious and appropriate choice of service according to the nature of its demand.

In this context, it is necessary to invest in specific health education actions, such as campaigns, and measures to strengthen Primary Care, so that users are aware of the specificity of each service.

CONTRIBUTIONS

Contributed to the conception or design of the study/research: Magalhães DF, Nunes MGJ. Contributed to data collection: Magalhães DF. Contributed to the analysis and/or interpretation of data: Magalhães DF, Nunes MGJ. Contributed to article writing or critical review: Magalhães DF, Nunes MGJ, Silva JC. Final approval of the version to be published: Magalhães DF, Nunes MGJ, Silva JC.

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