DOI 10.18471/rbe.v38.62853

NURSING REHABILITATION PRACTICE OF PEOPLE WITH SPINAL CORD INJURY: ACCESSIBILITY CHALLENGES IN PRIMARY CARE

PRÁXIS DA ENFERMAGEM EM REABILITAÇÃO DA PESSOA COM TRAUMATISMO DA MEDULA ESPINAL: DESAFIOS DE ACESSIBILIDADE NA ATENÇÃO PRIMÁRIA

PRAXIS DE ENFERMERÍA EN REHABILITACIÓN DE LA PERSONA CON TRAUMATISMO DE LA MÉDULA ESPINAL: DESAFÍOS DE ACCESIBILIDAD EN LA ATENCIÓN PRIMARIA

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How to cite this article: Alves DF, Schoeller SD, Cunha TEO, Santos SU, Freitas TS, Godoi A. Nursing rehabilitation practice of people with spinal cord injury: accessibility challenges in Primary Care. Rev baiana enferm. 2024;38:e62853.

Objective: to analyze the practice of the Primary Care nurse in the rehabilitation of people with spinal cord injury. Method: qualitative research, case-study type, carried out in the Primary Health Care of the city of Florianópolis, with verification of local accessibility, analysis of protocols adopted and face-to-face interviews with 16 nurses through observation of their consultations, conducted by Consolidated Criteria for Reporting Qualitative Research. Results: of the professionals, 62.5% assisted or assist people with spinal cord injury and 37.5% never cared for this trauma. Three categories of care were identified: rehabilitator, supported by prejudices and care with difficulties. Final considerations: the praxis of nursing denotes, in large part, reflective care in rehabilitation, although it presents inadequacies of accessibility and prejudices that hinder inclusion, which must be overcome as a way of strengthening public policies. The lack of accessibility continues to be a significant challenge with great impact on the care provided by nurses to the person in rehabilitation.

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Descriptors: Spinal Cord Injuries. Rehabilitation Nursing. Health Services Accessibility. Rehabilitation. Primary Health Care.

Objetivo: analisar a práxis do enfermeiro da Atenção Primária na reabilitação das pessoas com traumatismo da medula espinal. Método: pesquisa qualitativa, tipo estudo de caso, realizada na Atenção Primária à Saúde do município de Florianópolis, com verificação da acessibilidade local, análise de protocolos adotados e entrevistas presenciais com 16 enfermeiros mediante observação de suas consultas, conduzida pelo Consolidated Criteria for Reporting Qualitative Research. Resultados: dos profissionais, 62,5% atenderam ou atendem pessoas com traumatismo da medula espinal e 37,5% nunca cuidaram desse trauma. Identificou-se três categorias de cuidado: reabilitador, apoiado em preconceitos e cuidado com dificuldades. Considerações finais: a práxis da Enfermagem denota, em grande parte, o cuidado reflexivo na reabilitação, embora apresente inadequações de acessibilidade e preconceitos que dificultam a inclusão, que devem ser superados como forma de fortalecimento das políticas públicas. A falta de acessibilidade continua sendo um desafio significativo de grande impacto no cuidado prestado pelo enfermeiro à pessoa em reabilitação.

*Descritores***:** *Traumatismos da Medula Espinal. Enfermagem em Reabilitação. Acessibilidade aos Serviços de Saúde. Reabilitação. Atenção Primária à Saúde.*

Objetivo: analizar la praxis de enfermero de atención primaria en rehabilitación de personas con traumatismo de la médula espinal. Método: investigación cualitativa, tipo estudio de caso, realizada en la Atención Primaria de Salud del municipio de Florianópolis, con verificación de la accesibilidad local, análisis de protocolos adoptados y entrevistas presenciales con 16 enfermeras mediante observación de sus consultas, conducida por el Consolidated Criteria for Reporting Qualitative Research. Resultados: de los profesionales, el 62,5% atendió o atiende a personas con traumatismo de la médula espinal y el 37,5% nunca cuidaron de ese trauma. Se identificaron tres categorías de cuidado: rehabilitador, apoyado en prejuicios y cuidado con dificultades. Consideraciones finales: la praxis de enfermería denota, en gran parte, el cuidado reflexivo en rehabilitación, aunque presenta inadequaciones de accesibilidad y prejuicios que dificultan la inclusión, que deben ser superados como forma de fortalecimiento de las políticas públicas. La falta de accesibilidad sigue siendo un desafío significativo de gran impacto en el cuidado que brinda la enfermera a la persona en rehabilitación.

Descriptores: Traumatismos de la Médula Espinal. Enfermería en Rehabilitación. Accesibilidad a los Servicios de Salud. Rehabilitación. Atención Primaria de Salud.

Introduction

Spinal cord injury (SCI) is a neurological syndrome that causes physiological, emotional, social and economic consequences, causing the need for complex rehabilitation to meet the demands of adaptation of these people, aiming at a better quality of life and social reintegration[1]. It is estimated that, in Brazil, the incidence of this situation is approximately 6 to 8 thousand new cases per year, with 80% of the victims being male, 60% of them between the ages of 10 and 30 years. Most of the causes are traumatic, resulting especially from accidents with motorcycles, cars, injuries by firearm projectile and falls, being a condition with great socioeconomic impact for the country[2].

People suffering from SCI need a rehabilitation formed by a multiprofessional and interdisciplinary team, being the nurse essential in this process to recognize the demands of care and develop nursing diagnoses that show care interventions that improve the quality of life of these people[1].

