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Original Article

Acolhimento à demanda espontânea na Atenção Primária à Saúde: uma proposta de intervenção

Reception of spontaneous demand in Primary Health Care: an intervention proposal

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Authorship

Metadata

RESUMO

Introdução: A Atenção Primária à Saúde (APS) atende problemas de saúde dos mais simples até os mais complexos e utiliza o acolhimento como um ato tecnoassistencial que é parte dos processos de trabalho em saúde, com o intuito de atender todos que buscam os serviços de saúde. **Objetivo:** O objetivo deste estudo foi construir uma proposta de acolhimento à demanda espontânea, tomando os trabalhadores da saúde como sujeitos deste processo. **Metodologia:** Trata-se de um projeto de intervenção não controlado, qualitativo, a partir do Método do Arco de Charles Maguerez realizado em uma Unidade Básica de Saúde (UBS) localizada num município mineiro. **Resultados e discussão:** Com auxílio do Arco de Maguerez foi possível identificar problemas relacionados à comunicação, orientações quanto ao fluxo de atendimentos, atendimentos em tempo oportuno, ausência de perguntas relacionadas a avaliação de risco e vulnerabilidade, melhorias em relação à evolução de enfermagem, e ausência de autonomia e responsabilidade do usuário com sua saúde. **Conclusão:** A metodologia, por meio de encontros que possibilitaram discussões e mudanças no processo de trabalho, permitiu ao serviço incorporar em seu cotidiano o acolhimento à demanda espontânea com classificação de risco e vulnerabilidade a partir da elaboração de um Protocolo Operacional Padrão (POP).

Palavras-chave: Atenção Primária à Saúde. Acolhimento. Acessibilidade aos Serviços de Saúde.

ABSTRACT

Introduction: Primary Health Care (PHC) addresses health problems ranging from the simplest to the most complex, utilizing reception as a techno-assistive act that encompasses health work processes with the aim of attending to all who seek health services. **Objective**: The objective of this study was to construct a proposal for reception of spontaneous demand, taking health workers as subjects of this process. **Methodology**: This is an uncontrolled qualitative intervention project, based on the Charles Maguerez Arch Method, carried out in a Basic Health Unit (BHU) located in a city in the state of Minas Gerais. **Results and discussion**: With the assistance of the Maguerez Arch, it was possible to identify problems related to communication, guidance on the flow of care, timely care, absence of questions related to risk and vulnerability assessment, improvements in nursing evolution, and absence of user autonomy and responsibility for their health. **Conclusion**: The methodology, through meetings that enabled discussions and changes in the work process, allowed the service to incorporate into its routine the reception of spontaneous demand with risk and vulnerability classification through the development of a Standard Operating Protocol (SOP).

Keywords: Primary Health Care. User Embracement. Health Services Accessibility.

INTRODUCTION

In the Single Health System (SUS), Primary Health Care (PHC) is the first level of health attention, which aims to provide individual and collective health care actions to promoting and protect health, prevent health issues, diagnose, treat, rehabilitate, control damage, and preserve health[1]. It emerged as a form to convert the hospital care that is usually curative and individual into a collective, preventive form of care, attached to a region[2].

The PHC, as the gateway for SUS users, must be capable of dealing with health issues and recognize health risks, needs, and demands. It operates using many different technologies and must coordinate care itself, as it is the center of communication between the many points of care, in a horizontal, continuous, and integrated form of attention. Additionally, it must orient the networks, identifying the needs of the population assisted and organizing it in regard to other aspects of health care[3].

To do so, devices are required that allow improving the care provided. This is the goal of embracement, a tool that orients this process. In 2003, the National Humanization Policy (PNH), also known as HumanizaSUS was launched, in an attempt to organize the principles of SUS, proposing changes in management and care[4].

According with the PNH, which has embracement as one of its basis, this concept refers to recognizing the issues brought forth by the user as genuine and unique health needs. This requires those involved to be committed and form a bond. They must listen to the patient actively to evaluate their demands; impose limits when necessary; ensure that they are providing integral, responsible, and effective care; and mobilize and articulate the network of services[4].

In this regard, considering the PNH, embracing is an instrument to reorganize the system and the work process[4]. That is why embracement in health may happen at any moment and place, in the form of listening actively to users, which can be done by all health professionals. As this is done, bonds are established and attempts are made to deal with the issues presented, in order to effectively expand access to primary care and other levels of health. Embracement aims to reduce queues, organizing attention according to risk and vulnerability criteria, and in accordance with the problem-solving capacity of the service[5].

In most cases, the demands in PHC have the potential to be embraced and resolved using soft, soft-hard, and hard health technologies. Soft technologies consist of relationships, such as embracement; soft-hard indicates the knowledge; and hard, the organizational structure[6]. Furthermore, qualified administration is essential for health services to be properly carried out, especially in the PHC. It is imperative to adequately plan and ensure the flow of user care[7].

