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ORIGINAL ARTICLE

CHARACTERIZATION OF THE OCCUPATIONAL THERAPY SERVICE IN A CENTER OF REHABILITATION AND PHYSICAL MEDICINE

CARACTERIZAÇÃO DO SERVIÇO DE TERAPIA OCUPACIONAL EM UM CENTRO DE REABILITAÇÃO E MEDICINA FÍSICA

CARACTERIZACIÓN DEL SERVICIO DE TERAPIA OCUPACIONAL EN UN CENTRO DE REHABILITACIÓN Y MEDICINA FÍSICA

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ABSTRACT

Objective: to characterize the Occupational Therapy service in a Center of Rehabilitation and Physical Medicine reference. ***Method:*** descriptive, exploratory study, with a quantitative approach, with documentary basis of records in the period of 2011-2013 and observation of the service in Recife (PE), Brazil. For analysis, Microsoft Office Excel 2013® was used. ***Results:*** there was a reduction in the average waiting time to start Occupational Therapy; few professionals refer patients with any level of dependency for Occupational Therapy; occupational therapists of the service use the Bobath Concept as the main approach. ***Conclusion:*** the study helped to publicize the work of the occupational therapist providing a profile of the clientele and increasing the number of referrals and actions. ***Descriptors:*** Rehabilitation Centers; Occupational Therapy; Rehabilitation.

RESUMO

Objetivo: caracterizar o serviço de Terapia Ocupacional em um Centro de Reabilitação e Medicina Física de referência. ***Método:*** estudo descritivo e exploratório, de abordagem quantitativa, com base documental de prontuários no período de 2011-2013 e observação do serviço em Recife (PE), Brasil. Para análise foi utilizado o *Microsoft Office Excel 2013®*. ***Resultados:*** foi observada a redução no tempo médio de espera para iniciar a Terapia Ocupacional; identificado que poucos profissionais encaminham pacientes com algum nível de dependência para Terapia Ocupacional; os terapeutas ocupacionais do serviço usam o Conceito Neuroevolutivo Bobath como principal abordagem. ***Conclusão:*** o estudo contribuiu para divulgar o trabalho do terapeuta ocupacional oferecendo um perfil sobre a clientela atendida e aumentar o número de encaminhamentos e ações. ***Descritores:*** Centros de Reabilitação; Terapia Ocupacional; Reabilitação.

RESUMEN

Objetivo: caracterizar el servicio de terapia ocupacional en un Centro de Rehabilitación y Medicina Física de referencia. ***Método:*** estudio descriptivo, exploratorio, con enfoque cuantitativo, con base documental de registros en el período 2011-2013 y observación del servicio en Recife (PE), Brasil. Para el análisis, se utilizó Microsoft Office Excel 2013®. ***Resultados:*** se observó una reducción en el tiempo medio de espera para iniciar la terapia ocupacional; fue identificado que algunos profesionales se refieren los pacientes con cualquier grado de dependencia para Terapia Ocupacional; terapeutas ocupacionales del servicio utilizan el Concepto Bobath como el enfoque principal. ***Conclusión:*** el estudio ayudó a divulgar el trabajo del terapeuta ocupacional que proporciona un perfil de la clientela y a aumentar el número de referencias y acciones. ***Descriptores:*** Centros de Rehabilitación; Terapia Ocupacional; Rehabilitación.

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INTRODUCTION

According to the United Nations (UN), the rehabilitation in health care can be defined as "a time-limited process and with determined purpose, in order to allow a disabled person to reach the excellent physical, mental and/or functional-social levels"[1]. Thus, rehabilitation programs intend to develop the skills, with personal and community resources in order to promote independence and social inclusion of people with disabilities.[2]

In this context, the occupational therapist deals with the value, dignity and the reconstruction of a satisfying life with purpose, using human action, through the activities of the everyday and practical life of assisted individuals. The fundamentals of Occupational Therapy direct the professional to exam the patient beyond the disability and limitations, seeking to highlight the remaining capacity, valuing everything that is healthy.[3-4] Thus, it can be said that the goal of occupational therapy is to restore the patients to their maximum level of functional performance and independence in activities of daily living (ADLs), productive and leisure.[5-6]

Despite directly acting on the components of physical performance, the occupational therapist engaged in physical rehabilitation also develops, as far as possible, actions that impact on cognition and psychosocial aspects, promoting a more complete rehabilitation, social integration and improved quality of life.

