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RESPONSIVENES OF THE EMBRACEMENT WITH RISK CASSIFICATION: USER'S EVALUATION IN EMERGENCY CARE UNIT

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ABSTRACT

Objectives: to evaluate, with users, the responsiveness of the embracement with risk classification in an emergency care unit and to analyze the association between socio-demographic and care variables with the evaluation of responsiveness.

Method: quantitative, correlational study approach, developed in an emergency care unit in Santa Catarina (Brazil) with 459 users. A validated questionnaire was applied, with 25 questions, evaluated by Likert scale and organized in the domains: dignity, communication, agility, social support and facilities. The data were organized and processed with the Epi Info software and OpenEpi, using descriptive statistics and chi-square test.

Results: the domains that stood out with good responsiveness were dignity (97.8%), communication (93.9%) and facilities (91.1%). Agility obtained the lowest percentage (56.6%). The overall mean of good responsiveness of the user embracement with Risk Classification was 82.1%. There was a significant statistical difference in the characteristics of users' profile (gender, age, marital status and schooling) and the number of times the user was attended in the service with good responsiveness.

Conclusion: the user embracement with risk classification presented good responsiveness; however, there is a need for improvements, especially related to the agility of care. The evaluation of responsiveness by users is associated with socio-demographic and care variables.

DESCRIPTORS: Health services research. Emergency medical services. Nursing. Emergency nursing. User embracement. Triage. Quality of health care. Patient satisfaction

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RESPONSIVIDADE DO ACOLHIMENTO COM CLASSIFICAÇÃO DE RISCO: AVALIAÇÃO DOS USUÁRIOS EM UNIDADE DE PRONTO ATENDIMENTO

RESUMO

Objetivos: avaliar, com os usuários, a responsividade do acolhimento com classificação de risco em uma unidade de pronto atendimento e analisar a associação entre as variáveis sociodemográficas e de atendimento com a avaliação da responsividade.

Método: estudo de abordagem quantitativa, correlacional, desenvolvido em uma unidade de pronto atendimento de Santa Catarina (Brasil) com 459 usuários. Aplicado questionário validado, com 25 questões avaliadas por escala Likert e organizadas nos domínios: dignidade, comunicação, agilidade, suporte social e instalações. Os dados foram organizados e processados com o *software* Epi Info e o OpenEpi, sendo aplicada estatística descritiva e teste qui-quadrado.

Resultados: os domínios que se destacaram com boa responsividade foram dignidade (97,8%), comunicação (93,9%) e instalações (91,1%). A agilidade obteve o menor percentual (56,6%). A média geral de boa responsividade do acolhimento com Classificação de Risco foi 82,1%. Houve diferença estatística significativa das características de perfil dos usuários (sexo, idade, estado civil e escolaridade) e do número de vezes que o usuário foi atendido no serviço com a boa responsividade.

Conclusão: o acolhimento com classificação de risco apresentou boa responsividade, entretanto, há necessidade de melhorias, especialmente relacionadas à agilidade do atendimento. A avaliação da responsividade pelos usuários está associada às variáveis sociodemográficas e de atendimento.

DESCRIPTORIOS: Pesquisa sobre serviços de saúde. Serviços médicos de emergência. Enfermagem. Enfermagem em emergência. Acolhimento. Triage. Qualidade da assistência à saúde. Satisfação do paciente.

CAPACIDAD DE RESPUESTA DEL ACOGIMIENTO CON CLASIFICACIÓN DE RIESGO: EVALUACIÓN DE LOS USUÁRIOS EN UNIDAD DE ATENCIÓN DE URGENCIAS

RESUMEN

Objetivos: evaluar, con los usuarios, la capacidad de respuesta del acogimiento con clasificación de riesgo en una unidad de atención de urgencias y analizar la asociación entre las variables sociodemográficas y de atención, a través de una evaluación de la capacidad de la respuesta.

Método: estudio de abordaje cuantitativo, correlacional, desarrollado en una unidad de atención de urgencias de Santa Catarina (Brasil) con 459 pacientes. Se llevó cabo por medio de un cuestionario validado con 25 preguntas, evaluadas por la escala Likert y organizadas en los siguientes dominios: dignidad, comunicación, agilidad, soporte social e instalaciones. Se organizaron y procesaron los datos con el *Software Epi Info* y OpenEpi, siendo aplicadas la estadística descriptiva y el test chi-cuadrado.