Nevertheless, the hegemonic model of health is unfortunately focus on the spontaneous demand, which is described as the moment when a citizen goes to a health unit due to unexpected reasons that, they believe, make their visit unavoidable. This means that health care involves specific actions, generally surrounding the complaints of users. This leads to fragmented and unplanned health care, with few actions to prevent disease and promote health. As a result, it becomes impossible to value the principles and directives of primary attention and health networks[5].

Since the goal of the Family Health Strategy (ESF) is to reorganize care, and considering that providing attention to spontaneous demands of the population is the first and most accessed service in a Basic Health Unit (BHU), we must consider actions capable of overcoming these obstacles, which is one of the goals of embracement in health[8]. An Embracement with Risk Assessment aims to organize care according to risk, health issues, or degree of suffering, prioritizing more severe cases. It starts after the initial complaint is manifested or expressed by the citizens or their companions. It also guides the medical history and physical examinations, which are conducted to stratify risk and define how long care should take[9].

Triage also allows organizing demands according to severity and need for intervention. This system usually uses colors to represent the priority level for care. A common example is a four-color system, where red indicates immediate care and high risk of life; yellow indicates priority and moderate risk; green indicates treatment should be provided within the day, low risk or no important vulnerability; and blue indicates a non-acute situation, that may be solved with orientation or other forms of care and scheduled or postponed according to protocol[10]. To put this operation in practice, we must consider clinical and epidemiological knowledge, and subjective risks and vulnerabilities[9].

Nevertheless, what we see in practice is not in accordance with the proposals of embracement in health. This is due to several facts, such as health institution infrastructure; the understanding of the population about health services; lack of professionals; lack of responsibility with the service; outdated knowledge; doubts in decision making; and PHC underappreciation[9].

Considering the above, this study proposes the implementation of embracement with risk assessment to evaluate risk and vulnerabilities in a BHU from a city in the Zona da Mata region of Minas Gerais. Our specific goals are: planning and implementing workshops to discuss and reconsider the role of BHU professionals when it comes to the embracement of spontaneous demand with risk and vulnerability assessment, both in the BHU itself and in the reception of the health unit; and to analyze the possibilities and obstacles that interfere in the embracement of users who are seeking the health services of this unit.

METHODOLOGY

This is an uncontrolled, qualitative intervention project, using the conversation round method. It was carried out in a Basic Health Unit (BHU) located in a city in the Zona da Mata region of the state of Minas Gerais.

An intervention project can be controlled or non-controlled. In this type of intervention, participants are treated equally, and actions will be carried out daily. In this type of study, the researcher influences interventions, allowing for intentional changes[11].

This type of project aims to favor the organization of actions in health to achieve a goal. When a situation that can be modified using a situational diagnosis is found, an action is proposed, considering the reasons found critically and listed according to their priority[12]. The interventions aim to reduce risks, prevent, treat, resolve, or administer obstacles to health. The conclusion can be different from the one expected, involving absenteeism, solutions, a successful management of the problem, or the avoidance of complications[13].

Conversation rounds lasting one hour each were carried out every Thursday, in the protected hour of the BHU. The conversation round is a democratic and participative methodology that favors communication, professional autonomy, and shared thoughts, since participants manifest evidence and opinions on the topic, and these can be incorporated into the process[14].

Conversation rounds also aim to discuss a specific topic. The participants sit in a circle and are given the opportunity to express themselves following an order previously established by the facilitator, which is the one responsible for organizing and conducting the discussion. These rounds promote an environment of active listening and mutual respect, and it is important to avoid using cellphones, having unrelated conversations, or allowing for other distractions. During the meetings, respect for all must be preserved, so each participant feels safe and free to speak. To ensure that each person has their moment to speak, the facilitator can use a "speaking object", which is passed from one participant to another, helping regulate the flow of the conversation[15].

It is worth highlighting that the use of this methodology must be preceded by a planning stage, in which the organizer will determine the topic to be discussed, choose the location, define the date and time, and send invites to the participants, in addition to preparing the necessary environments and materials. There must also be a script, which will guide the mediator, by including a planning of activities related to the selected topic. This script must contemplate three stages of the round: the Opening remarks, which start the meeting; the Development, in which the activities proposed are carried out; and the Closing, which is a moment for participants to reflect on the discussions.

The methodology used to develop the conversation round was the Maguerez Arch, which is a Problem-Based Teaching strategy (PBT). The method of the arch was created by Charles

Maguerez and has five steps: observation of reality, key points, theorization, solution hypotheses, and application to reality[14]. Each stage will be discussed as the intervention is described below.

The theoretical framework used included the materials titled *Acolhimento com Avaliação e Classificação de Risco* (Embracement with Risk Assessment), by the Brazilian Ministry of Health (2004); the *Cadernos de Atenção Básica* (Basic Care Booklets), No. 28, Volume I and II, by the Ministry of Health (2013); the *Protocolo das Ações dos Enfermeiros nos Serviços de Atenção Primária* (Protocol for the Activities of Nurses in Primary Care services), by the Municipal Health Secretariat of Juiz de Fora (2013); The conversation round is a democratic and participative methodology that favors communication, professional autonomy, and shared thoughts, since participants manifest evidence and opinions on the topic, and these can be incorporated into the process[14].