A good indicator of the need for professional assistance in physical rehabilitation is the census of the Brazilian Institute of Geography and Statistics (IBGE), which, in 2010, indicated that the Northeast has had, since the census of 2000, the highest rate of disabled people in the country, with 26.63%. In this region, in the state of Pernambuco, among 2,425,900 inhabitants, 27.58% have at least one type of disability, exceeding the national average of 23.9%, the fifth largest national index.[7-8]

Given the scenario of a high number of people with disabilities and insufficient assistance in most municipalities, it was published the Ordinance No. 818/01 of the Ministry of Health/Office of the Minister. It recommends that the State Health Departments and the Federal District structure Physical Rehabilitation Networks with hierarchical and regionalized services, based on the principles of universality and comprehensiveness of health actions. Thus, it seeks to ensure to people with disabilities assistance at all levels of complexity, through multidisciplinary teams, being the occupational therapist required component in highly complex services and optional in less complex services. In addition, it was published the Decree Nº 185/01 of the Ministry of Health/Department of Health Care, which describes the changes of rehabilitation services and the regulation of procedures and forms to be used.[9-12]

Given the situation and the fact that there are few studies that address the characterization of physical rehabilitation services in the national context, this study characterizes the Occupational Therapy service in a Center of Rehabilitation and Physical Medicine reference.

METHOD

Descriptive and exploratory study, with a quantitative approach, conducted at the Center of Rehabilitation and Physical Medicine Professor Ruy Neves Baptista, located in the Institute of Comprehensive Medicine Professor Fernando Figueira (IMIP) in Recife (PE), Brazil.

For the study, data related to the last three years of operation, 2011, 2012 and 2013, were collected. Regarding the Center of Physical Rehabilitation, were surveyed: the services, human resources and infrastructure. And regarding the service of occupational therapy in adult neurology sector: referrals of attended patients according to the origin and specialty, the average time in the queue to start occupational therapy, conducts performed by occupational therapists, the justifications of discharge or disconnections, post-discharge referrals and social-epidemiological patient data. Data specific to other services provided at the Center were not included in the survey, as well as the Occupational Therapy in traumatology-orthopedic and pediatric sector.

To collect the social-epidemiological data, an analysis of medical records of patients identified in the waiting list of the described period was held, filed at the Medical Records and Statistics Department (SAME) and Rehabilitation Center. For information about the dynamics of the center, a documentary and observational research in the service was performed.

After selecting and reading the documents, the data were recorded in the Spreadsheet Program Microsoft Office Excel 2013®, analyzed and presented in the form of discursive report.

The research project was approved by the Ethics Committee in Research with human beings of the Health Sciences Center of the Federal University of Pernambuco

(CCS/UFPE), under opinion 640363/2014, CAAE 27598714.0.0000.5208.

RESULTS

In order to collect the data, all the located records were analyzed. Of those, 199 files were used in the research, being the exclusion criteria presented in Figure 1.