Moreover, nurses constitute the largest group of health professionals in the world, being fundamental at all levels of care, with integrated care centered on the person[3]. Thus, the nursing consultation enables assistance in individual care, being an opportunity to work rehabilitating care, aiming at the potential and independence, so as to promote health promotion and prevention of injuries[4-5].

For the World Health Organization (WHO)[6], rehabilitation is the union of measures that help people with health problems to enhance functionalities and minimize disabilities through interaction with the environment around them. Rehabilitation can be understood as an educational,

welfare and multiprofessional process that aims at a joint effort for the development of skills, prevention of complications and disabilities, encouraging social inclusion through education, in order to transform the thoughts and actions of people concerning the theme[7].

The Brazilian Law on the Inclusion of Disabled People (LBI-PcD), Law n. 13.146, of 6 July 2015, or also, Byelaw of Disabled People, defines accessibility as a guarantee to people with disabilities or reduced mobility of conditions to enjoy, with security and autonomy, "[...] spaces, furniture, urban equipment, buildings, transport, information and communication, including their systems and technologies, as well as other services and facilities open to the public, for public or private collective use [...]"[8:12], this being an indispensable requirement for inclusion.

The same device describes barrier as any impediment or difficulty that restricts or prevents "[...] the social participation of the person, as well as the enjoyment and exercise of their rights to accessibility, freedom of movement and expression, communication, access to information, understanding, safe circulation, among others [...]"[8:7].

Primary Health Care (PHC), one of the entry points to the Brazilian Unified Health System (UHS), acts as a communication center within the Health Care Networks (HCN), being essential in rehabilitation, assistance and continuity of care, because it is the level of care that is found in the territory of residence of the person[7,9]. PHC is constituted by the Basic Health Unit (BHU), when it does not have a Family Health team, and the Family Health Unit (FHU), when it has at least one team[10].

Rehabilitation in PHC has a significant role, being a dynamic process in which actions are related to the socio-cultural context of the person with disabilities, in order to improve their quality of life. Thus, nurses are responsible for care actions aimed at health education, based on guidelines directed to the user, their well-being and their family. Evidences from a study indicate that the ability to offer integrated care in PHC is fundamental for rehabilitation, biopsychosocial reintegration and recognition of the person, considering that rehabilitation nursing care involves social rights, affective bonds and solidarity[7,11-13].

However, people with SCI do not have proper follow-up at this level of attention and do not have the proper treatment that could be offered in this place, such as pressure injury (PI), in secondary or tertiary care. In this universe, the present research seeks to identify why this situational context, since the care at FHU is closer to the person's residence and therefore is presumed to be more easily accessible, which can mitigate health complications, to favor the prognosis and minimize the costs of care, contributing to the praxis of nursing, with the rehabilitation of the person with SCI and with the professional training in health. Thus, the study aimed to analyze the practice of primary care nurses in the rehabilitation of people with spinal cord injury.

Method

Qualitative, descriptive, exploratory research of the case-study type, carried out between July and December 2021, resulting from the Course Completion Work (CCW) of the main researcher[14]. The option for case study occurs by the possibility of reading the current phenomenon, drawn by multiple sources of evidence, including data obtained with the use of various techniques and instruments in a triangulation of relevant facts, constituting the actions of the actors involved[15]. It aims to deepen the thoughts and meanings of the phenomenon, as well as giving voice to people when considering conjuncture and subjectivity, in order to integrate health research and social sciences[16]. The research followed the basic guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ) for reporting.

The research scenario was the city of Florianópolis, capital of a southern state in Brazil, which has four operational health units, covering several neighborhoods of the city covered by the UHS. The site selected for the study was the PHC of one of the four Health Districts of the city, which has an active population of 380,659 people

attended in nursing consultations until February 2022, representing 25% of the total sample, chosen by the district's representativeness in relation to the absolute population[17]. The researchers who conducted the research are participants of the Laboratory of teaching, research, extension and technology in Nursing, Health and Rehabilitation (*(Re)Habilitar*) of the Federal University of Santa Catarina (UFSC), where they deepen their expertise, guided by a PhD researcher. On the reflexibility, the researchers are female nurses, integrated in an umbrella project that inserted them in the field. Training was conducted with the research advisor, also author of this article, and pilot interview, with subsequent discussion, without significant changes. The main investigator did not maintain direct contact with the research participants.

For the reflections of the emerging material, the proposal of the dialectical hermeneutic method was adopted as suggested by Minayo[18:77], in which: "[...] the speech of social actors is placed in its context to be better understood. This understanding has as its starting point the interior of speech. And, as a point of arrival, the field of historical and totalizing specificity that produces speech". The participants of the research were 16 nurses working in the FHU, for representing the totality of the chosen district, having as inclusion criterion to be in effective professional practice, crowded in PHC for at least 1 year at the time of the study. The exclusion criteria adopted was being absent from service, on vacation or leave; acting exclusively in management; being a resident. Of these, 93.75% were female and 6.25% male. The age ranged from 20 to 49 years, with service time ranging from 1 to 20 years. As for the training time, 50% graduated more than 10 years ago, all have a *lato sensu* postgraduate degree; 18.75% of them have a *stricto sensu* postgraduate degree; 6.25% are PhD and only 25% have rehabilitation-oriented training. None of the research guests refused to participate in the study.

In the data collection, the methodological proposal of Yin[19] was used for the case study, which occurred with the following triangulation: interview with the nurse and observation of the nursing consultation, based on a structured script; architectural observation of the environment, based on a checklist adapted from the current technical standard of the Brazilian Association of Technical Standards (ABNT) Brazilian Standard (NBR) 9050:2020, and analysis of protocols and municipal documents that guide the nurse's care in relation to people with SCI.

