ORIGINAL ARTICLE *DOI: 10.4025/cienccuidsaude.v16i4.37306*

QUALITY OF EMERGENCY IN MOBILE PREHOSPITAL CARE IN THE PERSPECTIVE OF PROFESSIONALS

Talita Lopes Garçon*
Jussara Simone Lenzi Pupulim**

ABSTRACT
This study aimed to evaluate the quality of Emergency PrehospitalCare (APH) from the SAMU professional perspective, with a quantitative, cross-sectional, exploratory and descriptive approach, done with workers from a mobile APH. To acquire the data, the subjects completed a socio-demographic and vocational training form, and the PrehospitalCare Quality Assessment instrument (AQ-APH), composed of two indicators of Care Quality (QA), structure and process for service,both consisting of aspects related to the service. The alternatives of answers, arranged on a Likert scale, ranged from Poor (1) to Excellent (5), being the higher the score the better the quality of care. The results showed that most aspects of structure were evaluated, predominantly between Regular and Good, and aspects of the work process prevailed between Good and Excellent. This demonstrates that the quality of urgencyof mobile APH is satisfactory and appropriate, but it does not reach the expected standard of excellence, denoting the need for more investments in improving infrastructure to ensure qualified service.

Keywords: Quality of Health Care. Emergency Medical Services. Emergency. Health personnel.

INTRODUCTION

The National Emergency Care Policy instituted the Prehospital Mobile component: Emergency Mobile Assistance Service (SAMU), associated to saving and rescue, medical regulation and single contact throughout the national territory - 192, counting on Basic Life Support (SBV) and Advanced Life Support (SAV) ambulances[1]. The SAMU-192 is prehospital care within SUS under a first level of attention to people with acutecondition (clinical, traumatic, psychiatric), outside the hospital. Prehospital mobile care (APH) consists of nurses, doctors, nursing assistants and first aid drivers, who aim to improve care, both professional and satisfaction with the work process, to meet quality for the users[2].

The emergency mobile APH operates 24 hours and counts with SAV vehicles (1/100,000-150,000 inhabitants) and SBV (1/400,000-450,000 inhabitants)[1]. The SAV is conducted by three professionals (driver, nurse, doctor) and provides care and transportation of high-risk patients in prehospital emergencies or intrahospital transport of those in need of intensive medical care. And the SBV, conducted by the first-aid driver and a nursing assistant, is intended for interhospital transportation of those without the need for medical intervention on the spot or transportation to the destination service[3].

The SAMU is a complex system of considerable social importance, and its main objective is to attend to victims at the site of occurrence, aiming to reduce the number of deaths, length of hospitalization and complications resulting from the lack of immediate care. Since it is the right of every citizen to receive quality public care in the health field, it is imperative to know the difficulties that may be affecting the quality and success of assistance to the population[4]. In the health field, quality consists in obtaining the greatest benefits through lower risks and, therefore, for its evaluation, a triad is established consisting of structure, process and result.

The structure comprises physical, human, material, financial and equipment resources, necessary for health care; the process refers to activities involving health workers and users, including ethical aspects of the professional relationship; and result corresponds to the final product of care provided, namely health, satisfaction of standards and expectations of users[5]. In this sense, the aspects that influence and interfere in the quality of care, pointed out by the professionals who work in emergency mobile APS, will allow an analysis of the structure and the assistance process, resulting in the perception of the quality of care provided[6]. This way, the objective of this study is to evaluate the quality of emergency Mobile Prehospital Care (APH) from the perspective of SAMU professionals.

[1]Research article, extracted from the TCC submitted to the Multiprofessional Integrated Residency Program in Urgency and Emergencies Attention of the State University of Maringá (UEM), Maringá-PR.