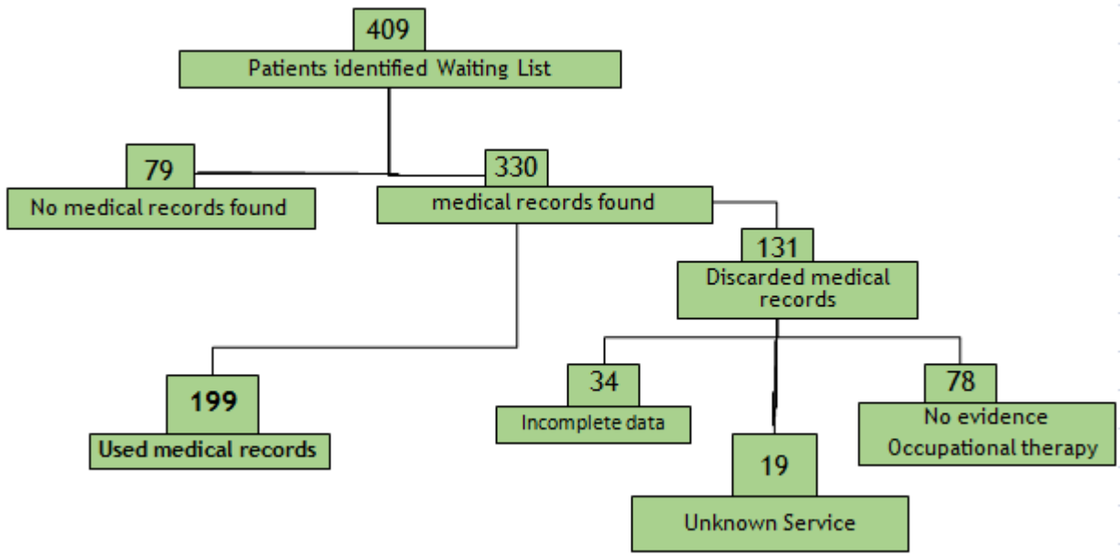

Figure 1. Organizational chart of the data collection scheme in the medical records of patients treated by occupational therapy.

As Ordinance No. 393/2010 of the Department of Health Care, on February 26 2010, the Center of Rehabilitation and Physical Medicine Professor Ruy Neves Baptista (CRIMIP) was accredited as reference service for the person with physical disabilities.[9,13]

The CRIMIP offers the service of a multidisciplinary and interdisciplinary team of social workers, nurses, physiotherapists, audiologists, doctors, music therapists, nutritionists, psychologists, nursing technicians and occupational therapists. As for the infrastructure, it has access ramps, adapted toilets, offices, interdisciplinary assessment room, a gym with equipment such as parallel bars and trampolines, a covered pool and adapted for wheelchair users thermal pool, Physiotherapy laboratory with equipment such as TENS and FES, Occupational Therapy room with AVD lab and an outdoor area for functional mobility training.[14]

In order to treat patients with some compromise in their occupational performance, the adult neurology service currently offers four occupational therapists, who are involved in various stages, from admission to discharge of those patients.

Admission of patients for neurological rehabilitation monitoring in CRIMIP is through screening, previously scheduled by referral of health professionals, and performed by a physiotherapist and a nurse, in order to assess whether the patient has, indeed, physical compromising. The exclusion criteria for the service are patients with neurological chronic compromising and already rehabilitated, that is, who have already been assisted by some rehabilitation service due to their last injury and/or who have cognitive impairment that makes it impossible to respond to verbal commands.

Thereafter, patients are referred to the Interdisciplinary Assessment, carried out by an occupational therapist, one physiotherapist and a speech therapist in order to identify which forms of therapies they fit and to conduct possible referrals to medical specialties. For entering the waiting list for this service, the patient has to belong to, at least, two of those three rehabilitation specialties. Patients who have dependence on their daily activities are admitted to the Occupational Therapy. Individuals who did not attend the service profile and receive guidance are directed to a less complex service.

The referral of patients to occupational therapy originates from different ways, being their specialties and origin sites analyzed (Figure 1). Only 19 (9.55%) external referrals to Occupational Therapy and Physiotherapy were identified, in contrast, 80 (40.2%) referrals were made just for Physiotherapy. As for the specialty, 100 (50.25%) referrals were made by neurologists. And for the origin, the amounts of referrals coming from the IMIP and Hospital Pelopidas Silveira were similar, with, respectively, 67 (33.67%) and 65 (32.66%). However, in the Interdisciplinary evaluation, other patients, in addition to those referred,

had some impairment in occupational performance, requiring, therefore, the service, joining, thus, the waiting list of Occupational Therapy.

