

Facilitators and barriers in the organization of physiotherapists' work in a specialized rehabilitation center

Facilitadores e barreiras na organização do trabalho de fisioterapeutas em um centro especializado em reabilitação


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Abstract

Introduction: Physiotherapy is part of the multidisciplinary team of specialized rehabilitation centers and seeks to offer users comprehensive care from a biopsychosocial perspective. **Objective:** To get to know facilitators and obstacles related to the physiotherapists' work organization in a specialized rehabilitation center present in their care practices provided and recommended for persons with disabilities. **Methods:** We conducted a qualitative, descriptive study, taking the case study as a guiding model, developed and analyzed from methodological resources of ethnography. Three data collection strategies were used: documentary research, direct observation and interviews with physiotherapists. Data were analyzed through the reconstruction of scenes, articulating the elements captured in the data production process. **Results:** The findings regarding the reception and welcoming pointed out how the aspects of demand and overloaded agenda make it difficult to adopt the embracement, however, welcoming practices are perceived during the assistance provided by the physiotherapist. Assessments and reassessments need to be reformulated, taking a common language base as a reference and for that it is necessary to induce management with an impact on the organization of work. The singular therapeutic project is not yet a reality in the institution, as its adoption also leads to changes and the dismantling of the established culture of assistance through productivity pressured by demand. **Conclusion:** Our study made it possible to identify the contribution of knowledge about the organization of work in the specialized center for the implementation or not of an approach that is closer to what is desired in terms of care in the biopsychosocial perspective.

Keywords: Biopsychosocial models. Integrality in health. Interprofessional education. Qualitative research.

Resumo

Introdução: A fisioterapia integra a equipe multidisciplinar de centros especializados em reabilitação e busca ofertar um cuidado integral na perspectiva biopsicossocial aos usuários.

Objetivo: Conhecer facilitadores e obstáculos relacionados à organização do trabalho do fisioterapeuta em um centro especializado em reabilitação, presente em suas práticas de cuidado prestadas e preconizadas à pessoa com deficiência.

Métodos: Trata-se de um estudo qualitativo, descritivo, tomando como modelo condutor o estudo de caso, desenvolvido e analisado a partir de recursos metodológicos da etnografia. Utilizaram-se três estratégias de coleta de dados: pesquisa documental, observação direta e entrevistas com os fisioterapeutas. Os dados foram analisados por meio da reconstrução de cenas, articulando os elementos capturados no processo de produção dos dados. **Resultados:** Os aspectos de demanda e agenda sobrecarregada dificultam a adoção do acolhimento, contudo percebem-se práticas acolhedoras durante a assistência prestada pelo fisioterapeuta. As avaliações e reavaliações precisam ser reformuladas, tomando como referencial uma base de linguagem comum e, para isso, é preciso uma indução da gestão com impacto sobre a organização do trabalho. O projeto terapêutico singular ainda não é realidade na instituição, visto que a adoção do mesmo também remete a mudanças e ao desmonte da cultura estabelecida de assistência por produtividade pressionada pela demanda. **Conclusão:** O estudo permitiu identificar a contribuição do conhecimento sobre a organização do trabalho no centro especializado para a efetivação ou não de uma abordagem que se aproxime do que se almeja em termos de cuidado na perspectiva biopsicossocial.

Palavras-chave: Modelos biopsicossociais. Integralidade em saúde. Educação interprofissional. Pesquisa qualitativa.

Introduction

Since the publication of the *Plano Viver sem Limites* (Live wWithout Limits Plan) in 2011, through the creation of the Care Network for People with Disabilities (CNPd) and the Specialized Rehabilitation Center (SRC), the interprofessional approach has been sought after. In this context, physiotherapy is part of SRC's multidisciplinary teams, made up of physiotherapists, occupational therapists, speech therapists, psychologists, doctors, nutritionists and nurses, and it needs to face the challenge

of offering comprehensive care from a biopsychosocial perspective, articulating intra- and intersectoral actions and making use of care tools in their practices to care for the large number of users in need in Brazil.¹

For guidance on operational measures and practices in the work routine of CNPD professionals, Hearing, Physical, Intellectual and Visual Rehabilitation Instruction (RI) was created, which provides general guidelines on important elements to develop comprehensive care for people with deficiency. In this sense, it brings elements of the work prescribed for SRC professionals, thereby provoking reflection on the organization of work to materialize the suggested care.²

Knowing the facilitators and obstacles in organizing the work of physiotherapists in the rehabilitation sector of the SRC can therefore elucidate how some practices aimed at people with disabilities prescribed in the RI are being carried out or not by physiotherapists on site and what their relationship is with the organization of work.