As procedures adopted, the researchers made prior contact by electronic means with the professionals participating in the survey, in non-probabilistic sampling, selected by convenience, to inform about the interests and reasons of the application of the study, as well as its importance and other characteristics necessary for the bond. In face-to-face interviews, it was discussed the existence of people with this condition in the territory; if they are assisted by the FHU; if the professional has already assisted people with these disorders, how this assistance was, reasons that led them to seek the main health problems, facilities and difficulties, adherence to treatment, complications; if they sought some type of material and what flow to get it; accessibility. The observation of the care had as a central point to understand if the care performed by the nurse is consistent with their speech, in relation to the embracement and rehabilitation.

The data collected were recorded by audio recordings, with notes in a field journal during the nursing consultation, as well as perceptions about the practitioner's praxis, and in an electronic form, the Google Forms, concerning the architectural observation of the site.

After the interview with the nurse, observation of the nursing consultation and the structured script, the study deepened on the experience of these professionals in relation to the care of people with SCI. The guiding question of the research referred to the fact that the interviewee presented some particularity in the experience of care of these people; some other questions were relevant to the understanding of the reality studied. Thus, by deepening the subject matter and by crossing the responses of participants,

it was possible to form a valuable range of information that emerged from the internal logic of the interviewees and the narrative based on their speeches, originating the categories of analysis, as shown in the results.

For data analysis, the proposal of Minayo[20] in qualitative research was used, according to which the study begins with the development of the research project and exploratory phase; followed by field work, in which the actions are implemented, in this case, the interview, the observation and study of documents on the subject, ending with the analysis and treatment of the identified empirical and documentary material. These actions delineated the cycle of this study, based on the research problem.

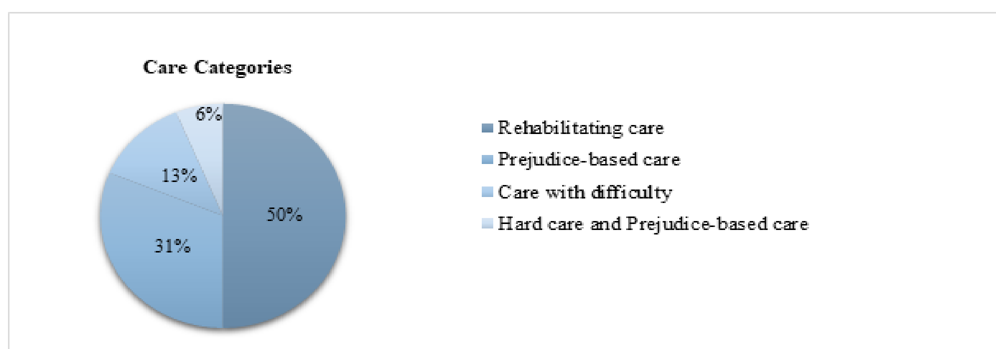
At first, the audio was transcribed; then, all collected material was dynamically read, aiming at the perception of praxis and saturation of data. In the second moment, there was the refinement of the reading, with observation of possible gaps of the actions, being returned for data validation and subsequent feedback from non-significant transcriptions by the participants. In the third moment, the profound interpretations of the material gave rise to categories through data triangulation and hermeneutic-dialectics[18]. Next, in a fourth moment, the treatment, inference and interpretation of results regarding the praxis of primary care nursing concerning the care of people with SCI. To maintain the anonymity of the interviewees, the personal names were replaced by the letter P (participant), followed by the ordinal number in order of performance.

The study was approved by the Human Research Ethics Committee (CEPSH), with registration of identification Certificate of Presentation of Ethical Appreciation (CAEE) n. 45216721.3.0000.0121 and Opinion n. 4.680.644, authorization of the Commission for the Monitoring of Health Research Projects of the Municipal Health Department of the City Hall of Florianópolis, as an integral part of the project Rehabilitation in primary health care: Practice of nurses. All the guidelines of the Resolution n. 510, of 7 April 2016, of the National Health Council[21], were met for the development of this study.

Result

Of the 16 nurses interviewed in a Health District of Florianópolis, 10 had already assisted or assist at the moment people with SCI and 6 had never assisted people with this condition. After analysis of the interviews and observation of the nursing consultation, to verify whether, in practice, the professional acted as in the speech, exercising or not a rehabilitating care, three categories emerged, and some professionals fell into more than one: *Rehabilitating care; Prejudice-based care* and *Care with difficulty*, as shown in Graph 1 below:

Graph 1 – Representation of care categories, Florianópolis, Santa Catarina, Brazil – 2021



Source: created by the authors.

Rehabilitating care, perceived in 50% of cases, helps the person to acquire and maintain optimal functionality in interaction with the environment around them, seeking to develop capabilities

with their new condition, prevent aggravations and complications, for better quality of life[7]. In this regard, the participants stated:

> *I think it's* [...] *being able to give a little new meaning to that process* [...] *trying to alleviate what's already in place and trying to reverse everything that's possible.* (P16).

> [...] *the intention is to resume function or mechanisms that help to carry out these activities in another way.* (P3).

Regarding care with difficulty, in 13% of the situations, it was noticed the lack of knowledge and training of the professional about the subject, in words like:

> [...] *despite being quadriplegic, he sits.* (P2).

> [...] *I don't have specific training, if I think about dealing with these patients who use wheelchairs, who have paraplegia, tetraplegia. I don't feel qualified.* (P4).

