

Primary care users' perceptions of waiting room ambience

Percepções de usuários da atenção primária sobre a ambiência da sala de espera

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Abstract

Introduction: The waiting room is an environment where health care service users and their companions spend a relatively long time, and its structure can impact the well-being of individuals in such settings. The aim of this study was to identify the perceptions of users at a Basic Health Unit (BHU) in Blumenau, Santa Catarina, regarding the waiting room. Additionally, we compared the structure of this environment, the users' perceptions, and the guidelines outlined in the Physical Structure Manual for Basic Health Units. **Materials and methods:** An adapted instrument from previous studies, tailored to the needs of this research, was administered to 80 users who were waiting for service in the waiting room. **Results:** It is noteworthy that 93.75% of users considered a space for children's amusement important. Almost half of the users (42.5%) mentioned being accompanied by children or babies at the BHU. The majority of users (97.5%) reported the availability of seating, but 70% rated the number of seats as insufficient. The waiting time was rated as good by 17.5% of participants, reasonable by 53.75%, and bad by 28.75%. **Discussion:** While the waiting room conditions partially meet the guidelines outlined in the Manual of Physical Structure for Basic Health Units in terms of structural aspects, users perceive additional structural needs that are not included in this instrument. **Conclusion:** In terms of processes, there is a need to make better use of the waiting room by proposing activities that contribute to welcoming and humanization.

Keywords: humanization of assistance; primary health care; structure of services

Resumo

Introdução: A sala de espera é um ambiente de permanência relativamente longa nos serviços de saúde. Sua estrutura pode impactar sobre os níveis de bem-estar de usuários e acompanhantes. O objetivo do presente estudo foi conhecer as percepções de usuários de uma Unidade Básica de Saúde de Blumenau/Santa Catarina sobre a sala de espera. A estrutura e a percepção dos usuários foram comparadas às diretrizes do Manual de Estrutura Física das Unidades Básicas de Saúde. **Materiais e métodos:** Um instrumento adaptado de estudos prévios foi aplicado a 80 usuários em espera de atendimento. **Resultados:** Entre estes: 93,75% consideraram importante um espaço para recreação de crianças; 42,5% afirmaram comparecer acompanhados de crianças ou bebês à UBS; 97,5% afirmaram haver locais para sentar-se, porém 70% consideraram a quantidade de assentos insuficiente. Quanto ao tempo de espera: 17,5% classificaram como bom; 53,75% como razoável e 28,75% como ruim. **Discussão:** As condições da sala de espera atendem ao Manual de Estrutura Física das Unidades Básicas de Saúde nos aspectos estruturais, entretanto os usuários percebem necessidades estruturais que não constam nesse instrumento normativo. **Conclusão:** Na dimensão dos processos, há necessidade de um melhor aproveitamento da sala de espera com a proposição de atividades que contribuem para o acolhimento e humanização..

Palavras-chave: humanização da assistência; atenção básica em saúde; estrutura dos serviços

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Introduction

The concept of *ambiance*, which originates in architecture, aims at the well-being of human beings in an enclosed space. In the context of healthcare, the National Humanization Policy (NHP) determines that in services, at all levels of complexity, the *ambiance* must not only be comfortable but also welcoming and conducive to social interaction¹.

The concern to offer an improvement in care precedes the specialized consultation; it starts when the user makes contact with the Basic Health Unit (BHU). The waiting room is an environment where users of health services and their companions spend a relatively long time. Its structure can impact the well-being levels of users, considering that human beings receive stimuli from the environment, which can affect their comfort, and, in turn, influence their behavior².

In this way, the waiting room must provide suitable levels of sensory stimuli to ensure that the stay in this room is comfortable, rather than merely tolerable. Furthermore, this stay can serve as an opportunity for health promotion activities. An environment that promotes well-being, health, and education aligns with the principles of the NHP, particularly when it meets the specific demands and needs of the individuals who pass through it. Each community has its own unique characteristics in terms of social, economic, educational, and cultural aspects¹.