Resultados: los dominios que se destacaron con buena capacidad de respuesta fueron: dignidad (97,8%), comunicación (93,9%) e instalaciones (91,1%). La agilidad obtuvo un porcentaje menor (56,6%). La media general de buena capacidad de respuesta del acogimiento con Clasificación de Riesgo fue de 82,1%. Hubo diferencias estadísticas significativas en las características de perfil de los pacientes (sexo, edad, estado civil y estudios) y de la cantidad de veces en que el paciente se atendió con una buena capacidad de respuesta.

Conclusión: el acogimiento con clasificación de riesgo presentó una buena capacidad de respuesta; sin embargo, hace falta mejorar, en especial en lo relacionado a la agilidad de la atención. La evaluación de la capacidad de la respuesta por los usuarios se asocia a las variables sociodemográficas y de atención.

DESCRIPTORIOS: Investigación en servicios de salud. Servicios médicos de urgencia. Enfermería. Enfermería de urgencia. Acogimiento. Triage. Calidad de la atención de salud. Satisfacción del paciente.

INTRODUCTION

The evaluation of services by users has become popular in Europe and the United States from 1980, in general through surveys.¹ Regarding to the evaluation studies of health services, these have gained greater focus in Latin America in recent years, and further research is needed to evaluate the services to know the work process and their functioning, understanding their needs under the gaze of the different subjects involved,² including users. In this sense, the responsiveness of health services is one of the evaluation approaches that should be investigated.

Responsiveness, defined by the World Health Organization (WHO) as non-medical aspects of care, is one of the intrinsic objectives of health systems since the beginning of the XXI century,³⁻⁴ when efforts have been implemented to measure it and to verify the factors that affect it.⁴ According to the WHO, responsiveness refers to how well the population's legitimate expectations are being met, understanding these as elements that are not directly linked to the individual's health status, but which affect their relationship with services and professionals, such as respect for care and the greater agility of this, with the shortest waiting time.¹

Thus, the concept of responsiveness comprises two main aspects: respect for people – ethical dimension that permeates the interaction of people with the health system; and the orientation for the client – related to user satisfaction with components not directly related to health care. The first aspect includes the elements of dignity, confidentiality, autonomy and communication, while the second one constitutes the agility in the care, social support, facilities and choice of care provider.⁵

In the international context, several studies are published on the responsiveness of health services in different contexts and scenarios.^{3-4,6} but in low- and middle-income countries, many of these, in development, little attention has been granted to the theme, and it is necessary to evaluate their health systems in terms of responsiveness.⁶

In Brazil, studies^{1,7-10} on responsiveness are rare. And in national and international publications, no research was identified aimed at evaluating the responsiveness of emergency and urgency health services, since the proposal launched by the WHO in 2000, fact which justifies the realization of this study in the scenario of attention to emergency care in the country, more specifically in the Emergency Care Unit (ECU), as this is a still recent scenario of care for the person in acute health condition, and which constitutes the Emergency Care Network (ECN).

Considering the responsiveness a way of measuring the quality of care, as well as the humanization of health care,¹¹ it is considered coherent to use the responsiveness approach as a paradigm of evaluation of the Embrace with Risk Classification (EWRC) by ECU users. Proposed in 2003 by the National Humanization Policy (NHP), EWRC is an attention strategy to the population implanted in the entrance doors of the Brazilian Health system, which aims to humanize health care through qualified listening.¹²

Thus, the National Emergency Care Policy (NECP) foresees that users receive emergency and emergency services through the EWRC, which includes the classification of risk and adequate and necessary intervention to the different diseases, being one of the requirements of the attention services of ECN.¹³ It is noteworthy that the EWRC differs from the screening, because it is characterized by an inclusive action that does not exhaust at the stage of the user's reception, but must occur in all places and moments of care in the health service, ceasing to be an isolated act to be, in this broader perspective, a device to drive internal, external and multidisciplinary networks, committed to the responses to the needs of users of emergency services.¹²

Given the above, and considering the need for quantitative user assessment surveys on EWRC,¹⁴ as well as the knowledge gap on the assessment of emergency services from a user perspective,¹⁵ in particular in the ECU, this study had as objectives to evaluate, with users, the responsiveness of

the embracement with risk classification in an emergency care unit and to analyze the association between socio-demographic and care variables with the evaluation of responsiveness.

