

## ACOLHIMENTO EM UNIDADES DE PRONTO ATENDIMENTO: PERCEÇÃO DE IDOSOS E SEUS FAMILIARES

### WELCOMING IN EMERGENCY CARE UNITS: PERCEPTION OF ELDERLY PATIENTS AND THEIR RELATIVES

### ACOGIMIENTO EN UNIDADES DE ATENCIÓN DE EMERGENCIA: PERCEPCIÓN DE LOS ANCIANOS Y SUS PARIENTES

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#### RESUMO

**Objetivo:** Compreender as práticas de acolhimento em Unidades de Pronto Atendimento na perspectiva de idosos e familiares à luz da Política Nacional de Humanização. **Métodos:** Estudo qualitativo realizado junto a vinte idosos e cinco familiares, que foram atendidos em duas Unidades de Pronto Atendimento. Os dados foram coletados, por meio de entrevistas semiestruturadas, e a análise conduzida pelas etapas analíticas da *Grounded Theory*. **Resultados:** Evidenciou-se que o acolhimento é percebido entre as práticas de receptividade, ao entrar no serviço e na escuta qualificada. Entretanto, também foram constatadas algumas dificuldades, como a demora pelo atendimento e aspectos referentes a ambiência e infraestrutura que prejudicam a acomodação adequada dos usuários. **Conclusão:** Apesar dos idosos sentirem-se satisfeitos, em decorrência de as necessidades de saúde serem supridas, há urgência na reestruturação e na organização dos serviços, capacitação profissional e estratégias de atendimento que proporcionem a esta população uma assistência com responsabilidade.

**Descritores:** Acolhimento; Humanização da Assistência; Enfermagem em Emergência; Idoso; Enfermagem Geriátrica.

#### ABSTRACT

**Objective:** To understand the welcoming practices in Emergency Care Units from the perspective of the elderly patients and their relatives in the light of the National Humanization Policy. **Methods:** Qualitative study performed with twenty elderly people and five relatives, who were assisted in two Emergency Care Units. The data were collected by means of semi-structured interviews, and the analysis was conducted using the analytical steps of Grounded Theory. **Results:** We found that welcoming is perceived as one of the user embracement practices, when entering the service, and through qualified listening. Nevertheless, we also observed some difficulties, such as delays in these services and aspects related to the ambience and infrastructure that hinder the adequate accommodation of users. **Conclusion:** Although the elderly patients feel satisfied by perceiving their health needs being met, there is an urgent need for restructuring and organizing services, thus promoting professional training and creating care strategies that provide this population with responsible care.

**Descriptors:** User Embrace; Humanization of Assistance; Emergency Nursing; Elderly; Geriatric Nursing.

#### RESUMEN

**Objetivo:** Comprender las prácticas de acogimiento en las Unidades de Atención de Emergencia desde la perspectiva de los ancianos y sus parientes a la luz de la Política Nacional de Humanización. **Métodos:** Estudio cualitativo efectuado con veinte ancianos y cinco parientes, tratados en dos Unidades de Atención de Emergencia. Los datos se recopilaron a través de entrevistas semiestruturadas, y el análisis se llevó a cabo utilizando los pasos analíticos de la *Grounded Theory*. **Resultados:** Se evidenció que el acogimiento se percibe entre las prácticas de receptividad, al ingresar al servicio, y en la escucha calificada. Sin embargo, también se observaron algunas dificultades, como la demora en la atención y aspectos relacionados con el ambiente y la infraestructura que dificultan la acomodación adecuada de los usuarios. **Conclusión:** Aunque los ancianos se sienten satisfechos debido a que se cubren sus necesidades de salud, existe una necesidad urgente de reestructurar y organizar tales servicios, ofrecer capacitación profesional y estrategias de atención que brinden a esta población una atención responsable.

**Descriptores:** Acogimiento; Humanización de la Atención; Enfermería de Urgencia; Anciano; Enfermería Geriátrica.

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## INTRODUCTION

Population aging has progressed in association with other factors, such as the chronic conditions that affect a large part of the elderly population and is, intensely, associated with the weaknesses of this age group. Chronic Non-Communicable Diseases (NCDs) represent an important challenge for public health, entailing disabilities that affect the quality of life of individuals and the economy of countries<sup>(1)</sup>. This phenomenon reveals new demands for the health system, which, linked to the existing challenges in the care network for the elderly person, bring repercussions for urgent and emergency services<sup>(2)</sup>, mainly to the Emergency Care Units (UPAs, as per its Portuguese acronym).

