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Original research article

Basic aspects of cooperation between occupational therapists and social workers in the social environment of patients after an acquired brain injury

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Abstract

Background: Coordinated rehabilitation plays a crucial role in helping patients with acquired brain injury (ABI) to return to active lives. Cooperation between occupational therapists (OTs) and social workers (SWs) is very important during the hospital-to-home transition.
Aim: The primary objective of the project was to map the coordinated rehabilitation of individuals after ABI within their social environment, aiming to help patients reclaim their lives despite the limitations of ABI. The purpose of this article is to identify and describe the impact of medical-social rehabilitation relative to interprofessional cooperation between OTs and SWs in the patient's home environment. The focus is on identifying the critical elements needed to maximize specialist collaboration.
Methods: The research was designed as an experimental qualitative study with auxiliary quantitative indicators in 17 case studies. The study included semi-structured interviews. In addition, the FIM system® and WHODAS 2.0 were used to objectify patient status monitored over time in individual cases.
Results: Five critical elements of cooperation were identified: (1) Quality of life, (2) Self-sufficiency, (3) Evaluation of the home, physical, and social environment, (4) Indication of aids, barrier-free modifications, and their financing, (5) Connection of health and social areas. After coordinated intervention, patients reported a gradual increase in their quality of life and self-sufficiency. The next continuity of rehabilitation services is very desirable, at least for maintaining the effect.
Conclusion: Specialist cooperation prevents patients from getting lost in the complicated systems of health and social services. It maximizes access to and effectiveness of these services, including the availability of financial aid and psychological support.

Keywords: Acquired brain injury; Coordinated rehabilitation; Interdisciplinary team; Occupational therapy; Social work

Introduction

Based on a review study, Connor et al. (2023) state that early supported discharge generates significant cost savings, reducing hospital length stays and long-term dependency. Thus it eases the transition home for patients after brain injury. Organizational and interprofessional factors are critical to the success of the process.

A person's ability to independently satisfy their personal needs in a particular environment is referred to as self-sufficiency (Arnoldová, 2015; Přibyl, 2015). Self-sufficiency is among the areas addressed by occupational therapists and social or health-social workers. According to Švestková et al. (2017), only a third of patients with severe disabilities return to their original quality of life. Another third require specialized aids, services, or support to reintegrate into employment and society. The final third are dependent on long-term care at home or an institutional environment. Adapting to new situations can often be difficult and problematic, not only for patients but also for their families and loved ones. Furthermore, broader social relationships are also significantly affected (Jellema et al., 2021).

The importance of early interventions by professionals and their neurorehabilitation teams cannot be overstated (Karol, 2014; Krogager Mathiasen et al., 2020; Mokrusch, 2021). Körner (2010) characterizes an interdisciplinary team as one where the individual experts are at the same hierarchical level. This leads to frank and open communication and cooperation among the team and is associated with greater effectiveness.

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An interprofessional approach is essential for coordinated neurorehabilitation. On the other hand, a multidisciplinary approach involves individual experts working in parallel on specific tasks. Individual autonomy among team members is high, while team communication is poor, with only problematic issues being discussed. Interprofessional teams work on patient goals, which are discussed regularly (Körner, 2010). Ponsford (2004) states that a team approach, focused on the needs of a person after brain injury, is critical for a successful return to the community following ABI. Occupational therapists (OTs) and physiotherapists (PTs) usually work in tandem. However, during the transition from institutional to home environment, close cooperation between occupational therapists and social workers (SWs) has proven to be very effective. OTs and SWs have many overlapping intervention domains, which can also be found in certain legal documents. In Czech legislation, this applies to Decree No. 55/2011 Coll. regarding the duties of healthcare and other professionals, as amended.

According to Czech Act No. 108/2006 Coll., on Social Services, as amended, and Decree No. 505/2006 Coll., which implements certain provisions of the Social Services Act, there are many common overlapping areas in both professions, especially in the area of social rehabilitation understood as specific activities aimed at achieving the independence and self-sufficiency of persons.

