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Eases and hindrances of reference in an emergency care unit

Facilidades e entraves da referência em unidade de pronto atendimento

Facilidades y barreras de referencia en una unidad de atención de emergencia

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Abstract

Objective: to describe, from the perspective of nurses and physicians, the eases and hindrances of referrals in an Emergency Care Unit. **Method:** a descriptive, qualitative study, carried out in an Emergency Care Unit in a city of Santa Catarina, Brazil. Seven nurses and 23 physicians participated. Data was collected through individual semi-structured interviews and analyzed using the Discourse of the Collective Subject technique. **Results:** the eases involved: having specialized reference services; patient severity; care in "zero vacancy"; good relationship among professionals of the emergency services and empathy. Among the hindrances were: difficult contact by telephone with hospitals and their overcrowding; difficulty in getting transport, especially for patients with stable clinical situation and the lack of ambulance from the municipality. **Conclusion and implications for the practice:** the referral facilities potentiate the attendance to urgencies, however, the hindrances, referring to hospital vacancy and transport, can compromise the integrality and continuity of care, requiring improvements in network health care.

Keywords: Health Services Research; Health Care Quality, Access, and Evaluation; Emergency Medical Services; Continuity of Patient Care; Nursing.

Resumo

Objetivo: descrever, na perspectiva de enfermeiros e médicos, as facilidades e os entraves da referência em uma Unidade de Pronto Atendimento. **Método:** estudo descritivo, qualitativo, realizado em uma Unidade de Pronto Atendimento de um município de Santa Catarina, Brasil. Participaram sete enfermeiros e 23 médicos. Os dados foram coletados por meio de entrevista individual semiestruturada e analisados mediante a técnica do Discurso do Sujeito Coletivo. **Resultados**: as facilidades envolveram: ter serviços de referência especializados; gravidade do paciente; atendimento em "vaga zero"; boa relação entre os profissionais dos serviços de urgência e a empatia. Dentre os entraves, estavam: contato difícil por telefone com os hospitais e a superlotação destes; dificuldade para conseguir transporte, sobretudo, para paciente com situação clínica estável e a falta de ambulância do município. **Conclusão e implicações para a prática:** as facilidades da referência potencializam o atendimento às urgências, porém, os entraves, referentes à vaga hospitalar e ao transporte, podem comprometer a integralidade e a continuidade do cuidado, necessitando de melhorias na atenção à saúde em rede.

Palavras-chave: Pesquisa sobre Serviços de Saúde; Qualidade, Acesso e Avaliação da Assistência à Saúde; Serviços Médicos de Emergência; Continuidade da Assistência ao Paciente; Enfermagem.

Resumen

Objetivo: describir, desde la perspectiva de enfermeros y médicos, las facilidades y barreras de referencia en una Unidad de Urgencias. **Método:** estudio descriptivo, cualitativo, realizado en una Unidad de Urgencias de una ciudad de Santa Catarina, Brasil. Participaron siete enfermeros y 23 médicos. Los datos fueron recolectados a través de entrevistas individuales semiestructuradas y analizados usando la técnica del Discurso Colectivo del Sujeto. **Resultados:** las facilidades involucradas: contar con servicios de referencia especializados; gravedad del paciente; servicio en "vacante cero"; buena relación entre los profesionales de los servicios de urgencias y la empatía. Entre los obstáculos estaban: el difícil contacto telefónico con los hospitales y su hacinamiento; dificultad para conseguir transporte, especialmente para pacientes con situación clínica estable y falta de ambulancia en la ciudad. **Conclusión e implicaciones para la práctica**: las facilidades de referencia mejoran la atención de emergencia, sin embargo, las barreras, relacionadas a la vacante hospitalaria y el transporte, pueden comprometer la integridad y continuidad de la atención, requiriendo mejoras en la atención en red.

Palabras clave: Investigación sobre Servicios de Salud; Calidad, Acceso y Evaluación de la Atención de Salud; Servicios Médicos de Urgencia; Continuidad de la Atención al Paciente; Enfermería.

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INTRODUCTION

The Brazilian Unified Health System (UHS) brought changes in the health care model with the rapid expansion of Primary Health Care (PHC), however, the lack of integration between the different services has produced fragmentation and large gaps in health care[1], including among emergency medical services.

