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Difficulties experienced by multiprofessional health teams in providing primary care for burn victims

Dificuldades vivenciadas na atenção básica pela equipe multiprofissional de saúde no atendimento ao usuário queimado

Dificultades vividas en la atención básica por el equipo multiprofesional de salud en la atención al usuario quemado

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ABSTRACT
Objective: to identify difficulties experienced in Basic Health Units by multiprofessional teams providing care for burn patients. **Method:** in this qualitative, descriptive study with 14 health personnel working in three basic health units in southern Rio Grande do Sul state, data were collected in June 2018 by semi-structured interview, and treated by thematic analysis. **Results:** the multiprofessionals reported that they considered their training insufficient and that they felt unprepared to provide first care and management when more specific burns presented, which was reflected in stress and anxiety. There were reports of divergences in procedures adopted and no protocol for appropriate burn management was in place. They pointed out that the physical structure and materials were unsuitable. **Conclusion:** the difficulties experienced in providing care to burn victims pose a need for training, and closer attention by management with a view to investing in physical resources, materials and protocols to enable this service.
Descriptors: Primary Health Care; Patient Care Team; Nursing; Burns.

RESUMO
Objetivo: identificar as dificuldades vivenciadas nas Unidades Básicas de Saúde pela equipe multiprofissional no atendimento ao usuário queimado. **Método**: estudo qualitativo, descritivo, realizado com 14 profissionais atuantes em três unidades básicas de saúde no Sul do Rio Grande do Sul. A coleta de dados ocorreu em junho de 2018, por meio de entrevista semiestruturada. Os dados foram tratados por análise temática. **Resultados:** os multiprofissionais relataram que consideram sua formação insuficiente e que se sentem despreparados para o primeiro atendimento e manejo, repercutindo em estresse e ansiedade, quando surgem queimaduras mais específicas. Identificaram-se relato de discordâncias nas condutas adotadas e a ausência de um protocolo para o manejo apropriado. Pontuaram que a estrutura física e insumos são inadequados. **Conclusão**: diante das dificuldades vivenciadas para o atendimento ao queimado, é necessário capacitação profissional e um olhar mais próximo pela gestão, para investir em recursos físicos, materiais e protocolos que possibilitem esse atendimento.
Descritores: Atenção Primária à Saúde; Equipe Multiprofissional; Enfermagem; Queimaduras.

RESUMEN
Objetivo: identificar las dificultades vividas en las Unidades Básicas de Salud por el equipo multiprofesional en la atención al usuario quemado. **Método:** estudio cualitativo, descriptivo, realizado junto a 14 profesionales que trabajan en tres unidades básicas de salud en el sur de Rio Grande do Sul. La recolección de los datos se realizó en junio de 2018, mediante entrevista semiestructurada. Los datos fueron tratados por análisis temático. **Resultados:** los multiprofesionales refirieron que consideraron su formación insuficiente y que no se sentían preparados para el primer cuidado y manejo, lo que reflejaba en estrés y ansiedad, cuando surgían quemaduras más específicas. Se identificaron diferencias en las conductas adoptadas y ausencia de un protocolo para el manejo adecuados. Apuntaron que la estructura física y los insumos son inadecuados. **Conclusión:** ante las dificultades vividas en la atención de personas quemadas, hace falta una formación profesional y una mirada más cercana por parte de la gestión, en el sentido de invertir en recursos físicos, materiales y protocolos que hagan posible esa atención.
Descriptores: Atención Primaria de Salud; Grupo de Atención al Paciente; Enfermería; Quemadura.

INTRODUCTION

In recent years, Primary Care (PC) has been growing and developing, gaining visibility and prominence with the approval of the National Policy on Primary Care (PNAB), which established that Primary Care Centers (PCC) are the gateway and communication center for the user in the health care network. Therefore, since they are the point of connection of the Unified Health System (SUS), PCCs must have a multidisciplinary team prepared to deal with any type of intercurrence, especially those that affect a large part of the population[1].