The Problematization Methodology was also applied. It is mostly used in contexts associated with life in society and uses the Maguerez Arch as an orientation. This methodology, based on learning about problems, allows considering certain topics as problems, in such a way that those involved become aware of a situation before it may take place.

Intervention setting

This project was carried out in a BHU with a Family Health team (FHt), located in the aforementioned municipality. It works non-stop from 08:00h to 20:00h, from Monday to Friday, with eventual activities planned for Saturdays. The unit is divided into four teams and provides care to three neighborhoods, attending from 15 to 16 thousand people.

The list of workers in the BHU include: a supervisor, five nurses, five nursing auxiliaries, four physicians, one pharmacist, thirteen community health agents, two receptionists, three general services assistant, and one doorman. Additionally, since the unit also has teaching/internship opportunities, there is one medicine undergraduate and one student from the technical course for nursing auxiliaries.

As for the services provided, the unit offers usual nursing care, such as consultations, vaccination, wound dressing, arterial pressure measurements, medication administration, and others, in addition to medical consultations. These are mostly scheduled consultations for hypertension, diabetes, prenatal, mental health, child health, etc., carried out alternately by physicians or nurses. Demand is preferably divided into acute cases, which are attended in the morning, and scheduled consultations (control consultations), that take place in the afternoon.

The profile of the population assisted in this unit mostly comprises women and the elderly, requiring scheduled activities for the hypertensive and diabetic, in addition to mental health follow up consultations.

The facilities are adequate for a set of actions and services, including a vaccination room; a procedure room; a service for the scheduling of consultations, exams, and National Health Cards (CNS); in addition to medical and nursing offices for each professional, and a meeting room. The health equipment used includes the e-SUS, in the module Citizen Electronic Records, which is used as the information system of all sectors.

Study subjects

The study included 11 participants, 5 from the nursing team, 4 from the medical team, 1 supervisor, and 1 receptionist of the BHU, all of whom take part in the embracement of spontaneous demand. Regarding participant profile, 8 were female and 3, male. With the exception of one participant, all the others have finished higher education. Regarding their ethnicity, 7 participants declared to be white, 2 to be brown, and 2 to be black. Regarding their experience in Primary Health Care (PHC), 5 participants have less than one year of experience, 2 have from one to five, and 5 have more than five years of experience.

The pathway of the intervention

Presentation of the intervention project to the municipal health management and the BHU team

The intervention project was presented to the Municipal Health Secretariat of Juiz de Fora and, later, to the FHt professionals, in December 2023. Requests were made for the interventions to take place during the BHU protected time - the period dedicated for planning, training, and other events in the unit. Thus, interventions took place on Thursdays, from December 2023 to January 2024.

The implementation process of the workshops was established after the municipal administration gave its permission. It was approved by the Research Ethics Committee at the Universidade Federal de Juiz de Fora – UFJF (opinion n.º 6.284.999; CAAE n.º 71274523.5.0000.5147) and all participants signed an informed consent.

Intervention proposal: using the Maguerez Arch

Bordenave and Pereira were the first to disseminate the Charles Maguerez Arch method, in 1982. This is a guide towards critical and creative concepts. Applying the Maguerez Arch as a methodology for embracement with risk assessment in the BHU allows elaborating issues from the observation of the context in which professionals are inserted. It also allows recognizing causes and provokers of any issues, choosing how to work with each key step, defining presuppositions necessary to solve the issues, and listing which options are applicable to reality[14].

The Maguerez Arch has five steps: 1- observation of reality: the problem is recognized; 2- key-point identification: potential factors and determinants of the problem are identified; 3- theorization of concepts: the best way to analyze each key point is selected; 4- solution hypotheses: hypotheses are elaborated to solve the problem; 5- Application to reality: hypotheses that can be applied in practice are selected.

The choice for an active methodology allows the subject to be the main actor of the process, helping prepare critical and reflective people, who jointly take part in the process of constructing knowledge[14].

Understanding the experienced/observed reality

When the population goes to the BHU, they are attended by the receptionist. She asks the users what type of service they are seeking and input their personal data into the e-SUS PEC information system in a fast and rigorous manner, referring them to the appropriate professional and type of care they need.

It should be noted that, in the reception area, there is no guarantee of secrecy or privacy to the population, as there is little space to accommodate users, which leads to crowding. Moreover, it is worth noting that users do not understand what "embracement" means, since they understand this practice as a pre-consultation or even a triage.

Later, users are called by nursing professionals and the BHU supervisors into their respective offices, where their complaints are received. Each professional embraces the patients appropriate to their specialty, and the supervisor attends patients from the extended-time team. The citizen is called depending on the time of day that they were inserted into the information system. Priority criteria such as age, comorbidities, etc., are not considered.