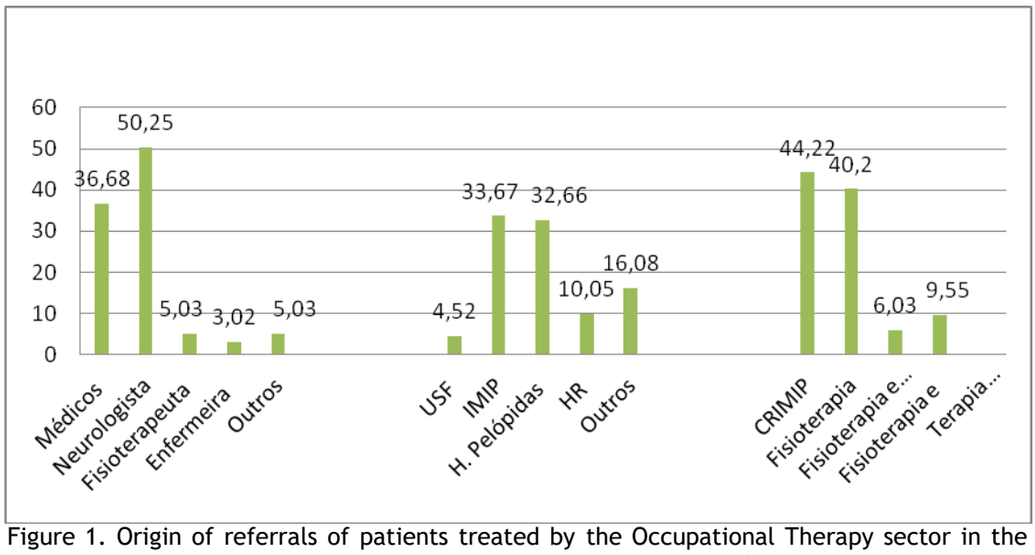

Figure 1. Origin of referrals of patients treated by the Occupational Therapy sector in the period 2011-2013, according to the specialty of source, origin and destination.

While waiting for the beginning of therapy, the patient is admitted to the Pre-attendances, consisting of eight meetings that occur weekly and are primarily directed to the most prevalent disease in the CRIMIP as cerebrovascular accident (CVA) and spinal cord injury (SCI). Professionals from various specialties of rehabilitation coordinate those meetings, which intend to promote the integration between patient and service, dynamically addressing issues related to pathology and treatments that will begin.

The average time on the waiting list to start occupational therapy was 3.27 months, not occurring simultaneously to other therapies. There was also a decrease in the average time over the last three years as graph 2 shows.

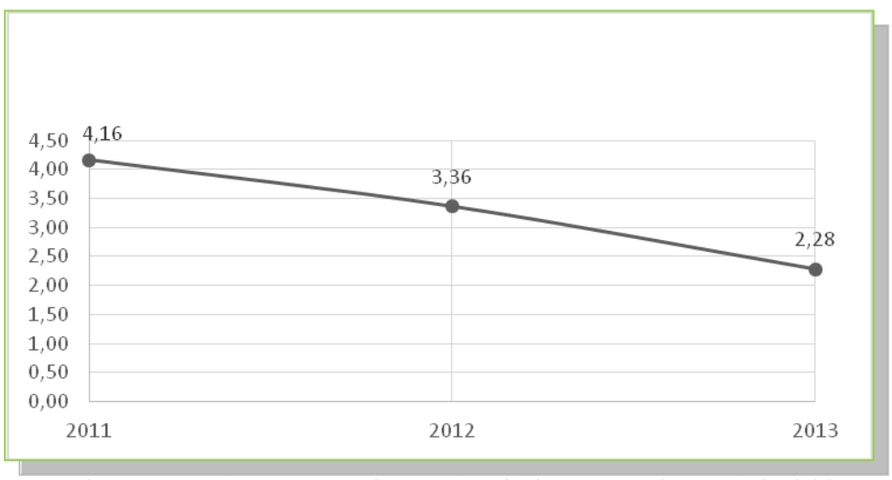

Figure 2. Average time to start Occupational Therapy in the period of 2011-2013.

When called by the Occupational Therapy, on pre-established day and time, the patient undergoes an initial assessment so that the areas, the components and committed occupational performance contexts are identified. In order to identify the priority areas of performance, directing the beginning of the treatment, the Canadian Occupational Performance Measure (COPM) is applied, performed only with the patient, excluding those with cognitive or low educational level commitment that hampers understanding and/or makes it impossible to get answers.