UPAs were implemented, in 2009, from the restructuring of urgent and emergency care consolidated by the National Emergency Care Policy (PNAU, as per its Portuguese acronym), being configured as non-hospital health services that aim to establish the relationship among the Primary Health Care Units (UBS, as per its Portuguese acronym), the Family Health Strategy (ESF, as per its Portuguese acronym) and the hospital network. As for their attributions, they play an important role in health care of medium complexity, thus allowing access to elderly users at this level of care<sup>(3)</sup>.

The structuring of PNAU took place in the same period of preparation of the National Humanization Policy (PNH, as per its Portuguese acronym), which constitutes a considerable step towards the qualification of emergency services, especially with regard to the welcoming, humanization and organization of the urgent and emergency system, established by the risk classification, where the user is cared for according to his/her health condition<sup>(4-5)</sup>.

The act of welcoming exceeds the perspective of access to the health service, since it involves an action of admission (entrance door) and reception of the user<sup>(4-6)</sup>. Therefore, welcoming is understood as a continuous process that requires sensitivity, knowledge and active responsibility from health professionals for the health condition of the elderly patient<sup>(4-5)</sup>, with the association of the three constituent spheres in carrying out this practice: posture, attitude and care technology; mechanism for expansion and facilitation of access; and device for (re) organization of the teamwork process<sup>(5)</sup>.

The pertinent literature points to a study that deals with the welcoming of the elderly

patient in Primary Health Care (APS, as per its Portuguese acronym)<sup>(7)</sup> and even in hospital emergency services<sup>(4)</sup>, but research with this audience in UPAs is scarce, and there is a need for understanding about welcoming in the assistance offered to this population group, as well as the importance of these Units in the organization of care, based on the perception of the elderly users themselves and their relatives.

In the meantime, we raised the following question: What is the perception of the elderly patients and their relatives about the welcoming practices in UPAs? We believe that the answer will enable the focus on the development of welcoming actions, thus making us aware of the situations and the way in which they are being developed, which can contribute to the improvement of this activity by managers and professionals, in order to provide improvements in the quality of the services offered. Accordingly, this study aims to understand the welcoming practices in UPAs from the perspective of the elderly patients and their relatives in the light of the National Humanization Policy.

## METHOD

This is a qualitative study, adopting PNH as its theoretical framework and Grounded Theory analytical techniques as its methodological framework. It was performed in two UPAs in a medium-sized town in the southern region of the country, responsible for the local intermediate emergency care.

In order to select the participants, we performed a draw among individuals aged 60 years or over, who were cared for in UPAs, during the month of November 2015. This period corresponds to one month before the beginning of data collection, which took place between December 2015 and April 2016, with twenty elderly people and five relatives, with the purpose of providing remembrance of the welcoming process during the assistance in the Unit.

The first contact with the participants was via telephone, through a UPA employee, to whom previous invitations were made to participate in the study, and then we scheduled times with the same.

In the face-to-face meeting, we checked the cognitive condition of the elderly patients, according to the Mini Mental State Examination (MMSE), taking into account the level of education<sup>(8)</sup>, with 20 points for illiterates, 25 for individuals up to four years of schooling, 26.5 for those who

studied from five to eight years, 28 for people with nine to 11 years of schooling and 29 for those with more than 11 years of schooling<sup>(8)</sup>. Moreover, the elderly patient should have clinical condition to participate in the study. For the elderly patients who did not have a preserved cognitive condition, we invited their relatives, where the following criteria were respected: also having cognitive capacity evaluated by MMSE and being the main caregiver of the elderly individual.

The participants were instructed on the research and its objectives, the voluntary nature and the need to record the speeches. The interviews lasted an average of 26 minutes, with the majority being held<sup>(23)</sup> at the homes of the elderly patients, using a data collection script that had its content adapted by specialists in the area<sup>(9)</sup>. This consisted of three parts: sociodemographic characteristics of the elderly patient and his/her family; care characteristics; and questions about the welcoming during care in UPA, which were prepared in accordance with PNH<sup>(5)</sup>: “For you, what is welcoming?”, “How was your welcoming in UPA X?”. The interviews were conducted by a nurse, master student, with experience in qualitative research and member of a study and research group on aging linked to a university located in Paraná.