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Within this context, burns are considered a serious public health problem, ranked worldwide as the third most common cause of accidental death in childhood. The United States alone has two million burn victims a year and Brazil is not so different, as one million people are affected, with a higher prevalence among children and low-income people[2,3].

Given the above and considering the importance of providing timely care, the Brazilian Burn Association recommends that people seek help at the health unit closest to the location of the burn accident, preferably the PCC, but in its absence, an emergency care unit[4].

In PCCs, which are considered the gateway for users, mainly in small cities and communities with difficult access to hospital institutions, healthcare teams must have skills and abilities to deal with initial care, management and recovery of burn victims and to promote health education aiming to prevent these occurrences[5]. Therefore, nursing professionals and other members of the healthcare team must seek knowledge and update their skills on the first care to burned patients, since the right care can reduce risks, complications and sequelae[6].

Studies on the treatment of burn victims in the PCC are scarce. Most studies address the care provided before or during hospital admission[7-9]. However, authors point out that PC professionals do not include preventive care for burns in their routine. As multipliers of information, they need to be updated on the main risk factors and prevention measures to provide health education guidelines for the safety of the population[5].

For this, they need an adequate infrastructure that enables assistance to burn victims. Thus, research focusing on the work of professionals in the management of burn victims is extremely necessary, as its absence demonstrates the fragility and need for continuing education of healthcare teams regarding this knowledge gap in PC[5-10].

Therefore, it is necessary to identify and describe the difficulties of the multidisciplinary PC team in the care of burn victims, highlighting the problems experienced, reflecting on the strategies for their resolution and raising awareness in managers to improve these areas. In this regard, the present study aims to identify the difficulties experienced by multidisciplinary professionals in the PCCs in the care of burn victims.

METHOD

This is a descriptive study with a qualitative approach, part of a research entitled “Work of the professionals of PCCs in the care of burn victims”, carried out in a city in the south of Rio Grande do Sul, in three PCCs.

Participants were selected by convenience, according to the following inclusion criteria: being a professional of Family Health Strategy (FHS) team. Professionals in long leaves of absence, who would not return to activities during the collection period, due to medical reasons (n=1) or pregnancy (n=1) were excluded from the study. Of the total of 27 eligible professionals, one was on vacation, two were on extended leave, one refused to participate and nine were not found after three attempts of contact, which was understood as refusal to participate. Thus, 14 professionals participated in the research, including five nurses, four physicians and five nursing technicians.

Data was collected in June 2018 in the health service during office hours by a trained nursing student with no prior relationship with the participants. It was organized in two blocks: the first aimed to characterize the participants through socio-demographic data (age, gender, education, time since graduation, additional education/graduation, time working at the PCC, among others). The second block was a semi-structured interview with the objective of assessing the difficulties experienced in the care of burn victims, through questions about the work routine; the barriers experienced in the care of burn victims; if they received training for this type of service, if they felt prepared for the service and what they deem important for improvements to occur.

The interviews occurred in the professionals’ offices, with privacy and freedom of expression, and were recorded and later transcribed. Each participant was identified with the letter (N) for nurse, (P) for physician, (NT) for nursing technician, followed by the ordinal number representing the order in which the interviews were conducted. After transcribing the interviews word-by-word in Microsoft Word, they were read in full. The data emerging from the research were analyzed according to the Minayo’s approach[11], in two stages: the first was an exploratory investigation phase and the second was the interpretation. That is, the information reported by the participants was carefully read for three times, and the lines that answered/met the study objective were highlighted. The last phase had two steps: ordering and classifying the data.

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The research complied with Resolution No. 466 of December 12, 2012 of the National Health Council and was approved by the Research Ethics Committee, with a Certificate of Presentation and Ethical Appreciation in the Plataforma Brasil. The Informed Consent Form was signed in two ways, one kept with the interviewee and the other with the researcher. The Consolidated criteria for Reporting Qualitative research (COREQ), a checklist with 32 items that must be described in qualitative research for greater methodological rigor, were followed.