Given this scenario, the question arises: what are the facilitators and obstacles related to the organization of the work of SRC physiotherapists, present in their care practices for people with disabilities? The aim of the present study was to understand facilitators and obstacles related to the organization of the physiotherapist's work at the SRC, on the basis of the care practices recommended by the RI, whether or not provided to people with disabilities. Knowing the above elements will allow us to infer the contribution of the work organization to the distance between prescribed work and actual work at the SRC.

Methods

Considering that the production of data at the SRC was centrally guided by direct observation, we opted for writing what seeks to express and bring the reader closer to the experiences and transmit what was seen, heard and felt during the study. The study was qualitative and descriptive, taking the case study as its guiding model.³ Qualitative data were obtained from July to December 2022, in a center specialized in rehabilitation IV (four rehabilitation modalities: auditory, physical, intellectual and visual), in the state of Paraíba, Brazil, observing and dialoguing with physiotherapists of both sexes, with employment relationship of more than six months, and who worked in the rehabilitation sector.

Data production was carried out with the association of three techniques: documentary research, direct observation with conversation approaches, when necessary, and interviews with physiotherapists, also collecting sociodemographic data from these professionals, as shown in Table 1.

We worked with data triangulation with the aim of enabling a more in-depth analysis of the facilitators and obstacles in the routine of physiotherapists that influence the performance of some practices aimed at people with disabilities at the SRC.⁴

From the data collected, some scenes were reconstructed, articulating the elements captured in the data production process. In this sense, the scenes followed the formatting of the techniques that gave rise to the data, seeking to understand the difficulties in organizing physiotherapists' work after learning the nuances between live work and that prescribed in the rehabilitation sector of the SRC, and which also corresponded to themes important for the care of people with disabilities that emerged during the observation period.

The records described in the field diary were part of the textualization generated by observation at the research site. Analyzing these records with detailed descriptions of the observed scenes made it possible to perceive details and subtleties of the physiotherapists' work organization.⁵ Semi-structured interviews were carried out with physiotherapists, who had worked for more than 6 months helping people with disabilities at the SRC. The interviews followed a script with questions directed to actions and activities that are recommended by the RI for the SRCs and generated around twelve hours of audio, later transcribed.⁶

The data was analyzed using ethnographic analytical techniques, initially exploring the materials, perceptions and questions obtained during direct observation, conversation approaches and interviews. In the analysis process, we sought to bring together the emic (participant's vision) and etic (researcher's vision) perspectives in a movement to merge the two horizons.⁷ The analyses were carried out in a non-linear way, as the data were produced like a spiral of analysis.⁸

Table 1 - Characterization of the physiotherapists (P) interviewed

	Sex	Training time	Postgraduate degree or specialization	Time working at SRC	Support profile
P1	F	29 years	Postgraduate degree in respiratory physiotherapy, and in teaching and learning; Master's degree in progress	15 years	Prescribing orthoses and prostheses
P2	M	19 years	Master's degree in public health	14 years	Adult rehabilitation + Child rehabilitation
P3	F	5 years	Postgraduate degree in neurofunctional physiotherapy	3 years	Child rehabilitation
P4	F	20 years	Postgraduate degree in kinesiotherapy resources	17 years	Prescribing orthoses and prostheses
P5	F	18 years	Master's degree in progress	14 years	Child rehabilitation
P6	M	5 years	Postgraduate degree in traumato-orthopedics	1 year and 4 months	Adult rehabilitation and hydrotherapy
P7	M	19 years	Master's degree in public health	14 years	Adult rehabilitation + Child rehabilitation
P8	M	26 years	Postgraduate degree in gerontology, and in traumato-orthopedics	6 years	Child rehabilitation
P9	M	32 years	Postgraduate degree in neurofunctional physiotherapy	30 years	Adult rehabilitation + Child rehabilitation
P10	F	19 years	Postgraduate degree in cardiorespiratory physiotherapy	6 years	Child rehabilitation
P11	F	15 years	No postgraduate degree	10 years	Child rehabilitation
P12	F	8 years	Postgraduate degree in progress in physiotherapy in ICU	4 years	Child rehabilitation
P13	F	2 years	No postgraduate degree	1 year	Child rehabilitation

Note: F = female; M = male; SRC = Specialized Rehabilitation Center; ICU = Intensive Care Unit.

