A Intervenção Do Enfermeiro De Reabilitação Na Promoção Da Acessibilidade

La Intervención De Los Enfermeros De Rehabilitación En La Promoción De La Accesibilidad Arquitectónica

The Role Of Rehabilitation Nurses To The Architectural Accessibility Promotion

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RESUMO

Enquadramento: os enfermeiros de reabilitação são decisivos na promoção de ambientes acessíveis pela eliminação de barreiras arquitetónicas para a reintegração das pessoas com mobilidade condicionada.

Objetivos: Compreender se a eliminação de barreiras arquitetónicas são uma preocupação dos enfermeiros.

Metodologia: estudo quantitativo, descritivo, exploratório. Técnica de amostragem não probabilística acidental em bola de neve, constituída por 56 enfermeiros. A colheita de dados efetuou-se através de um questionário *ad hoc* de autopreenchimento recorrendo ao formulário *GOOGLE,* em Novembro de 2016.

Resultados: 60,7% dos enfermeiros não sabe a quem se dirigir para eliminar barreiras arquitetónicas e 58,9% não desenvolve nenhum tipo de intervenção nesse sentido. Verificamos diferenças significativas favoráveis aos enfermeiros de reabilitação em relação a deterem mais conhecimento sobre: legislação específica para a acessibilidade (p=0,000) e, a quem se dirigir para solicitar a eliminação de barreiras arquitetónicas na comunidade (p=0,024).

Conclusão: a acessibilidade e a eliminação de barreiras arquitetónicas devem fazer parte da prática diária dos enfermeiros.

Descritores: enfermagem em reabilitação; estruturas de acesso; pessoas com deficiência; limitação da mobilidade

RESUMEN

Marco contextual: Los enfermeros de rehabilitación son decisivos en la promoción de espacios accesible mediante la eliminación de barreras arquitectónicas para la integración de las personas con movilidad reducida.

Objetivo: Comprender si la eliminación de barreras arquitectónicas son una preocupación de los enfermeros

Metodología: estudio cuantitativo, descriptivo, exploratorio mediante un muestreo no probabilístico accidental en bola de nieve, con una muestra de 56 enfermeros. Se aplicó un cuestionario ad hoc de auto-llenado con recurso al formulario GOOGLE, en noviembre de 2016.

Resultados: 60,7% de enfermeros no saben a quién se deben dirigir para eliminar barreras arquitectónicas, el 58,9% no realiza ningún tipo de intervención en este sentido. Se observa diferencias significativas a favor de enfermeros de rehabilitación que tienen mayor conocimiento sobre: legislación específica para la accesibilidad (p=0,000) y a quién deben de dirigir la solicitud de eliminación de barreras arquitectónicas en la comunidad (p=0,024).

Conclusión: La accesibilidad e la eliminación de barreras arquitectónicas deben ser una parte de la práctica diaria de los enfermeros.

Descriptores: enfermería en rehabilitación; estructuras de acceso; personas con discapacidad; limitación de la movilidad

ABSTRACT

Background: the rehabilitation nurses are decisive to the promotion of accessibility trough architectural barriers elimination, which promotes the reintegration of persons with reduced mobility.

Objectives: to understand nurses' concernment about the elimination of architectural barriers.

Methodology: a quantitative, descriptive, exploratory study using an accidental non-probabilistic snowball sampling method, composed of 56 nurses. For data collection, an ad hoc self-administered questionnaire was applied, using Google forms, in November 2016.

Results: 60.7% of nurses don't know whom to adress to eliminate barriers and 58.9% did not implement any intervention in that sense. Verified significant statistical differences that favor the rehabilitation nurses concerning their knowledge about: specific legislation about acessibility (p=0.000) and whom to adress to request the elimination of architectural barriers in the community (p=0.024).

Conclusion: the accessibility and the elimination of architectural barriers should be a part of the daily pratice of nurses.