After starting their first therapy mode in service, the patients shall be referred to the Functional Assessment, carried out by occupational therapist, physiotherapist and psychologist, and consisting of a series of standardized instruments to monitor general physical and psychosocial aspects of the individual before, during (quarterly revaluations) and at the end of treatment. Instruments are used, such as the Functional Independence Measure (FIM), Modified Ashworth Scale, Thoracic Lumbar Performance Scale, Fugl Meyer Scale, Scale ASIA (American Spinal Injury Association), the Cognitive Levels Scale from Rancho Los Amigos, Quality

Assessment of life - WHOQOL/abbreviated SSQOL-Brazil.

Focusing on motor rehabilitation, the occupational therapist of this service uses different approaches, being the Bobath Concept elected by the service and the most used by all its professionals. In addition to the training of AVD, through exercises and activities, one seeks the restoration of the committed components that are required for occupational performance. Most patients required interventions to restore sensorimotor components such as tactile sensitivity, strength, range of motion, tone, gross and fine motor coordination (forceps and hold), control and postural alignment. Others, with a low level of dependence, required only some guidelines and adjustments to improve functional performance.

In some cases, deficits compensatory behaviors are used by changing the method the activities are performed, adapting objects, orthosis prescription and confection, and also guidelines for environmental adaptations, which may be temporary compensation, while the components are not reestablished, or permanent, when the functions before the injury cannot be entirely restored.

The need and potential for improvement are determining factors for the frequency of therapy, that may be once or twice a week, also existing the possibility of group care or with the joint efforts of professionals from different specialties.

In addition to individual assistance, occupational therapists develop orthotic workshops, performing prescription, preparation and training; and wheelchairs workshop, performing indication, measurement, adaptation and training. These services are provided both for patients admitted to CRIMIP as to other SUS users who need them.

The average treatment time was not analyzed, since this aspect is influenced by factors that are difficult to access and not available in the medical records. Due to lack of data, the main reasons for discharge were not quantified, but it was possible to verify the existence of discharge by achieved objectives and many disconnections by excessive absences in service.

Specific referrals after discharge from the service were not identified in the medical records, just a few for "maintenance" or "less complex service". Nevertheless, many referrals for cognitive rehabilitation were identified during the treatment.

With regard to diagnosis of patients, 114 (57.29%) were Encephalic Vascular Accident (EVA), 41 (20.6%) Traumatic Brain Injuries (TBI), 10 (5.03%) Medullary Lesion (ML) and 34 (17.09%) are other neuropathies, being EVA the most prevalent disease in the last three years (graph 3).

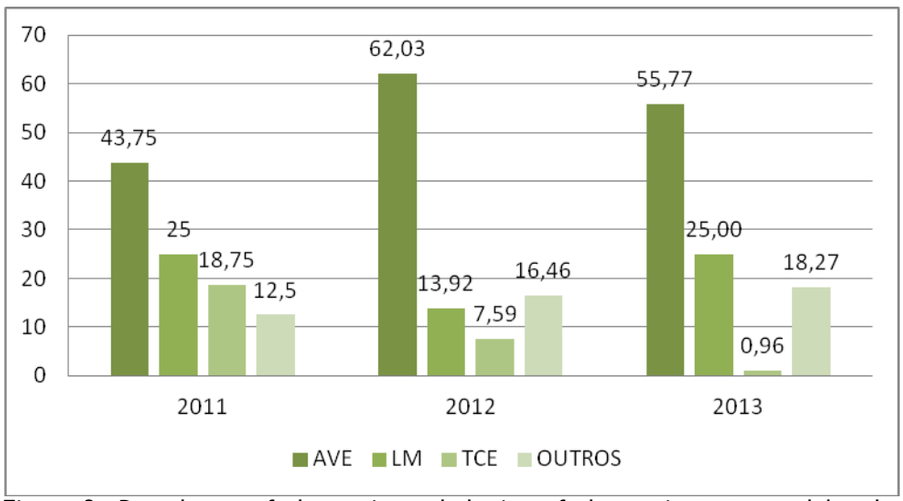

Figure 3. Prevalence of the main pathologies of the patients treated by the Occupational Therapy sector in the period of 2011-2013.