Thus, in 2008, the National Policy on Regulation (NPR) was created, in which the Regulation of Access to Care stands out, focusing on the organization, control, management, and prioritization of access and care flows in the UHS. It aims to regulate UHS services of different technological densities (primary, secondary, and tertiary care), which are now organized in Health Care Networks (HCN) to provide the health care alternative that best meets the patient's needs, such as emergency care and hospital beds. It contemplates the normatization of the flow of patients' transfer by regulation centers, which implies their reference to services of different technological densities, considering the relationship between supply and demand for actions and services[2].

Among the HCN, there is the Urgent and Emergency Care Network (UEN), especially the Emergency Care Units (ECU), provided for in the National Policy for Emergency Care (NPEC)[3], which are committed to comprehensive health care.

In this sense, a well-agreed reference should be implemented in the municipality itself and outside when necessary. However, the pre-hospital care services signal the still deficient functioning of this reference[4] with losses to the population, which has no guarantees regarding its right to integral health.

The ECU is intended to care for patients with acute pathologies and urgent cases, still, it often uses the referral mechanism to refer severe patients who need a service of higher technological density, transfer to large hospitals or specialized hospitals. Nevertheless, in the country, there is a partial integration of the ECU with the HCN, especially with the UEN, due to structural difficulties in referring patients[5].

In view of the above and considering the relevance of the referral for the consolidation of the principle of integrality of the UHS and the NPEC, this study aimed to describe, from the perspective of nurses and physicians, the eases and hindrances of referral in an Emergency Care Unit.

METHOD

This is a descriptive study with a qualitative approach, conducted in the ECU of a municipality in Santa Catarina, Brazil, opened in 2012, where 34 professionals (ten nurses and 24 doctors) worked. The unit was selected for its consolidated implementation experience with a minimum operating time of two years and qualification acknowledged by the Ministry of Health.

Participants were selected intentionally, considering as inclusion criteria: being a nurse or doctor in the ECU, with at least three months of service, regardless of work shift, and participate in the patient referral. Four professionals did not participate in the study: two because they worked only in risk classification, one because of leave during the data collection period and another due to refusal. Thus, the research consisted of 30 participants. Those who met the eligibility criteria were invited personally, in the ECU, by the main researcher, to participate in the study, at which time they were informed about the purpose and procedures of the research, and scheduled for data collection and signing of the Free and Informed Consent Term (FICT).

Data collection took place from November 2015 to February 2016 and was conducted through individual interview, using a semi-structured script with questions related to the personal characteristics of the participants (age, gender, professional category, time of training, time working in the ECU and working in another institution) and regarding the eases and hindrances in the referral from the ECU to the hospital. The interviews were conducted by the main researcher, at the professionals' workplace, without the presence of other people. It is noteworthy that the environment was private and there was no interference. The interviews, recorded on audio files and transcribed in full by the same researcher, lasted an average of 20 minutes. Data collection ended when all eligible professionals were interviewed.

In the analysis, the technique of Collective Subject Discourse (CSD)[6] was used, which comprises a discourse-synthesis elaborated with parts of speeches with similar meaning. The technique involves four methodological figures: Key Expressions (KEs); Central Ideas (CIs); Anchoring (AC) and CSD. The KEs are excerpts from the individual speeches that contain the essence of the statement. The CIs comprise the meaning(s) of the statement present in the KEs. Similar CIs are grouped into a single one. The AC is an expression that appears sometimes and refers to beliefs or representations used to support positions, however, it was not identified in the statements of the participants of this study. The CSDs are written in the first person singular and comprise the meeting of the KEs with similar CIs or ACs[6].

For data organization, the software QualiquantiSoft, version 1.3c, was used. In the software, first all the participants and the two guiding questions of the study regarding the reference were registered. Then, the participant's statements were transported from Microsoft Word, where they were transcribed, to the CSD Software. The data was organized in that software by participant and question. In each participant's statement, the KEs and the respective CIs were identified. Subsequently, the similar CIs of all participants were joined to form a single CI, and the KEs with the same sense or meaning were joined together, constituting the CSD.

The study followed the recommendations of Resolution No. 466, December 12, 2012, of the National Health Council, and was approved by the Research Ethics Committee of the Federal University of Santa Catarina under Opinion No. 1,048,858 and CAAE: 43555715.8.0000.0121. Participants signed the FICT and were identified by the letter "I" (interviewee) followed by the sequence number of the interviews (I1, I2, ... I30).