Descriptors: rehabilitation nursing; architectural accessibility; disabled persons; mobility limitation

INTRODUCTION

The influence and impact that the built environment has on people encourages them to create adaptable responses in the environment. Thus, the environment affects self-care and an adequate environment allows for personal development, the maintenance of independence despite individual capacity, the establishment of real goals and the adaptation of behavior to achieve these results. [1,2,3]

Architectural barriers are present in the various spaces and contexts of our day-to-day life and are considered obstacles built in the urban environment or in buildings and that prevent or hinder the free movement of persons who experience a temporary or permanent disability. [4.5]

In an accessible environment a person with mobility in a wheelchair, blind or elderly, does not show difficulty, but anyone in an inaccessible environment can experience mobility impaired. [6]

It is essential to understand the intervention of the rehabilitation nurse in eliminating architectural barriers and promoting accessible environments for people with limited mobility. According to the Regulation of Specific Competences of the Specialist Nurse in Rehabilitation Nursing, this professional "enables the person with a disability, activity limitation and/or participation restriction for the reintegration and exercise of citizenship" and "promotes mobility, accessibility and social participation" for the demonstration of knowledge about specific legislation, awareness of the community for the adoption of inclusive practices, identification and elimination of architectural barriers, and also being able to issue technical-scientific opinions on the structures and social equipment of the community. [7]

The study of this phenomenon should not only focus on the perspective of the person with limited mobility, but should be extended to other actors involved in this process, such as rehabilitation nurses, exploring new paths and a holistic approach to the rehabilitation process, intervening equally way, in the physical dimension, but also in other dimensions such as the social inclusion of people with disabilities. [8]

The rehabilitation nurse has a preponderant role in creating conditions that help the person with limited mobility, promoting participation in the community, favoring their autonomy and independence.

With this study we aim to: understand whether architectural accessibility and the elimination of architectural barriers for persons with limited mobility are a concern of nurses; to analyze the differences between rehabilitation nurses and other nurses regarding architectural accessibility.

The purpose of this study is to sensitize rehabilitation nurses to the promotion of architectural accessibility, in order to extend the provision of care to the level of reintegration into society and the exercise of citizenship.

Given the context, we ask ourselves: Do rehabilitation nurses have increased knowledge about the elimination of architectural barriers?

Having as research questions:

• How do nurses position themselves on the promotion of architectural accessibility?

• Are there differences between rehabilitation nurses and other nurses regarding accessibility?

This research is a previous study entitled "Architectural barriers - context of nurses" as part of a broader research project on the promotion of architectural accessibility in counties, for the inclusion of people with limited mobility, whose results are already published. [9]

METHOD

This is a descriptive, exploratory study, using the quantitative paradigm.

The nurses are the study population. The sampling technique was non-probabilistic accidental snowball, and the sample consisted of 56 nurses. Inclusion criteria: nurses who access social networks (facebook) and email, and data collection was carried out through an ad hoc self-administered questionnaire using the Google form, in the period of November 2016. The construction of the questionnaire was carried out from the current legislation by the time.

Variables considered: sociodemographic characteristics; knowledge about legislation with three dimensions: the legislation itself, the process of activating the means, the beginning of the process; knowledge of the international accessibility symbol (yes and no); interventions in daily practice; architectural barriers existing in the nurses' area of residence.

Data were processed using the IBM SPSS software program, version 20.0, and descriptive statistics were used by calculating absolute (N), relative (%) frequencies; measures of central tendency (mean and median), measures of dispersion (minimum, maximum and standard deviation) and non-parametric tests. For data analysis, a value of $p < 0.05$ was adopted – statistically significant. (10)

Throughout the research, the required ethical standards were complied with, and the study was approved by the Ethics Committee of the Nursing School of Porto (Opinion nº 11/2017). Informed consent was obtained online using the GOOGLE form, when responding to the questionnaire.