Regarding the socio-demographic profile of individuals treated at the Occupational Therapy Service (Table 1), 120 (60.3%) were men, 112 (56.28%) were between 25 and 59 years, 86 (43.22%) stated that they were married or in stable relationships, 92 (46.23%) had incomplete primary education and 183 (91.96%) were from the Metropolitan Region of Recife. Among the municipalities, there was a prevalence of 99 (49.75%) patients residing in Recife.

Table 1. Socio-demographic Profile of the patients treated by the Occupational Therapy sector in the period of 2011-2013.

Socio-demographic profile	n =199)	%
Gender		
Male	120	60.30
Female	79	39.70
Age Group		
12 - 24 Years	23	11.56
25 - 59 Years	112	56.28
> 60 Years	64	32.16
Marital Status		
Single	76	38.19
Married/Stable Union	86	43.22
Divorced	16	8.04
Widower	21	10.55
Educational Attainment		
No Education	35	17.59
Incomplete Elementary School	92	46.23
Complete Elementary School	17	8.52
Incomplete High School	10	5.03
Complete High School	35	17.59
Incomplete College	1	0.50
Complete College	9	4.52
Mesoregion of Origin		
Metropolitan Region	183	91.96
Zona da Mata	8	4.02
Agreste	6	3.02
Serão	1	0.5
São Francisco Region	1	0.5
Cities		
Recife	99	49.75
Jaboatão dos Guararapes	39	19.6
Olinda	11	5.53
Camaragibe	11	5.53
Others	32	16.08

Among the socioepidemiological data, only the quantification of the patients receiving the benefit of Continued Provision was not possible due to insufficient information.

DISCUSSION

Due to the need to resort to the evolutionary history of patients to define medical procedures, it became mandatory, by Ordinance No. 40/92 of the Ministry of Health/Department of Health Care, the registration in single medical record of care provided to the patient by all health professionals at a particular institution, including the occupational therapist.[15]

More than half of the study records were discarded because they were not found or had inconclusive data. This fact is not a characteristic specific to the described service, but reflects the difficulty of storage and control of these documents in the form of papers, associated with problems such as illegible content, incomplete or ambiguous information; downtime to more than a professional at the same time; possibility of loss and the need for physical space and personnel responsible for this storage.[16]

Furthermore, in some records, there was no description of the evolution of the development of procedures performed in many service patients, which is justified by the substantial time interval in which the daily evolutions needed to be suspended because the service faced bureaucratic difficulties, making it impossible the rehabilitation team to access the records.

Created more than a decade, the Patient Electronic Medical Record (PEP) enables quickly recording the data related to the attendances, offers greater security and reliability of records, is a vehicle of communication between the team, and increases the productivity of the service. Data from 2010 showed that only 5-9% of Brazilian hospitals have PEP, with no great prospects for short-term implementation in other services. In addition to high costs for implementation of the PEP, the absence of studies that prove the financial returns that this system can bring contributes to low investment in this technology that would bring better quality of service to patients and of work for professionals.[16-7]

The IMIP Rehabilitation Center has all the professionals required in the minimum staff in Ordinance No. 492/13 of the Ministry of Health/Department of Health Care, with the addition of a music therapist, being able to offer expert assistance to people with high complexity physical disabilities. In addition to

the multidisciplinary character, the professionals work in an interdisciplinary manner, discussing pipelines and joint action, enabling the cooperation of all in the process of fully rehabilitating the subject.[18]

The contrast between the number of referrals to occupational therapy and the number of patients requiring assistance may show lack of knowledge by other professionals of the skills of that profession. Patients with neurological impairments, given the influence of this system on the functioning of the body, are likely to have some degree of dependence. Physiotherapy, as observed, is already referenced in a more consolidated manner in the rehabilitation process. However, partially or completely restoring the physical structure does not guarantee the return of the patient's functionality. Furthermore, there are cases in which some aftereffects will be permanent, and, consequently, in the absence of assistance, so will the dependence.[7,19-21]

Thus, from the assumption that full assistance must be provided to the subject, every professional should be aware of the importance of occupational therapy, as well as other specialties. This is an indicator of what actions to implement in order to promote the role of the profession within the health care network, providing that patients return to their activities with maximum functionality and independence.