At this time, since the user is already in the information system, the professional opens the field for inserting notes about their first embracement, listening to the patient and asking them why they are searching for "embracement". In most cases, these notes are related to the patient's complaints and the time it took to start.

In this first listening, we noticed that there are often no questions related to risk and vulnerability, and vital signs are frequently no measured. Thus, this is a nursing consultation with no criteria or rigor. This is an issue if one is to be able to solve a demand with clarity, objectivity, and in a timely manner, not including clarifications about the work process of the service and other issues in the Health Care Network (HCN).

It also became clear that users often seek medical care for demands that could be scheduled, such as new prescriptions and requests for exams and their evaluation. This shows that the user is not co-responsible for their health.

There are also acute cases that require a spontaneous consultation, as fast as possible. Depending on clinical analysis and the beginning of the symptoms, patients with these cases will be attended in the same day if there are physicians available, or scheduled for an appropriate time, in the same week. After their doubts are clarified, the citizen is referred as appropriate.

RESULTS AND DISCUSSION

Stages of the Maguerez Arch – Observation of Reality

At first, in accordance with the first stage of the Maguerez Method, the researcher was present in the setting, to carry out observations. At the time, she observed the receptionist as she embraced the users in a fast manner, with not many details, inserting them in the information system. Then, the users were called by the nurse from the reference team, who listened to their complaints attentively and, depending on the complaint, referred them to a medical consultation.

User embracement by three nursing professionals was observed; two of the cases were solved by the nurses themselves. At first, it was found that users were not given a clear explanation about the flow of care. A professional clearly had trouble explaining their conduct, repeating themselves constantly, and the it was clear that the user did not understand them. There was also a case in which a teenager complaining about vaginal symptoms was accompanied by her guardian, which prevented a better understanding of her case (the adolescent was noticeably embarrassed and did not reveal further information that could be pertinent to her case).

After the observation, a first meeting was conducted with the nurses, physicians, and interns, in addition to the health service manager and the receptionist. At first, the goal of the meeting was explained, encouraging a discussion about the work process regarding "embracement". Then professionals were encouraged to clearly express their knowledge about the topic, and differentiate between "embracement" and "triage", showing that they needed a deeper knowledge about the topic.

Then, a discussion was started among professionals, involving the topics: mean length of consultation; waiting time; problem-solving capacity; limits of the care provided and which clinical demands can wait; potential roles to be performed by nurses according with the Municipal Nursing Protocol; and applicability of the Manchester Protocol in the PHC[16].

Stages of the Maguerez Arch – Identifying Key-Points

After the reality was observed and a consensus was reached with the other participants

of the study, the following key-points were defined: communication between professionals; lack of guidance regarding the flow of care; clear and objective language with the user; timely nursing pre-care; lack of questions about risk and vulnerability and lack of vital sign measuring (incomplete anamnesis) for the immediate care of those who need it; improvements regarding nursing evolution and lack of autonomy and responsibility of the user regarding their health, for example, a high demand for prescriptions.

Maguerez Arch – Theorization

The third stage started with a discussion about Embracement and Risk Classification, using an expository class with materials related to the topic, including: *Acolhimento com Avaliação e Classificação de Risco* (Embracement with Risk Classification), by the Brazilian Ministry of Health (2004); *the Cadernos de Atenção Básica* (Basic Care Booklets), No. 28, Volume I and II, by the Ministry of Health (2013); the *Protocolo das Ações dos Enfermeiros nos Serviços de Atenção Primária* (Protocol for the Activities of Nurses in Primary Care services), by the Municipal Health Secretariat of Juiz de Fora (2013).

It was reiterated that user embracement is a practice that should be present in all relationships of care, when health workers and users meet, and in the act of embracing and listening to people. Thus, it can take place in many ways, and it is considered to be an act of approximation, inclusion, and humanization. The professional embraces, listens to the user, and gives them appropriate responses, in order to solve their problems with co-responsibility. This also promotes qualified listening, the establishment of bonds, and ensures access, the continuity of care, and the articulation between services[10].

Additionally, it was made clear that attention to spontaneous demand and, especially, to urgency and emergency, involves actions that must be carried out in all health care services, including basic health care. These actions include organizational aspects of the team and their work processes, in addition to problem-solving aspects of care and conducts[16]. It is also worth noting that embracing users in the PHC is often a bureaucratic process, organized in order of arrival, by the professional responsible, and patients with more serious cases are not prioritized. This shows the need of an embracement that includes risk evaluation, which is a type of care that focus on the complexity level, identifying which individuals require immediate care, considering health issues and the potential risk[17].

Regarding risk and vulnerability evaluations, it was pointed out that it helps ensure equal access, helping identify different degrees of risk and more urgent situations, prioritizing them appropriately. In the reception area itself the professionals can identify which situations show a

greater risk or intense suffering, such as children with high fever, agitated users, people with difficulty breathing and older persons with chest pain[10].