RESULTS

The sample consists of 5 male participants (8.9%) and 51 female participants (91.1%) which are on average 32 years-old, with a minimum and maximum limit of 22 and 63 respectively, and one standard deviation of 7.9 years.

With regard to years of professional practice, on average they have been working for 8.9 years, corresponding to a mode of 8 years and a standard deviation of 7.869; with a minimum of less than a year and a maximum of 37.

As for training, 44.6% have a degree, 21.4% have a specialty in rehabilitation nursing, 10.7% have another specialty, 3.6% have a master's degree in rehabilitation nursing, 16.1% have another master's and 3.6% have a PhD. Most of them work at the hospital level (76.8%), 17.9% in other places (such as homes, day care centers, schools) and 5.4% in the community.

According to the normality test (Kolmogorov-Smirnov test) we verified that the sample distribution is not normal, in terms of age or length of professional practice (p=0).

We found that 31 nurses (55.4%) have knowledge about specific legislation for accessibility to buildings and establishments that receive public, public roads and residential buildings and 25 do not (44.6%).

Regarding the process of activating means responsible for the elimination of existing architectural barriers for people with limited mobility in the community, 23 nurses (41.8%) say they know, and 32 (58.2%) do not know about the process. In case they need to request some intervention to eliminate architectural barriers for people with disabilities in the community, 22 nurses (39.3%) know who to turn to, but 34(60.7%). do not know

More than half of nurses (58.9%) in their daily practice do not develop any type of intervention to eliminate architectural barriers for people with disabilities, but 41.1% say they intervene in this area.

As for the international symbol of accessibility, 83.6% know it and 16.4% of the nurses do not know it.

From the analysis of the nurses' view of the architectural barriers existing in the environment surrounding their area of residence, we found, as shown in table 1, that sometimes sidewalks and other pedestrian paths, such as ramps and stairs, comply with the provisions of legislation (87.5 %); sports facilities have at least one accessible route for people in wheelchairs (57.1%) and an adapted shower cabin (58.9%); public pools have at least one access to water via a ramp/mechanical means (53.7%); public buildings have at least one accessible route inside (48.2%) and adapted sanitary facilities in public places such as coffee shops, schools, supermarkets, health center (69.6%).

It should be noted that regarding parking spaces for people with reduced mobility, 50% of nurses report they often exist and 25% state that they always exist. As for walks and other walking routes, nurses never mentioned always complying with the legislation.

Dimensions	Never		Sometimes		Usually		Always		Total	
	N	%	N	%	N	%	N	%	N	%
Tours and other walking routes comply with the legislation	3	5.4	49	87.5	4	7.1	0	0.0	56	100
Sports facilities have at least one wheelchair accessible route	3	5.4	32	57.1	19	33.9	2	3.6	56	100
Sports facilities have at least one adapted shower cabin	10	17.9	33	58.9	10	17.9	3	5.4	56	100
Public swimming pools have at least one access to water by ramp/mechanical means	16	29.6	29	53.7	6	11.1	3	5.6	54*	96,4
Public buildings have at least one accessible route to access their interior	4	7.1	27	48.2	19	33.9	6	10.7	56	100
Parking spaces for people with reduced mobility	0	0.0	14	25	28	50	14	25	56	100
Adapted sanitary facilities (coffee shops, schools, supermarkets, health center)	1	1.8	39	69.6	15	26.8	1	1.8	56	100

In this question there was a 'missing'

Table 1 - Opinion on the most frequent architectural barriers in accessing public places / public road, in the area of residence

There were no statistically significant differences regarding knowledge of the activation process of the means responsible for the elimination of existing architectural barriers for people with limited mobility in the community (p=0.281); specific legislation for accessibility to public buildings and establishments, public roads and residential buildings through Ordinance nº163/2006 (p=0.504); they know who to turn to if they need to request intervention to eliminate some type of architectural barrier for people with disabilities in the community (p=0.142) and; in the exercise of its daily practice, it develops some type of intervention in order to eliminate architectural barriers for people with limited mobility, promoting mobility, accessibility and participation (p=0.229).

