



Journal of Nursing  
Revista de Enfermagem  
UFPE On Line

ISSN: 1981-8963

## ORIGINAL ARTICLE

IMPLICATIONS OF THE PHYSICAL STRUCTURE OF FAMILY HEALTH UNITS IN  
WORK DYNAMICSIMPLICAÇÕES DA ESTRUTURA FÍSICA DE UNIDADES DE SAÚDE DA FAMÍLIA NA DINÂMICA  
DO TRABALHOIMPLICACIONES DE LA ESTRUCTURA FÍSICA DE UNIDADES DE SALUD DE LA FAMILIA EN LA  
DINÁMICA DEL TRABAJO*Bruna Riechel Strehlow<sup>1</sup>, Rosane Teresinha Fontana<sup>2</sup>*

## ABSTRACT

**Objective:** to analyze the physical structure of the Family Health Strategy units and its implications for the work dynamics. **Method:** evaluative research, of qualitative approach, accomplished through simple observation, systematic observation and interviews with employees of the nursing team in the second half of 2014. Data from the interviews and observation were analyzed using thematic analysis. The study complied with the ethical principles for research on humans. **Results:** on the analysis of interviews and observation, it can be inferred that the physical structure has non-conformities with the law. **Conclusion:** it was found that professionals are dissatisfied with the physical structure, which directly influences the dynamics of their work. **Descriptors:** Architecture of Health Care Facilities; Environment of Health Institutions; Occupational Health; Family Health.

## RESUMO

**Objetivo:** analisar a estrutura física das unidades de Estratégia de Saúde da Família e suas implicações na dinâmica do trabalho. **Método:** pesquisa avaliativa, de abordagem qualitativa, realizada por meio de observação simples, observação sistemática e entrevistas com os trabalhadores da equipe de enfermagem, no segundo semestre de 2014. Os dados das entrevistas e da observação foram analisados mediante análise temática. O estudo respeitou os preceitos éticos para a pesquisa em seres humanos. **Resultados:** diante da análise das entrevistas e da observação, pode-se inferir que a estrutura física possui inconformidades legais. **Conclusão:** constatou-se que os profissionais estão insatisfeitos com a estrutura física, o que influi diretamente na dinâmica do seu trabalho. **Descritores:** Arquitetura de Instituições de Saúde; Ambiente de Instituições de Saúde; Saúde do Trabalhador; Saúde da Família.

## RESUMEN

**Objetivo:** analizar la estructura física de las unidades de Estrategia de Salud de la Familia y sus implicaciones en la dinámica del trabajo. **Método:** investigación evaluativa, de enfoque cualitativo, realizada por medio de observación simple, observación sistemática y entrevistas con los trabajadores del equipo de enfermería, en el segundo semestre de 2014. Los datos de las entrevistas y de la observación fueron analizados mediante análisis temático. El estudio respetó los preceptos éticos para la investigación en seres humanos. **Resultados:** frente al análisis de las entrevistas y de la observación, se puede inferir que la estructura física posee inconformidades legales. **Conclusión:** se constató que los profesionales están insatisfechos con la estructura física, lo que influye directamente en la dinámica de su trabajo. **Descriptor:** Arquitectura de Instituciones de Salud; Ambiente de Instituciones de Salud; Salud del Trabajador; Salud de la Familia.

<sup>1</sup>Resident nurse, Multidisciplinary Residency Program Integrated with Elderly Health, University of Passo Fundo. Passo Fundo (RS), Brazil. E-mail: [brunariechel@hotmail.com](mailto:brunariechel@hotmail.com); <sup>2</sup>Nurse, PhD Professor in Nursing, Graduate and Postgraduate Courses, Universidade Regional Integrada do Alto Uruguai e das Missões/URISAN - Santo Angelo Campus. Santo Angelo (RS), Brazil. E-mail: [rfontana@urisan.tche.br](mailto:rfontana@urisan.tche.br)

## INTRODUCTION

The Family Health Strategy (ESF), established in 1994, is the gateway to the National Health System whose scope covers the organization and strengthening of primary care. With the proposed substitutive change of the traditional model of this type of care and focused on improving the living conditions of people, the ESF are empowered to solve 85% of the health problems of a community, which must be structurally prepared and have human resources needed for these activities. It is noteworthy that the ESFs deal with a population of four thousand people, therefore, they need to have an adequate space for professionals to perform their activities.<sup>1</sup>