In addition to expanding the production of knowledge about the theme, there is the expectation that this research may contribute to the improvement of the health care of the population in the ECU, as well as stimulate the development of new researches on the subject.

METHOD

Study of a quantitative, correlational approach, developed in an ECU in Santa Catarina (Brazil). It was adopted as criteria for the unit choice the minimum working time of two years, due to the consolidated experience of implementation of the EWRC, and the ECU's qualification, by Ministerial Ordinance.

The sample of users was calculated considering the number of visits performed in the ECU, in the period of one year (February 1, 2014 to January 31, 2015), which corresponded to 80,016 services. It was adopted the confidence interval (CI) of 95%, estimation accuracy of $50 \pm 5\%$ and sample loss of 20%. To calculate the sample size, the SEstatNet® 1999-2013 was used. Thus, the sample consisted of 459 users attended by the EWRC.

For the selection of the participants, a non-probabilistic sampling, of the type for convenience, was chosen. The inclusion criteria were users aged ≥ 18 years, admitted to the ECU and who received care: by the reception team, by the nurse, in the risk classification, by the physician in the consultation, and also by the nursing technical team, in the drug administration. Users who presented difficulty in communicating and/or incoherence in the information when answering about the socio-demographic characterization were excluded.

The data were obtained from June 30, 2015 to August 10, 2016, by the researcher, three undergraduate students (scholarship holders of Scientific Initiation Institutional Scholarship Program - PIBIC) and a doctorate student in the nursing area, trained by researcher and accompanied by her during the first collections performed. Data were collected through a questionnaire that deals with EWRC responsiveness, elaborated from existing models¹⁶⁻¹⁷ and validated in three stages (first evaluation by judges and second and third semantic evaluation with users of the ECU).¹⁸

The questionnaire used consisted of two parts: user identification, and data on the assessment of EWRC responsiveness. The user identification variables were date of birth, age, sex, race/color, marital status, schooling degree, origin, and "Are you being served by the user embracement with Risk Classification (EWRC) for the first time?" The evaluation of the EWRC's responsiveness was composed of 25 questions organized in five domains: dignity (five question - 1 to 5); communication (five questions - 6 to 10); agility (four questions - 11 to 14); social support (two questions - 15 and 16); and facilities (nine questions - 17 to 25).

The domains were defined as: dignity - patient guarantee of being well received and treated with respect and consideration in the health service; communication - ensuring adequate signage on the sectors both through staff and information boards; channels for users' Ombudsman and the facility to get information about documentation, procedures, exams, among others; agility - ensuring rapid emergency care and short waiting time for consultations and treatment;⁵ social support - ensuring user access to their social support network (family and friends) during the care provided by the health service;¹⁹ and, facilities - guarantee a clean and comfortable care place for patients.⁵ These domains are classified in two dimensions: respect for people (dignity and communication) and guidance for the client (agility, social support and facilities).¹⁹

Based on the evaluation of the responsiveness proposed by the WHO,¹⁷ each question was assessed using a Likert scale, with one of the values being standardized in the form of an ordinal scale: never (1 point); rarely (2 points); almost always (3 points); and, always (4 points). The domains of

communication and facilities admitted the measures: very bad (1 point); bad (2 points); good (3 points); and, very good (4 points). For the domains of dignity, social support and facilities, the measure was also opportunistic: not applicable (5 points) indicated when the user could not evaluate the question for lack of observation.

Thus, considering the number of questions in the domains, the minimum and maximum score possible for each domain ranged from: 5 to 20 points for the domains of dignity and communication; 4 to 16 points for the agility domain; 2 to 8 points for social support; And, 9 to 36 points for the facilities domain. The overall score of the questionnaire could range from 25 to 100 points being the higher the value, the greater the EWRC responsiveness.

Data collection with users, through interviews, occurred on all workdays and shifts (morning/afternoon/night). After medical care, the user already with the prescription of the medication, was informed about the study and then invited to participate in the same signing the term of Free and Clarified Consent (TCLE), and answering the questionnaire of characterization of participants and responsiveness evaluation. The data were collected while the users received the medication(s) or at the end of this(s), in the medication room, observation or in the corridor near the offices, where they awaited medical reassessment. All participants received guidance on the study and signed the TCLE.