However, there are significant statistical differences, with p = 0.000, in the knowledge of the international symbol of accessibility; in compliance with legal provisions on sidewalks and other pedestrian routes; the sports facilities have at least one wheelchair accessible route, and have at least one adapted shower cabin; in public swimming pool facilities there is at least one access to water by ramp or mechanical means; in Public Administration buildings there is at least one accessible route to access its interior; in social zones; in public services (coffee shops, restaurants, schools, supermarkets, health centers,

among others) there are sanitary facilities for people with reduced mobility; and with p=0.030 in public parks there are parking spaces for people with reduced mobility.

After analyzing the data in the overall sample, two groups were formed, nurses with a specialty in rehabilitation nursing and nurses without a specialty in rehabilitation nursing. Thus, 40 nurses do not have a specialty in rehabilitation nursing (71.4%) and 16 (28.6%) do. Nurses with a specialty have an average of 33.69 years of age, with a standard deviation of 9.17 years, and have been working for an average of 10.64 years, with a standard deviation of 9.54 years.

On the other hand, nurses without a specialty in rehabilitation nursing have an average of 31.48 years, a standard deviation of 7.44 years and have been working for an average of 8.37 years with a standard deviation of 7.22 years.

There is no association between having or not having a specialty in rehabilitation nursing and gender (p=1). There is a perfect association between professional training and being or not a rehabilitation nurse (p=0.000).

There is no association between the workplace and being or not a rehabilitation nurse (p=0.974).

There is a perfect association between being a rehabilitation nurse and having knowledge about specific legislation for accessibility to buildings and establishments that receive public, public roads and residential buildings through Ordinance No. 163/2006 (p=0.000).

There is an association between being a rehabilitation nurse and knowing who to turn to if you need to request intervention to eliminate some type of architectural barrier for people with limited mobility in the community (p=0.024) and knowledge of the activation process of the means responsible for eliminate existing architectural barriers for people with disabilities in the community (p=0.04).

There is no association between being a rehabilitation nurse and in the exercise of daily practice developing some type of intervention to eliminate architectural barriers for people with disabilities, promoting mobility, accessibility and participation (p=0.390). There is no association between being a rehabilitation nurse and knowing the international symbol of accessibility (p=0.710).

There are no statistically significant differences between the two groups regarding the existence of architectural barriers in the area of residence of these nurses, highlighting: sidewalks, ramps and stairs comply with legislation (p=0.516); sports facilities have a wheelchair accessible route (p=0.375); have an adapted shower cabin (p=0.275); in public pools there is access to water via a ramp/mechanical means (p=0.213); Public Administration buildings have an accessible route to the interior (p=0.775); in public places there are parking spaces for people with reduced mobility (p=1); in public services there are adapted sanitary facilities (p=0.317).

DISCUSSION

We wonder how nurses stand on the promotion of architectural accessibility, given that, in reality, more than half of the participants in our study (55.4%) declare that they have knowledge about the specific legislation for accessibility to buildings and establishments that receive the public. , public roads and housing buildings through Ordinance nº163/2006, of 8 August, but 44.6% of nurses do not know, despite the fact that, in our country, the legal framework of accessibility and mobility for all refers us to the year of 1997.

Currently, Ordinance No. 163/2006 of 8 August is in force, designated as Accessibility regime for buildings and establishments that receive public, public roads and residential buildings[11]. This advises the use of the international accessibility symbol, in a place that is easily seen, read and understood by anyone standing or sitting, so that they can be guided and directed towards accessible entrances/exits and routes, as well as identifying reserved parking spaces for people with reduced mobility and accessible toilet facilities.