RESULTS

Of the 30 study participants, 23 were physicians (76.7%) and seven were nurses (23.3%). There was a predominance of

female professionals (n=16; 53.3%) and in the age group of 31 to 40 years (n=13; 43.4%). As for length of practice, physicians and nurses with two or more years of work at the site represented 53.3% (n=16). Half of them (n=15; 50%) had graduated at least two years ago (maximum eight) and most of them (n=18; 60%) had some complementary training, especially residencies and specialization courses.

From the statements, three CIs emerged with their respective speeches (CSD): one referring to the eases of the referral of the patient from the ECU to the hospital (CSD 1) and two relating to the hindrances for the referral (CSD 2 and CSD 3). These speeches were composed of the statements of 19, 26 and 21 participants, respectively.

CI 1 – Referral facilities: having specialized referral services; patient severity; "zero vacancy" care; good relations between professionals in the emergency services and empathy.

CSD 1 – *The referral facilities depend on the service. It is a little easier to have specific points, like, I know that a patient has a heart attack, he goes to Cardiology [...] when it is a more specialized service, the vacancy is more guaranteed. Another factor that makes it easier is the patient's condition: the higher the severity, the faster the care and the advanced support is hardly denied when the patient meets well-defined criteria for transportation by MECU in the mobile Intensive Care Unit (ICU) [...]. When it is very urgent, MECU takes the patient to the hospital in "zero vacancy", that is, even without any vacancy. Although not all hospitals accept the "zero vacancy", oftentimes, we have to do this because, really, here, they can't stay. [...]. Another factor that helps is when the physician has contact with someone in the referral service, some colleague who can help [...] and also with transportation [...]. In addition, things become easier when there's common sense and good will from the referral professional to accept [the patient's transfer], of the MECU and the technical director of the ECU to get the transport [...].* (I1, I2, I6, I7, I11, I12, I13, I14, I16, I17, I19, I21, I22, I23, I24, I26, I27, I28, I30)

CI 2 – Hindrances in referral: difficult telephone contact with hospitals and hospital overcrowding.

CSD 2 - *To transfer the patient, I have to get a vacancy in the hospital and the phone contact is very difficult, nobody answers, even if I insist. A lot of time is wasted on this. [...] the biggest difficulty is the issue of vacancies, beds, ICU beds mainly. We face overcrowding in all hospitals in the region of Florianópolis. [...] The reference protocols are being completely left aside. It seems to me that it is a subjective issue of who is in the reference hospital to accept or not the patient [...]. There is a lot of wear [ours], they [hospital professionals] don't understand our situation, this is an ECU, not a hospital. Although in theory there is a bed regulation system in Santa Catarina, in practice it doesn't work. We've already had conflicts with them because of this [...]. So, the patient stays here for days, even though there is no hospitalization, because, theoretically, in the ECU, the patient shouldn't stay more than 24 hours. So, the doctors and the whole team often end up getting stressed by the few material resources that we have here. Besides, sometimes it is overloaded, there are many patients to attend to and people are left waiting for a few hours [...].* (I1, I2, I3, I4, I5, I7, I8, I9, I10, I11, I12, I13, I14, I15, I17, I19, I20, I21, I22, I23, I25, I26, I27, I28, I29, I30)

CI 3 – Hindrances in referral: difficulty in getting transport, especially for patients with stable medical conditions and the lack of an ambulance from the municipality.

CSD 3 – *One of the biggest obstacles is getting the transport to transfer the patient to the hospital [...] because you lose hours trying to get it. The big problem is referring patients in milder conditions, intermediate cases, since the MECU does not send an ambulance for these cases [...] in stable condition, but that can become unstable [...]. Frequently, the physician responsible for regulation doesn't see the criteria of severity nor the need for this referral, and we are left with our hands tied, we have no way to transport and the patient suffers the most. Sometimes, when the regulator changes, in half an hour the transportation problem is solved. The impression is that they don't have a protocol, or if they do, not all of them follow it [...]. It's a great stress when it's time to call for transportation. We've already had several problems with the MECU medical team [...]. There is a lack of understanding of the law of urgencies and emergencies [...]. Today, the municipality no longer has the ambulance to perform basic transportation [...]. Oftentimes, for relatively severe cases, in which the family members have a car, we choose to explain the situation and send them to the hospital after obtaining a vacancy there [...]. However, in many cases, the patients don't meet the criteria of severity, but they also don't have the means to go by themselves[...]. If the patient does not meet the criteria for transportation with the MECU's alpha ambulance, and most of them don't, we have to ask for their basic ambulance [...] and then, usually, the doctor who is on duty here has to leave to accompany the patient [...].* (I1, I2, I3, I4, I5, I6, I7, I8, I9, I11, I14, I16, I17, I18, I21, I23, I24, I27, I28, I29, I30)