The participation of OTs in these activities, as well as medical-social or social workers, is highly desirable. In this context, interprofessional education plays a significant role, e.g., through intercollegiate collaborations. Such education helps to reflect new professional realizations around the concepts of collaboration, leadership, roles of different professions, and the importance of communication (Karpa et al., 2018). Patients after acquired brain injury and their families expect integrated transitional care that enables long-term self-management at home. Gaps in discharge planning combined with a lack of timely post-discharge support contribute to unmet care needs and affect patients' ability to cope with changes (Chen et al., 2021).

Materials and methods

The aim of this research grant No. GAJU 138/2016/S, named Coordinated Rehabilitation of Patients with Brain Injury, was to map the coordinated rehabilitation of patients after ABI in their home environment using methods and techniques of social work, physiotherapy, occupational therapy, medicine, speech therapy and psychology, to significantly help patients to start living their lives again (despite limitations caused by the disease). This article addresses one of the project's objectives within the framework of occupational therapy outputs: to identify and describe the impact of medical-social rehabilitation on interprofessional cooperation between occupational therapists and social workers in the patient's home environment, with a specific focus on identifying key elements that maximize specialist collaboration.

The research was designed as a pilot experimental, qualitative study with auxiliary quantitative indicators to objectify patient status monitored over time in individual cases. The study was longitudinal and funded from 2016–2018. After 2018, additional data collection and interventions were conducted regarding the time of the patient's entry into the study. The study was completed in April 2021 using Computer-assisted telephone interviewing (CATI) for the final assessments of all patients. The research participants included patients after ABI (and their family members) who received three months of coordinated rehabilitation. Rehabilitation was recommended by physicians and provided by PTs (two regular visits per week), OTs (6 visits), and SWs (6 visits). It took place in patients' home environment during the subacute phase of their disease, i.e., after discharge from medical facilities. In specific cases, patients were also included in psychological or speech therapy interventions (these interventions were not home-based). OT and SW visits took place together (four visits in the first three months, and follow-up visits in the sixth and ninth months). If necessary, another individual intervention was arranged with the patient, or the solution of compensatory aids and distance counselling. In April 2021, control measurements were performed by an OT or PT. The telephone interviews were performed by the same therapists who conducted the 3-month intervention with the patients.

For a detailed description of the rehabilitation intervention and timeline of research tools, see Suppl. Fig. S1. The basic criterion for the selection of ABI patients was the preservation of communication skills, i.e., the ability to take part in a controlled interview using the FIM (Chumney et al., 2010) and WHODAS 2.0 questionnaires (Sládková and UZIS 2016; Üstün et al., 2010), as well as additional questions regarding social interactions. Patients were selected by occupational therapists at the Rehabilitation Department of České Budějovice Hospital (Czech Republic) after performing selected tests (FIM and MMSE). The study included all patients from 2016 and 2017 whose health and social conditions met the inclusion criteria. The implementation of the research was approved by the Ethics Committee of the Faculty of Health and Social Sciences at the University of South Bohemia in České Budějovice. The study participants gave informed consent.

A total of 21 patients with ABI were recruited for the study. Of those, four ended their cooperation during the research, and their data was excluded from processing. The main reason for discontinuation involved moving out of the 30 km radius of České Budějovice. Of the 17 patients who completed the study, most were stroke patients (Table 1). Patients underwent home rehabilitation, as well as follow-ups after six and nine months, and in April 2021.

Interview recordings were processed using the ATLAS.ti program and included a systematic analysis of case reports (examination and therapy reports). Basic descriptive statistics were used to evaluate the results in the quantitative part of the study. While the number of patients involved was sufficient for qualitative processing, it was too low for statistical processing. Therefore, the conclusions from statistical analyses can only be considered as pilot results that can be used to formulate objectives for future research.

To determine the impact of medical-social rehabilitation (emphasizing ways to improve interprofessional cooperation between OTs and SWs in patients' home environments), data collected from semi-structured interviews and case studies underwent qualitative analysis (Hendl, 2016).

Results

Based on the case reports and interviews analysis, and in accordance with the competencies of OTs and SWs (Czech Decree No. 55/2011 Coll.), we identified five areas of overlapping responsibilities and duties of cooperation between OTs and SW. The thematic analysis was conducted by an OT. Some areas are also supported by quantitative outputs.