The organization and processing of data occurred in the *Epi Info Software* version 3.5.2, using descriptive statistics (absolute and relative frequencies, mean, median and standard deviation). Data processing was also based on the analysis proposal presented in the WHO Responsiveness Assessment study,²⁰ also adopted by other researchers.^{4,11,21-24} Thus, the answers of the questions and their respective domains were dichotomized in “weak responsiveness” (poor responsiveness) and “good responsiveness” (good responsiveness), the latter being defined as the percentage of users who responded: almost always (3 points) and always (4 points); or, good (3 points) and very good (4 points). It was adopted in the study that the “poor responsiveness” corresponds to the percentage of users who attributed the answers: never (1 point) and rarely (2 points); or, very bad (1 point) and bad (2 points). The answer “does not apply” (5 points) was not considered in the calculations, since the users who opted for it did not express their opinion about responsiveness.

In each domain, the average percentage of the respective questions represents the responsiveness of the same. To obtain this average were added the percentages of good and poor responsiveness corresponding to the domain questions, and the result was divided by the number of questions of this. Thus, the best and the worst performances of good and weak responsiveness were obtained between the domains.

In order to verify the relationship between good and poor responsiveness to variables of the socio-demographic profile, gender (male and female), age group (< 60 and ≥ 60 years), schooling (< 12 years of study and higher education level), marital status (with and without partner) and number of care in the ECU (first attendance and more) was used the Chi-square test (χ^2), being adopted $p < 0.05$ as a significant value. For the analysis, the software Epi Info™ and the OpenEpi electronic version 3.01 were used.

RESULTS

Were interviewed 459 users, of whom the majority were women ($n=272$, 59.3%), with less than 12 years of schooling ($n=403$, 87.8%) and from the municipality of Biguaçu ($n=361$, 78.6%). The users were predominantly married or in a stable union, that is, with a partner ($n=231$; 50.3%), and aged below 60 years ($n=362$; 78.9%), with a median age of 41 years ($SD=17.5$). The majority reported that it was not the first care in the ECU ($n=376$; 81.9%).

Regarding the evaluation of EWRC's responsiveness, in the Dignity domain the “always” response (4 points) was attributed by the great majority of users to all their issues, highlighting the “Privacy in the physical examination by the nurse” with the highest percentage of users (96.1%) (Table 1).

Table 1 - Users' assessment of Dignity, Agility and Social Support domains. Florianopolis, SC, Brazil, 2016. (n=459).

Dimensions	Domains	never	rarely	almost always	always	does not apply
		n (%)	n (%)	n (%)	n (%)	n (%)
Respect for people	Dignity					
	Treated with respect by the nurse in EWRC*	2 (0.4)	7 (1.5)	23 (5.0)	427 (93.0)	-
	Treated with respect by other professionals	2 (0.4)	12 (2.6)	58 (12.6)	387 (84.3)	-
	You had the opportunity to speak freely about their problem	4 (0.9)	16 (3.5)	29 (6.3)	410 (89.3)	-
	Privacy in physical examination by nurses	-	1 (0.2)	15 (3.3)	441 (96.1)	2 (0.4)
Customer Orientation	Privacy on physical examination by physician	-	7 (1.5)	29 (6.3)	420 (91.5)	3 (0.7)
	Agility					
	Adequate waiting time for EWRC with the nurse	68 (14.8)	78 (17.0)	111 (24.2)	202 (44.0)	-
	Informed about the waiting time	392 (85.4)	13 (2.8)	17 (3.7)	37 (8.1)	-
	Adequate waiting time for medical care	100 (21.8)	113 (24.6)	97 (21.1)	149 (32.5)	-
	Adequate waiting time to receive the medicine	13 (2.8)	20 (4.4)	83 (18.1)	343 (74.7)	-
	Social Support					
	You had the opportunity of a companion	24 (5.2)	24 (5.2)	19 (4.1)	127 (27.7)	265 (57.7)
	You had opportunity of support by friends/family	8 (1.7)	10 (2.2)	8 (1.7)	28 (6.1)	405 (88.2)

* EWRC: Embracement with risk classification.

Regarding the Agility domain, the answer “never” (1 point) obtained the highest percentage (85.4%), attributed when asked if the user was “Informed about the waiting time”. In the Social Support domain, the answer “did not apply” (5 points) was the option of the majority of users (57.7% and 88.2%), indicating that they did not need Social Support (Table 1).