This study was approved by the Research Ethics Committee of the Federal University of Paraíba (CAAE: 37347020.3.0000.5188). Presence at the time of consultations and interviews were authorized by users and service professionals, and all participants signed an informed consent form.

Results and discussion

Twenty-eight visits were carried out in different shifts and days of the week, a necessary distribution so that differences in the routine, flows and demands of the sector could be experienced during direct observation guided by the RI.¹ The corpus of this study was structured with the complement of conversation approaches and interviews (Table 1).

The ethnographic approach made it possible to immerse oneself and, above all, experience the object of investigation, expanding the vision through a close look and from within the SRC, seeking to measure the intensity so as not to hinder understanding.

After learning about the biopsychosocial approach and the aspects of the prescribed and actual work in the care practices provided by physiotherapists for people with disabilities, the focus was redirected to identify the elements of the work organization of these professionals at the SRC, which hindered or favored the performance of the work prescribed in the regulations. For this, the critical analysis of the object studied was carried out according to the three emerging categories: i) reception and welcome; ii) evaluation and reevaluation; and iii) singular therapeutic project.

Reception and welcoming of users: a process under construction

Entering the rehabilitation sector, one sees the reception environment, flows of users, family movements, exchange of information with the receptionist, and all aspects suggested by the RI regarding user reception were analyzed. It was observed that upon arrival, users and companions/caregivers go to reception, sign in and sit down in the chairs provided for them in the sector.

Reflecting on this scene and highlighting it, a companion was observed with her daughter (service user) and an informal conversation began about that moment experienced, welcoming the user, waiting location and times, seeking to better understand that time.

We are always welcomed here. We have been part of [name of the institution] for many years, and we have been well attended to since the first contact, which is where she was evaluated. Near the entrance, there is a reception room, and there, the mothers who come from far away have chairs and benches to sit on, there is a table where they bring breakfast, a bed for the child. It's very cozy, I'm not going there anymore, because I come in my own car during her appointment time, but before I went, and it was very good support (Mother/caregiver, Field diary, 08/04/2022).

It is important to emphasize that reception is not considered a space or physical location, but rather an ethical stance of professionals, as well as the institution, and that it is not necessary to have a specific professional or time to carry it out, but it involves sharing knowledge, demands and, mainly, in carrying out a qualified listening to the subject, with responsibility and resolution according to the individuality of the other.⁹ It can be understood as a tool capable of promoting the bond between users and professionals, enabling a better understanding of the disease and co-responsibility in the treatment proposed, also stimulating self-care.¹⁰ Furthermore, it is also a practice of reorganizing the work process and an action that health professionals should seek to add to their work organization. Therefore, institutions must guarantee conditions to develop it, allowing greater resolution, connection and access to health services.^{11,12}

Through observation and the family member's report, it can be concluded that the user's welcome in the SRC physiotherapists' work sector is done with actions, such as direct access to talk and answer questions with the receptionist, and with a physical space that promotes comfort while waiting for the schedules and demands of the sector. It is observed, however, that this practice is not systematically carried out by physiotherapists, so the reflection arises: does the physiotherapist perceive the welcome at reception as an integral part of their work organization? Would it be interesting for this professional to approach this practice? Does the institution offer objective conditions for the physiotherapist to carry out this action?

Reflecting on these issues allows us to rethink the way physiotherapists provide care with the inclusion of the "welcoming" tool in the organization of these professionals' work. It is considered that including it is important to broaden the view of the way in which

the service is organizing its care practices and how these can influence the reception. It was found that the physiotherapist did not participate or did not frequently participate in welcoming activities in environments such as reception, in addition to not having time slots for this practice in their schedule. Still, the question remains: what could justify this lack of involvement of physiotherapists with the reception practice?

It is possible to consider some hypotheses, such as there being a wide demand of users for each professional, with appointment times being filled and with a short space of time between one service and another, which can be a barrier to carrying out another action other than physiotherapy care. However, it was possible to observe that during some services, physiotherapists create a bond with the user and that, at this moment, space opens up within the moment of assistance, carrying out actions from the perspective of the concept of welcoming.