*Resident Health Professional- Nursing. State University of Maringá (HUM/UEM). Parana Brazi E-mail: tallitalopesgarcon@hotmail.com
** Nurse. PhD in Nursing.Professor at the Department of Nursing (UEM) Paraná, Brazil. E-mail: jslpupulim@uem.br

METHODS

A quantitative, exploratory, descriptive and cross-sectional study with a multiprofessional team working in the mobile APH of Maringá-PR, SAMU-192. The criteria for inclusion were to be 18 years of age or older, to be an effective member of the SAMU professional staff that had been working for three months in the Prehospital Mobile service and not to be during the period of data on vacation or health leave.

The total number of professionals in the service is 76, being 20 physicians, nine nurses, 23 nursing assistants and 24 first-aid assistant, five ambulances of SBV and one of SAV, two bases, one of them in the Southern region of the municipality and the other in the North region, both of which are attached to a fixed prehospital service, and attending approximately 385,753 users from Maringá and region[7]. A total of 59 professionals out ofthe 76 working at SAMU 192-Maringá were approached. One if refused to participate in the research for doing only paper work. Nine were on vacation and eight on medical leave. Thus, 58 professionals were effectively involved in this study, including seven nurses, 17 physicians, 18 nursing assistants and 16 rascuerdrivers.

The data were collected from June to September 2016, using a validated instrument, (AQ-APH) Prehospital Care Quality Assessment, which contains two indicators, structure and process of Quality of Care (QA)[8]. Each indicator evaluates the three dimensions of the service rendered, eight service structure and nine the work process. This instrument is divided into three parts: a) personal identification b) professional identification c) service structure and process. In this study, only aspects related to structure and process will be addressed.

The aspects related to the structure are: state of comfort, comfort and safety to the user inside the ambulances, physical structure, material resources, confidence demonstrated by the professionals during the service, confidence of the staff in the base office, permanent education. And about process are: access, reception, humanization, response time, service performed by the team, respect for users'privacy, guidelines on health care and health, relationships between professionals and users, users' opportunity to make complaints and multiprofessional articulation[8].

The alternatives of answers are arranged in a Likert scale, in five points: Poor (1), Bad (2), Regular (3), Good (4) and Excellent (5), the higher the score the better the quality of the attendance. The data obtained were entered in a spreadsheet of the program Microsoft Excel 2010 and analyzed statistically with Software Statistica 8.0. The results are presented in simple frequency and percentage tables.

The research was approved by the research ethics committee of the State University of Maringá (COPEP), protocol no. 1,646,925 and CAAE: 56723016.1.0000.014, according to nº 466\12 - CNS. All participants signed the TCLE in two ways.

RESULTS

Half (50%) of professionals were between 30 and 39 years of age, 74.1% are males, 72.4% are married, 56.9% are completing or are in third grade and 31.0 % are nursing assistant (high school). Regarding to working time in the institution, 41.4% had from one to four years and 11 months of service time and 34.5% from five to nine years and 11 months, with 94.8% of professionals work for the institution they like. As for professional training, 48.3% participated in courses, 58.9% had another work link and 46.6% had a workload of 30 to 40 hours a week. The majority (77%) participated in training for less than six months and 87.9% mentioned that permanent education is valued in this service. However 94.8% feel the need for new training to act in emergency situations, despite the frequent participation of training. (Table 1).

According to Table 2, referring to SAMU's structure for service, the physical structure of the service is indicated by 50% of professionals as Good and by 22.4% as Regular. Ambulance status is defined as Regular (46.6%) and Good (34.5%), matching with the perspective of comfort within the ambulance, Regular (43%) and Good (39.7%).

Nevertheless, 53.4% of the staff considers Good the security offered to the user in the ambulance, while 25.9% defined as Regular. The safety of the team in relation to the base office is considered as Regular (36.2%) and Good (31%), while the confidence showed by the team to the patient during the visits to 50% of the subjects is Good and for 37.9% is Excellent. The availability of supply for the service was indicated as Good (67.2%) and Excellent (20.7%). And 44.8% of professionals report that the permanent education service at SAMU is Good and for 29.3% it is Regular.