The unit consists of professionals, including nurses, responsible for the development of numerous activities in order to intervene in the health-disease process; promote social control; focus on groups and risk factors; perform comprehensive and continuous basic care activities for the community; implement health policies, initial care in emergency care and development of intersectoral actions aimed at promoting health, among others.<sup>1</sup>

The nurse is an effective member of the multidisciplinary team of the ESF with social recognition and especially for being an active subject in the process of consolidation of this strategy as integrative and humanizing health policy.<sup>2</sup> The specifics of their activities encompass the development of comprehensive care, actions for promotion and protection of health, prevention of diseases, diagnosis, treatment and rehabilitation.

Assisting in the planning and evaluation of the physical structure of health facilities contributes to the organization of care in ESF, which justifies the study. Besides, gathering elements to discuss the adequacy of the ESF to the health legislation regarding the physical structure and discussing whether the conformation favors meeting the needs of service users and work dynamics provides health and safety of users and workers.

For these activities to be developed effectively, the physical structure should consider the work dynamics and the flow of people in and out of the unit. The Ministry of Health proposes that the structure complies with the current legislation for the construction and renovation of architectural projects and suggests its distribution in four levels, covering, respectively, reception and waiting rooms, doctors' and nursing offices, procedures and support offices.<sup>1</sup> The physical environment of an ESF should be cozy and

spacious, both for users and for health workers, with a view to a healthy environment.

In addition, inadequate physical structure of health services, as pointed out in a study, can act as a generator of conflict and subsequent violence against workers, which may occur due to the clustering of patients and decreased defensible space.<sup>3</sup> Working conditions, including the environment, can influence the worker positively or negatively, bringing appreciation or depreciation of them.<sup>4</sup> It is worth remembering that working conditions cover not only physical aspects, but interpersonal working conditions, social aspects and workers' perspectives.<sup>5</sup>

The objective of this study was to analyze the physical structure of the Family Health Strategy (ESF) units and its implications for the work dynamics.

## METHODOLOGY

This is an evaluative research with qualitative approach, designed to find out whether a practice or policy is functioning properly<sup>6</sup>. The study was conducted at the Family Health Strategies of a city of Rio Grande do Sul state. In all, nine ESF participated in the study, and these were composed of nine nurses and nine nursing technicians.

The research was conducted in the second half of 2014. The data were collected through an interview with the workers of the nursing staff and through simple and systematic observation. Simple observation was recorded in a field diary and made in 1 hour periods. Systematic observation was made from an instrument developed by the researchers, composed of a script of elements to note about the physical structure, grounded in the Manual of Physical Structure of basic health units: family health and its ground plan. It is appropriate to point out that the study did not intend to evaluate the physical area and dimensions according to the recommended ground plan.

The study was based in items 5 and 6 of the aforementioned Manual<sup>1</sup>, on structural characteristics as for the Ambience, Ventilation, Lighting, Floors and Walls, Roofing, Finishing materials, Flow of people and materials, Doors, Windows, Washbasin and sinks, Countertops, cabinets and shelves, Exterior, Signaling and, on some considerations of the environments that integrate the Family Health Unit, which involve: Meeting room, Community Health Workers' Room, Stockroom, Pharmacy, Outpatient Clinic, Service room, Doctor's

Strehlow BR, Fontana RT.

Implications of the physical structure of...

offices, Procedures Room, Vaccines Room, Collection Room, Nebulization Room, Dressing Room, Dental Services Room, Teeth-brushing area, Compressor and Pump Area, Support Room, Bathrooms, Kitchen and pantry, Cleaning area and Cleaning Material storage room, Sterilization and Supply Center, Utilities Room, Waste storage and Solid Waste Shelter.

Data from interviews and observation were analyzed by using thematic analysis.<sup>6</sup> The project was approved by the Ethics Committee of the Universidade Regional Integrada do Alto Uruguai e das Missões, Santo Angelo campus / RS, under opinion No. 475876. Subjects received an Informed Consent Form (ICF) and the person responsible for the municipal health management received a Declaration of Co-participant Institution. The study complied with the ethical principles recommended for research on human subjects. Authors chose to nominate the units by alphabetical letters and numbers for participants.