Scene 1: Physiotherapy care with welcoming actions

- *Are you doing any exercises at home?*
 - *I'm starting to do it after I started learning from you, doctor!*
 - *What has this adaptation process been like?*
 - *Some days are easier, others are more difficult, I'm still getting used to it, one day at a time.*
 - *Is your family helping you at home with this adaptation, or to do the exercises?*
 - *Yes doctor, they help me whenever they can (...). wow, this exercise was difficult, I'm heavy (laughs).*
 - *It is very important that you begin nutritional monitoring to help you lose weight and facilitate rehabilitation [User name, who underwent the unilateral transfemoral amputation process, and was overweight].*
 - *It's true, doctor, it's going to help me a lot, isn't it? I'll try to make it easier for myself.*
- (Physiotherapist 1 and user, Field diary, 08/01/2022).

When observing and analyzing the scene, it is recognized that the professional in question carried out actions such as: qualified listening on adaptation issues, guidance on exercises in the home environment for continuity of care, interest in knowing about the family context, in addition to guidance on to the help of another professional to assist in the recovery process, showing an expanded view of the user during the service. It is important to highlight, however, that not all professionals carry out these actions during their care and some

conduct them in a more technical and mechanized way, that is, with a focus solely on the physical rehabilitation of users. In addition to the above, there is reflection on this listening, which is based on clinical aspects aimed at facilitating the care provided by the physiotherapist, which is in fact what is expected in terms of reception.

Rehabilitation encompasses aspects beyond care behaviors. It involves identification of obstacles and needs of the individual, connections between relevant factors of the individual with the environment, planning, definition of goals, implementation of measures and their effects on the routine of these individuals.¹³ The rehabilitation process in the health service is a challenge, as it is responsible for enabling the individual to face a new biopsychosocial reality.¹⁴

According to Solla,¹⁵ welcoming means humanization of care, guaranteeing access to health and qualified listening to the user's health problems, taking responsibility for resolving their problem and assuming an attitude capable of welcoming the user. In this sense, producing listening that only meets the interests of physiotherapeutic rehabilitation seems insufficient given the complexity inherent in caring for people with disabilities.

Reflecting on the scenes above allows us to understand the importance of physiotherapists being included and included in reception spaces, and how much they can contribute to the care process of users in these spaces. Visualizing assistance and its interfaces with reception encourages us to advocate the inclusion of the reception tool in the work process of this professional.

Furthermore, the importance of including other professionals in this task is also claimed, as it is clear that there is fragility in the way reception takes place in the researched sector. Improvements in work organization can be implemented, such as distributing the multidisciplinary team into micro-teams and defining days and locations for welcoming users in the sector and making adjustments to demands and schedules to include this practice in the professionals' routine, as it strengthens comprehensive care for the patient.

Inserting this strategy into the care process in the work of physiotherapists makes it possible to go beyond physical care, encompasses more effective communication and creates an adequate bond between the user and the professional, ensuring that their concerns are understood by those offering the care. This strengthens users' adherence to treatment and care and reduces health inequities.¹⁶

Assessment and reassessment as a strategy for a comprehensive approach and work organization

During the study, it was observed that the initial assessment was carried out in the screening and diagnostic sector, with the aim of determining the ICD code (International Statistical Classification of Diseases and Related Health Problems) of the users, and that physiotherapists carried out a new assessment based on an assessment form made available by the service (Documentary research, 08/01/2022). However, this assessment had not yet taken place in an interprofessional manner, with different members of the rehabilitation team, to obtain other perspectives on the possible conduct that would be adopted in the sector, in addition to the priorities that should be established at that time.

Scene 2: Assessment with comprehensive care actions

The examination was initiated by the physiotherapist, who continued taking anamnesis, palpation, and evaluating development phases. The professional soon noticed that the child was crying and had difficulty evaluating them at the time, starting to include the mother in the evaluation process: "Mom, has he been able to roll over on his own at home? [change in position], does he try and be interested in picking up the objects?" Then follow with other assessment moments, including palpation. She notices something different in the child's chest and immediately reports "Mom, I'm just going to get a stethoscope and I'll come back", returns to the examination room, performs the child's lung auscultation and highlights: "His lungs have a lot of secretion, I'm going to call the respiratory physiotherapist to examine him", leaving the room for a few minutes. The mother observes the movement and waits for the professional to return, who this time arrives with a colleague, who performs the child's lung auscultation and reports "mom, he is really congested, is he taking any medication at home?" "He had the flu a few days ago and his lungs were full, but he's not taking medication." The respiratory physiotherapist signals to the mother and her colleague: "Let's do it like this, today I have a vacancy at 10:20 am because the patient won't be able to come, go to the room with him and I'll check him and try to help or give some guidance today, since he's very congested." The mother thanks them, they bid each other farewell, and

then the specialist leaves the room (Physiotherapists 2 and 4, mother/user, Field diary, 07/21/2022).