The implementation of the Pre-attendances while awaiting the beginning of the treatment, in addition to providing targeted information to patients, promotes the immediate inclusion of the service, and may contribute to the non-withdrawal of treatment while waiting in the queue.

No studies were found to serve as parameter to analyze whether the average time to onset of occupational therapy is significant. However, with regard to health procedures, an intervention as early as possible is urgent, since the long wait to start the rehabilitation can compromise the quality of patient recovery, and the establishment of permanent sequelae that compromise the quality of life . Therefore, it is worth investing in strategies such as increased professional team and expansion of physical space, thus increasing service capacity, to continue reducing this waiting time, which will serve as the service indicator for future analysis.

The Canadian Occupational Performance Measure (COPM), used in CRIMIP, is one of the ratings most used by occupational therapists both for assistance and for research, and is now implemented in over 35 countries. Its application allows for focused treatment on the priorities of the patient, the measurement of these priorities, assessing the patient's perception of their occupational performance and satisfaction related to concerning areas, quantitative and qualitative way of reassessing the changes over occupational therapy intervention program. Therefore, an evaluation is indicated for the start of therapy.[22-4]

The service system with pre-established schedule is extremely favorable for patients who do not need to wait for a full time, as in other sectors of health care, in which patients are attended in order of arrival at the service.

Regarding the Functional Assessment, this includes a variety of standardized tests, allowing to see various aspects of the patient, favoring a more targeted assistance to individual needs, monitoring the progress during treatment to check the effectiveness of the chosen behavior or changing needs and attest the gains made during treatment at discharge. In addition, the registration of such data will facilitate the discharge process, as well as the development of research.

In theory, it is expected the patient to be discharged from service after reaching its maximum level of functionality. However, in some cases, the patient no longer has a significant development, which can be led to another service, for maintenance therapy to maintain the gains. Ideally, this maintenance is performed in less complex services, near the patient’s residence. However, occupational therapists have found difficulty in performing these referrals due to the reduced number of these professionals in rehabilitation services. As a result, the patient does not fit in the service of high complexity may be deprived of assistance.

Still referring to discharges, were found many service disconnections for excessive unexcused absence, and the factors to why the patient is instructed about the allowed faults and notifying in case of illness or something that makes it impossible to attend therapy are unknown. It is therefore an important issue to be analyzed in order to minimize these problems by reducing evasion and discontinuation of treatment.

Since most patients treated at the service has a low level of income, most of those is dependent on public transport to move up to the Rehabilitation Center. Although there is some accessibility in public transport, it is still indeed the difficulty of accessibility in the streets and the lack of transport with the elevators in good working order. Recently,

State Government started the program "Pernambuco Conduz – Caminhos para a acessibilidade" to provide a free shuttle service for people with disabilities, taking them from home to care facilities with comfort and safety. Despite representing a breakthrough, this program still needs improvement with regard to compliance schedules and expansion, in order to reach the whole population. Once the wait to get started using the transport is depending on the routes and the location of the patient's residence, it can last for many months. Although the service's focus is the motor rehabilitation, a demand of some patients for therapies with primarily cognitive approach was observed. Once the stroke and TBI are among the most prevalent pathologies, depending on the location of the lesion, there may be sensory-motor impairment and cognitive from mild to severe, which is often more limiting than the physical weaknesses, and may be the main obstacle to the performance of a physical skills.

The Stroke, identified as the most prevalent disease among patients of Occupational Therapy in the last three years in service, is the second largest cause of death worldwide, and is one of the leading causes of hospitalization in the country, and cause some kind of disability in most patients.[19] In the state of Pernambuco, the mortality rate for cerebrovascular diseases was 58.2 per 100,000 inhabitants in the 2011 record, the latest of the Public Domain of the Unified Health System (DATASUS).[26] These data show the importance of investing in government campaigns to promote the control of risk factors such as hypertension, diabetes, smoking, physical inactivity and obesity, to reduce the incidence of stroke, as well as investing in deepening theoretical and practical knowledge for the multidisciplinary team that accompanies these patients.