Of the respondents, 83.6% know this symbol, however, although the legislation suggests this symbol, its use is still not widespread; since in a study carried out in 27 schools in the municipality of Chapecó, in which they assessed the external and internal environment of schools in terms of accessibility conditions, they reported that no school had the presence of this symbol. [12]

Local councils are the government body that is closer to the people and which they can use to eliminate some architectural barriers; therefore, they have a strong focus on promoting an accessible and barrier-free environment for all. [13]

In a study carried out in three counties in the center region of Portugal, in which they carried out a documentary survey of the municipal management programs in these counties, they found a housing program that aims to improve the conditions of architectural accessibility, for example, through the construction of small houses interior repairs. [5] In the same study, they also found that in some counties there are programs to intervene in the environment and in green spaces, which include measures to adapt the spaces for people with limited mobility.

When asked if they know or know the process of activating the means responsible for the elimination of existing architectural barriers for people with limited mobility in the community, 41.8% of nurses know, but more than half (58.2%) do not. In the development of their professional practice, if you need to request intervention to eliminate some type of architectural barrier for persons with disabilities in the community, 60.7% of nurses do not know who to turn to.

From this we can understand that there is no articulation between the health sector and local authorities in this matter, despite some Councils having an Provider for Persons with Disabilities, Health Promotion Offices or Active Aging Programs. [5]

The United Nations Report on the right to housing and life in cities for people with disabilities emphasizes that local authorities are extremely important in the development of plans that guarantee access without architectural barriers to public spaces and services in order to promote life independent. [14]

In order to understand whether nurses develop actions aimed at promoting accessible environments, we verified that, of the total sample and, in their daily practice, more than half (58.9%) do not perform any intervention in the scope of the elimination of architectural barriers in the community, despite "*acting as a resource for individuals, families and communities facing challenges posed by health, disability and death*". [15]

One of our goals was to analyze the differences between nurses with and without a specialty in rehabilitation nursing on architectural accessibility, so we wonder if there are differences between rehabilitation nurses and other nurses on accessibility.

According to the skills of the rehabilitation nurse [7], it is their responsibility to work for the inclusion of people with limited mobility, showing that despite the functional limitations, their integration and participation in different contexts (work, leisure...) is possible. This fact is corroborated by our study, which confirms an association between being a rehabilitation nurse and having knowledge about specific legislation for accessibility, knowing whom to turn to if needed to request intervention to eliminate some type of architectural barrier in the community, and knowledge the process of activating the means responsible for its elimination.

As one of the skills of rehabilitation nurses is to identify and guide the elimination of architectural barriers in different contexts of the person, it was expected that, in the exercise of daily practice, they would develop some type of intervention in this regard, promoting mobility, accessibility and participation. However, no statistically significant differences were found.

Regarding the existing architectural barriers in the nurses' residence area, we found statistically significant differences in the buildings of Public Administration, in which only sometimes have at least one accessible route to access its interior; in social zones. The 2011 Census, state that "the majority of buildings were not accessible to people with reduced mobility" and that around 59% of the buildings had no accessible entrance for people with reduced mobility [16].

Also the sidewalks and other pedestrian routes, such as ramps and stairs, only sometimes comply with the legal provisions, with a statistically significant relationship, and on the public road sidewalks are of great importance for people with reduced mobility and become serious barriers to the free and safe movement of people due to its inadequate dimensions or in some cases due to its absence, as well as, due to its state of conservation, bumps on the floor and the existence of plant elements, urban furniture and the inclination of the ramps that, sometimes, are so steep that have to rely on the help of others to overcome the gaps. [11, 17]

In the reality of the participants, there are significant statistical differences as to whether sports facilities have or not have at least one accessible route for a wheelchair, and at least one adapted shower cabin; and in public swimming pool facilities there is at least one access to water by ramp or mechanical means.