Risk stratification and the evaluation of vulnerabilities will not only help decide the type of intervention (or provision of care) necessary, but also how long it should last. In Primary Care (PC), as opposed to an emergency room, rigid time limits for the care provided after a first contact are not necessary. On the other hand, it is important to prioritize the care to some cases, as not to keep a person suffering for a long period. Thus, the stratification of risk and evaluation of vulnerabilities can be quite useful[10].

Another element highlighted was the importance of considering not only biological risks, as it is essential to remember that certain conditions increase vulnerability. Embracement is an opportunity to include these conditions, considering them as part of plans of care - since it is a moment when the user is searching for help and, in general, is more open and inclined to have a dialog with the health team[10].

Examples included: a malnourished child who had not been taken to childcare consultations for eight months; a 50-year-old man who went to a health service for the first time after many years; a woman of childbearing age who had not underwent cytopathological exams for four years, works as maid (with no formal contract) and takes care of three children, all minors[10].

One of the professionals expressed doubt about whether a 50 year old man who is often absent from the BHU was a priority. It was mentioned that, by using this example, we considered exactly those who do not come back for follow-up consultations in the BHU, but only in specific cases, when they believe they need it. Workers who, due to scheduling and other issues, do not come often to the BHU, were also discussed, reiterating the opportunity of providing care considering criteria of risk and vulnerability.

It should be noted that, in examples such as this one, a more thorough anamnesis must be carried out, associated to the measuring of vital signs, since, if these signs are altered, they must be treated in the same day. Additionally, we emphasized the fact that the patient should leave with their care already planned.

We also discussed the importance of listening to the user as they arrive, in order to assess the need for immediate care, provide or facilitate first care, identify individual and collective vulnerabilities, classify the risk to define care priorities, organize the disposition of patients in the facility in order to accommodate those who need observation or medications, or who are waiting for removal to another service, or those who are suspected of carrying airborne infectious diseases (meningitis, for example), and refer them for care according to their classification.

It is well known that, depending on the demands, the person who is listening can be responsible for interventions (to a greater or lesser degree). For example, if a user delayed

menstruation of cough (with no signs of a severe condition) for more than three weeks, and a nurse is already listening and evaluating them, the nurse can already consider asking for a pregnancy test and a sputum culture, respectively, considering local protocols or Ministry of Health recommendations[10].

Moreover, we emphasized the risk classification in the BHU aims to increase the speed of attention, using a pre-established protocol to do so. This protocol analyzes the needs of the user and provides them with care focused on the degree of complexity, not only on the order of arrival. Furthermore, this type of classification is relevant for the quality of care, since it orients professionals regarding the necessary interventions and indicates how long it should last (more severe cases are prioritized, but users should be informed about this priority and reassured about waiting time).

We also addressed chronic conditions, cases in which the BHU is responsible for guiding the users their area regarding health services made available by the health unit and including them in programmatic actions, scheduling consultations (nursing, medical, odontologic, and others), discussing the case in team meetings, sending them to intersectoral actions, and other elements of patient care. Regarding acute conditions, they should be classified as: Immediate Care - high risk of life, immediate intervention by the team; Priority Care - moderate risk, requires rapid intervention by the team, and may interfere with the order of care; Care within a Day - low risk or absence of risk and vulnerability, but the user's demand needs to be resolved on the same day.

It is worth remembering that, according to Ordinance No. 1,600, which reformulates the National Emergency Care Policy and establishes the Emergency Care Network in the SUS, care for users with acute conditions must be provided by all services that work as gateways into the SUS health services, including the PHC. This makes it possible to provide integral and effective care to the user, transferring them to a higher-complexity service when needed[16].

The concept of triage was also discussed, in order to differentiate it from embracement. This is a categorization method based on a series of concerns, including the severity of a disease or lesion, the prioritization of patients for treatment, and the idea of doing as much as possible for the patient. The role of the health worker regarding triage, it should be noted, is using a specific protocol, determined by the health institution[18].

In the PHC, a negative aspect of the Manchester Triage System (MTS) is the need to attend users with acute issues, which means that professionals must be careful so the attention provided to urgent cases does not affect the care provided to chronic or social cases, which require resources and follow up from all those involved in the process of caring. Positive aspects include: it helps avoiding following the order of arrival to provide care and ensure access to the service, enabling equality, promoting access into the health system, and ensuring care[19].

As for its shortcomings, it makes user access more convoluted; there is no embracement and professionals are indifferent to the suffering of users as they treat subjective issues in an objective way; questions the autonomy of the subject in their health/disease/care process; and when used as the only response to the needs of users, the MTS becomes insufficient, as it does not address subjective, affective, social, and cultural elements[19]. The offer of care from the nursing workers was also discussed, as they can be the first to carry out measures to increase comfort, until the physician evaluates the individual, leading to considerations about the nursing protocol of the municipality.