The Manual of Physical Structure of Basic Health Units (MPSBHU) determines that aspects such as lighting, thermal comfort, and noise must be periodically evaluated to maintain the quality of the environment for both users and the healthcare team. When referring to *ambiance*, the manual addresses the presentation and organization of physical

and architectural spaces, the presence of technologies, as well as visual, olfactory, and auditory stimuli. It also specifies various structural characteristics, including ventilation, lighting, floors, walls, roofing and finishing materials, flow of people and materials, doors, windows, lavatories, sinks, countertops, cupboards, shelves, and signage. However, it provides several considerations regarding these structures: a) for ventilation, it emphasizes the need for proper ventilation in all areas of the BHU that must have windows (preferably made of durable materials) or some equipment that circulates the air; b) the environments should be well-lit, with a preference for natural light; c) the walls must be smooth and washable, while the floors should have a firm and non-slip surface; d) the physical structure should allow access for people with disabilities; e) the doors must be coated with washable material; f) cupboards and shelves should have a smooth and easy-to-clean surface; g) there must be signage in the environments, which can be done through texts or figures (visual), characters in relief, Braille, or raised figures (tactile), as well as auditory resources (sound)³.

It is important to note that MPSBHU (Manual of Physical Structure of Basic Health Units) does not impose standardization of BHU structures, but rather aims to assist municipalities that face challenges in defining these structural issues. Each space should be adapted to the local reality, taking into consideration the expected number of users and facilitating access for trainees from educational institutions as part of their learning routine³.

Understanding the environmental factors that influence well-being is the focus of studies in various fields of knowledge, including Psychology, Architecture, Ergonomics, among others. These studies have contributed to the development of humanization guidelines in healthcare facilities worldwide⁴. The standardization of structures provides guidelines for creating welcoming spaces



with balance and harmony, taking into account the contributions of arts, accessibility, lighting, color, and cultural values⁵.

According to the size of the BHU, it is recommended to plan for more than one waiting room. If there are multiple teams, the space can be integrated with the reception. In the case of having two ESF teams in the same establishment, the waiting room should be able to accommodate approximately 30 people³. The BHU examined in this study has a waiting room integrated with the reception and two ESF teams. Team I serves 4,323 users, while Team II serves 3,927 users, resulting in a total of 8,250 users.

The consideration, by the healthcare and management teams, of the users' perceptions regarding the ambience at the BHU aligns with the practices of co-responsibility and protagonism in the SUS (Unified Health System). This study aimed to explore the perceptions of users at a BHU in Blumenau, Santa Catarina (SC), regarding the waiting room. Furthermore, it compares the structure of this environment with the set of user perceptions based on the MPSBHU (Manual of Physical Structure of Basic Health Units) guidelines³.

Materials and methods

Cross-sectional, quantitative study. Data collection was conducted between May and August of 2014, during both morning and afternoon sessions, with a sample of 80 users from a Basic Health Unit (BHU) in Blumenau, SC. The selection criteria included being present in the waiting room, waiting for assistance at the time of data collection, and agreeing to participate in the study.

The instrument used for data collection was a questionnaire adapted from those presented by Quintino⁶ and Sousa⁷, taking into account the dimensions outlined in Chart 1. In the modified instrument, the response options were changed to "Present

/ Absent" or "Present / Absent / I don't know." When respondents were asked about the conditions of any of the dimensions, the response options were "Good / Reasonable / Bad," and for the question about waiting time, the response options were "Short / Reasonable / Excessive." In some questions, the option "Do you consider it important?" was included, and the answer options were "Yes" and "No." In the ventilation/thermal control item, for users who indicated the presence of ventilation equipment, an additional descriptive question was added: "Which ones?"

A question regarding the implementation of health education activities in the waiting room was also included in the questionnaire. It aimed to gather information about whether any activities were conducted, which ones specifically, and if the user participated, their thoughts and reasons for participation. Two additional open-ended questions were incorporated into the instrument: "What do you think should be present in this waiting room that you cannot find?" and "What areas do you believe need improvement in the waiting room?"

Initially, individually, users who were in the waiting room were invited to participate in the research by answering the questionnaire. Those who agreed to participate in the study were directed to a specific chair present in the room itself, with a desk in front of it, positioned in such a way as to allow observation of the entire environment. Once seated, they read and signed the Informed Consent Form (TCLE) together with the researcher sitting next to them. Afterward, they responded to the research instrument, reading it together with the researcher, who recorded each response on the Likert scale.