## RESULTS

A total of 18 participants were interviewed, of which 89% were women, eight were nurses and 10 were nursing technicians. Interview data were collected in nine ESF in the municipality and the data from observations were collected in eight ESF, as one unit was under renovation. It is noteworthy that the observation was discussed based on the Manual of Physical Structure of Basic Health Units: family health, in items 5 and 6.<sup>1</sup>

### ♦ The physical structure and the interface with the work dynamics and care to users

Data collected showed that nursing workers are not satisfied with the physical structure of the ESF. The vast majority of respondents said that the physical space was small, the number of rooms, furniture and materials was deficient, hampering the dynamics of nursing work. Some professionals said that often needed to bring materials from their home and spend their own money to develop their activities and improve the ESF conditions. Also, difficulties about access to toilets for workers and disability in the cleaning process have been reported in the unit.

*The space is very small, the outpatient clinic and the reception are very small. There is no meeting room, waste storage, kitchen. There is no room to wash and store cleaning supplies. It [the health unit] is cozy, but it is small. There is no bathroom for professionals; we have to go in that bathroom inside my room, where women*

*change for the Pap smear test. We also store cleaning materials in the bathroom and it makes it difficult for them, too (Nurse 6).*

*We should have a bathroom for the employees; we have to go in the patients' bathroom. [...] The vaccine room is small. The sink we use to wash the breakfast dishes is the same used to wash the cloths to clean the ESF floor; it should be separated. In my room, there are many materials on the stretcher, there is no place, it is very tight. In the doctor's room is also like this (Nurse 3).*

The observations allowed validating the reports about the poor working conditions of the nursing team as for the physical structure of the units, a situation that hindered the organization of work. All the reception rooms were attached to the waiting room. Many of them had one or two chairs for professionals sit while filling the care records, and they took turns to sit. Chairs were mostly in bad conditions of use. Some units had no vaccines room and, among those who had, only one was located on the unit's doorway, as recommended by the manual. None had sink and faucet that allow using them without touching with hands.

A few units had utilities room; in others the bathroom used by patients and professionals was the same. Five units had area for cleaning material storage. In one of the units, this area was together with the kitchen.

None of the units had records room, administration / management, meeting room and room for community health workers. In all units, the file with the records was located at the front desk, which diverges from the recommended by the manual. Most of the units had pantry and kitchen for the team, but small, that allowed the entry of one or two people at a time. In this environment, there were not always chairs and tables. In just two units the space was favorable for having snacks and only one unit had lounge, computer, television and chairs.

In five units, there was only one bathroom for patients, not separated by gender, except for one; in three, the patients' bathroom was used also for contaminated waste storage or other materials; in most units, professionals' bathroom was located inside the nurse room, also used by users who undergone the Pap smear. In one, the "stockroom" was located inside this bathroom. In only two units, the bathroom was exclusive for the team. Only one unit had stockroom. The drugs were stored in the nurse's room in the outpatient clinic and in the reception.

It is important to highlight the disbelief of a professional front to the attention of managers regarding workers' requests on the necessary reforms.

*The outpatient clinic, where we prepare medications and dressings, is small, but we adapt to the space; there is no use in dreaming, they will never fix it; this has been like this for years (Nursing technician 1).*

Much of the ESF nurses reported having room for nursing consultation, however this was not exclusive. The room was also used for meetings with community health workers and other activities with the team.

*Yes, but it is not exclusive. It is used as team room (Nurse 9).*

*It is not exclusive. It is used for meetings. But I do the tests, but it is not exclusive. If I am performing a consultation, my colleagues cannot use the bathroom (Nurse 6).*

It was observed, as for the number of medical offices, that six units had three offices and two, four offices. The offices, in most of the units, were shared by doctors and nurses. The offices had gynecological table, but not all had a private bathroom. As for dental care, all had dental office. In one of them, the dentist's chair was in poor condition. In the same place where the team applied the medication, they performed dressings.

*The medication is in my room and the doctor's office. Sometimes, we have to do Pap smear and there is medical appointment and the user cannot do it or needs to wait [...]. Another problem is the outpatient clinic, there we apply drugs and at the same time carry out dressings, the user is very exposed. It is at the dirty and clean area. The waiting room is also very tight (Nurse 1).*

The speeches of professionals demonstrated the difficulty in performing reception and humanization; there was no room to host users. Accessibility for people with disabilities was not guaranteed.