Table 3 presents the aspects related to the work process in the SAMU, showing that the reception given by the team to the users is defined by 58.6% of the professionals as Good and by 29.3% as Excellent, coinciding with their view on humanization during the assistance provided by the team, Good (51.7%) and Excellent (41.4%).

Table 1. Frequency distribution of variables evaluated in health professionals - SAMU 192. Maringá, 2016.

Variables		N	%
Age range	From 20 to 29 years	3	5.2
	From 30 to 39 years	29	50.0
	From 40 to49 years	17	29.3
	From 50 to 60 years	9	15.5
Gender	Female	15	25.9
	Male	43	74.1
Education	Middleschool	2	3.4
	Undergraduateschool	33	56.9
	Graduateschool (finished/unfinished)	23	39.7
Marital status	Single	12	20.7
	Married	42	72.4
	Divorced	4	6.9
Professional education	Nursingassistant	18	31.0
	Registered Nurse	7	12.1
	Medical doctor	17	29.3
	Rascuer driver	16	27.6
Lenght of time in the institution	1to 4 yearsand 11 months	24	41.4
	5 to9 yearsand 11 months	25	43.1
	10 to 14 yearsand 11 months	9	15.5
Lenght of time in the urgency and energencyservicea	1to4 yearsand 11 months	16	27.6
	5 to 9 yearsand 11 months	20	34.5
	10 to 14 yearsand 11 months	13	22.4
	15 to 20 yearsand 11 months	6	10.3
	20 or more years	3	5.2
Reason for working in the institution	Because he/she enjoy it	55	94.8
	Byimposition	1	1.7
	Public position	2	3.4
Took courses	Yes	28	48.3
	No	30	51.7
Has another link of work	No	24	41.4
	Yes	34	58.6
Weekly hours	From 30 to 40 hours	27	46.6
	From 41 to 60 hours	11	19.0
	61 hours or more	20	34.5
Lenght of time since last emergency trainning	6months	45	77.6
	1 year	9	15.5
	2yearsor more	4	6.9
Feel valuable at work	Yes	51	87.9
	No	7	12.1
Frequency of trainning	Yes	55	94.8
	No	3	5.2
Feel the necessity of training to work in the emercy situations	Yes	55	94.8
	No	3	5.2

Source: Research data from 2016.

Table 2. Frequency distribution of the aspects on the structure for service of the SAMU evaluated by the professionals. Maringá, 2016.

Aspects \ Evaluation	1. Verybad		2. Bad		3. Regular		4. Good		5. Excellent	
	N	%	N	%	N	%	N	%	N	%
C1. The conservation of ambulances is	4	6.9	7	12.1	27	46.6	20	34.5	-	-
C2. The physical structure in this service is	4	6.9	7	12.1	13	22.4	29	50.0	5	8.6
C3. Comfort inside the ambulance is	3	5.2	6	10.3	25	43.1	23	39.7	1	1.7
C4.Comfort inside the ambulance is	3	5.2	5	8.6	15	25.9	31	53.4	4	6.9
C5. The availability of materials for your service was	2	3.4	1	1.7	4	6.9	39	67.2	12	20.7
C9. The confidence demonstrated by the staff during the attendance usually is	0	0.0	1	1.7	6	10.3	29	50.0	22	37.9
C15. The confidence of the staff in relation to the support (base - SAMU facilities) offered by this service are	8	13.8	11	19.0	21	36.2	18	31.0	-	-
C16. The permanent education in this servisse is	1	1.7	8	13.8	17	29.3	26	44.8	6	10.3

Source: Research data from 2016

Table 3. Frequency distribution of the aspects related to the work process for service of the SAMU evaluated by the professionals. Maringá, 2016.