The collection and analysis of the data took place concurrently. After each interview, we performed the transcription of the speeches and their analysis, being essential to guide the selection of the next participants. Throughout the course of this stage, we complied with the criteria for sampling and theoretical saturation, a time when the onset of new codes was not perceived<sup>(10)</sup>.

When developing the constant comparative method, as proposed by Strauss and Corbin<sup>(10)</sup>, we observed that the clinical condition of the participant influenced the understanding about the welcoming performed in UPAs, being necessary to carry out the study with elderly people classified by all colors, according to the Manchester Protocol used in these Units<sup>(11)</sup>, Blue, Green, Yellow and Red, in order to better understand the object of study.

Accordingly, we conducted the interviews, initially, with eight elderly people classified by the Green color; followed by seven elderly people, classified by the Yellow color; five classified as Blue; and five relatives of elderly people with cognitive decline and unstable and more severe clinical situations, classified as Red.

In order to analyze the data, we adopted the open and axial analytical techniques of Grounded Theory, as these resources allow a technical systematization for the collection and analysis procedures that emphasizes the importance of knowing, understanding and interpreting the nature of events and situations<sup>(10)</sup>. In open coding, the data were analyzed line by line in order to identify each incident, thus generating 35 codes that, after grouping, fostered the elaboration of concepts. In axial coding, the data were regrouped in order to obtain a clearer and more complete explanation of the phenomenon under study, thus associating categories with subcategories, through a systematic analytical process of comparing and connecting the data<sup>(10)</sup>.

During the open coding, the use of these steps allowed us to identify how the elderly patients understood the welcoming practices in UPAs; and, through axial coding, we made the combination of codes in two axes, corresponding to the two categories: “Satisfaction with the welcoming in UPAs” and “Difficulties faced in the welcoming process in UPAs”.

The study was held in accordance with the requirements of Resolutions 466/2012 and 510/2016, with approval of the project by the Standing Committee on Ethics in Research with Human Beings of the State University of Maringá, under CAAE: 51328915.3.0000.0104 and Opinion nº 1.375.173. All the participants signed the Free and Informed Consent Form. In order to ensure their anonymity, the speeches were identified with the letter “I” for the Elderly patients and “F” for the Relatives (according to the Portuguese language), followed by the number of the interview and the risk classification obtained.

## RESULTS AND DISCUSSION

Of the 20 elderly participants in the research, the age ranged between 60 and 85 years, with an average of 69 years. There was a predominance of the female gender (14), where the marital status of the majority was married (13). Moreover, 17 had an education level of up to four years of schooling. The main health complaints that led them to seek UPAs were related to diseases of the musculoskeletal system and of the connective tissue<sup>(9)</sup>.

Concerning the five relatives, three were daughters of the elderly patient, one wife and one former daughter-in-law. The age was between 40 and 78 years, with an average of 61 years. All were females, four developed work activities pertaining

the care of the elderly patient and household tasks, three had up to eight years of schooling. The main complaint that motivated the relatives to take the elderly to UPAs was related to Cardiovascular Diseases.

### **Satisfaction with the welcoming in UPAs**

In this category, we introduce the satisfaction with the welcoming in the Units studied, which, from the perspective of the participants, was related to the organization of the service, the risk classification, as well as the light technologies of qualified listening and bonding, which were positively pointed out in the receptivity to the service and in the way of caring for on the part of the professionals, which is among the guidelines of PNH.

Among the aspects of welcoming pointed out as satisfactory by the elderly patients and their relatives, we can mention the organization of the service, especially with regard to the Welcoming With Risk Classification (ACCR, as per its Portuguese acronym): "(...) I think this classification that they do at UPA is right, because when you have something that can wait, you can even go to the health center"(I12-Yellow).

According to the research participants, when arriving at UPA, the user is classified by four different colors and in line with their clinical condition, thus defining the outcome of care: "(...) the nurse assisted me, she realized that my pressure was little changed, then she gave me the yellow sheet, because when you have an emergency, the doctor assists you first" (I12-Yellow). "When I get there, I'm welcomed. If there are people in front of me, I wait a little and then I'm called to do the screening. If it's an emergency case, the same screening already puts me inside. When it's not an emergency, I undergo the screening, go back to the reception, sit in the chair, wait and then the doctor calls me" (I7-Green).