The results were analyzed using descriptive statistical tools and non-parametric statistics, since the data were collected through scales of nominal and ordinal levels of measurement⁸. The open-ended questions from the instrument were



categorized, and the response frequencies were recorded. The research protocol was approved by the Ethics Committee for Human Beings of the Fundação Universidade Regional de Blumenau under certificate number 21197213.2.0000.5370.

Results

The participants in this research were between 19 and 67 years old, consisting of 24 men and 56 women. Among them, 21.25% had incomplete primary education, 17.5% completed elementary education, 10% had incomplete secondary education, 40% completed secondary education, 3.75% had incomplete higher education, 6.25% completed higher education, and 1.25% were post-graduates. Most users (56.25%) visited the BHU (Healthcare Unit)

occasionally, 32.5% visited monthly, 6.25% visited weekly, and 5% visited daily. As for the type of care, 38.75% had scheduled appointments, and 61.25% required urgent care. 40% of users had a defined appointment time, while 60% did not have a defined appointment time. Out of the 80 users, 42.5% said they visited with a child or baby, and 57.5% visited alone.

Table 1 shows the percentages of responses given by users on the items of signage, accessibility, and adjacent environments. Accessibility for people with disabilities was evaluated positively by most users, but many were unable to answer. Nevertheless, there is wheelchair access and a bathroom adapted for people with disabilities at the BHU. However, two users highlighted in the open questions that there is no handrail for the elderly to support themselves when moving around the space.

Table 1: Percentages of responses given by participants on: signs, accessibility, and adjacent environments. Blumenau - SC - 2014.

Category	Presence	Absence	I don't know
Signage for rooms and offices	57,50	28,75	13,75
Accessibility for people with disabilities	47,50	21,25	31,25
Changing room	42,50	18,75	38,75
Children's bathroom	10	60	30
Attached bathroom	91,25	7,75	--
Employee identification	76,25	23,75	--
Space for children's recreation	16,25	83,75	--
Disease prevention information	82,5	17,5	--

In the category regarding the changing room, the data obtained may reflect the users' lack of knowledge regarding the non-use of this service. In the open questions, it was observed that two users highlighted the need for a changing room in the men's bathroom, as it is only available in the women's bathroom.

The questions about the "attached bathroom" and "information on disease prevention" had the options "Present" or "Absent". For the items "attached bathroom", "bathroom for children", and "space for children's recreation", there was a question regarding whether users

considered these items important or not. All users considered a bathroom attached to the waiting room important. There is a female and a male bathroom attached to the waiting room, both with two toilets, one of which is adapted for individuals with disabilities, featuring grab bars and an elongated door.

The "bathroom for children" and the "space for children's recreation" were considered important. It is noteworthy that eight users mentioned the recreation space in their discursive responses, and almost half of the interviewees stated that they come to the BHU accompanied by children or babies.

In the category "information on disease prevention," most users considered it present. The waiting room has posters on health education and disease prevention. Two users highlighted the importance of having more health education posters in the open-ended questions. One user suggested showing educational videos on the TV in the waiting room, and another user asked for the removal of posters containing strong scenes related to diseases. A small portion of users mentioned that some health education activities took place in the

waiting room. When asked about these activities, three users mentioned a group for pregnant women, two users mentioned lectures by professionals, one user mentioned the distribution of information, and one user mentioned the existence of posters about health promotion in the waiting room. None of the users claimed to have participated in these activities.

Table 2 shows the percentages of responses given by users regarding equipment and furniture.

Table 2: Percentages of responses given by participants on: equipment and furniture. Blumenau - SC - 2014.

Category	Presence	Absence
Audiovisual equipment	100	0
Places to sit	97,5	2,5
Trash cans	38,75	61,25

All participants considered the audiovisual equipment present in the waiting room, and the majority considered this equipment to be good **in condition**.

The number of seats was assessed as insufficient by most respondents. In the open-ended questions, 10 users pointed out the need for improvement in seating conditions, while 13 users suggested the addition of more seats. It was observed that during the morning period, which experiences higher user demand, the available seats were insufficient, and some people had to wait standing up. Some of the benches at the BHU are made of wood. When the waiting time is relatively long, the

comfort of the seating **is** reduced due to the aforementioned factors. In the open-ended questions, 10 users indicated that the service should be faster. It is noteworthy that 60% of the consultations did not have a defined time.