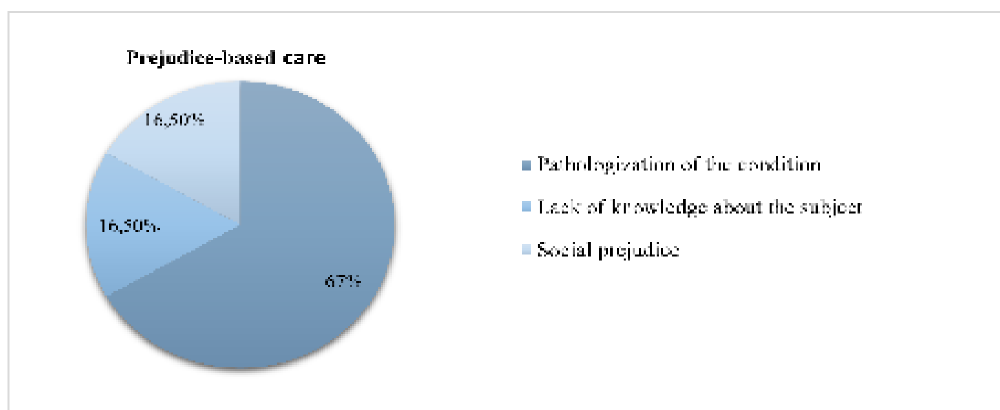
In 6% of the cases, there was a mixture between care with difficulties and prejudice-based care, due to the pathologization of the situation, when the professional claimed that it was the doctor who followed the person, as if the nurse was not qualified to do this follow-up, in phrases such as:

> [...] *some patients are only assisted by the doctor.* (P11).

> [...] *a patient was shot and left paralyzed, but I don't know if it is considered a spinal cord injury?* [...] *he used to go for the probe and for the evaluation, when he opened this wound* [...] *he used to go almost every week.* (P10).

The prejudice-based care, 31% of cases, was subdivided into pathologization of the condition, social prejudice and lack of knowledge about the subject, as shown in Graph 2, below:

Graph 2 – Prejudice-based care. Florianópolis, Santa Catarina, Brazil – 2021



Source: created by the authors.

The pathologization of the condition was the most prominent area within the prejudice-based care, reaching 67% of situations in which professionals believe that the person with SCI due to their *pathology* should be treated primarily by the team doctor, in words such as:

> [...] *their things are more for* [...] [doctor's name hidden] *than mine* [...] *for pathology* [...]. (P1).

> [...] *I don't know* [...] *the doctor* [...] *she has more contact with it, she talks about it a lot* [...]. (P13).

The situation of prejudice-based care can be identified with respect to social prejudice in the passage: "The perception we had is that he was an invalid (P9)". As for the lack of knowledge about the subject, it occurs when the nurse associates time to the execution of rehabilitation care, identified in the speech:

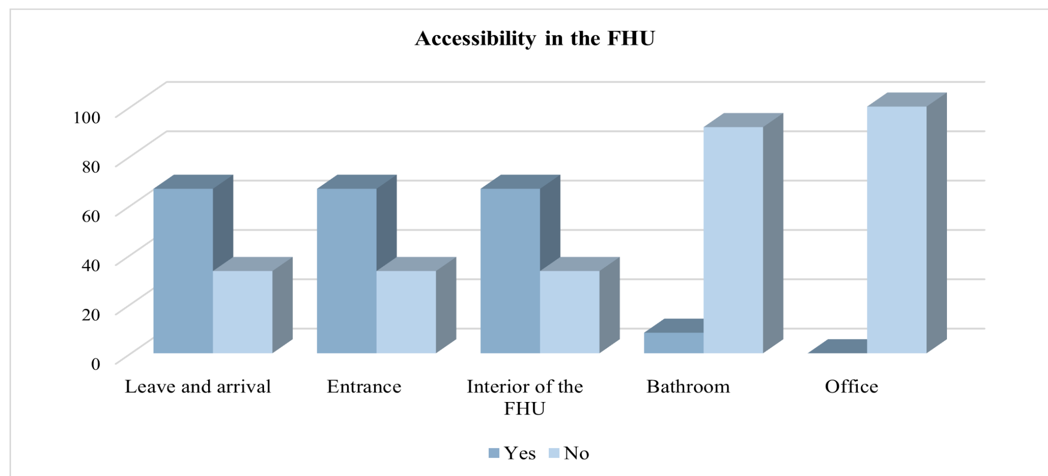
> [...] *I think we would have a very important role in the issue of rehabilitation* [...] *if we had more time for that* [...]. (P12).

Notwithstanding, the Municipal Health Department of Florianópolis has a permanent commission for the nursing systematization, which successfully develop protocols that guide nurses' service in PHC, there are no protocol documents regarding the care of people with

SCI[22]. There is also the Practical Approach to Care Kit (PACK), a program developed to improve health systems and to instrumentalize the work of professionals in primary care, aiming to strengthen health services so that better results are achieved. However, this program also does not cover the specificities of the care of these people[23].

Concerning the architectural observation, an observation roadmap was used based on the technical standard ABNT NBR 9050:2020[24], which provides about accessibility to buildings, furniture, urban spaces and equipment, to assess the accessibility in the FHU, and the following situation is found:

Graph 3 – Accessibility in healthcare facilities in Florianópolis, Santa Catarina, Brazil – 2021



Source: created by the author.