With regard to socio-demographic data in relation to gender, the prevalence among male is consistent with other studies on the most prevalent diseases, stroke, SCI and TBI.[26-8]

Most patients seen in occupational therapy sector belonged to the age group 25-59 years, which also corresponds to the range of highest concentration of people of working age in the country.[7] It was also identified that most of the patients had incomplete primary education, as well as people with no education. The World Disability WHO report says that people with disabilities have more difficulty entering the labor market and educational background. These data, associated with the temporary or permanent removal of their production activities, hospital costs and health services use arising from disability, generate socio-economic impacts to the country and the subject.[29]

The prevalence among patients who reported being married or in a stable relationship may reflect adverse realities. The existence of a spouse and children enables their involvement in rehabilitation, as a promoter component and as partakers of treatment. The sessions in Occupational Therapy clinic are usually weekly with the need to be passed on activities of guidelines to be performed at home. Thus, the existence of a family relationship can contribute to the progress of the patient. Also should the occupational therapist be aware of the trend of overprotection in which the family performs the activities for the patient, whereas is more practical to let him try to overcome the difficulty, affecting the gain of independence.

Still on the family influence in rehabilitation, a study of patients with spinal cord injury indicates a high rate of divorce among respondents after the accident. Among them, 21 exposed the difficulty in maintaining a marital relationship when coexists dependent relationship and caregiver, as well as points the primary caregivers' reports, usually children or close relatives, who feel unprepared and overwhelmed to suddenly take on this function.

By understanding the importance of the caregiver, the CRIMIP psychology service created Caregivers Group, open to all companions of patients treated at the site. The group has at its center the caregiver, who has time and space to make interpersonal and listening exchanges with professional and other companions.

Since the occupational therapists try to see the individual holistically, and that the family makes up the environmental context of the patient, they are directly involved in the process of illness and treatment. The insertion of a disabled person in the family changes the dynamics of all its components, both for the demand for assistance and the financial commitment when the patient was the main provider. Thus, this family deserves attention and assistance from the staff at all stages of treatment, not only when we identify problems already installed.

Most patients came from the metropolitan area of Recife, indicating that few patients from distant cities go to Recife to have access to expert assistance. This may be associated with the implementation of the Physical

Rehabilitation Center in the arid zone of the state, which also features the Occupational Therapy service and other specialties. This data, however, does not exclude the need to ascertain whether the persons who do not reside in the metropolitan area have assistance.

Since disability generates socio-economic implications for the individual, it is noteworthy the importance of identifying the receipt or not of the Continued Benefit, a data not found in most of the analyzed charts. The commitments in the family income of the patient may influence their performance and commitment to treatment.

CONCLUSION

The characterization of this service enabled the visualization of relevant aspects of the Occupational Therapy service at the Center of Physical Rehabilitation of the IMIP and this professional field.

The records, besides having great value to define the conduct of all professionals, were a major source of data for research. Therefore, it is noteworthy reinforcing the importance of studies that reflect the importance of PEP, favoring its implementation, to improve the care, the communication between professionals and the access to data in researches. Similarly, one should stimulate and encourage moments so that the correct recording of information and proper storage of all documents occur.

Since the family deserves care and attention, it is suggested to complement such assistance by examining the possibility of entering, or not, the Functional Assessment of standardized tests, to identify problems in the relatives most involved in patient care, such as Caregiver Overload Scale-Zarit, which evaluates how the caregiver activities have committed his/her social life, physical and emotional well-being.

Given the difficulty of coordination between the levels of complexity in the service network, it is proposed that, alongside the Regional Council of Occupational Therapy (CREFITO), the performance and provision of the mapping of available Occupational Therapy services, so that referrals are made in a targeted way, reducing the chances of the patient being helpless when not finding a service.

Aiming to provide the fullest possible assistance to the individual, it is important to provide stable cognitive rehabilitation for patients who need it, either by linking them to another institution that offers the service or by contracting a professional for such activity.

Through this research, materials may be created as leaflets and brochures, publicizing, for the community, the types of patients and pathologies attended at this service, and what can be offered as a treatment especially by the Occupational Therapy. Similarly, it expected to raise awareness of both health professionals as government agencies about the importance and need for this profession in rehabilitation, in order to implement actions aimed at the dissemination of the service and, consequently, to increase the number of referrals for occupational therapy interventions in the area of physical rehabilitation.

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