ACCR is an important device implemented in emergency services based on PNH<sup>(5)</sup>. This tool has the primary function of integrating welcoming, thus humanizing care, through the promotion of health practices and actions targeted at the institutionalization of care to users in urgent and emergency services with quality, through the planning of flow, thus prioritizing more severe cases<sup>(12)</sup>. The welcoming method used in the studied UPAs causes the individual to be evaluated by a nurse, immediately, upon arriving at the Unit and, based on their clinical condition, the corresponding risk classification is defined, which

determines if the patient should obtain immediate medical care or should wait<sup>(11)</sup>.

Another aspect referred to as satisfactory about the welcoming in the studied UPAs concerns the need for laboratory monitoring for the stability of illnesses, as in the case of the elderly patient with NCD: "When I arrived at UPA, I said at the reception that I had gone to do the exam and I showed the form. One lady called me out. I was well treated. I didn't even sit down to wait. After that, she collected the blood, and she said: wait a little while I'm preparing to give the result" (I19-Blue). The availability of the services offered in UPAs draw the attention of users because of the wide possibility of access to exams and resoluteness of care<sup>(13)</sup>.

In the entire care process, whether it is in the risk classification, in the medication room or in the medical consultation, the satisfaction of the elderly patients and their relatives was notorious when they spoke about the empathy of the professionals in the assistance provided, endorsed by them as a synonymous with welcoming: "Welcoming is their way of treating us, welcoming with affection and dedication. When I was at UPA accompanying my mother, they were always asking how she was doing. This gives us more strength. (...) The welcoming was great!" (F23-Red).

The act of welcoming is not limited to a cordial reception, but also includes the active listening of the user, bond, resolution and professional performance. Qualified listening is a crucial element in the welcoming process, since it aims to promote a positive and responsible response to the resolution of your need, through interventional practices, which is the final product of the health work<sup>(4-6)</sup>.

Although the emergency services are permeated by an accelerated routine and conducive to the development of technicality, on the part of the professionals, the humanization of the care provided is notorious, thus valuing the family members as caregivers, respecting the legal aspects and providing them with support in the face of the situation experienced, with responsibility and dedication. Empathy is part of the humanization process, being extremely important for valuing care and quality of care, which are recognized by the study participants as the main aspects that generate satisfaction with the service.

Associated with the welcoming practices mediated by the professionals, the participants

mentioned the right of the elderly person to have a caregiver, praising the way in which they are welcomed, including the provision of food during their stay: "The UPA employees even warned that if someone wanted to get there as a caregiver, due to my age, he could" (I10-Yellow). "When I needed to go to UPA, everything was always organized (...). Furthermore, they gave me food, because I was accompanying my mother" (F23-Red).

Such factors are paramount when it comes to the elderly people, regardless of the clinical condition, they need qualified care, due to functional and/or cognitive limitations, or even because they are in a totally strange environment. In this context, one of the practices that can facilitate the care of these individuals is the monitoring by someone of their preference. This is a fact positively mentioned by the elderly patients in this study, who received this information, from the moment when they entered the service. We should underline that the right of the elderly person to have a caregiver during his/her stay in health services is also among the guidelines of PNH<sup>(5)</sup>.

In addition to enabling monitoring, another important attribute of welcoming was explained in this research, the provision of food for the caregiver. It is known that the supply of physiological needs is among the strategies for the proper functioning of UPA<sup>(3)</sup>. Much more than just meeting the basic human needs of the user, among the functions of the act of eating, there is the hedonic function, for the pleasure of eating and living together, since eating meals is part of the culture of the individual<sup>(15)</sup>, and this is closely related to the humanization practice.

Among the satisfactory aspects of the organization of the work process of these Units, we can mention the follow-up of care and achievement of the expectations of the individual, which is considered fundamental to the care of the elderly patient in UPAs: "Firstly, I went to the reception, and then to the doctor and to the medication room. After that, they referred me to the health center. There were a lot of people, but they called me out right away. They treat us very well" (I18-Blue).