The nursing protocol of this municipality was elaborated in 2003 by a commission established by the Department of Health, Sanitation, and Development of Primary Health Care. It was updated in 2013 by nursing professionals from the municipal health service and professors from the nursing faculty at the Universidade Federal de Juiz de Fora (FACENF - UFJF). It was also evaluated and approved by nurses during the first Program of Permanent Education in Nursing (PEP - Nursing).

The 2013 version of the document does not address all vital cycles, although it recognizes their importance. It also states that the focus must be providing care to children from 0 to 10 years; sexual and reproductive health; adult health, especially regarding non-transmissible diseases; arterial hypertension; diabetes mellitus; and obesity. The document reflects advances regarding children care. In the previous protocol, it was offered until 02 years of age. It also started considering men in issues related to sexual and reproductive health and began discussions about obesity.

The manuscript also states that the protocol should be updated when needed, considering any updates made to the manuals from the Ministry of Health and the State Health Secretariat, or any legal determinations regarding professional roles, associated to the health needs of the population. It is also important to create a Permanent Commission for the Review of Protocols, including members from the FACENF - UFJF and other teaching institutions from the municipality. The protocol was elaborated to guide nursing professionals about: "what should be done", "when", "by whom", and "to whom" when providing care to the population mentioned. It is also important for professionals to be continuously updated, verifying Manuals and Notebooks of the Primary Care of the Ministry of Health and the Guidelines of the State Health Secretariat of Minas Gerais.

Stages of the Maguerez Arch – solution hypotheses

After relevant discussions in the conversation rounds, we began to define potential hypotheses for the solution of challenges found in the process of embracement in the BHU. The

proposed solution was offering health education for users in informative activities in the waiting room. This space was to be an important part of a strategy to raise the awareness of the population about the services provided by the BHU and the flow of care, emphasizing spontaneous demands. The waiting room is a powerful tool, as it allows for an intervention between health workers and users, who, in turn, belong to different age groups, social and cultural classes, with many experiences and demands[20].

Starting from this premise, it was agreed that, although each nursing and medicine professional would care for users within their specialties, when the demand was high, cases could be redirected for the professionals available, always after the teams communicated. This was essential to ensure the continuity of care without overloading a single professional. Another agreement was the need to use clear, stable, and objective language when interacting with users. The group also decided that, if a professional called a patient and they did not respond, this should be registered in the information system, so the team would be aware of the situation.

The standardization of the flow of care was discussed and considered essential to organize the process in the BHU. The main focus was on the most common demands, which were classified into three categories of risk: high, intermediary, and low. Situations that did not fit into the first two categories were automatically classified as low risk. With this, the elaboration of a Standard Operational Protocol (SOP) for user embracement was agreed upon, in order to standardize actions and optimize treatment.

Additionally, a playful poster was created to inform the population about priority care, the importance of calling the patient, and the differences between spontaneous and scheduled demand. Clearly defining these risk categories was also essential to increase treatment efficiency. Immediate care was reserved for situations of high risk of life, in which urgent interventions are required. Priority treatment, in turn, was destined for moderate cases, which must be solved quickly. Finally, attention in the same day was established for low risk cases, those that, despite not being urgent, still must be solved within the day. These classifications aim to ensure that care is fast, organized, and efficient, contributing to improve the quality of the service provided.

Together with BHU professionals, we elaborated the SOP for the Embracement and the Nursing Pre-Care. The SOP of the Embracement should be practiced by all BHU professionals, even though all of them know who is responsible for the embracement and, generally, that is the person who has the first contact with the user. That said, the receptionist, must organize and direct, adequately, attention, before the nurse embraces the patient. This helps avoid unnecessary waiting and potential confusion in embracement, ensuring equal access to services, providing necessary guidance, creating bonds between client and professional, and assessing the need for immediate acre.

A professional, when caring for a user, must also take into consideration the importance of ambience and privacy, since they enable and promote the dialog necessary to identify a demand and offer an immediate solution, within the autonomy of the professional whenever possible. When the demand cannot be solved, the professional must refer the user to adequate care by a specific professional, recording in the information system all pertinent information, so they can deal with all basic human needs affected in a timely manner.

Regarding the Nursing Pre-Care SOP, its main proposal was ensuring equal care, identifying people with different levels of risk and prioritizing more urgent cases. Starting with this classification, professionals would be guided to stratify risks and evaluate user vulnerabilities, in order to direct the intervention needed and determine the time necessary to deal with each case. The first person responsible for listening to the demands of the patient has the crucial role of evaluating whether immediate care is necessary. If needed, they can carry out interventions gradually, prioritizing attention according to severity and preventing users from suffering unnecessarily while waiting for proper care.

The nursing workers have a set of responsibilities, including patient and/or companion embracement, checking personal data, recording their condition at arrival (such as whether they needed a wheelchair), and measuring their vital signs. They must also identify vulnerabilities and evaluate the need for immediate care. Additionally, one of their roles is classifying risk and defining care priorities, disposing the patients in the service, accommodating them according to the need for observation, medication, removal into other services, or precautions regarding infectious and contagious disease.