The following parameters were found: 66.67% of the FHU have leave and arrival place; of 58.33% of spaces that have parking, only 50% have reserved places for disabled people and those that have these places, only 33.33% are in accordance with what the technical standard establishes. There was no report regarding the findings by nurses.

The place of leave and arrival is essential for a person with reduced mobility, since it allows them to stay closer to the destination, however, parking is also relevant, because it allows the disabled person to drive alone and park more safely, which gives them greater independence.

In relation to the entrance, 66.67% of the FHU are accessible, 100% have viable doors, but only 33.33% have adequate access ramps. The ramp adjusted to the standards is fundamental, because if it exists, it is because there are stairs on site, and it is the way that will allow the person in a wheelchair (P.W.C.) to enter the place with greater ease and independence.

About the interiors, in 100% of the FHU surveyed, there are: corridors with adequate width for the transit of P.W.C.; at least one of the rooms for each type of accessible service; arrangement of furniture that allows the circulation of wheelchair and floors with regular, firm, stable and non-slip surface. Nevertheless, in 8.33%, there are no return pockets, which facilitate the complete maneuver of a wheelchair, enabling mobility in the corridors. In 72.73% of them, there are no accessible drinking fountains, which allows the wheelchair user to drink water independently. Thus, of the evaluated aspects, there is a total of 66.67% of suitable environments.

An alarming aspect is that only 8.33% of the bathrooms comply with the regulations. Only 25% of the bathrooms have support bars next to the washbasin, at this height, or, in the case of those built into countertops, there are no support bars fixed on the side walls. These items provide greater security and independence. In 25% of the

washbasins, there is no front approach area for P.W. C. to extend.

In 66.67% of these toilets, the taps of the washbasins can be activated by lever, electronic sensor or equivalent devices, because many people with this condition cannot make the movement to open a threaded tap. In the sanitary boxes, 75% have easy-opening handles (lever type), which is interesting for the same reason as the tap, since the rotating handle or other similar model can hinder opening and restrict access.

Significant fact is that only 33.33% of these accessible toilets have a washbasin in the box, which is a low number, since most of these people self-catheterize to empty the bladder. The lack of a washbasin hinders hygiene, and may increase the incidence of recurrent urinary tract infection (UTI), one of the main pathologies that affect this population.

Regarding the support bars, 91.67% are allocated to the chamber pot, however, in only 66.67% of cases they comply with the standard, being essential to provide support and safety for the transfer. Another hindrance is that only 58.33% of these places guarantee areas for diagonal, lateral and perpendicular mobility, as well as maneuvering area for 180º rotation, essential requirements to cover the diversity of disabilities.

The height of the sanitary basins is adequate in only 8.33%, parameter that should be similar to the wheelchair seat, to avoid falls or traumas during the transfer. The flush trigger is appropriate in 75% of the places, which means that in 25% of the bathrooms, the person needs help even to trigger the flush.

In 100% of the spaces where nursing consultations take place, there are doors with the possibility of being opened with a single movement, with lever-type handles, adequate door dimensions and physical space that allows the entry of a wheelchair, plus area for wheelchair maneuvering without displacement.

Nonetheless, in 100% of the offices, including the recently built units, there is no accessible stretcher (which can be lowered to facilitate transfers) in any sector of the health unit, which makes it difficult to provide basic care, as, for example, the performance of a cytopathological examination in a woman in a wheelchair. The accessible stretcher is not part of NBR 9050:2020, however, the researchers included it because they consider an important factor to perform due care, since the stretcher is already high for a person without limitations, so much so that there is a ladder to climb it, in the case of a wheelchair, it would be necessary many individuals to assist this effort.

Therefore, the main finding on accessibility is that none of the FHU in this District is 100% accessible. The one that came closest to this possibility only did not reach the totality because it did not have a suitable stretcher on site, but was fully in accordance with the technical standard.

The interviewees revealed tensions in the dynamics regarding the power relations of social actors verified in nursing care, which needs to be rescued as a constitutive praxis of the work process, not only as rhetoric, but in synergy between management, health professionals and people with SCI.

Discussion

As observed, the nursing care performed by PHC nurses contributes to people develop their potential to face and overcome the restrictions and adversities arising from the new condition resulting from the health-disease process. Half of these professionals (50%) perform a rehabilitating care whose praxis has a transformative intention in the life of the person, aiming at greater independence through the prevention of worsening disabilities or the emergence of complications, with preservation and restoration of residual functionality and encouragement to social inclusion, although there are some professionals who are not aware that they perform a rehabilitating care. However, the lack of accessibility becomes an obstacle to this service and to the due attendance of people with SCI in PHC.

The LBI-PcD marks the advance in relation to benefits, visibility and contemplation of other rights, which advances state legislation. It

highlights the importance of guaranteeing to DP the full exercise of their social rights to health and public building, aiming at their well-being. When the state regulates Direct and Indirect Public State Administration, health care providers have an obligation to provide priority and appropriate care for DP, ensuring that these individuals have access to public or private health services. Thus, health institutions should allow the access and use of goods and services to these individuals by eliminating architectural barriers and obstacles[8].

Currently, the Proposal for an Amendment to the Constitution (PEC) n. 33/2021 is in progress in the Chamber of Deputies, which originated in the Senate with PEC n. 19/2014, which aims to insert the right to accessibility and mobility among the individual and collective rights of art. 5th of the Federal Constitution[25]. The importance of including accessibility and mobility rights among the stone clauses is irrefutable, but one of the biggest problems is the lack of applicability of current legislation, which establishes accessibility that has not been implemented so far.