Due to the reported work dynamics, the continuity of care expressed by referral to another service could be perceived among the welcoming practices. When the individual seeks the Unit, due to conditions sensitive to primary care, the physician usually provides the necessary care, and then he/she is referred to PHC to be cared for with

longitudinality<sup>(15)</sup>, a preponderant characteristic of the elderly citizens who have a high frequency of exacerbations of their chronic conditions. In addition to that, it is essential that primary care performs its functions of coordinating care, since the integrality of care becomes fragmented without this service.

Nevertheless, the care in UPAs has shown weakness in the counter-referral system for PHC, which affects the health system as a whole<sup>(16)</sup>. When considering that 'Protagonism, Co-responsibility and Autonomy of Subjects and Collectives' is among the principles of PNH, it is essential that workers and users recognize their role in health production<sup>(5)</sup>, thus promoting communication between points of care, as proposed by the Brazilian health model<sup>(15)</sup>.

### **Difficulties faced in the welcoming process in UPAs**

Some problems in the welcoming process in UPAs were also reported by the elderly patients and their families. Among which, we highlight issues linked to the indiscriminate demand in these services that cause delay in the service time, problems with the ambience and human and material resources incompatible with the number of users served.

An example mentioned was the speech of an elderly patient who sought the Unit to administer medication prescribed by a physician who followed-up his health problem, but there was a need to wait for a medical consultation, so that the professional could transcribe his medication, even in possession of the medical prescription: "I have anemia, the doctor prescribed six medications and had to apply one intravenous drug a week, with serum. (...) I went to UPA, but I think the delay was very difficult. I was classified as blue color, and then they assisted everyone in front of me, I just went to receive an injection and had to go to the doctor" (I21-Blue).

Although there are records of advances in the Brazilian health care model, in terms of reorganizing the Health Care Network (RAS, as per its Portuguese acronym) and enhancing its intercommunication<sup>(13,16)</sup>, we can observe that there are still flaws in the standardization of certain procedures. This practice can generate discomfort among users, as they do not know which service to search for, thus demonstrating the lack of information regarding the functions of each point of attention linked to RAS. In addition,

they generate unnecessary care in UPAs, which could happen directly in PHC<sup>(3)</sup>.

However, it must be considered that the misinterpretation of information or, even, exposure of limited information, can contribute to non-urgent demands in UPAs<sup>(4,13)</sup>. Overcrowding in these Units leads to more time spent in care actions, which entails discontent to the user in the welcoming process, as this aspect corresponds to a virtue of welcoming, as well as generates dissatisfaction in the professionals, due to the lack of continuity in the work<sup>(2)</sup>.

Associated with the waiting time, there is also weakness regarding the availability of test results. It is worth underlining that this is a challenge faced in health services, in general; therefore, it corroborates with the pertinent literature, because the time to be assisted and to receive the results of the medical tests is a reason for high dissatisfaction by the population<sup>(17)</sup>.

For the participants of this study, it leads to a delay in the behavior of the medical team regarding the outcome of the clinical situation of the elderly patient: "I waited a long time, because I had collected a lot of exams, which takes three and a half to four hours to get ready. When it was ready, I had to wait a long time for the doctor to come and talk about what really happened, if my mother was going to be admitted or if she was going to exit (...)" (F22-Red). "The problem with this UPA is the exams you've to send to another place and you've to wait a long time for the result. There aren't all exams there. They only collect and send it to another place, then you have to wait for the result, and then they decide whether you'll be discharged or you'll need to remain hospitalized" (I2-Green).

We should highlight that none of the UPAs in the studied town have a laboratory to carry out biochemical analysis of the tests. From the testimony, we can note that the user mentioned the forwarding of biological material to another service, located next to one of the Units, responsible for the biochemical analysis of the tests of the local health services<sup>(8)</sup>.

Despite the discontent of the elderly patient, the legislation provides for laboratories outside the Unit, which allow access to tests for users with the existence of a room to be used to collect materials, within a technically acceptable time interval and according to parameters defined by the locoregional teams<sup>(3,11)</sup>. The importance of guiding the population on the work organization of these health facilities should be reinforced,

which also corresponds to one of the forms of welcoming.

In addition to the waiting time for procedures held at the Unit, the infrastructure was also identified as a weakness in the process of adequate welcoming. The overload in these services has generated overcrowding, which makes the infrastructure of the service incompatible to assist everyone with quality: "That injection room could have more chairs, but it's small, there is no way. I believe that's why it takes so long to serve us" (I21-Blue).