It was observed that several aspects of the conduct carried out by the physiotherapist were positive and demonstrated that it broadens the user's clinical vision, such as including the family member in the care process, in addition to visualizing the need for a specialized look at a clinical aspect, which allows us to understand that the practices of the professional in question are aligned with comprehensive care, since the practices learned in the care production process must go beyond technical knowledge.¹⁷

By broadening the horizon to aspects of work organization that are present implicitly in the scene, we reflect on questions such as: Why this articulation of assessment with different perspectives, whether from a professional specialist in an area or professionals from the multidisciplinary team? Does it not occur frequently or routinely in the sector? What work organization issues prevent this strategy from being carried out, thus seeking a comprehensive assessment of the user, analyzing their context and needs? Could it be the high demand and flow of users in the sector? The ingrained culture of rehabilitation established at the site? Or would there be a need for greater investment in strategies that would induce service management to expand and implement this care strategy?

Reflecting on how live work is carried out, it is possible to analyze aspects of how this work is organized that imply the implementation of work practices proposed and expected by the guidelines for implementing and operating the SRC. Among these, it is possible to observe that there is a high demand of users for physiotherapy; consequently, a schedule that allows little flexibility to include other activities, as professionals must provide assistance to an average of five or six users per shift (Documentary research, Service schedule - 08/04/2022).

Within the interprofessional team, each specialty has its own individual service hours and does not have time on the agenda for moments of multidisciplinary coordination, such as assessment, consultations and case discussions with the team.

We serve an average of five users per shift, I'm a 30-hour employee, so it takes an average of 45-50 minutes per service, right? (Physiotherapist 3, Conversation approach, 08/11/2022).

Here, there are professionals who have worked in this sector for years, and they already follow a routine in providing care, you know? And often they don't want to do anything different (Physiotherapist 6, Field diary, 08/11/2022).

Through the report and observation, it was inferred that there is a model of care provision ingrained by some physiotherapists, which may imply an obstacle to achieving the biopsychosocial model in the provision of care. To minimize this, it is essential that professionals and work practices are aligned with the biopsychosocial model, so that better outcomes are achieved and so that the person with disability is in fact at the center of care, and not the peripheral aspects, such as the particular way that each physiotherapist wants to manage their work to the detriment of the user's needs and the force of productivity in the contemporary world that imposes its production belt on living work.¹⁸

In contrast, there are also professionals who are willing to make changes possible. These are present in permanent education training and seek to adhere to new routines in carrying out work when suggested and inserted by management. A possible strategy to facilitate multidisciplinary meetings in the expanded assessment at the SRC would be the use of the International Classification of Functioning, Disability and Health (ICF) as an assessment system and inducer in the therapeutic plan, not only for the physiotherapist, but also for the interprofessional team.

Therefore, including the ICF in therapeutic planning, as a form of periodic assessments to monitor the evolution of the individual's clinical condition and context and as a reassessment strategy, would allow professionals to produce universal and standardized data on factors related to the entire individual's health context, and would facilitate and expand access to different professionals and interventions necessary for each case.^{19,20}

Health education strategies should be considered together with other measures to restructure daily practices. What stands out here is the organization of work groups to experiment and evaluate new approaches, flows and procedures and, in the future, to expand these investments to other workers, incorporating what proved to be useful and adjusted to the principles that govern the provision of care at the SRC.²¹

With the deepening and observation of the professionals' routine, also noted is the gap in the reevaluation

aspect, being a topic that did not emerge in the conversations between the professionals, with no actions or reevaluation instruments being noticed during the routine, making it necessary to approach the topic with a professional.

Here in the sector, we do not have the habit of reevaluating patients, only if it is necessary to be discharged, or for another reason, but it is not routine (Physiotherapist 8, Conversation approach, 11/24/2022).

With the professional's report, it can be seen that the reassessment of users is not frequently carried out by physiotherapists in the sector and, when reflecting on the topic, the question arises: What issues in the organization of work in the service justify the absence of this practice in the routine of physiotherapists?