NBR 9050:2020 establishes how accessible spaces should be, however, it is not followed in basic items, such as the presence of a washbasin in the sanitary box intended for DP[24]. Furthermore, this technical standard still lacks adaptations, such as the fact that it does not cover accessible stretchers in public health services, an item considered essential by researchers for the proper care of these people and, therefore added in the note for accessibility consideration.

How to expect a person with SCI to go to the PHC for a PI dressing, for example, if they do not have a suitable stretcher for their care? Will the health professionals of these places have to group those present to help this person climb on the stretcher? And when there is no one on site who can support, is there need to reschedule the care? How to perform a rehabilitating care in these conditions? Will this person need help every time they need to quench their thirst or go to the bathroom?

Accessibility is of paramount importance to increase self-esteem and promote the independence and freedom of the person with disabilities. Until when will their rights be suppressed by the inobservance and inapplicability of the current legislation? The legislation of a country aims to guarantee legal security for its citizens, especially with regard to fundamental rights such as health, but for these rights to be effective, the standards must be followed and, in relation to accessibility, Brazil is still far from this goal.

According to the World Health Organization[26], although people with disabilities require additional health care, they face obstacles to access this type of service, so as to have harmful consequences for their health and well-being. The mortality rate is 2 to 3 times higher than the average population and demand higher care costs, since they seek assistance already with aggravated health situations, requiring, as a corollary, more complex and expensive treatments. Rehabilitation is cited as a point of global attention, essential for universal coverage of services, as proposed in the 2030 Global Rehabilitation Agenda[27-28].

In a recent study, conducted by Brazilian researchers with people with SCI, many participants reported that there were no significant changes in their routine due to the pandemic of the new coronavirus (SARS-CoV-2), because they already experienced social isolation, being prevented from participating in society due to the accessibility challenges existing in Brazil[29]. Other studies have reinforced this context that architectural accessibility is not effective and confirmed the dissatisfaction of health service users, due to the fact that the structures do not meet their needs, hindering their mobility[30].

Inclusion is intended to generate conditions so that DP can relate naturally, participate in the social environment in which they live, with the possibility of passing through any building, whether public or private, advancing towards equal rights to integrate and participate in all social environments, without experiencing any kind of discrimination or prejudice. Accessibility, in its different forms, promotes this inclusion[31]. PHC is an important support base for the person with SCI, to favor rehabilitation, but it requires the promotion of accessibility in these places.

However, with this research, it is noticed that this inclusion is still far from being achieved, because if there is no adequate accessibility in health services, let alone in other places.

It was also noted that half (50%) of the nurses working in this first level of health care provides comprehensive and rehabilitating care, but the large number of professionals (31%) is worrying - the second largest category found – that exercise care based on prejudices, whether social (16.50%), lack of knowledge of the subject (16.50%) or pathologization of the condition (67%).

The pathologization of the condition may be a consequence of the biomedical model-centered culture, which considers disability as a health/disease problem, such as failure of a body system or function that is abnormal and pathological and, consequently, must be treated by a doctor[7], thought still present in the speech of many nurses interviewed.

The biomedical model has long prevailed in the health field, focused on disease, in which, often, the person was called by their own pathology[7]. Nevertheless, over the years, there was a modification in the light nursing care technology, which began to consider the person in a holistic way, as well as the instrumentality in the health service, providing an integrated scientific, collaborative and participative care that respects and ponders the socioeconomic and cultural context in which the person is inserted, but as it was possible to perceive, there are still many professionals in transposition[32].

However, it is questioned how much health practices have actually expanded rehabilitation care or just emptied its concepts, without a paradigm shift in relation to health care, in the function of power relations established in the hegemonic biomedical model that sometimes leads to fragments and contradictions reflected in services. In this context, interrelations directly interfere with the rehabilitation process, along with other economic, political, cultural, historical and religious determinants that violate the right of people with SCI and are not recognized[13,32]. The World Health Organization[26] understands that, for the inclusion of DP, it is necessary to guarantee fundamental rights, in order to take into account the principle of equity, accessibility to services, health care equipment, products and environments and comprehensive care considering each phase of life and inclusive health systems.

Nevertheless, even with policies directed to DP, the appropriate implementation has not yet been achieved, resulting in non-compliance by public institutions, including health agencies. The absence of supervision and planning actions to certify health units are considered as fundamental causes of lack of accessibility[33]. In addition, the absence of architectural accessibility, as well as in services, favors the exclusion of DP in environments essential for their formation as citizens[34].

The analysis of the data collected showed as a limitation of the study the restriction of collection in an area of coverage of the study restricted to the municipal scope. However, since the data extraction reaches only one District, although it is a relevant cut of coverage for this municipality, it would not be possible to generalize as a photograph of the national territory, which opens space for replication of the research.

Thus, the present study, given the results presented, contributes to serve as a basis for future research applications of public policies that promote interventions aimed at improving the lives of people in rehabilitation, as well for reflection of health professionals, since it shows the reality experienced by individuals with SCI when seeking care in PHC.

Final Considerations

In the praxis of nursing in rehabilitation, it was noticed that most PHC nurses perform a rehabilitative reflexive care, aiming at the integrality of the person with SCI, seeking the improvement of individual functionality to promote independence, social reintegration and quality of life, as a proposal for improving the technologies used. Therefore, there should be training and development in the continuing and permanent

education of the professionals involved, in order to minimize inequalities in health.