Most users did not consider the presence of a trash can in the waiting room. However, there is a trash can **be** available in the BHU waiting room. It is worth noting that the trash can is located next to the drinking fountain, which may make it difficult for users to access it easily.

Table 3 shows the percentages of responses given by users regarding the conditions of physical properties.

Table 3: Percentages of responses given by participants about physical properties. Blumenau - SC - 2014.

Conditions	Good	Reasonable	Bad
Lighting	96,25	3,75	0
Noises	58,33	33,33	8,33
Thermal comfort	56,25	40	3,75
Physical space	53,75	40	6,25
Waiting room	43,75	48,75	7,5
Clean and painted walls	31,25	55	13,75

The lighting was considered good by most users. The BHU waiting room has

10 lamps, a wide entrance door, and a window to enhance natural lighting.



Thermal comfort was rated as good by just over half of the respondents. In the waiting room, there is a window and a wide entrance door that is always open, as well as air conditioning and a fan.

In the physical space category, four users stated during the descriptive questions that the waiting room should be larger.

According to Table 3, the walls were considered to be in reasonable conditions of cleanliness and suitability by most users. The cleanliness conditions of the BHU were referred to as good by most users.

Discussion

The discussion will follow the order of the response categories presented in the results, relating the findings to the MPSBHU and what the current literature discusses on the subject.

Signage for rooms and offices, mentioned as present by most users, consisted of written signs, which can pose a challenge for illiterate users who may not be able to benefit from the guidelines provided. The MPSBHU suggests the use of international symbols to indicate furniture, rooms, and bathrooms³. It is well-known that in order to create a conducive environment, effective signage is necessary to enhance user autonomy, whether through tactile, auditory, or visual means, thereby reducing the risk of disorientation². In this case, Braille signs could be implemented, along with the identification of universally recognizable designs in the environment.

Accessibility is referred to as both the possibility of reaching a place and the perception and understanding required to safely and autonomously navigate buildings and facilities⁵. For a BHU with two ESF teams, it is recommended to have a bathroom for people with disabilities, although this item is not mandatory³. When a healthcare facility does not meet ideal standards, such as lacking horizontal bars in the bathrooms or having only steps at the entrance, these elements are considered architectural barriers that can hinder people

with disabilities from accessing healthcare services⁹. The BHU researched has wheelchairs, bathrooms for individuals with disabilities (both male and female), and a ramp at the entrance, which are basic aspects of environmental accessibility.

The MPSBHU does not specifically describe the presence of a changing room, but it suggests that a BHU with two teams should have two toilets for the users³. However, in the surveyed BHU, the changing room is only available in the women's bathroom, which can potentially cause embarrassment for a father who visits the facility alone with his child and needs to change their diaper.

The MPSBHU does not explicitly mention the need for a space for children's recreation. However, the guideline of humanization encourages innovation to foster closer relationships between users and staff¹. Additionally, most users considered this item to be important. The use of a toy library has been extensively studied, particularly in hospital and inpatient settings¹⁰⁻¹¹⁻¹². It is important to expand the concept of play for health promotion in primary care as well, as it can help reduce the potential stress of waiting and serve as a resource for the healthcare team in the treatment of children.

Only a few activities in the waiting room were described by the research participants. A small portion of the users considered the waiting time to be good. Therefore, implementing activities specifically designed for this population could be effective in making better use of this time. By optimizing the waiting time and planning educational activities in healthcare, it promotes interaction and facilitates the internalization of knowledge, which can lead to potential changes in harmful habits among individuals¹³⁻¹⁴.

Waiting rooms end up reflecting current social issues and power relations and can be used as a public space for solidarity, dialogue, and awareness-raising education, encouraging change and fostering active citizenship¹⁵. The ambiance



is also closely related to the people (1). Thus, activities can go beyond lectures and the distribution of pamphlets. It is possible to create groups and implement actions aimed at empowering the users on relevant health issues¹⁶⁻¹⁷⁻¹⁸.

People who are waiting for care initially do not know each other or have any established connections. However, activities can be implemented by the health team, fostering a dialectical exchange between popular knowledge and professional expertise¹⁸. While waiting, users often discuss their anxieties and the quality of the service. In this context, health education activities during the waiting period can help alleviate anxieties related to clinical care, serving as opportunities for users to express themselves and communicate with others¹⁹. These moments can even strengthen the bond between the healthcare team and the local population²⁰.