Aspects \ Evaluation	1. Verybad		2. Bad		3. Regular		4. Good		5. Excellent	
	N	%	N	%	N	%	N	%	N	%
C6. Access to the service by number 192 is	1	1,7	2	3,4	10	17,2	30	51,7	15	25,9
C7. The arrival time of the ambulance to the place of the call is	1	1,7	1	1,7	6	10,3	41	70,7	9	15,5
C8. The reception in this service by the professionals to the users is	1	1,7	1	1,7	5	8,6	34	58,6	17	29,3
C10.During the service, the respect to the privacy to the users in that service is	0	0,0	4	6,9	3	5,2	25	43,1	26	44,8
C11. Humanization during the assistance provided by the team is	0	0,0	1	1,7	3	5,2	30	51,7	24	41,4
C12. The guidelines on the procedures performed and health status, provided by the SAMU 192 Maringá staff, to users in this service are	1	1,7	0	0,0	4	6,9	41	70,7	12	20,7
C13. The relationship between professionals and users in this service is	2	3,4	2	3,4	11	19,0	35	60,3	8	13,8
C14. The opportunity given to users to make complaints in this service is	0	0,0	0	0,0	6	10,3	31	53,4	21	36,2
C17.The articulation of multiprofessional work in this service is	0	0,0	3	5,2	10	17,2	40	69,0	5	8,6

Source: Research data from 2016.

The guidelines provided by the team on procedures performed and health status are considered Good by 70.7% of professionals and Excellent by 20.7%, and 53.4% say that it is an opportunity given to users to make complaints about care and for other 36.2% is Excellent. The articulation of multiprofessional work is evaluated by the team as Good (69%) andRegular (17.2%) and, equally, the interpersonal relationship between professional and user is considered Good (60.3%) and Excellent (13.8%). Regarding the users' privacy during the service provided, 44.8% of the professionals are Excellent and 43.1% are Good. Accessibility to SAMU by telephone contact 192 is considered Good (51.7%) and Excellent (25.9%), while the arrival time of the ambulance to the call location, defined by the majority as Good (70.7%) and by only 10.3% as Excellent.

DISCUSSION

The majority of the subjects are in the age group in which the labor activity is more active and productive economically (30-49 years), predominating the male gender. Similar data were found in a study on mobile APS, with prevalence of men (67.5%) and age from 28 to 48 years (95%). Likewise, the socio-demographic aspects of SAMU professionals can be evaluated, evidencing that 61.4% were male. The prevalence of men is probably associated with the characteristic of the work and the physical exertion they perform when developing their daily activities, such as movement of stretchers and excessive weight[9]. For example, it was observed in this study that all 16 rascuer drivers are male and that only three of the doctors are female. However, women are the majority in the nursing team.

Regarding professional training, the fact that a large part of the team has completed or is in undergraduate school, proves that professionals are investing in their career, seeking improvement and updating. This is most evident when one observes that 23 of them attended or are pursuing a postgraduate (specialization, masters degree), corroborating with a study that demonstrated that 40% of the team that acts in APS services are specialists and that the great majority of them specializes in urgency and emergency[10].

It was found in this study that most of the professionals have worked in SAMU for less than five years, which may be justified by the creation of the service at the end of 2006, that is, the service is still new, as in all of Brazil[1]. Still, most of them have another employment relationship, with work ranging from 40 to 60 hours per week or more. This situation is more common among physicians and rascuer drivers, whose work schedule allows the accumulation of jobs.

The predominant majority (94.8%) of professionals work in this institution because they like it, corroborating a study carried out at SAMU Natal-RN on the professional satisfaction of the nursing team, where 96.1% like and are satisfied to work in this service. The same study highlights that satisfaction with work is directly related to satisfaction with oneself and, therefore, the more satisfaction factors the greater will be the competence to provide qualified assistance[11]. Fixed and mobile APS requires trained staff, and having experienced professionals qualify the care for the patients.