*There is no way we can give individual attention; we have to do in front of others. Sometimes the patient needs differentiated service and to know what they want, we end up exposing the patient, it is complicated. We schedule the appointments, the dentist and I, not to cause tumult. But in the medical consultations ... the unit gets crowded. In the group day, it is impossible to give guidance, they stay in the waiting room, it is a lot of people (Nurse 6).*

*Yes, for example, if there was a ramp, we could have done the Pap smear of a wheelchair user a long time ago (Nurse 3).*

It was found that of the eight ESF, six had a cozy atmosphere. It was observed that only one unit had public telephone, as recommended in the manual. This is a significant fact, since the team had to use their own cellphones to communicate and / or to activate other services, including emergency care.

In line with the accessibility requirements, all the door handles were lever type. Few units had toilet adapted for people with special needs, including support bar. In compliance with the flow of people, the width of the doors was not adequate for half of the units, as it did not allow the passage of disabled people and / or with limitations. As for access, some units had ramp, however, it was very steep, others had none or steps were high, about 30 centimeters. No unit had non-slip surfaces. Only two units had handrail on the outside. The signaling of services was only visual.

Such structures imply noncompliance with ethical principles, such as confidentiality, non-maleficence, justice, among others, to the extent that does not meet the needs of users and workers, which constitute situations of dissatisfaction and conflicts. These non-conformities can compromise the work dynamics, in that it interferes with the autonomous management of the nurse and with the quality of work and disregards the humanization of care.

#### ◆ Implications of the physical structure in occupational and user's health

The physical structure of the ESF exposes users and workers at risk of ergonomic, chemical, biological and psychosocial accidents.

*Yes, the father and the mother come with the child to receive vaccine and the room is flooded, they run the risk of falling. They get shoes and socks wet. Asthmatics users also suffer with mold, they have cough, shortness of breath and itching. Mothers cannot go up with the stroller because it has no ramp (Nurse 3).*

*Contaminated waste is collected only once a week, every Monday. The smell is very bad and it needs to stay in a room within the ESF because there is not a covered area outside the ESF to put it. The outpatient clinic is too small, the drawers where the syringes and needles are put are close to the stretcher, it is complicated to open. If we want to put a wheelchair inside the clinic, we cannot even move, because there is the table, the stretcher, the chair and the cabinet (Nurse 1).*

*[...] In the clinic, when it rains, everything gets wet. They came to fix the internet*

Strehlow BR, Fontana RT.

Implications of the physical structure of...

*connection and they broke the tiles, when it rains it floods the vaccine room, the hallway, the doctor's room. In the dentist's room some devices burned because of the rain, she stayed two months without working. The physical area is wet. [...] We also get wet because it rains within the ESF, we stumble on the cardboard we use to cover the ESF (Nurse 3). [...]*

Workers reported that, in the reception desk, they keep exposed face to face with users, exposing themselves to biological and psychosocial risks.

*Since we do not have a reception area to make the appointments, we are making them through the window for our safety. Once a drunk patient came and yelled at us, so we are doing it through the window (Nursing technician 2).*

Professionals cited illnesses resulting from extreme temperatures in summer and winter, characteristic of the region, favoring exposure to physical agents temperature and humidity.

*Certainly, in the summer it is an unbearable heat, the cold is awful. Mildew (I have rhinitis, sinusitis, headache). In four months, I had 3 respiratory infections, I took antibiotics, I was in bed, I had fever. I attach it to my workplace, my immunity lowered too much (Nurse 3).*

The existing furniture in the ESF was placed incorrectly, forcing inadequate postures by nursing workers and consequent musculoskeletal pain.

*Back pain to stay crouched, in a bad position; pain in the upper limbs from checking pressure, there are people who come every day to check it. In the home visit it is also bad (Nursing technician 6).*

As for an area / room for interpersonal relationships, only one unit had a lounge and meeting room for the team.