Table 1. Demographic indicators and FIM results for the 6-month follow-up

Patient	Diagnosis	Specific hemiparesis	Age	Sex	FIM 0 (max value 126)	FIM 1	FIM3	FIM6
CB1	CVA	Right-sided	77	M	79	83	86	86
CB2	iCVA	Left-sided	52	F	113	115	121	121
CB 3	CVA	Left-sided	71	F	105	106	106	106
CB 4	iCVA	Left-sided	72	M	59	59	83	101
CB 6	iCVA	Right-sided	78	F	115	125	125	125
CB 7	iCVA	Left-sided	82	F	99	107	110	111
CB 11	iCVA	Left-sided	74	F	107	121	123	123
CB 12	hCVA	Left-sided	48	M	105	109	117	118
CB 13	Traumatic brain injury	Left-sided	42	M	100	108	117	117
CB 14	iCVA	Left-sided	58	M	66	69	71	75
CB 15	iCVA	Right-sided	62	M	114	117	124	125
CB 16	iCVA	Right-sided	66	F	111	114	114	114
CB 17	iCVA	Left-sided	77	F	92	104	111	111
CB 18	Multiple brain injury	Multiple brain injury	35	M	90	98	116	116
CB 19	iCVA	Left-sided	59	F	103	113	116	116
CB 20	iCVA	Left-sided	86	M	94	97	99	99
CB 21	Aneurysm	Tetraplegia	42	F	26	28	39	47
Average value					**93**	**98**	**106**	**107**
Maximum value					**115**	**125**	**125**	**125**
Minimum value					**26**	**28**	**39**	**47**

Note: iCVA – ischemic cerebrovascular accident; hCVA – hemorrhagic cerebrovascular accident; FIM 0 – FIM at project entry; FIM 3 – FIM after 3 months; FIM 6 – FIM after 6 months

1. QUALITY OF LIFE

Research suggests, that if therapy is not continued (at least to maintain the patient condition), patients often deteriorate to their original level, in some cases, even worse (according to the subjective evaluation using WHODAS 2.0), range 100–0% (worst-best) – Suppl. Table S2.

After one and three months of coordinated cooperation, patients reported a gradual increase in their quality of life (QoL). However, after six and 12 months, a trend toward deterioration or stagnation can be observed. During this 6–12-month period, patients were no longer undergoing coordinated rehabilitation. Three to four years after the end of coordinated rehabilitation, only two patients reported a positive result after evaluation of their QoL. At the same time, these patients have other specific rehabilitation goals to achieve a higher QoL: *"Short-term memory is affected in relation to normal functioning"* (Patient 13); *"… the strength and function of the right hand; to engage in workshop activities"* (Patient 15). In other patients, we noted stagnation or deterioration of their condition based on a subjective evaluation of the QoL using WHODAS 2.0. In some cases, patients lack communication and contact with another person: *"I have no one to talk to…"* (Patient 1) Communication was especially mediated by social workers: *"It also helped me when you came here, that you at least listened to me, that I could talk about my lamentations"* (Patient 11). Nevertheless, among them we can also find patients who had already come to terms with the disease: *"… I'm satisfied. I'm looking forward to the garden, how I'll garden and relax there"* (Patient 2); *"I feel positive. I'm falling, but it turned out well… I'm glad… that I can take care of myself during the day…"* (Patient 18).

When asked within CATI: *"How would you imagine your ideal life now?"*, some patients still reported returning to the state before the disease: *"I wouldn't have any paralysis or heart complications, that's what I'd like"* (Patient 3). Another patient reported an increase in their QoL related to being able to drive a car again.

However, clients lack follow-up rehabilitation, guided home exercise, or spa levers: *"I'm doing well, but I'd like to go to rehabilitation again and to a spa…"* (Patient 13). One patient stated that they had had further rehabilitation and frequented a day centre for people with brain injury. Six patients died during the study. We were unable to determine the status of patient 16 at the end of the study.

2. SELF-SUFFICIENCY

The development of self-sufficiency in individual cases was objectively monitored by OTs using the FIM assessment. Social workers evaluated needs based on patient interviews.