DISCUSSION

The professionals' statements, in the three CSDs, portray the factors that facilitate or are configured as obstacles to the referral in the ECU. CSD 1 showed that the specialized hospital services, such as cardiology, are points of the HCN that facilitate

the patient's access to the hospital vacancy. The lines of care implemented in the country can contribute in this sense. The line of care for Acute Myocardial Infarction (AMI), for example, aims to articulate and integrate all points of care, expanding and qualifying the access in an agile and timely manner[7]. However, a research alerted on the need to improve professional training, especially for the knowledge of care flows in the line of care of this pathology[8].

A study conducted in the United States, with 139,494 patients diagnosed with AMI with ST-segment elevation, evaluated that after the implementation of a regionalized system of care, there was a 7.1% increase in admission/access to a referral hospital, as well as a statistically significant increase in the probability of percutaneous coronary intervention on the same day. The research also showed that the AMI care network was associated with lower mortality in seven days and reduction of readmission in 30 days[9]. It can be inferred that patients in acute cardiologic situations find, in referral hospitals, access to the service they need.

Another factor that facilitates referral to the ECU is the severity of the patient's clinical condition, which favors access to advanced transport by MECU. Although sometimes with delays, the advanced support ambulance is sent to remove the critically ill patient from the ECU to the hospital, a relevant aspect for patient safety in health care.

In spite of this, a national study investigated the profile of care and satisfaction of patients assisted by MECU and highlighted that recognizing which type of help is most requested by the population allows for better planning and reorganization of care according to the severity of the clinical condition. Still, patients showed satisfaction with the service provided, having considered that it meets the population resolutely[10].

The "zero vacancy" emerged as another facilitator of referral. It is a resource that includes access to minimal survival resources and critical resources for diagnosis and treatment in cases of high potential for morbidity and mortality.[5] It also assumes that any health service must guarantee care in the emergency room, providing vacancies to receive patients transported by MECU, even in situations where there are no beds. The MECU has the authority to allocate patients in the service network and must simply communicate its decision to emergency physicians[11].

MECU professionals understand that they should be assisted without questioning whenever they arrive with the patient, which does not mean that this assistance occurs in the absence of resistance, manifested in attitudes such as delay in receiving the patient and withholding of equipment (stretchers and cervical collars) [12], which can have consequences for patient safety and subsequent care provided by the MECU. One study confirmed that safety risks accompany the patient's entry into the hospital service, since the patient often remains in the MECU gurneys[13].

Other factors that facilitate the referral can be understood as personal resources inherent to health professionals: good professional relationships between services and empathy. Good professional relationships, based on knowledge networks and personal contacts, are an alternative resource in the referral of patients to the hospital, although they are still considered a precarious mechanism of integration between the points of care of the UEN, given that the established rules and resources are insufficient to solve the problems[14].

A Swedish study, investigating the interaction between an Urgent Care Center (UCC) and adult and pediatric hospital emergency rooms, identified the following as a challenge: getting professionals from both services to know each other, which would decrease controversies and increase trust between the teams. UCC are health services, typically composed of physicians, nurses and nursing assistants, which function at the intermediate level of health care, between hospital emergencies and primary care[15], similar to the Brazilian ECU.

With regard to the empathy of professionals in these services, it can be noted that, in the daily life of the ECU, this is often a resource that professionals possess in order to face the obstacles in the referral, and is characterized by attitudes of common sense and goodwill among professionals from pre-hospital and hospital services. Empathy is understood as one of the relevant moral values in professional training[16]. In an emergency service, among the factors that constitute empathic ability, a greater capacity to be sensitive to the situation of other people stood out among the professionals[17].

A study, which aimed to define the principles of best practices for inter-hospital transfers, identified that the management of the transfer request and the exchange of information are among the elements to overcome the problems encountered in this process[18], aspects evidenced when professionals resort to the technical director of the ECU to arrange transport with MECU and rely on the skills and abilities of the hospital physician to ensure the patient's transfer.