*We try to establish [the interpersonal] with what we have. There should be a meeting room for community health workers. They stay at the reception area along with the patient. I have to talk to them at reception desk (Nurse 4).*

Some physical structure conditions may jeopardize not only users' health, but also workers' health. There were irregularities exposing the worker and the user to biological, chemical, physical, ergonomic risks of accidents and also psychosocial risks, such as dirt, poor cleaning and maintenance, improper covering material, lack of inputs for correct handwashing, poor ventilation, deficiencies in the provision of PPE, inappropriate processing of material security problems and "policing" of the unit, etc.

Much of the units was in regular conditions of cleaning and conservation, because,

according to workers, there was no professional to perform this activity. Thus, the cleaning of the building was carried out by the nursing staff. It is noteworthy that there were sinks with liquid soap and paper towels, but not all rooms had 70% alcohol.

The cover material and the doors, although made of washable and waterproof material, were dirty at the time of observation. In some units, the painting was not full, it was moldy and dirty. Not all the walls were made of washable materials and many were rough surfaces. All units had grouted floors and most of these had cracks, hampering the cleaning and favoring the accumulation of microorganisms. As for the width of the corridor, some were smaller than 1m20cm.

As for ventilation, most of the windows was 'sliding' type and ventilation flaps with railings. No unit had air-conditioned environment or exhaust fan. The mold, present in all units, was responsible for some cases of allergies among workers. Another inadequacy was water infiltrations, common problem in all units. In only two, solid waste was put outside the unit, as recommended by the manual; in others, where waste was stored inside the unit, the odor was foul. No unit had a place to put uncontaminated waste.

It was observed the processing of material, held in places not appropriate in most units, showing disregard and / or ignorance of the law. As for the reception room, washing and decontamination of materials, some units had them and also exclusive sterilization room, however, the material was stored at the outpatient clinic.

In three ESF, autoclave was located at the dentist's room; in the other three, at the clinic. In most of the units, all processing of material occurred in the clinic. There was also attention for the use of personal protective equipment, partially used by most workers, ignoring universal precautions. In some units, only glove was used. The disinfection of material occurred, in most of the units, in the procedures room and was made with 2% glutaraldehyde.

None of the units had security guards, causing insecurity to the nursing worker due to constant exposure to violence, especially psychological. The subjects reported that verbal abuse occurred daily. Much of the nursing team said they suffered from stress resulting from poor organization of work.



## DISCUSSION

All ESF studied had inadequate infrastructure to meet the team's needs and, consequently, the health user, similar to other recent studies<sup>4,7</sup> in which the authors found that the conditions in public health institutions are adverse to the workers' and users' health and that they need to fit the available physical structure and / or improvising, bringing unfavorable implications to everyday work dynamics.

Similar results were found in a study in Bahia that evaluated physical environment, material resource and staff in basic units. It was identified that the two municipalities were deficient in physical structure. In one of the municipalities, only 12.5% of the ESF had the basic facilities; in another municipality, only 4.5% had it.<sup>8</sup>

A study that exposed how nurses in health units of Cuiaba (MT) perceived the local infrastructure and its influence in practice pointed out that the inadequacy of the physical structure and material causes reduction in user access to the service and the resoluteness of actions, besides dehumanization and discontinuity of care, with loss in provision of services, performance and qualification of practices.<sup>7</sup>

The reports showed that workers are exposed to risks daily. Much of the units have mold on the walls and do not have adequate cleaning conditions. Humidity and temperature, physical risk agents, are considered a discomfort, as well as leaks and infiltrations on rainy days. Inadequacies in the physical area expose workers to situations that can lead to accidents and other illnesses.<sup>4</sup>

A study that evaluated the structure of primary care health units in two municipalities that joined the ESF found, similarly to the present study, poor state of repair and hygiene of units, infiltrations and poor lighting and the absence of ramp access and sanitary adapted to suit people with special needs. Many units were located in physical structures that had not been built for this purpose, as adapted houses, which did not comply with the legislation for health care.<sup>8</sup>

An investigation in 2009 showed cases of chronic sinusitis due to the small, moist environment of the basic health unit.<sup>9</sup> Ergonomic risk may be present in inadequate physical areas, thus favoring wrong and uncomfortable positions for the nursing workers.<sup>4</sup>

Nursing workers, who already suffer from excessive workload, low pay, psychosocial overload and work accidents, conditions that can cause damage to their health<sup>10,4</sup>, are still exposed to precarious conditions of physical structure and materials to work with, which shows managers' negligence to those who daily produce health to people.