It is worth noting that, although the domains Dignity and Communication constitute the same dimension (*respect for people*), the findings of the first are presented in Table 1, and those of the second, in Table 2, given the fact that have a distinct response pattern. In Table 1 the possibilities of response are never, rarely, almost always, always and does not apply, while in Table 2: very bad, bad, good, very good and does not apply. For the same reason, the results referring to the Agility domain were presented in Table 1 and those referring to Social Support and Facilities, in Table 2.

In the Communication domain, the response “very good” (4 points) predominated, represented by the highest percentage (60.1%) of users, regarding to “Location and rooms identification”. Regarding the Facilities domain, the answer “good” (3 points) was highlighted, attributed by 56.4% and 51.2% of the users, related to “Comfort of the waiting room” and “Comfort of the nursing care room”, respectively. It is worth noting that the cleanliness and comfort of the room for the collection of exams

Table 2 - Users' evaluation in relation to Communication and Facilities domains. Florianopolis, SC, Brazil, 2016. (n=459).

Dimensions	Domains	very bad	bad	good	very good	does not apply
		n (%)	n (%)	n (%)	n (%)	n (%)
Respect for people	Communication					
	Nurse's communication	3 (0.7)	8 (1.7)	231 (50.3)	217 (47.3)	-
	Other professionals' communication	4 (0.9)	22 (4.8)	206 (44.9)	227 (49.5)	-
	Clear and easy to understand information	11 (2.4)	21 (4.6)	168 (36.6)	259 (56.4)	-
	Location and identification of the rooms	2 (0.4)	20 (4.4)	161 (35.1)	276 (60.1)	-
	To get information	17 (3.7)	31 (6.8)	146 (31.8)	265 (57.7)	-
Customer Orientation	Facilities					
	Waiting room cleaning	5 (1.1)	40 (8.7)	219 (47.7)	143 (31.2)	52 (11.3)
	Waiting room comfort	21 (4.6)	71 (15.5)	259 (56.4)	99 (21.6)	9 (2.0)
	Rest room cleaning	18 (3.9)	35 (7.6)	126 (27.5)	121 (26.4)	159 (34.6)
	Nursing Care room Cleaning	1 (0.2)	5 (1.1)	164 (35.7)	186 (40.5)	103 (22.4)
	Nursing Care room Comfort	4 (0.9)	12 (2.6)	235 (51.2)	168 (36.6)	40 (8.7)
	Doctor's Care room Cleaning	3 (0.7)	5 (1.1)	163 (35.5)	221 (48.1)	67 (14.6)
	Doctor's Care room Comfort	5 (1.1)	12 (2.6)	195 (42.5)	213 (46.4)	34 (7.4)
	Exam collection room cleaning	1 (0.2)	11 (2.4)	63 (13.7)	78 (17.0)	306 (66.7)
	Exam collection room comfort	2 (0.4)	16 (3.5)	64 (13.9)	76 (16.6)	301 (65.6)

were evaluated by most users (66.7% and 65.6%) as "not applicable" (5 points), in general because they had not collected exams in the ECU (Table 2).

The "Privacy in the physical examination by the nurse" of the Dignity domain obtained the highest percentage of responsiveness (99.8%), while the lowest percentage (11.8%) was identified when asked if the user was "Informed about the waiting time" in the Agility domain (Table 3).

The best and worst performance of EWRC responsiveness was attributed to Dignity (97.8%) and Agility (56.6%), respectively. All domains presented an average of good responsiveness above 50%, that is, most users assessed that EWRC in the ECU has a good responsiveness (overall mean=82.1%) (Table 3).

When analyzing the domains of responsiveness, according to socio-demographic and attendance variables in the ECU, statistically significant differences were identified between the variables: gender and the Dignity (0.0120), Communication (0.00001), Agility (0.0115) and Facilities (0.0001) domains; Age group and the Communication (0.0000001), Agility (< 0.0000001) and Installations (< 0.0000001) domains; marital status and the domains Dignity (0.0301) and Agility (0.018); education level and the Communication (0.0111) and Facilities (0.0237) domains; and number of times the patient was treated in the ECU (first time or not) and the Agility in the care (0.0001) and Facilities (0.0223) domains. No variable presented statistical significance with the Social Support domain (Table 4).

Table 3 - Responsiveness of User embracement with Risk Classification according to the domains Dignity, Communication, Agility, Social Support and Facilities. Florianopolis, SC, Brazil, 2016. (n=459).