Professionals must record all guidance provided to the patient in the information system, referring them to wait for attention, if necessary. It was also agreed that, when verifying patient data, professionals must check and update, if needed, their records within the system, asking them to search for a Community Health Agent (CHA) if an update is necessary.

Regarding the attention to patients with contagious infections, the team agreed to ensure that masks were used and recorded all guidance provided, in order to give support to the actions taken. Other common issues, such as requiring lab exams, renovating medical prescriptions and using physical therapy reports were also addressed, with clear definitions for procedures regarding how to treat these demands adequately and according to the parameters established by the protocols.

Another quite relevant element in BHU are the requests for new prescriptions. It can be said that at least half the embracements each day have this goal. With this in mind, the group discussed whether it was necessary to individually evaluate each case. Nevertheless, when the users report that they lost their previous prescription, they must present a police report of the fact so the new prescription is produced. During the study, one of the physicians was on leave from

the BHU, and it was decided that the prescriptions of his patients would be distributed among the other professionals in the unit.

Nurses were suggested to request laboratory exams, as long as legally backed and well-trained, since this is one of the prevalent demands in nursing embracement. It was also agreed that lab exams brought by the users will be evaluated first, and if an alteration is found, the patient will be embraced in the same day by the physicians. They, in turn, will place notes in the information system, when they guide patients to come for evaluations of the lab exams in spontaneous demand.

Furthermore, it was decided that medical reports for physical therapy and physical aptitude will be produced in scheduled consultations, with the exception of a few cases; in these, nurses will be able to expedite the process by asking for an electrocardiogram (ECG). It is worth remembering that this exam will be carried out by nursing professionals, as long as they are properly trained in specific training sessions, although they are not responsible for medical reports[23].

During discussions, doubts also emerged about the coding of the attention provided within the information system, especially concerning the use of Code 46 for consultations in the Primary Health Care. According with the e-SUS PHC manual, active listening is the first type of attention offered to the user who came to the BHU with a spontaneous demand, in order to embrace, get information about their health, and guide them to proper treatment. Thus, the complaints of the user must be recorded using the most specific code possible[21].

These adjustments and protocols are essential to ensure that treatment has quality and efficiency, prioritizing more urgent needs and respecting the particularities of each case, always focusing on humanization and in providing comprehensive care for the user.

Steps of the Maguerez Arch – application to reality

During the 5th stage, we could observe points that were already modified, which were: activities were performed in the waiting rooms; scheduling was carried out in a timely manner; acute and chronic complaints were better differentiated; requests for referrals and exams were made in scheduled consultations (and, depending on the case, the exams were requested by nurses); improved patients' understanding of the flow and paths within the service; medical professionals provided guidance for specific cases with spontaneous demands that required exam assessments.

Regarding which points can still be improved, the following stand out: cases can be better explored, through questions about the determinants and conditioning factors of health, so that risk and vulnerability are evaluated; the importance of carrying the CNS could be better

emphasized in the waiting rooms; the RAS could be better explained; the co-responsibility of the user for their health could be improved, since many patients seek the BHU only for new prescriptions; cases could be attended more objectively and effectively; and patients should be called by their full name.

In the waiting room, the following topics were addressed: what is spontaneous demand and scheduled demand; when to seek the BHU and what orientations they can give, reiterating the difference between the care in the BHU, in the Emergency Care Unit (ECU) and in emergency hospitals; classification of priorities (sunflower cord, over 80 years old, followed by over 60 years old, pregnant women, newborns, and those who have pertinent age-clinic condition correlation); the importance of silence and attention so the user knows when they are called; and the method of meeting the demands (depending on the case, the patient may not be attended by a doctor specialized in their specific issue, in the case of acute demands).

At first, in 2021, the Municipal Administration approved and sanctioned Law No. 14.239, which provides for the development and free distribution of the "Sunflower cord" to anyone who has a disease, disability, and/or disorder that is considered to be invisible, so these persons can be recognized in public and private environments[26]. It is also worth noting that the waiting room encourages users to provide truthful information to the professional who first listens to them, in order to be able to solve their problem. Its importance is remarkable, since, as they receive care, users can recognize the type of demand and the proper referrals.

We observed that users neglected the presentation of the CNS and other personal identification documents. In this context, in the waiting room, it is essential to clarify that these documents ensure the access and integration of the users in the public health actions and services. Proper care to patient data also allows avoiding errors when calling them. Thus, we suggest that professionals should call patients by their full name.

In the waiting room, it was possible to clarify the flow of the health service better in all levels of attention, since it was found that patients did not understand the network behind their requests, assuming that referring to a specialist would be simple, for example. Additionally, this opportunity should be taken to transform the users in co-responsible parties for their own health, especially considering medical prescriptions.

In the BHU considered here, citizens often searched the service spontaneously to update prescriptions when these were expired, expediting the process. It should be noted that one of the principles of the PNH is that subjects and collectives should assume a main role, being co-responsible for their care and having autonomy. This means that each user has a role regarding their own rights, and the production of their health[10].