The non-use of PPE can become harmful to nursing. In addition to the voluntary neglect, physical structure with inadequate ventilation and lighting makes the use of PPE uncomfortable, contributing to poor adherence due to intense heat<sup>11</sup>. However, there are circulating infectious agents, such as parasites, in the care to pediculosis and scabies; bacteria, in contact with biological material in the development of nursing consultation; contact with tuberculosis, leprosy; in the Pap smear; in probings, dressings, inhaled therapies; viruses, resulting from contact with the flu virus, hepatitis, AIDS; as well as fungi and protozoa, among others, resulting from nursing care in activities developed in direct care to the user, either inside the unit or in community spaces. These agents may be transmitted by the hands or by use of dirty / or non-processed materials or even through the air.<sup>12</sup>

In addition to biological, chemical agents arising mainly from the administration of drugs, vaccines and contact with disinfectants and antiseptics expose workers to diseases, such as allergies and cancer, if there is negligence in the use of PPE<sup>12</sup>. It is appropriate to note that according to the Collegiate Board Resolution (RDC) No. 42 / 2010 of the National Health Surveillance Agency (ANVISA)<sup>13</sup> it is mandatory the availability of alcohol for antiseptic rubbing of hands at the places of care and treatment of all health services, and this was not observed in the study settings.

Combined with this problem is the fact that, by exposing themselves to risks, workers also expose the user, because the lack of adherence to the use of PPE recommended for health work not only is contrary to the Regulatory Standard No. 6<sup>14</sup> which provides that the employer must provide the equipment and workers must use them, but also contributes to infections related to health care, in that it disregards the standard precautions necessary for safe care.

Research conducted in 28 primary health care centers in Nepal, to achieve knowledge and practices for infection control identified, among other results, that only 22% had correct knowledge of universal precautions and 72% reported that they had never used

high-level disinfection in instruments. The reasons for the failure include lack of equipment for high-level disinfection and deficiency of knowledge and technical skills.<sup>15</sup>

Security guards and actions to protect workers from abuse of patients and families are reported in other studies. Violence against workers is a common phenomenon in other units.<sup>16,17,4,10</sup> The lack of security is considered a risk to workers' health because it generates psychological distress<sup>4</sup>. The reduced number of personnel, inadequate resources and problematic interpersonal relationships can be associated with aggression<sup>16</sup>

Given the analysis of observation, it can be inferred that, according to the plan indicated by the Manual of Physical Structure of the Basic Health Units, in annex 1<sup>1</sup>, no unit was in compliance with this legislation. Some parts of the Manual, identified as nonconformities, will be discussed below.

The waiting room should be comfortable for its users, including good lighting and temperature conditions, allowing the interaction of these, with chairs in sufficient number and in good condition. The reception must have a desk, four chairs, shelves, message board, computers and phones.

A study aimed to evaluate the structure available in ESF units as for prenatal care found that in 11.6% of the units the reception rooms were inadequate, 9.2% had no pre-consultation room and among those that had it, 37.3% were inadequate. There was no area for team meetings in 11.6%, and 30.2% had no place for meetings of educational groups, of those that had it, 58.2% were considered inadequate.<sup>18</sup>

The records room should allow the keeping of records with safety and restricted access, which does not exist. A consideration of the records and their importance in a service of this nature is valid. In addition to being a legal document that allows knowing the health history of the user, organizing them properly gives care an organized feature. It is recommended by the Manual that the filing of individual records is grouped by family. Organizing the records by family, gathering all its members in a single document, gathering information on the care provided, is essential to the principle of comprehensiveness and can help identify links between family factors in illness and in health recovery<sup>19</sup>. The nurse can assist in the performance of this practice.

Windows should be made of aluminum or PVC, as these are more durable and better cleaning materials and the units should have an exhaust fan, but this was not observed in any of the ESF. As for the floors and walls, the

RDC 50/2002<sup>20</sup> establishes that the materials suitable for covering walls, floors and ceilings of these environments are those resistant to washing and the use of disinfectant and that the finishing materials to be used must make the surfaces monolithic, with the smallest possible number of slots or slits.<sup>20</sup>

The physical structure of the units must allow access for individuals with disabilities; have access ramps, doors with enlarged dimensions, grab bars and lever-type knobs, and this was not found in all units. A study identified the absence of ramps and handrails in basic health units in seven states of Brazil.<sup>21</sup> It should be considered the signalization of environments and forms of communication and signaling carried through texts or pictures (visual), embossed characters, Braille or embossed figures (tactile) and auditory resources (sound). The width of the corridors should be equal to or larger than 1m20cm.