Dimensions	Domains	Responsiveness	
		Poor	Good
		n (%)	n (%)
Respect for people	Dignity	51 (2.2)†	2239 (97.8)†
	Treated with respect by the nurse in EWRC *	9 (2.0)	450 (98.0)
	Treated with respect by other professionals	14 (3.0)	445 (97.0)
	You had the opportunity to speak freely about their problem	20 (4.4)	439 (95.6)
	Privacy in physical examination by nurses	1 (0.2)	456 (99.8)
	Privacy on physical examination by physician	7 (1.5)	449 (98.5)
	Communication	139 (6.1)†	2156 (93.9)†
	Nurse's communication	11 (2.4)	448 (97.6)
	Other professionals' communication	26 (5.7)	433 (94.3)
	Clear and easy to understand information	32 (7.0)	427 (93.0)
	Location and identification of the rooms	22 (4.8)	437 (95.2)
	To get information	48 (10.5)	411 (89.5)
	Agility	797 (43.4)†	1039 (56.6)†
	Adequate waiting time for EWRC * with the nurse	146 (31.8)	313 (68.2)
Customer Orientation	Informed about the waiting time	405 (88.2)	54 (11.8)
	Adequate waiting time for medical care	213 (46.4)	246 (53.6)
	Adequate waiting time to receive the medicine	33 (7.2)	426 (92.8)
	Social Support	66 (29.0)†	182 (71.0)†
	You had the opportunity of a companion	48 (24.7)	146 (75.3)
	You had opportunity of support by friends/family	18 (33.3)	36 (66.7)
	Facilities	267 (8.9)†	2793 (91.1)†
	Waiting room cleaning	45 (11.1)	362 (88.9)
	Waiting room comfort	92 (20.4)	358 (79.6)
	Rest room cleaning	53 (17.7)	247 (82.3)
	Nursing Care room Cleaning	6 (1.7)	350 (98.3)
	Nursing Care room Comfort	16 (3.8)	403 (96.2)
	Doctor's Care room Cleaning	8 (2.0)	384 (98.0)
	Doctor's Care room Comfort	17 (4.0)	408 (96.0)
	Exam collection room cleaning	12 (7.8)	141 (92.2)
	Exam collection room comfort	18 (11.4)	140 (88.6)
Overall responsiveness (average)		1320 (17.9)†	8409 (82.1)†

* EWRC: Embracement with risk classification; † Average percentage relative to the domain.

Table 4 - Socio-demographic characteristics and user service according to the responsiveness of the domains evaluated. Florianopolis, SC, Brazil, 2016. (n=459).

Variables	Dignity			Communication			Agility			Social support			Facilities		
	F*(n)	B*(n)	p†	F*(n)	B*(n)	p†	F*(n)	B*(n)	p†	F*(n)	B*(n)	p†	F*(n)	B*(n)	p†
Gender															
Male	13	918	0.0120¶	34	901	0.00001**	301	447	0.0115¶	23	64	NS§	82	1179	0.0001**
Female	38	1321		105	1255		496	592		43	118		185	1614	
Age group (years)															
<60	47	1758	‡	131	1679	0.0000001**	681	767	<0.0000001**	31	54	‡	246	2153	<0.0000001**
≥60	4	481		8	477		116	272		2	37		21	640	
Marital status															
Has a partner	19	1134	0.0301¶	65	1090	NS§	379	545	0.018¶	34	99	NS§	137	1408	NS§
No partner	32	1105		74	1066		418	494		32	83		130	1385	
Schooling††															
<12 years	49	1963	‡	113	1902	0.0111¶	706	906	NS§	56	159	NS§	224	2463	0.0237¶
College degree	2	276		26	254		91	133		10	23		43	330	
First attendance															
Yes	5	406	NS§	24	398	NS§	115	217	0.0001**	2	31	‡	33	476	0.0223¶
No	46	1833		115	1758		682	822		64	151		234	2317	

* F=Poor responsiveness; B=Good responsiveness; † x2 (Mid-P exact); ‡ x2 impaired by low number (<5); §NS: not significant; || with partner=married and stable union; No partner=single, separated, divorced and widowed; ¶P <0.05; ** p <0.001; †† <12 years=uneducated, complete and incomplete elementary and high school; College level=incomplete, complete and post-graduate higher education.