RESULTS

The professionals participating in the study were predominantly female, with a mean age of 38.35 years, ranging between 29 and 55 years. The mean time of training was 9.5 years, with the minimum of six months and maximum of 21 years. The mean time working on the PCC was 2.7 years, however, the mean time working in the profession was 9.1 years.

Among the nine professionals with higher education, eight have graduate degrees in the areas of internal medicine, family health, women's health, mental health, preceptorship, medical law, assistance projects and public health or master's and doctorate degrees. Regarding the training courses offered by management, only eight have participated and reported that none involved burns. Only one participant had training on skin lesions in general.

Regarding the difficulties experienced by the multidisciplinary PCC team to care for and continue the treatment of burn victims, three themes emerged: Insecurities in the first care and management of burn victims; Disagreements among professionals in the care of burn victims and the lack of a protocol in the services; Lack of adequate physical structure, materials and supplies for the care and treatment of burn victims (Figure 1).

Insecurities in the first care and management of burn victims	Insufficient academic training Little understanding on the topic Feeling of unpreparedness associated with the stress and anxiety of care Care of burned children Care in cases of burns caused by chemical and inhaled substances
Disagreements among professionals in the care of burn victims and the lack of a protocol in the services	Absence of a protocol for the care Disagreement in care measures
Lack of adequate physical structure, materials and supplies for the care and treatment of burn victims	Lack of space to stabilize the user and apply dressings and serum Lack of materials to apply dressings Lack of adequate medications for the treatment Lack of supplies for venipuncture Financial difficulties of users to buy medication that the pharmacy does not provide

FIGURE 1: Themes and characteristics of the difficulties in the care of burn victims. Pelotas, RS, Brazil, 2018.
Font: research data, 2018.

Insecurities in the first care and management of burn victims

The professionals reported that they did not have or had academic training on burns. In addition, they expressed they are unprepared and have little knowledge on the topic, which is a barrier to the care provided in the PCCs where they work.

> *No, no. In my training as a technician I actually didn't have in-depth training, it was very basic like that [talking about wounds in general], and in the hospital we also didn't learn about burns, only wounds. (NT1)*

> *Lack of preparation, I recognize that I have to study and prepare. It's actually that when this happens, when we have to answer a questionnaire like this, that we realize that we're not preparing, and some day a burn victim will appear. (N4)*

> *With children it is very difficult [...] it is more difficult to provide care to children? [...] because the child's skin is more fragile, they are very little beings.... and they are very...I don't know, it is just more difficult. [...] (NT5)*

> *These issues of chemical burns, it's something that, for me is very difficult, inhalation... I don't know how to say it properly, what has to be done, if it is a shock, because you have to evaluate the heart. (P2)*

> *I think the most difficult thing for us is...maybe the airway issue, if the airway is compromised, that kind of thing, we don't have the supplies for that. We also don't have training for everything, we end up missing this training [...] Hydration, I think it's a very complex thing [...] we end up doing it too much, we overcalculate or undercalculate, but it's wrong, and it should be right. (P3)*

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Disagreements among professionals in the care of burn victims and the lack of a protocol in the services

Another difficulty mentioned by the participants in the care of burn victims was the lack of a protocol to indicate the actions that should be taken, support professionals in their development, strengthens the assistance provided, and solve the disagreements regarding the therapeutic measures.