The vaccines room should be located so that the user does not transit in the other dependencies of Basic Health Unit. The Manual<sup>1</sup> recommends that there is a nebulization room, containing benches for patients, countertop with sink, nebulization system with filters and faucets that allow using them without touching with hands. The unit must have stockroom and there should be an exclusive bathroom for the team. The pantry / kitchen should be a comfortable space for the team, with table, cupboards, stove, refrigerator, among others. Some units did not have these areas. Consulting rooms can be shared, which is according to the manual, but there should be a private bathroom in offices used for performing gynecological examination.

For processing the material, as recommended by the Manual, there should be a reception room, a washing room and a decontamination room, that should communicate by window with the sterilization room and the sterile material storage room. As for the reception room, washing room and decontamination room, two units have them; there is also an exclusive room for sterilization, however, the material is stored in the outpatient clinic. The RDC 50/2002<sup>20</sup> provides for a simplified Sterilization and Supply Center and for this activity. In most of the units, the disposal of secretions and waste was inadequate. In order to describe the adequacy of the physical structure of the Sterilization and Supply Centers of Primary Health Care Units in accordance with current ANVISA standards, a survey conducted in Alagoas (BR) pointed out that most units

performed the cleaning of materials properly, however, not all had the recommended structure and size. In the preparation and sterilization room of units, irregularities were observed in relation to the dimensions and most did not have the necessary equipment, demonstrating, as in the present study, that many units are still incompatible with the ANVISA regulations, which hinders the work of health professionals, as well as the process of sterilization of materials, thus disqualifying the care provided to the community<sup>22</sup>.

The ESF is the gateway of health services and if it functions effectively and comprehensively, the secondary and tertiary care will not need many investments, which is different from the current situation. Given the above, the vast majority of the units are not in accordance with the specific legislation, contributing to insecurity in work organization and hindering directly actions for accessibility, humanization and hosting users. The health of nursing workers, in this context, should also include discussions about macro and micro-management; the professional who provides care also needs care, proper ambience and should be participatory in the reflections to improve work environment and its structure.

### FINAL THOUGHTS

From interviews with the nursing staff and observations in the ESF, it was found that no unit is in full compliance with the law.

It was found that professionals are dissatisfied with the physical structure, which directly influences the dynamics of their work, generating occupational hazards, and illness of the nursing team. Besides, they make use of improvisation with the available materials, because they need to keep working. Also, users' needs are not fully met and accessibility is not guaranteed.

It is necessary that there is participation of users, workers and managers in the planning of health facilities, and that this planning is grounded in the physical structure manual recommended by the Ministry of Health. Disregarding the physical structure of these units may result in disruption of work processes with negative influence on meeting the needs of service users and workers.

Some limitations permeated the study, although these had no significant implications for compliance with the proposed objective. An ESF was being refurbished during the research and in some units the researcher found some reluctance on the observation. It is important to note that in four ESF, the researcher had to return twice, since the unit was crowded and / or some professional was

lecturing courses or assisting in another health facility. It is note remembering that an ESF was under renovation. Some professionals were reluctant to observation, not allowing that observation was complete.

There was no intention to discuss the architecture of services and their dimensions, but drawing attention to the importance of physical infrastructure for quality work dynamics. Rulers of the three spheres of government must face health care in a more serious and responsible manner. Enough of neglecting the determinants and health conditions; research has made its role, reporting, alerting. Hopefully, it will be used for the promotion of public health.

It is suggested to carry out more studies designed to discuss the managerial and administrative aspects linked to the planning and construction of the physical areas.

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Submission: 2015/04/20

Accepted: 2016/05/27

Publishing: 2016/07/01

#### **Corresponding Address**

Rosane Teresinha Fontana  
Rua Sete de Setembro, 1126  
CEP 98800-000 – Santo Ângelo (RS), Brazil