DISCUSSION

The results show that users' evaluation of domains related to respect for people, which includes being treated with dignity and having good communication with the professionals in the EWRC, was more positive than for the domains related to customer orientation, which refer to the agility of care, social support received during care and service facilities. These results indicate ethical qualification and humanization in the care of users, which is consistent with the proposal of the NHP EWRC.¹² The care taken with technical and relational competence by the professionals in meeting the needs of the user can guarantee quality and effectiveness in the assistance provided.²⁵

The data of the present study evidenced the need for improvements in the service infrastructure, such as a more welcoming environment (cleanliness and comfort), but, above all, the orientation to the user about waiting times for medical care, since this aspect had the most negative evaluation in the research. The increase in the number of professionals can also expedite service, reducing waiting time.

In this regard, ECU professionals who perform EWRC need to inform the user about the risk classification process and the waiting time according to their clinical condition, which contributes to the satisfaction of the user and his / her family,²⁶ making them feel less anxious and safer.¹⁴ This information constitutes the guideline of the Ministry of Health related to EWRC, which determines that in the emergency services the probable waiting time is informed to the user without immediate risk and to their relatives.¹²

As the waiting time does not depend solely on the user's classification, but also the number of professionals working in the service, this makes the attendance slow, especially when emergency situations arise, in which there is a greater concentration of the team²⁶ to the detriment of the other cases.

The EWRC responsiveness in the ECU evidenced similarities and differences with other researches in different contexts. Unlike international studies,^{4,21-23} the domains were evaluated with good responsiveness by the majority of users, however, they indicated the need for improvements, such as adjustments in the furniture to provide comfort to users and companions.

In this research, dignity and communication occupied the first two positions in the ranking of performances of responsiveness, a result that little differs from that identified in Iranian studies, in which the second best performance was assigned to one of these domains.^{4,22-23} In Nigeria, the result revealed greater divergence, since dignity and communication represented the third and fourth best performances.²⁷

In Brazil, studies developed in the Family Health Strategy (FHS)⁸ and in an outpatient referral unit of the SUS,¹⁰ revealed also that the domains of dignity and communication are among the three best rated by users. In the *Fundação Oswaldo Cruz* care units, the findings on dignity were negative, with privacy being the aspect of responsiveness that indicated the greatest failure in services.¹

In Iran, it was attributed more negative performance to the domain facilities,⁴ diverging from the data found in the present study. Furthermore, in Nigeria and South Africa, agility was considered one of the priority areas of intervention to improve health service responsiveness, due to its poor performance in the evaluation studies.^{6,28}

At the national level, research on responsiveness in the FHS revealed among the poorly evaluated domains by the users, the agility in the care and the facilities.⁸ In a similar context, the evaluation in relation to the facilities was negative, as they were inadequate and little resolute to the desires and expectations of the population.⁹ In the *Fundação Oswaldo Cruz* units, the waiting time for the service (agility domain) and the cleaning (domain facilities) also had negative assessments. The delay in being served motivated a complaint among the users, who consider waiting for a time longer

than the tolerable one for the attendance.¹ In a referral outpatient unit of the north and northeast regions of the country, the rapid attendance obtained the most negative result in the evaluation of the users.¹⁰

Despite the good responsiveness of the agility domain, identified in the present study, the worst performance attributed to it shows that it should receive special attention in the search for improvement of responsiveness in the ECU, which may require adjustments in reference and counter-reference system, because the waiting time can be decreased depending on the flow of users looking for the service. Another research indicates that the search for immediate attention, not characterized as an urgent demand, together with the lack of material, the physical structure characteristics of the Units and human resources, jeopardizes the agility of the attendance at the ECU.²⁹ In this sense, the EWRC would have an important contribution in guiding the users in relation to the levels of attention of the health system and, consequently, directing them to the service most appropriate for their condition.²⁶

The findings referring to the social support domain also deserve reflection, since its performance may be related to the restrictions of the ECU, which formally permits companion only to people with disabilities, elderly and minors. Another factor that negatively influences the performance of this domain is the user's lack of opportunity to receive, during his service, the support of friends and/or family members, especially in relation to food, since, according to NECP, as it is a service where the user must stay for a limited time (24 hours), does not provide diet. Regarding the study that involved the EWRC care corroborates that users should have their basic needs attended and the right to a companion in situations of prolonged waiting for care.³⁰

Although the results reflect the reality of an ECU in Santa Catarina, they resemble those of other studies developed in Brazil⁸ or in other countries,^{6,22,28} in which dignity and agility are evaluated domains among the best and the worst, respectively.