Considering the professional qualification, according to the majority of the subjects the participation in courses and training is valued. However, the need for training to act in emergency situations prevails. Thus, the creation of Permanent Education Nucleus (NEP) with themes and goals to be achieved make training a strategy that develops competence in the professional to be more proactive, productive, creative and innovative. This satisfies the organizational objectives and contributes to the formation of the team to carry out the activities[12]. However, APS practitioners are warned that knowledge comes from a variety of sources, including initial training, recent courses of emergencies, experience in a specific condition, and ability to perform procedures that are required by users[3]. Therefore, dedication and continuity of studies are important to update knowledge and improve skills for a good care.

Regarding the aspects related to the structure for the service of the SAMU, the permanent education was evaluated as reasonable, denoting the need for greater investment in the training. It was observed that in the service in question there is a NEP, composed of two nurses and a nursing assistant, whose commission proposes and organizes the programming according to the lack of the service.

In the professionals' perspective, the physical structure of SAMU indicates it is sufficient, but it requires improvements, coinciding with another

study, in which the majority of professionals (71.4% doctors, 70% nursing technicians/assistants) pointed out that the physical structure is not enough, but it still does meet the demand for the service[13]. However, it is understood that the state of conservation of ambulances is acceptable, and the condition of vehicles is reasonable. The proportion of vehicle per number of inhabitants recommended by PNAU[1] is met by the municipality of Maringá. However, no spare ambulances were observed, which makes it difficult to replace those sent to repair and maintenance, assuming that this, in the view of the subjects, compromises the preservation of vehicles and impairs the care.

The physical structure is an important characteristic and must be evaluated constantly, as it influences the dynamics of stabilization of the patient's condition inside the ambulance[8]. According to the team, the comfort inside the vehicles is just reasonable, which does not meet the expectations of the professionals. The safety offered to the user inside the ambulance is considered satisfactory and adequate. Likewise, the confidence demonstrated by the team to the user during the service, indicated predominantly as satisfactory, demonstrates that professionals feel safe in providing such assistance is related to the high participation in courses and training, which contributes to improve knowledge and develop skills techniques. Emergency teams coexist with unpredictability, being vital the theoretical and practical training for greater safety in the procedures performed, greater resolution, reduction of deaths and severe injuries, and, therefore, generate satisfaction to users and staff[14].

The safety of the staff at the baseoffice (SAMU Base) was assessed as deficient. This refers to the need for greater investment for the safety of professionals. It should be emphasized that the work activity of these professionals implies great risks, such as being out on theroad, subject to trampling and violence, as well as the possibility of accidents with biological materials.

On the other hand, for the vast majority of professionals, the availability of materials for care is sufficient and adequate, as recommended by Ordinance No. 0248/GM, in relation to equipment and medicines for APS to be executed with quality[1]. Supplies are productive factors, of a physical nature, with a certain durability, used in procedures and assistance to patients[15]. Thus, it is advised at the beginning of the shift to test the material, it reinforces the institution's commitment to quality, which results in professional satisfaction, commitment and responsibility with a service of excellence[16].

In the aspects related to the work process in the SAMU, the humanization during the assistance provided by the team was considered, mainly, satisfactory and adequate, in emphasis to the right of the citizen to receive quality public health care. In 2000, the Ministry of Health created the National Humanitarian Assistance Program (PNHAH), which proposes integrated actions aimed at changing the user assistance standard in public health services in Brazil and improving the quality and effectiveness of care provided by these institutions[17]. It is worth noting that it is peculiar to SAMU to serve the user in public spaces and this seems to arouse in professionals greater concern with humanization.

The reception provided during the service, also evaluated mainly as satisfactory and appropriate, corresponds to the understanding that welcoming is a assistance- technical action, that is, a qualified listening process directed to the assistance, which implies changes in the professional-user relationship, facilitates the reorganization of services and improvement of care quality, with the patient as the main axis and activeparticipant[18].