The obstacles of the ECU in the referral are related to the hospital vacancy (CSD 2) and transportation (CSD 3). Regarding the vacancy, there is difficulty in establishing telephone contact with hospital professionals to refer patients, in addition to hospital overcrowding.

One study, conducted to increase the efficiency of inter-hospital transfers made via telephone call and decrease the number of negative transfers, successfully applied measures to facilitate this process, considering the difficulties encountered - prolonged waiting time and dissatisfaction of patients and the institution. The measures included: trained staff to answer the initial phone call; establish quick contact with the attending physician and standardize the data to be informed in the transfer[19]. In detriment of telephone contact, an American study suggested the use of telemedicine, an alternative that allows greater efficiency and agility in the management of inter-hospital transfers, in addition to enabling professionals to gain time to perform the necessary clinical care to patients[20].

Still with regard to hospital vacancies, in Turkey, the lack of hospital beds is an important cause of overcrowding in emergency rooms, configuring itself as a multi-causal phenomenon in all parts of the world[21]. In the city of Rio de Janeiro, Brazil, as access to beds is difficult due to their reduced number, hospital back-up

has been a major obstacle to the work in the ECUs[5,14], in line with the findings of this study.

The difficulties in the process of transferring patients to the hospital, from contact with referral professionals to the actual transfer, are marked by consequences: delay in care at the appropriate place with possible damage to the patient's health status; impairment of care for people awaiting for care in the ECU; changes in the work process; stress and frustration in ECU professionals. In India, the lack of an organized referral system compromises the optimal care of critically ill children, which stimulated the development of an educational intervention about referrals to hospitals, carried out with health professionals in different health units, and such intervention improved the quality of referral letters[22].

Among the competencies of the ECU is the referral of patients to hospitals when their complaints have not been resolved within 24 hours of observation[23]. But the difficulties of transfer, especially regarding the unavailability of hospital beds, make the ECU a place of "temporary hospitalization", a phenomenon corroborated by a study conducted in the ECUs of Rio de Janeiro in which the little availability of hospital back-up beds makes patients remain under care until there is clinical improvement in a "hospitalization" in pre-hospital environment, exceeding the observation period of 24 hours recommended for these units[5]. This phenomenon represents a distortion of the purpose and possibilities of care of the ECU[4].

The ECU, understood as an inpatient unit, accommodates the lack of beds instead of addressing it. Thus, it is imperative to improve the integration between the points of care of the UEN and qualify the hospital back-up[5] so that the service capacity of the ECU and the patient's right to timely care in an appropriate location is respected.

The professionals also revealed that there is no follow-up of referral protocols of patients from the ECU to the hospital and, although in theory there is a hospital bed regulation system in Santa Catarina, in practice it does not work. In consonance with this, a research evidenced informal and parallel mechanisms of bed regulation in the transfer of patients to the ICU, especially with the use of the WhatsApp® application, with the weakening of formal information and communication technologies (Regulation System - SISREG, protocols and flows). This type of regulation produces biases in prioritizing access by technical criteria, signaling the fulfillment of particular interests[24].

In Sweden, a study revealed that even with a guideline based on diagnosis and severity, regulating the distribution of patients between hospital Emergency Departments and the UCC, there would still be some ambiguity on how to interpret it, and it was deemed necessary to recruit personnel with long experience in triage to avoid mistakes[15].

In Brazil, the regulatory frameworks of the care regulation policy are defined and there are norms, objectives, goals, protocols and flows linked to it; however, its implementation is marked by interferences so that, during institutional negotiation, particular interests prevail over technical criteria based on users' needs. In addition, there are local conflicts and communication problems with the State Regulation Center[24].

In another study[25], the difficulty of the regulation sector in ensuring beds for patients in the ECU was attributed to the fact that most admissions occur directly in hospitals, without the intermediation of regulatory centers. In certain situations, there is a differentiated flow of referral with priority classification that sometimes highlights problems in accessibility, jeopardizing the continuity of care. Moreover, in the search for beds in private hospitals and hospitals affiliated to UHS, patients in the public health system compete with those with health plans and access to private care.