> *Challenges? The first is not having a protocol for us to feel safe, knowing that we are doing "that" with the support of the Regional Nursing Council (COREN) and the management [...] (N2)*

> *Maybe this issue of instability due to the extension and the type of burn, that's what would make me more uncertain about what to do. (P2)*

> *[...] we don't have a protocol in the service, so I have to follow the prescription of the doctor who sent us the user from anywhere, and I have to comply with that medical prescription, the doctor is asking and I don't have a protocol to say "no, that we don't do here", this is a weakness of our service, I have no support to say that. We have many, many disagreements, or at least we had, on how to treat burns, then we have a doctor asking us to apply Nebacetin [antibiotic ointment for skin conditions], which it's something I don't do, I don't agree with that, there are doctors asking "the patient arrived and I want you to pop the blister now", so within the same service we have several divergences. [...] I feel this difficulty when dealing with these various medical procedures, we need standards, something more well defined, to treat burns in Primary Care. (N2)*

Lack of adequate physical structure, materials and supplies for the care and treatment of burn victims

The physical structure was considered inadequate by the PCC professionals, due to the lack of a room for patient care, to apply dressings or serum, which had a negative effect on the quality of care, as well as the lack of appropriate supplies and materials for treatment. The professionals demonstrated interest in improvements in physical structure.

> *[...] our care room there in the reception, which would be our Emergency Room, does not have a chair for the person sit and get an IV therapy, for hydration, for example. The dressing is applied with the person sitting there, sometimes with their arm or leg resting on a stool on the bed, we don't have a dressing room, we don't have a resting room to make IV medication, to do the serum, and while the person is sitting there being treated, there are two or three others there being seen [...] (P4)*

> *We do not have access [to material for venous access], we cannot do the puncture, we do not even have an IV to do this hydration [...] I think we are not prepared to this care, our unit is not prepared to deal with this, even with the professionals, the structure does not offer the supplies for this. (P1)*

> *When you need silver sulfadiazine [bacteriostatic cream] and the patient can not buy it, it is also a challenge, a bad thing for us, because we know about the poverty of these families, and we also don't have it in the [health] network [...] but we do not have this medication in our district pharmacy, so this is also an obstacle [...] (N2)*

> *Oh, the challenge is the medications that sometimes are not available in our pharmacy, and sometimes you know that patients are poor and won't be able to buy the medication [...] no matter how much you clean, if you don't have the medication to use and they can't buy it, it becomes very complicated. (NT1)*

DISCUSSION

The fact that the professionals interviewed care for or are able to care for people with burns generated reflections on the need for them to be sufficiently prepared for this. However, they report that the training received was not enough for them to feel secure when providing care to the burn victim. They reported that burns were addressed at some point during undergraduate study, but it was a consensus that this content was superficial or associated with other skin lesions.

This reality was also evidenced in a research carried out with 107 students in the last year of the nursing course, of which 77 did not have the opportunity to provide primary care to a burn victim during their training. In addition, 84 respondents considered that the theoretical content was superficial and insufficient to ensure safety in care[12].

In the medical area, a study that aimed to assess the knowledge of medical students about initial care for burn victims revealed a predominance of knowledge regarding the classification of burns, type of fluid used for hydration, calculation of ideal diuresis and use of gastric protectors. Furthermore, students who did their internship in Burn Treatment Units were more assertive in specific issues[13]. This demonstrates that academic or professional experiences,

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in addition to a solid theoretical basis, contribute to the preparation of the professional for the first care and management of burn victims with safety and sufficient knowledge.

Another study carried out with nurses, nursing technicians and assistants, physical therapists and physicians found that practical experience with the first care to burn victims is extremely important for the construction of knowledge. Even though the study was carried out with professionals of the urgency and emergency sector, which deal with stressful situations and traumas such as burns, most professionals had basic, inadequate or no knowledge about immediate care and treatment for skin lesions[8].

The emotional state is also a factor that seems to influence cases of more specific burns or burns that are uncommon in PCCs. The reports show that the feeling of unpreparedness is exacerbated when there is discomfort and is associated with the stress and anxiety of caring for a burn victim. In addition, these feelings are heightened when the patient is a child.

Therefore, pre-hospital care for burn victims requires a good clinical assessment and specific skills and knowledge of professionals, which will reflect in good prognoses. However, there are still controversies in the literature regarding the actions that should be taken[14]. These disagreements are also mentioned in the speeches of the participants of this study, who face them during their care practices. It is believed that their evaluation and behavior can also generate bad or good prognoses for the patient.