In the researched waiting room, there was a TV and a stand for it. These items are considered essential for healthcare facilities³. It was observed that the TV was always on, broadcasting open channels, during the data collection period. However, these channels may not be of interest to users²¹ or even induce stress, such as news programs²². The TV can be utilized as a tool for promoting health education activities. Making educational videos and documentaries available to users who are waiting for care can enhance their waiting experience and provide valuable health-related information.

For a BHU (Basic Health Unit) with two ESF (Family Health Strategy) teams, the waiting room must be able to hold approximately 30 people. Places to sit and a trash can are essential items for the waiting room³. In the BHU study, the waiting room holds 30 users, but not all of them are seated, which can affect comfort depending on the waiting time and the reason for coming to the service. It is important that there are enough chairs, as well as that they are large enough to support any type of body, upholstered, made of durable

materials, and easy to clean. These factors significantly improve the waiting experience²¹.

In order to provide good conditions for staying in a place and ensure environmental comfort, other sensory aspects are sought, such as temperature, ventilation, and light. These factors affect the habitability condition, as well as noise, which mainly impacts emotional issues and behavior⁵. It is recommended that all spaces be well-lit, incorporating as much natural lighting as possible. It is also essential for BHUs to have windows or ventilation tools to ensure air circulation³. Lighting, which is considered good by most users, directly influences well-being, by providing visual and psychological comfort, as well as contributing to safety in clinical environments²³. Thermal comfort is another factor that influences well-being. Since the data collection was carried out between May and August, when the climate was not hot, it may explain the positive results in this category. However, it is important to note that the waiting room only has one air conditioner. Based on the findings, it is suggested that the physical space of the BHU could be larger to accommodate more chairs and allow for better air circulation during peak demand.

According to MPSBHU, floors and walls must be washable and have a smooth surface. In addition, ease of cleaning is a structural feature that must always be observed³. The cleanliness and equipment in the waiting room make a good first impression on users, generating trust²¹. The BHU meets the cleanliness standards, but the painting of the walls could be improved, according to the users.

Conclusion

The methodological difficulty in evaluating the ambience specifically in the waiting room is evident, as there are no standardized instruments available for this analysis in MPSBHU. It is recommended to

develop an instrument to ensure a standardized evaluation of the ambience. Some dimensions evaluated in the present study are not mentioned in MPSBHU, including space for children's recreation, disease prevention information, conducting health education activities, and having a changing room and bathroom for children. These aspects have the potential to enhance the humanization of the environment.

It is considered that studies on ambience should consider the perception of those who use the environment and contribute to the health team in order to improve both the architectural aspects and the actions developed in the waiting room.

The waiting room of the researched BHU partially met the MPSBHU guidelines in structural aspects, although all items were present, such as lighting, noise, thermal comfort, and physical space, presenting a good ambience in these areas, and with greater acceptance by users.

It reinforces that ambience, in addition to the physical space, is also the

creation of a welcoming place that allows people to connect. At the researched BHU, few activities took place in this sense.

It is recommended to develop several activities that contribute to the principles of the NHP: groups, lectures, and the delivery of guidance material, the exhibition of educational videos, and recreational activities with children. These actions, in addition to encouraging the appropriation of knowledge, strengthen the relationship with the multidisciplinary team.

In summary, the qualification of ambience goes beyond the physical structure, requiring the planning of activities in the waiting room that must consider **the** characteristics of the territory and the subjects based on their social, cultural, life, and health demands. This effort must involve the team and management from the perspective of Permanent Education for the development of appropriate skills, competencies, and attitudes.

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Check I: Dimensions assessed in the modified instrument on ambience.

Quintino (2008)	Sousa (2010)	Common dimensions
Accessibility for people with disabilities	Electrical installation safe for children	Signage for rooms and offices
Attached bathroom	Space for children's recreation	Noise and ventilation
Waiting room	Trash bins and children's bathroom	
Places to sit		
Audiovisual equipment		
Lighting		
Physical space		
Cleaning conditions		
Waiting time		

How to cite this article:

Hafemann EA, Nunes CRO. Primary care users' perceptions of waiting room ambience. *Rev. Aten. Saúde*. 2023; e20238966(21). doi <https://doi.org/10.13037/ras.vol21.e20238966>