In the evaluation of the responsiveness of a health system, it is important to know the systematic differences between the different subgroups of the population. It is considered important to know, for example, whether or not responsiveness is perceived differently among women, the elderly (60 years and over), lower income people, and individuals with lower levels of education (up to 12 years) in relation to other.²⁴

In this sense, the results of the association between the users' socio-demographic profile and the evaluation of the responsiveness of the ECU are in line with international studies,^{6,31} but there are also divergences.^{4,28,32} In Nigeria, an association between sex and the domains of dignity and agility was identified, with the positive evaluation being more significant among men than among women, a result also evidenced in Canada regarding agility.³¹ The level of schooling revealed an association with the facilities, which were better evaluated by users with higher education than by those with lower educational levels.⁶

Contrary to the results of the present investigation, in China, the elderly evaluated more negatively the facilities of health services when compared to young users.³² In South Africa, among outpatient users, no association between gender and age was identified for responsiveness,²⁸ as well as for mental health services in Iran.⁴

It is noteworthy that the responsiveness studies developed in Brazil^{1,7-8} did not evaluate the association relationship between socio-demographic variables and responsiveness results, which makes it difficult to compare the findings of the present study in the scope national.

In general, ECU users evaluated EWRC with good responsiveness. It is important to emphasize that, in the case of a public service, feelings of gratitude may arise due to the public offer of the service, as well as the courtesy norms, which are social obligations to show respect for authority (health professionals and the researcher), or by understanding that criticism may be an inconvenient comment, resulting in a positive pattern of response to the evaluation.³³

Also, interpersonal relationships between the user and the different professionals who provide care: from the receptionist to the physician,³⁴ may interfere in the users' evaluations about the service. Thus, it is considered in this study the possibility of gratitude bias, predicted in research^{8-10,35} performed in public services and where there is affinity established by the user with the health professionals.

Another important aspect is the fear of losing the right to care, so the evaluation with users should consider the choice of the moment and the place of the interview, because they can interfere with the type of response given.³⁴ In order to avoid this kind of bias in the present research, whenever possible, users were not interviewed in the presence of ECU health professionals, and it was often necessary to interrupt the interview when they entered the site.

On the evaluation of responsiveness in public and private health services in Nigeria, a study comparing the results between the two types of services showed statistically significant differences between them in the evaluation of each domain of responsiveness, being only the communication domain best evaluated in the service public than private.⁶ In South Africa, in general, responsiveness was higher in private services when compared to that identified in public health units.²⁸

Methodological biases proper to the evaluation of health services should be considered when the study is based only on the subjectivity of the users. However, the use of instruments for evaluating responsiveness may reduce part of the subjectivity of the evaluation of the quality of services,³⁵ care considered in this investigation when using an instrument designed for this purpose and validated, as to the content, by experts in the methodology and theme approached.

As a limitation of this research, it is pointed out that data collection was performed only on working days, and the sampling was non-probabilistic, which would allow the inclusion of atypical subjects to the population. However, it is noteworthy that the representative sample allows the generalization of data for other contexts and assigns relevance to the study.

It is believed that this research contributes to give political visibility to users, actors traditionally little considered in the discussion of public policies in the country. Moreover, the research expands the production of knowledge about responsiveness, an important aspect in the evaluation of health and nursing services, as well as about the EWRC.

CONCLUSION

The users of the ECU evaluated the service with good responsiveness. The domains with the best performance of responsiveness were dignity, communication and facilities, respectively, while agility presented the worst performance, followed by the social support domain.

The good responsiveness of the EWRC in the ECU had more expressive results among the male participants, with 60 years old or more, who have companions (married and in a stable union), college education level and who are being attended in the unit by the first time.

As suggestions for future studies, it is important to develop similar researches in ECUs from different contexts of the country, in order to evaluate the implantation of this pre-hospital component, of the National Emergency Care Policy, under the perspective of responsiveness. Comparative studies on responsiveness in public and private health services in Brazil may also contribute to the advancement of knowledge in this theme. Also, it is considered relevant that the investigations carried out in Brazil seek to identify the association between the subgroups of users and the responsiveness attributed by them in the evaluation of the health services, since the results can contribute to the planning of the actions of improvements.

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NOTES

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