Associated with the insufficient number of chairs, the participants highlighted the discomfort caused by the furniture: "The youngest people were standing in the corridors, because there was no chair for everyone to sit on, and the chairs were not comfortable" (I6-Green). It is worth mentioning the report of an elderly patient who was with a caregiver and, due to the discomfort of the accommodations, he suffered malaise and had to be assisted: "That day, I went to UPA, because I was accompanying my granddaughter who had colic in her kidneys, when I spent the whole night, without sleeping, sitting in that horrible and hard chair, which made me sick, and then I was assisted by the doctor" (E13-Yellow).

Still regarding the ambience, the interviewees highlighted problems with the hygiene and comfort in UPA: "Perhaps because there are a lot of people, it wasn't clean, there're people who throw things on the floor, some end up vomiting and others step on it. And also about ventilation, we asked the nurse to regulate the air conditioning a little bit, because we're cold" (I6-Green).

It is known that the infrastructure compromises nursing care concerning the care of the elderly population<sup>(18)</sup>. This also goes against the guidelines of PNH, which recommends that health facilities have adequate physical structure and ambience, so that users achieve, comfortably, care, thus mitigating their suffering<sup>(5)</sup>.

The ambience is strongly linked to the welcoming process. In health, it refers to the physical space understood as a place for social, professional and interpersonal relationships that should allow welcoming, resolute and humanized care<sup>(19)</sup>. For the participants of this research, the ambience of the analyzed UPAs is less than expected, especially with regard to comfort, cleanliness and ventilation, being limited to conservative welcoming with isolated practices of checking and organizing queues. A study

conducted in Atlanta-Georgia corroborates this condition, where the comfort of the chairs was among the factors that most influenced the dissatisfaction of the elderly patients in emergency services<sup>(19)</sup>.

In addition to these issues, overcrowding in emergency services does not only influence the overload of its infrastructure, but entails the production of works incompatible with the number of professionals, which, for the elderly patients, directly interferes in the process of welcoming in UPA: "When I was served at UPA, there were few professionals, this may have influenced the delay, as when I went to undergo the X-ray, there was no employee, the room was closed with a sheet of paper on the door saying that he had gone to the child emergency, then it took a long time to do my X-ray"(16-Green).

According to PNH, professionals are key elements for the success of the welcoming process<sup>(5)</sup>, being that the work overload in UPAs affects the main aspects of welcoming, such as the qualified listening and the determination of priorities for emergency care<sup>(20)</sup>, besides implying a longer waiting time for medical care. Accordingly, for those who seek services in emergency situations, the waiting time for care represents the maintenance of life.

## CONSIDERAÇÕES FINAIS

The data obtained in this study have allowed us to know how elderly users and their relatives understand the welcoming in UPAs, which indicated satisfaction with the care received on the part of professionals, mainly related to the qualified listening and the resolution of health problems that motivated the search for these services. We also identified some difficulties faced in the search for these services, characterized by waiting time, great demand, incompatibility of the infrastructure and a shortage of professionals.

The results of this study point out to the managers of UPAs the need to implement protocols and strategies that enable improvements in the quality of care, since the act of ensuring the resolution of needs can mean continuity in the quality of life of this population. It also points to the need to reorganize the health services that comprise the RAS network, especially with regard to strengthening and providing greater investment in PHC, so that it can exercise its role as coordinator and organizer of care and that users use the primary care services properly, in a way that the quality and the organization of

UPAs are positively affected. Moreover, we should underline the importance of health professionals in the empowerment of the population for the conscious search for emergency health services.

Concerning the involvement of professionals in welcoming practices, it must be considered that nursing has in its context the art of care and constitutes the category with the greatest number of professionals in UPAs; therefore, we should consider that the consolidation of the devices of PNH is essential for these team members, so that they can promote the qualification of assistance. Accordingly, we hope that this study will allow these professionals to reflect on the assistance offered to the elderly population in these services.

As a limitation, the study brings exclusively the perception of the elderly patients and their relatives assisted in UPAs, which demonstrates that new research with health professionals can be promising for further investment in health and for the advancement of knowledge in nursing and health. Nevertheless, the social impact of the results found, since the quality of the welcoming reflects on the time and on the outcome of care targeted to the elderly patient, brings contributions to the fields of health and nursing and may support new studies focused on improving the welcoming of the elderly people in emergency health services.

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