Regarding the attention, many professionals appeared to understand non acute situations. Possible conducts inthis regard include guidance about the services offered in the unit,

anticipation of actions prescribed in protocols, such as pregnancy tests and immunization; and scheduled/planned consultations. Thus is a way to recognize the importance of the history and the clinical vulnerability of the user. In acute situations or in acute events of chronic diseases, patients are directed for care according to their priority.

Regarding this demand, we noticed that, through active, qualified, and objective listening, correlated to organization of work processes and flow of care, it is possible to schedule, timely, planned consultations, and some cases were scheduled for the same day or week. It is worth emphasizing the user and involving them in decision making, so they can understand and get to know how the services are offered in the BHU.

We recommend that health workers should have a greater theoretical knowledge regarding the differentiation between acute complaints and planned ones - for example, a hypertensive and/or diabetic patient with respiratory symptoms. In such a situation, it is worth remembering that, even if the user has morbidities according their care should be scheduled, they may be going through acute events that require care.

A more in-depth exploration of cases is necessary to ensure equity and that risk and vulnerability are properly stratified, in order to provide care to the user in line with their demands. As a result, we recommend professionals to pay attention to the individual as a whole, not only to their biological characteristics[10]. Thus, anamnesis and vital sign measurement are important tools to establish a bond and recognize changes in the factors that determine and condition health[24].

On the other hand, we could observe, albeit less than expected, professionals that were classifying and stratifying patients, prioritizing attention and preventing a person to continue suffering for long periods of time. This is only possible when we consider factors that increase the vulnerability objectively, efficiently, and timely, which depends on each professional.

Regarding referral requests, users were embraced and directed to scheduled consultations with physicians, for more detailed evaluations of each case. Additionally, nursing workers requested lab exams when pertinent, in order to expedite the flow of the patient within the service. Another factor we observed was that patients who were there for spontaneous demand were asked to show their exams, since some cases require immediate interventions.

FINAL CONSIDERATIONS

The Family Health strategy (FHs) is the backbone of the expansion, consolidation, and improvement of the Basic Care National Policy (BCNP), providing inclusive, accessible, and highly effective attention based on the health needs of the community. The embracement was shown to help achieve universal access, improve multiprofessional and intersectoral work,

increase the quality of health care, and humanize health practices[25]. Therefore, this study is extremely relevant, as it can transform the reality of health attention.

Using the Maguerez Arch method allowed the health service workers to build, collectively, a proposal to embrace the spontaneous demand that included risk classification and vulnerability, in line with the specificities of the service, the community cared for, and the professionals. This was possible after periodical meetings with these professionals, which encouraged reflections about their roles in Primary Health Care (PHC), promoted discussions to improve the work process and constructed the SOP (Standard Operating Procedure) to better conduct the flow of user care, especially regarding the embracement of spontaneous demand.

Additionally, we highlight the fact that nursing professionals have the main role in embracing said demands. Nevertheless, their consultations and guidance are still not widely disseminated and respected. We suggest that this method should be applied in all BHUs in the city, so active health workers can contribute to elaborate a Nursing Protocol with clearer flows, guiding them about the nursing skills involved in embracement, and showing the limits of their actions.

In this regard, we recommend training sessions in protected times for Permanent Education, so professionals can understand their attributions in this context, as well as the ethical and legal aspects that guide their profession. Moreover, educational activities to inform the population about PHC services and the responsibility of users regarding their own health are remarkably important. Similarly, it is essential to promote discussions about the work processes of the team often, as a way to ensure that embracement actually takes place and, as a result, universal and equal access to health care becomes possible.

This study had some important limitations. These include the resistance to change from some professionals that are used to traditional practices, which may have hindered adherence to the intervention. Furthermore, there was no long-term, objective evaluation, which compromised a precise measurement of the effects of the intervention. The evaluation of the impact was restricted to the health team, and the direct effects of the intervention in the embracement of the users were not considered, preventing a broader understanding of results.

In many health units, the working process, especially the embracement of spontaneous demand with risk and vulnerability classification may be slow, due to undersized personnel, inadequate infrastructure that makes it difficult for users to have privacy, and the lack of commitment from professionals. Furthermore, for the process to be effective, there must be multiprofesisonal teams in the PHC, as provided by Ordinance GM / MS No. 635, of May 22, 2023, since this process does not involve only the nursing team[27]. Therefore, it is essential to ensure that this intervention proposal is implemented in all Basic Health Units (BHUs) in the municipality.

We propose that this study should be applied and discussed with all PHC professionals in the city, so embracement and risk classification can be implemented in all BHUs, considering their particularities. This proposal aims to allow a discussion about the topic in the Family Health strategy (FHs), implementing necessary adjustments to improve embracement when dealing with unplanned demands, involving in this process not only health workers but also the community that receives their care, which would improve even further the attention provided.

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