According to professionals, this could be improved if there was a municipal protocol for care to burn victims, as their conduct would be based on protocol, reducing the difficulties, insecurities and differences in the care provided. In the city where the study was carried out, there are no care protocols for skin lesions, especially burns. Researchers with an interest in the subject noticed the absence of care protocols in their practice and carried out a literature review study, which identified a lack of research on nursing care and use of protocols for the care of burn victims, highlighting their importance[15].

It should be noted that the use of protocols contributes in multiple perspectives to the main gateway to the SUS, PHC. They can be considered care management technologies and help guaranteeing the right to health and strengthening interprofessional work, consolidating SUS' policies and supporting professionals in their decision-making process[16]. To ensure access to care for burn victims, specifically at the primary level, the multidisciplinary team must be supported by their services and management, so that individualized and quality care can be provided[3].

Correa[17] explains that after the burn, the patient must seek the PCC, Emergency Care Unit (UPA) or SAMU, where the professionals will assess the BSA involvement and the severity and complexity of the burn, to give appropriate referrals. Less severe burns can be treated and monitored in PC, while medium and severe burns need initial care with hydration, analgesia and dressings and subsequent referral for urgent regulation.

Therefore, it is essential that, in addition to comprehensive care, the PCC can also provide medication, supplies and materials, in a physical space that is appropriate for observation and administration of serum, especially ringer's lactate, with distilled water, supplies for venipuncture, masks, ventilators with air reservoir, oxygen, materials for dressings and analgesic drugs available[18]. In addition, all PCCs should have a procedure room, a dressings room and an observation room[19].

However, it is evident that these recommendations are not the realities of the PCCs in this study and that the professionals interviewed do not believe that sufficient materials, supplies and spaces are available. The reports show the concern with the physical structure of the PCC. The lack of a reserved room makes it difficult to provide comprehensive care and to carry out important procedures such as serum therapy and dressing.

The lack of physical structures is part of other realities in the country, as a study carried out with FHS professionals to understand emergency care found similar problems regarding lack of medication, supplies and adequate physical space. The need for multi-professional training on care to burn victims was also pointed out, with the expectation that PHC management can offer it. Thus, one of the forms of training is continuing education, an important tool for the improvement of professionals that can improve qualification for emergency care in PC[20].

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Study limitations

The limitation of the study is that it cannot be generalized, as data were collected in three PCCs, which may or may not resemble the reality of other units in the city and in the country. However, it is worth noting that the study was conducted with a multidisciplinary team and the difficulties experienced are shared by nurses, physicians and nursing technicians.

FINAL CONSIDERATIONS

The development of this study allowed identifying the difficulties experienced by multidisciplinary professionals in the care for burn victims in PCCs. Their training was considered insufficient for this type of care, due to the lack of experiences in the area. The professionals feel stressed and anxious when caring for more specific burns, such as electrical burns, burns to the airways and burns in children.

The lack of protocols in PHC is an obstacle for standardized and systematized care, as there are differences in conduct between multidisciplinary professionals. The inadequate physical structure, which does not guarantee privacy and makes it difficult to carry out procedures such as stabilization/evaluation, serum therapy and dressings is also seen as an obstacle and is strongly associated with the lack of materials and supplies, such as venipuncture equipment, dressings and medication, such as 1% silver sulfadiazine.

It is necessary to develop further studies that address the care of burn victims in PHC, as published literature on the topic is scarce. These studies should verify if similar difficulties occur in other locations, as they represent barriers to health access for burn victims in Brazilian PHC. In addition, management should give further attention to care of burn victims, creating and encouraging professionals to create/follow protocols that guide and standardize their conduct, without making it stifle or overlooking the humanization and comprehensiveness of care. Training is also a necessary strategy to qualify care in this area, in addition to the provision of adequate physical structure, materials and supplies, which have a direct impact on the care provided to patients and on the prognosis of burns. And, finally, the theme should be included in academic training, with theoretical and practical knowledge.

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