Likewise, respect and privacy during care were evaluated as satisfactory, indicating that such care is adequate. According to the SAV-SAMU protocol, the general rules for approaching public service calls, with the press in the scene, crowds or social turbulence, requires not exposing the victim to public observation and attention when removing the clothes, not providing personal information about the case, and not to facilitate the photographing[19]. The team must follow the protocol preserving the victim and their relatives, with dignity, respect and high professionalism.

Indications prevailed that the guidelines made by the team on the procedures performed and the health status of the users are satisfactory. Furthermore, the subjects revealed that the multiprofessional articulation is satisfactory, demonstrating that this aspect is important for the synchronized execution of the teamwork process in the SAMU, reinforcing that it is an essential condition for the quality of care[8]. In order to do so, the strengthening of a good multiprofessional relationship is due to the meeting

of the team, after each service, to discuss and rethink the work process and the environment, constructing strategies collectively through a democratic management model.

According to most, the arrival time of the ambulance to the incident site is appropriate. The location of the ambulances, the number of teams, the reception of the calls and the protocols to classify calls are factors that induces the response time[19]. In summary, the structure aspects for the service of the SAMU 192 Maringá, in general, were evaluated as reasonable, except for the availability of materials and the safety showed by the staff in the attendance. This indicates that the current structure is acceptable and sufficient to attend, but it still presents elements that require investment and improvement, such as the maintenance of ambulances and SAMU facilities, so as to guarantee safety to professionals at the base office.

Faced with the aspects about work process, it is evident that what depends on the action and qualification of the professionals, the service is considered as satisfactory and adequate. It is possible, in this case, to relate the incentive of the service and personal initiatives of participation in courses and trainings main factors for the acting and performance of the team. These data corroborate with another investigation in the emergency service, in which the interviewees also evaluated positively the quality of the local structure, with emphasis on the availability of supplyand financial resources, physical structure and professional qualification[16].

It is known that the SAMU team faces several challenges and difficulties in the daily life of its activities. The relevance of the service to society is recognizable because it came to standardize and regulate a specific type of life-saving care, in which efficacy decreases morbidity and mortality rates due to trauma and violence[20]. SUS management must ensure its implementation and promote constant improvement and evaluation to adjust its operation. It is necessary to integrate the SAMU into the Emergency Care Network, promoting its consolidation and, consequently, the quality of prehospital care.

CONCLUSION

From the perspective of the professionals, the structure and process for the service of SAMU 192-Maringá, the available resources are satisfactory and sufficient, highlighting some aspects as excellent, however, they denote deficiencies that can compromise the performance and the quality of the assistance. In this sense, one of the limitations of the study was not to identify in a specific and detailed way the problems and difficulties pointed out by the professionals, so it is suggested that other studies are carried out in this direction. Finally, the evaluation of the quality of emergency mobile APS - SAMU 192, in the perception of the team, reflects a satisfactory and adequate service, with enough resources for the service, but does not contemplate the desirable infrastructure and the standard of excellence for a qualified service.

QUALIDADE DO ATENDIMENTO PRÉ – HOSPITALAR MÓVEL DE URGÊNCIA NAPERSPECTIVA DOS PROFISSIONAIS

RESUMO

Estudo com objetivo avaliar a qualidade do Atendimento Pré-Hospitalar (APH) móvel de urgência na perspectiva dos profissionais do SAMU, com abordagem quantitativa, transversal, exploratória e descritiva, realizado com trabalhadores que atuam diretamente no APH móvel. Para obtenção dos dados os sujeitos preencheram um formulário sócio demográfico e sobre a formação profissional, e o instrumento Avaliação da Qualidade de Atendimento Pré-Hospitalar (AQ-APH),composto de dois indicadores de Qualidade da Assistência (QA), estrutura e processo para o atendimento, ambos constituídos de aspectos relativos ao atendimento. As alternativas de respostas, dispostas numa escala Likert, variam de Péssimo (1) a Excelente (5), sendo quanto maior a pontuação melhora qualidade da assistência. Os resultados evidenciaram que a maioria dos aspectos sobre estrutura foi avaliada, predominantemente, entre Regular e Bom, e dos aspectos sobre processo de trabalho prevaleceu entre Bom e Excelente. Isso demonstra que a qualidade do APH móvel de urgência é satisfatória e apropriada, porém não atinge o padrão de excelência esperado, denotando-se a necessidade de mais investimentos na melhoria da infraestrutura para garantir um atendimento qualificado.