We know that the regular practice of physical activity, in people with physical disabilities, shows positive results in their perception of quality of life[18]. However, in a study that evaluated the main barriers and the main perceived facilitators for the practice of physical activity by people with physical disabilities, regarding indicators related to the environment and architectural accessibility, they did not find statistically significant differences; that is, these factors do not interfere positively with the practice of physical activity. [19]

Perestrelo [20] assumes it is essential to mobilize in favor of the other, developing a democratic and participatory culture, which is why we consider important the existence of a commitment on the part of health professionals, namely rehabilitation nurses, in the elimination of architectural barriers through requests and proposals for improving accessibility conditions. Since there is a weak involvement of these professionals in promoting accessible environments, particularly in their area of residence, as there are no statistically significant differences between having and not having a specialty in rehabilitation nursing.

In short, and given the initial question, we can say that rehabilitation nurses have increased knowledge compared to other nurses about the elimination of architectural barriers. However, to reinforce people's gains in architectural accessibility, it is essential to create synergies, through the identification and mobilization of networks of local actors (economic, political, social, associative, among others), valuing community networks and other informal networks. [21]

Rehabilitation nurses must expand efforts between the various partners, bring people's decisions closer and meet their needs, according to the contexts in which they develop their professional practice, looking for creative solutions to particular problems, such as the elimination of architectural barriers on public roads and public places, but also in their homes. We recognize that the built environment often needs to be rethought in view of its use by people with reduced mobility.

CONCLUSION

Nursing is a scientific discipline that usually has as its central point the provision of care to the person; however, the target of nursing care is also the family, a group, a community or society.

By the application of Ordinance No. 163/2006, it was expected that in February 2017 there would be no architectural barriers in places of public use as the deadline for adapting the spaces (buildings, establishments and equipment for public use whose

construction date was earlier expired) to 1997). However, our results demonstrate that architectural barriers still exist in nurses' areas of residence.

With this study, we understand that accessibility and the elimination of architectural barriers are not a concern in the provision of care by nurses, since there were no statistically significant differences regarding the knowledge of the process of activating the means responsible for the elimination of architectural barriers; specific legislation for accessibility; if know who to turn to if need to request intervention to eliminate some type of architectural barrier and whether in the exercise of daily practice develop some type of intervention in order to eliminate architectural barriers.

There are differences between nurses with and without a specialty in rehabilitation nursing, namely in the knowledge of specific legislation for accessibility, knowing who to turn to if you need to request intervention to eliminate some type of architectural barrier for persons with limited mobility in the community and knowledge of the process of activating the means responsible for eliminating architectural barriers. But, there are no differences regarding the development of some type of intervention in order to eliminate architectural barriers in your professional practice.

The results showed a need for nurses to develop practices that promote integration and civic participation by promoting accessibility conditions.

Given the skills of rehabilitation nurses, their importance in promoting accessible environments is unquestionable. However, they must take ownership of these skills and their increased responsibility as a citizen, getting involved in the improvement of accessibility conditions. We believe that it is important for the gains in quality of life of people with disabilities that rehabilitation nurses have a more proactive attitude in this area.

Rehabilitation nurses and local municipal bodies can be a binomial of health promotion and architectural accessibility, since they are the political actors in the construction of inclusive territories, by complying with legal provisions, building inclusive cities for persons with limited mobility.

The progressive elimination of architectural barriers is essential for people with limited mobility to have access to all systems and services in the community and to enjoy their rights as citizens.

The limitation of the study is related to the sample size, which is not representative of the universe of nurses.

We consider it important to develop other studies that assess the difficulties that nurses face in their daily practice when they want to eliminate architectural barriers, as more than half recognize that they do not develop any type of intervention to eliminate architectural barriers and understand how it can be enhanced its action in promoting accessible environments.

We believe that it is essential to carry out a study on the implementation of the measure proposed by the National Plan for the Promotion of Accessibility regarding the training of new professionals and the inclusion in the study plan of training modules on the theme of accessibility, as well as rethinking the creation of a network necessary to guarantee the conditions of accessibility for people with disabilities.

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