A major obstacle to this is still the lack of accessibility, despite all existing legislation on the subject, due to the lack of formal standardization for the construction of the ideal architectural model corresponding to that available at ABNT. Thus, it is perceived that we still need to work in favor of the inclusion of DP in society, to meet the scope of rehabilitation and existing policies.

There should be a fight against prejudice, since most of the health professionals participating in the research denote working on the basis of the biomedical model, considering disability as a pathology that must have treatment performed by the doctor, instead of a holistic care performed by nursing in rehabilitation, to meet what the Principle of Integrality of the UHS and evidence-based rehabilitation advocate.

Collaborations:

1 – conception and planning of the project: Deisimeri Francisca Alves and Soraia Dornelles Schoeller;

2 – analysis and interpretation of data: Deisimeri Francisca Alves, Soraia Dornelles Schoeller and Tony Ely de Oliveira Cunha;

3 – writing and/or critical review: Deisimeri Francisca Alves, Soraia Dornelles Schoeller, Tony Ely de Oliveira Cunha, Sandra Urbano dos Santos and Thiara Silveira de Freitas;

4 – approval of the final version: Deisimeri Francisca Alves, Soraia Dornelles Schoeller, Tony Ely de Oliveira Cunha, Sandra Urbano dos Santos, Thiara Silveira de Freitas and Adilson de Godoi.

Competing interests

There are no competing interests.

Funding sources

One of the authors is supported by the Coordination for Improvement of Higher Level Personnel academic Excellence Program CAPES/PROEX, Brazil.

Acknowledgements

We would like to thank the Health Department of the city of Florianópolis for collaborating with the research development.

References

1. Clares JWB, Guedes MVC, Freitas MC. Construction of nursing diagnoses for people with spinal cord injury in rehabilitation. Rev esc enferm USP. 2021;55:e03750. DOI: https://doi.org/10.1590/S1980-220X2020038403750
2. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Diretrizes de Atenção à Pessoa com Lesão Medular [Internet]. Brasília (DF); 2015 [cited 2022 Jan 22]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_atencao_pessoa_lesao_medular_2ed.pdf
3. Reynolds NR. The year of the nurse and midwife 2020: activating the potential and power of nursing. Rev Latino-Am Enfermagem. 2020;28:e3279. DOI: https://doi.org/10.1590/1518-8345.0000-3279
4. Cabral DS, Nascimento MC, Miranda TPS, Silva Júnior SI, Bittencourt F, Silva SA. Evaluation of healthcare networks by nurses in the Family Health Strategy. Rev esc enferm USP. 2020;54:e03589. DOI: http://dx.doi.org/10.1590/s1980-220x2018048703589
5. Garcia NP, Viana AL, Santos F, Matumoto S, Kawata LS, Freitas KD. The nursing process in postpartum consultations at Primary Health Care Units. Rev esc enferm USP. 2021;55:e03717. DOI: http://dx.doi.org/10.1590/s1980-220x2020005103717
6. World Health Organization. Rehabilitation [Internet]. Geneva (CH): 2024 [cited 2024 May 28]. Available from: https://www.who.int/news-room/fact-sheets/detail/rehabilitation
7. Schoeller SD, Martins MM, Faleiros F, Ramirez N. Enfermagem de reabilitação. Rio de Janeiro (RJ): Thieme Revinter; 2021.
8. Rocha LRM, Oliveira JP. Detailed textual analysis of the Brazilian Inclusion Law: perspectives and advances in relation to the rights of people with disabilities. Práxis Educativa. 2022;17:1-16. DOI: https://doi.org/10.5212/praxeduc.v.17.19961.048
9. Giovanella L, Martufi V, Ruiz DC, Mendonça MHM, Bousquat A, Aquino R, et al. The contribution of

Primary Health Care in the SUS network to face Covid-19. Saúde debate. 2020;45(130):748-62. DOI: https://doi.org/10.1590/0103-1104202113014

10. Brasil. Ministério da Saúde. Portaria Nº 397, de 16 de março de 2020. Altera as Portarias de Consolidação nº 2/GM/MS, de 28 de setembro de 2017, nº 5 de 28 de setembro de 2017, e nº 6/GM/MS, de 28 de setembro de 2017, para dispor sobre o Programa Saúde na Hora, no âmbito da Política Nacional de Atenção Básica [Internet]. Brasília (DF); 2020 [cited 2022 Feb 02]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2020/prt0397_16_03_2020.html

11. Felisbino J, Nitschke RG, Viegas SMF, Machado WCA, Marco SS, Tholl AD. Potencies-limits in the rehabilitation of people with post-COVID-19 sequelae in everyday primary health care. Rev Interfaces. 2023;11(2):1968-78. DOI: https://doi.org/10.16891/2317-434X.v11.e2.a2023.pp1968-1978

12. Acordi I. Reabilitação na atenção primária à saúde: práxis do enfermeiro [dissertação]. [Internet]. Florianópolis (SC): Universidade Federal de Santa Catarina; 2022 [cited 2024 Sep 22]. Available from: https://repositorio.ufsc.br/xmlui/handle/123456789/240891

13. Schoeller SD, Martins MMFPS, Ramos FRS, Vargas CP, Zuchetto MA, Lima DKS. Rehabilitation nursing care and emancipatory process. Rev Enf Ref. 2020;5(2):e19084. DOI: https://doi.org/10.12707/RIV19084

14. Alves DF. Práxis do enfermeiro da atenção primária no cuidado às pessoas com traumatismo da medula espinal [trabalho de conclusão de curso]. [Internet]. Florianópolis (SC): Universidade Federal de Santa Catarina; 2022 [cited 2024 Oct 06]. Available from: https://repositorio.ufsc.br/handle/123456789/230859