Palavras-chave: Qualidade da Assistência à Saúde. SAMU. Urgências. Profissional de Saúde.

CALIDAD DE LA ATENCIÓN PREHOSPITALARIA MÓVIL DE URGENCIA EN LA PERSPECTIVA DE LOS PROFESIONALES

RESUMEN

Estudio con el objetivo de evaluar la calidad de la Atención Prehospitalaria (APH) móvil de urgencia en la perspectiva de los profesionales del SAMU, con abordaje cuantitativo, transversal, exploratorio y descriptivo, realizado con trabajadores que actúan directamente en la APH móvil. Para recolección de los datos, los sujetos rellenaron un formulario sociodemográfico y sobre la formación profesional, y el instrumento Evaluación de la Calidad de la Atención Prehospitalaria (EC-APH), compuesto de dos indicadores de Calidad de la Atención (CA), estructura y proceso para la atención, ambos constituidos de aspectos relativos a la atención. Las alternativas de respuestas, dispuestas en una escala Likert, varían de Terrible (1) a Excelente (5), siendo cuanto mayor sea la puntuación mejor la calidad de la atención. Los resultados evidenciaron que la mayoría de los aspectos sobre estructura fue evaluada, predominantemente, entre Regular y Buena, y de los aspectos sobre proceso de trabajo prevaleció entre Bueno y Excelente. Esto demuestra que la calidad de la APH móvil de urgencia es satisfactoria y apropiada, aunque no alcance el nivel de excelencia esperado, denotándose la necesidad de más inversiones en la mejoría de la infraestructura para garantizar una atención calificada.

Palabras clave: Calidad de la Atención a la Salud. SAMU. Urgencias. Profesional de Salud.

REFERENCES

1. Ministério da Saúde (BR). Portaria n. 1864, de 29 de setembro de 2003. Institui o componente pré-hospitalar móvel da Política Nacional de Atenção às Urgências, por intermédio da implantação do Serviço de Atendimento Móvel de Urgências em municípios e regiões de todo o território brasileiro: SAMU 192 [Internet]. Brasília (DF); 2003 [citado 2013 jul 11].Disponível em: http://dtr2001.saude.gov.br/sas/PORTARIAS Port2003/GM/GM-1864.htm.

2. Brasil. Portaria nº 2048 de 5 de novembro de 2002. Diário Oficial da República Federativa do Brasil. Brasília (DF) [Internet]. 2002 nov 12 [citado 2013 dez 10]. Disponível em: http://dtr2001.saude.gov.br/samu/legislacao/leg_2048.htm.

3. Carreno I, Veleda CN, Moresch C. Características da equipe de atendimento pré-hospitalar no interior do Rio Grande do Sul. Rev Min Enferm.2015 jan-mar; 19(1):88-94.

4. Silva SF da, Ilha S, Diefenbach GD, Pereira JC. Silva SF, Lucio DBM. Dificuldades vivenciadas em um serviço de atendimento móvel de urgência: percepções da equipe de enfermagem. Rev Enferm Cent.-Oeste Min. 2014 maio-ago; 4(2):1161-72.

5. Donabedian A. The definition of quality and approaches to its assessment. Explorations in Quality Assessment and Monitoring. Chicago: Health Administration Press; 1980.