It was also observed that there is a lack of systematization of clinical practices and protocols that maintain the standardization of physiotherapists' activities, such as maintaining reevaluation habits as a routine in the sector. This fragility may reflect on the care provided to users, as systematizing activities in a health center allows the alignment of practices carried out by professionals, and inserting guidance protocols favors the implementation of educational, promotional and preventive actions. All of this is in accordance with the prescribed work standardized in the instruction that serves as a guide for professionals.^{22,23}

Singular therapeutic project

In an attempt to understand the importance of team interaction for better care and effectiveness in the organization of the service, the perspective was observed and expanded on occasions and situations that favored the exchange of knowledge and cooperation of the entire team. It was noticed that some professionals discussed cases among themselves, shared information about the care and treatment of a specific user and exchanged knowledge on different topics. Therefore, it was possible to consider the relevance of the situation and how the exchange of knowledge favors and benefits the user in the health care process and in the therapeutic strategy adopted by the professional.

In view of the above, it is possible to reflect on the importance of the Singular Therapeutic Project (STP) for the organization of work in the service, as it is a weakness present in this sector; it is not systematically carried out,

which can harm the resolution of demands and the quality of care provided. In this context, it is possible to reflect: What barriers occur in the organization of work that limit the alignment of physiotherapists with other professionals to produce STP?

We never had a singular therapeutic project here, many years ago we discussed clinical cases, but it was never a discussion for things to work the way they were supposed to, you know, for us to discuss, it ended up that the STP meetings were just reports and the clinical cases were postponed, so many years ago there was a time of clinical cases, but not a singular therapeutic project (Physiotherapist 3, Interview, 2022).

In view of the above report, it appears that not carrying out the STP is a weakness of the service and that this gap in the organization of work distances the work practices of professionals in the SRC from the work prescribed by the RI. It is important to highlight that the STP is an instrument of great importance for the care of people with disabilities that assists health actions, as it establishes and organizes care, promotes autonomy and protagonism of subjects and contributes to users' perception of co-responsibility.²⁴

One of the barriers analyzed was the lack of discussion between management and professionals about the feasibility of adopting STP in the work organization. As reported, it is clear that the work of physiotherapists was strongly based on rehabilitation and within their private spaces of care. It is therefore argued that an induction is necessary, initially from managers, to coordinate, implement and discuss actions that favor the approach of these strategies within the sector, strengthening the qualification of care provided to users and team integration.

It is claimed that it is necessary for the SRC to face the challenge of adopting STP as a practice and with it changes in the pre-existing organization and work process, in order to shape routines to improve health care and assistance for users.²⁵ Therefore, it is important to mention that the preparation of the STP is a work proposal for the professionals who make up the SRC and its production must be carried out by the service's multidisciplinary team, individuals with disabilities and caregivers/family members, allowing them to play a leading role in their health care.²⁶

Given the above, it is possible to reflect that intro-

ducing STP into the work organization of SRC physiotherapists can have an impact on their work practices, favoring their form of assistance and health care. The STP enables the exchange of knowledge between physiotherapists in the sector, with the multidisciplinary team and with users, thus favoring assistance focused on the subject's completeness, providing closer ties between users, family members and professionals and rationalizing the work of the team.²⁷

Conclusion

When analyzing the practice of receiving and welcoming users at the SRC, it was found that there is no systematic involvement of the physiotherapist in these processes. It is also inferred that the demand for care and the lack of flexibility in schedules can make involvement in these practices difficult, but it is observed that during user care, physiotherapists carry out, to some extent, actions that are close to the broader concept of welcoming, which can be enhanced while there is no induction into the establishment of multidisciplinary reception spaces at the SRC.

User assessments at the SRC are guided by specific forms for each sector, and physiotherapy is no different. It is clear, however, that adopting an assessment form that does not produce information capable of communicating with other professionals creates obstacles for the biopsychosocial approach to be implemented at the SRC. In this sense, it is proposed to use the ICF to produce assessment instruments that can dialogue with each other. Therefore, it is argued that management plays an essential role in this process, encouraging discussion and ongoing education on this topic, as well as establishing working groups for its implementation.

Finally, regarding the STP, it is clear that it is not yet a reality within the SRC, even though it is recognized as an important communication device between members of the care team and users, and as a tool to organize the work process with a view to resolution and longitudinal monitoring of cases. To achieve this, it is necessary to face the challenge of a rehabilitation culture centered on the conduct of each professional and their isolated production of care and guided by productivity goals of modern capitalism to the detriment of centrality in the user's demands.

Authors' contributions

NFS developed the research project and, together with JEFPJ and RFN, worked on writing the research project and methodological proposal and gathered and analyzed the data. GEGB and DTG participated in the methodological development and, together with NFS, GNV and RFN, did the writing and editing of the paper. All authors approved the final version of the article.

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