15. Pereira LTK, Godoy DMA, Terçariol D. Case study as scientific research procedure: reflection from clinical work. Psicol Reflex Crit. 2009;22(3):422-9. DOI: https://doi.org/10.1590/S0102-79722009000300013

16. Oliveira ESF, Brasil CCP, Higa EFR. Qualitative research in health: countless possibilities and views. Ciênc saúde coletiva. 2021;26(2):384-5. DOI: https://doi.org/10.1590/1413-81232021262.40972020

17. Santa Catarina. Prefeitura de Florianópolis. Informações de Saúde. População Ativa na APS [Internet]. Florianópolis; 2022 [cited 2022 Feb 12]. Available from: https://sus.floripa.br/info/

18. Minayo MCS, organizadora. Pesquisa social: teoria, método e criatividade. Petrópolis: Vozes; 2002.

19. Yin RK. Estudo de caso: planejamento e métodos. 2. ed. Porto Alegre: Bookman; 2015

20. Minayo MCS. Qualitative analysis: theory, steps and reliability. Ciênc saúde coletiva. 2012;17(3): 21-6. DOI: https://doi.org/10.1590/S1413-8123 2012000300007

21. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução Nº 510, de 07 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais [Internet]. Brasília (DF); 2016 [cited 2022 Feb 24]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2016/res0510_07_04_2016.html

22. Santa Catarina. Secretaria Municipal de Saúde de Florianópolis. Protocolos de enfermagem [Internet]. Florianópolis (SC); 2023 [cited 2023 Sep 19]. Available from: https://www.pmf.sc.gov.br/entidades/saude/index.php?cms=protocolos+de+enfermagem&menu=9&submenuid=1478

23. Rede de Pesquisa em Atenção Primária à Saúde. Programa PACK Brasil Adulto: ferramentas para profissionais de saúde [Internet]. Brasília (DF); 2022 [cited 2022 Feb 11]. Available from: https://redeaps.org.br/2021/06/27/programa-pack-brasil-adulto-ferramentas-para-profissionais-de-saude/

24. Associação Brasileira de Normas Técnicas. NBR 9050: acessibilidade a edificações, mobiliário, espaços e equipamentos urbanos [Internet]. São Paulo (SP); 2020 [cited 2022 Jan 04]. Available from: https://www.abntcatalogo.com.br/

25. Brasil. Câmara dos Deputados. Proposta de Emenda à Constituição (PEC) nº. 33, de 01 de outubro de 2021. Altera o art. 5º da Constituição Federal para prever o direito fundamental à acessibilidade e à mobilidade [Internet]. Brasília (DF); 2021 [cited 2022 Feb 04]. Available from: https://www.camara.leg.br/propostas-legislativas/2301270

26. World Health Organization. Countries in the European Region commit to disability-inclusive health systems and societies [Internet]. Geneva (CH): 2022 [cited 2024 May 28]. Available from: https://www.who.int/europe/news/item/14-09-2022-countries-in-the-european-region-commit-to-disability-inclusive-health-systems-and-societies

27. World Health Organization. Fifth Global Forum on Human Resources for Health [Internet]. Geneva (CH): 2023 [cited 2024 Sep 23]. Available from: https://www.who.int/teams/health-workforce/about/5thglobalforum-hrh

28. Cieza A, Causey K, Kamenov K, Hanson SW, Chatterji S, Vos T. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study, 2019. Lancet. 2020;396(10267):2006-17. DOI: https://doi.org/10.1016/S0140-6736(20)32340-0

29. Faleiros F, Alves D, Schoeller SD, Machado GCA, Corbo L, Zuchetto M. What Will the Post-Pandemic World Be Like?: A Qualitative Study on the Perceptions of Brazilians with Spinal Cord Injury. J Rehabil Health Stud. 2022;9(1):e113705. DOI: https://doi.org/10.5812/mejrh.113705

30. Dos Santos I, Lima FPA, Resende AD, Guimarães MP. Promoting accessible environments through user experience return: standardized accessibility and real accessibility. Rev Projetar. 2022;7(2):148-60. DOI: https://doi.org/10.21680/2448-296X.2022v7n2ID27738

31. Cantorani JRH, Pilatti LA, Helmann CL, Silva SCR. The accessibility and the inclusion in a Higher Education Federal Institution since the law no. 13.409. Rev Bras Educ. 2020;25:e250016. DOI: https://doi.org/10.1590/s1413-24782020250016

32. Cunha TEO, Schoeller SD, Martins MMFPS, Alves DF, Vargas CP, Zuchetto MA, et al. Rehabilitation: collective construction of a concept in a focus group. F1000Res. 2023;12:1-14. DOI: https://doi.org/10.12688/f1000research.129073.1

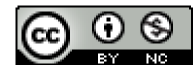
33. Araújo YFL, Coura AS, França ISX, Souto RQ, Rocha MA, Silva JC. Accessibility to Basic Health Units for People with Physical Disabilities. Cogitare Enferm. 2022;27:e75651. DOI: http://dx.doi.org/10.5380/ce.v27i0.75651

34. Rodrigues M, Bernardino JLF, Moreira MV. Attitudinal barriers: the exclusion that limits the accessibility of people with disabilities. Rev Ibero-AM Estud Educ. 2022;17(2):1311-26. DOI: http://dx.doi.org/10.21723/riaee.v17i2.15058

Received: July 29, 2024

Approved: October 26, 2024

Published: January 08, 2025



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