6. Donabedian A. The quality of care: how can it be assessed? J Am Med Assoc. 1988 Sep.; 260(12):1743-8.

7. IBGE. Normas de apresentação tabular. 3ª. ed. Rio de Janeiro;2012.

8. Dantas RAN, Torres GV, Salvetti MG, Dantas DV, Mendonça AEO. Instrumento para avaliação da qualidade da assistência pré-hospitalar móvel de urgência: validação de conteúdo. Rev Esc Enferm USP. 2015; 49(3):381-7.

9. Zapparoli AS, Marziale MHP. Risco ocupacional em unidades de Suporte Básico e Avançado de Vida em emergências. Rev Bras Enferm [Internet]. 2006 [citado 2017 jan 25]; 59: 41-6. Disponível em: http://www.scielo.br/scielo.php?pid=S0034-71672006000100008&script=sci_arttext.

10. Romanzini EM, Bock LF. Conceptions and feelings of nurses working in emergency medical services about their professional practice and training. Rev Latino-Am Enfermagem. 2010;18(2):108-12. Inglês, Português, Espanhol.

11. Campos RM, Farias GM, Ramos CS. Satisfação profissional da equipe de enfermagem do SAMU/Natal. Rev Eletr Enf [Internet].2009[citado 2017 jan 25];11(3):647-57. Disponível em: http://www.fen.ufg.br/revista/v11/n3/v11n3a24.htm.

12. Lemos MC, Passos JP. Satisfação e frustração no desempenho do trabalho docente em enfermagem. REME: Rev Min Enferm. 2012; 16(1):11-7.

13. Silva JG, Vieira LJES, Pordeus AMJ, Souza ER, Gonçalves MLC. Atendimento pré-hospitalar móvel em Fortaleza, Ceará: a visão dos profissionais envolvidos. Rev Bras Epidemiol [Internet]. 2009 [citado 2017 jan 25];12(4):591-603. Disponível em: http://www.scielo.br/pdf/rbepid/v12n4/09.pdf.

14. Santos MC, Bernardes A. Comunicação da equipe de enfermagem e a relação com a gerência nas instituições de saúde. Rev Gaúcha Enferm. 2010 jun;31(2):359-66.

15. Garcia SD, Haddad M do CL, Dellaerosa MSG, Costa DB da, Miranda JM de. Gestão de material médico-hospitalar e o processo de trabalho em um hospital público. Rev Bras Enferm. 2012 mar-abr; 65(2): 339-46.

16. Silva LG, Matsuda LM, Waidman MAP. A estrutura de um serviço de urgência público, na ótica dos trabalhadores: perspectivas da qualidade. Rev Enferm. 2012 abr-jun; 21(2): 320-8.

17. Barbosa GC, Meneguim S, Lima SAM, Moreno V. Política Nacional de Humanização e formação dos profissionais de saúde: revisão integrativa. Rev Bras Enferm [Internet]. 2013 [citado 2017 jan 1];66(1):123-7. Disponível em: http://www.scielo.br/pdf/reben/v66n1/v66n1a19.pdf.

18. Bellucci Júnior JA, Matsuda LM. Implantação do Sistema Acolhimento com Classificação e Avaliação de Risco e uso do Fluxograma Analisador. Rev Enferm. 2012 jan-mar; 21(1): 217-25.

19. São Paulo. Prefeitura Municipal. Secretaria Municipal da Saúde. Protocolos de atendimento Pré-Hospitalar. Suporte Avançado à vida. São Paulo; 2012.

20. Duarte BRA, Freitas DM de, Santana JCB. Atendimento pré-hospitalar: percepção de docentes de enfermagem diante do atendimento com múltiplas vítimas. Rev Enferm UFPE. 2009 abr-jun;3(2):230-6.

Corresponding author: Talita Lopes Garçon, Rua São João, nº 124, apto 403. CEP. 87030-200. Zona 07, Maringá-PR. Celular: (44) 99965-8477. Email – tallitalopesgarcon@hotmail.com

Submitted: 22/04/2017
Accepted: 12/12/2017