In this meander, an Icelandic study highlighted that establishing formal relationships between intermediate urgent care facilities, such as ECUs and hospital emergency rooms, can improve communication, facilitate transfer, and increase patient and physician satisfaction[26]. The findings of the study, corroborated by the literature, reinforce that, in Brazil, there is a great need for the regulatory process in health, performed by the public authorities, to be consolidated in an effective manner to ensure decisions consistent with the interests of the population[25].

Other barriers in the referral of patients from the ECU to the hospital, expressed in CSD 3, relate to the difficulty in getting transport, especially for patients with a stable clinical condition, besides the lack of ambulances in the city. The difficulty in getting transport for non-life-threatening situations gains importance when considering the number of patients who need this type of transport. It is known that the demand for care in low severity situations or without the purpose of mobile emergency services is an international phenomenon and predictable in health systems[27]. The basic support ambulance becomes more requested due to the higher occurrence of minor incidents[28].

The difficulties related to the transport of patients in stable clinical situations may have consequences for them when they are transferred by their own means, due to the fact that their clinical condition may become unstable without adequate attention, with possible worsening and compromising of their safety. In this meander, the relevance of protocols in the transfer of patients between services is emphasized, and this study revealed a fragility in the implementation of those. The lack of standardization of protocols for continuity of care represents an important risk to patient safety in the transfer involving pre-hospital care[13].

A study conducted in Spain proved that the lack of standardization of transfers increases the likelihood of adverse events and highlighted the relevance of standardizing this process by means of a written record that supports verbal transfer and the transmission of information, in an appropriate and timely manner, in order to increase patient safety[29].

When the patient is transferred with the accompaniment of the ECU medical professional in a basic support ambulance, the repercussions fall mainly on the professionals who remain in the service in smaller numbers to care for patients, and on the waiting time for care, which becomes longer, aspects that can generate dissatisfaction. In this sense, another study, conducted with

459 patients in the same ECU in Santa Catarina, showed that the worst performance in care was attributed to agility (waiting time), indicating that adjustments are needed in the referral system in order to reduce the waiting time for those who seek the service[30].

Regarding transportation, the professionals' discourse also revealed that there are conflicts between the professionals of the ECU and the MECU regulation physicians, either due to unavailability of ambulances or differences in care protocols. The inadequate functioning of the flows and referrals contributes to maximize conflicts between teams belonging to services of different technological densities of the UEN[31]. The literature has asserted that conflicts among professionals favor individualistic, fragmented actions, antagonistic to the universal and solidary nature of the UHS[32].

The regulatory function of the MECU is essential in its relationship with the network, but, in order for this to happen, the normative aspect of the NPEC must prevail (as a rule from the point of view of rights and obligations)[27]. However, the professionals' speech points to the lack of understanding about the legislation regarding emergency care in the country, and they must follow the established norms to ensure safe referral to the patients in acute situation.

This study, as well as others already published on the subject[5,13-14,24,31], highlights obstacles in the referral of patients to hospitals, which indicate the need for evaluative research on the regulation of access to care in the UHS, given its relevance in ensuring a more equitable and integral care. It is also pointed out[33] that, ten years after the institution of the National Policy on Regulation, it has not received any evaluation proposals, only a preliminary proposal of its evaluability.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The eases in the ECU referral involve technical and inherent factors to health professionals. The former include: having specialized referral services; the severity of the patient; and "zero vacancy" care. The other factors are the good relationship between the professionals in the emergency services and empathy. As for the referral hindrances, they are related to hospital vacancies and transport, respectively: difficult contact by telephone with hospitals and their overcrowding; difficulty in getting transport, especially for patients with a stable clinical situation, in addition to the lack of ambulances in the municipality.

The eases in referral potentialize the care of emergencies, however, the hindrances, related to hospital vacancy and transport, may compromise the totality and continuity of care and require improvements in network health care. Thus, the results demonstrate the need for greater integration between services, investments in expanding pre-hospital and hospital care, and improvements in patient transfer processes.

The identification of the aspects that facilitate referral and those who hinder it has implications for practice by producing a situational diagnosis, which allows, especially for nurses with management training, to plan and implement improvements in access to services of greater technological density, in search of integration between the points of care and the consolidation of the Emergency Care Network, idealized as a public policy.

The study was limited to the professional participation of the medical and nursing categories (nurses), however, the findings may contribute to improve the referral. Further studies are suggested, supported by the assumptions of quality, access and evaluation of health care, involving professionals from other points of the UEN, including Regulation, to expand the understanding on the subject.

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