When we focus on the development of needs from months to approximately three years after ABI (based on the interviews conducted by social workers with patients and their family members), the key factor that entered needs analysis was SELF-SUFFICIENCY (Suppl. Fig. S2).

Self-sufficiency divides the needs of patients into two areas:

(1) Those who are self-sufficient, satisfied, or “only” need additional rehabilitation. Regarding coping strategies, self-sufficient patients have already coped with the consequences of ABI – for example, by choosing other means of transport than those they were used to: *“I've completely written off the car, I take the bus everywhere or let myself be driven, I can't keep up with the traffic, and I don't even want to drive anymore. I ride my bike...”* (Patient 2). Self-sufficiency and its emotional impact are well illustrated by patient 18: *“I'm glad it's the way it is now. That I can take care of myself during the day. I know that even if I'm alone for a few days, I can do it.”*

(2) Non-self-sufficient patients often long to return to their state before ABI. These individuals often require more professional care, which may not be available in the absence of coordinated rehabilitation. Compensatory aids, rehabilitation, and the need to manage pain are key issues for patients with limited self-sufficiency. The need for self-sufficiency was expressed well in the following statement: *“I wish I was more independent, could brush my teeth, comb my hair, eat, but my shoulder doesn't work”* (Patient 21).

It is evident that the initial input of the interprofessional team made it possible for patients to orient themselves in the services and assistance offered (counselling by social workers) – *“I think we did everything well, directions were clear, and outcomes were good”* (Patient 13). However, the termination of rehabilitation services and *de facto* loss of coordination mean that patients may become dissatisfied with their current condition and want a return to their life before ABI.

According to the FIM, the most significant improvement was shown by a patient who had an entry score of 90 points and an output FIM of 116 points (Patient 18). This patient was more active in their occupational therapy compared to the others, with sessions once a week since there were many goals to be addressed. However, at the 6-month follow-up, they did not continue to improve (FIM = 116). The smallest FIM improvement was 1 point for a patient who had an entry score of 105 and an output score of 106 points (Patient 3). The highest baseline score was 115 points; this patient also had the highest exit score (125 points) after the three-month intervention (Patient 6). A maximum of 126 points can be obtained in the FIM rating, which indicates complete independence.

Examining the FIM score alongside the client's perception of their status reveals a correlation: clients with low FIM scores and reduced self-sufficiency are typically not yet in a state to cope effectively with their condition: *“... I don't exercise anywhere, only once every six months for botox... I don't want anything more.* [The wife adds that the husband does not like the hospital environment, it has a bad psychological effect on him]. *I want to be able to go out more. We walk using a walker every day... to manage the transfers from the wheelchair to the bed”* (Patient 14, FIM value on enter: 66, FIM value 3 months after the therapy: 75). Patient 21 with the lowest overall FIM rating (26 entry, 3 months after therapy: 47) also comments on unsatisfied needs: *“If I could move somewhere... I won't stay at home alone. When my husband goes for a run, my daughter or son is with me.”*

3. EVALUATION OF THE HOME, PHYSICAL, AND SOCIAL ENVIRONMENT

From an occupational therapy perspective, clients primarily experience the impact through modified daily living activities using compensatory aids. *“... In fact, she helped me by showing me various aids”* (Patient 7); *“I tried new aids that I didn't know I could buy or that the insurance company would pay for”* (Patient 12). The focus on the indication of compensatory aids and the modification of the home environment is also appreciated by another client, where the effect on mental well-being can be clearly perceived: *“The handrails were being addressed... various aids. For example, the armpit roller, the toilet attachment. That is probably the most important thing for me... You understand... that I don't have to urinate in the living room anymore”* (Patient 8).

The evaluation of the home environment was included as part of the physical component of the overall patient environment assessment (Fig. 1).

In terms of the social environment, caregivers, relatives, other contacts, and overall personal relationships were significant facilitators. The following people were most often mentioned by patients (in order of frequency): partner, son/daughter, granddaughter, mother, neighbours. The psychological aspect also proved to be very important in this context. For example, patient 13 often mentioned: *“I miss my children.”* It is obvious that this greatly affects the overall psychological well-being of the patient.

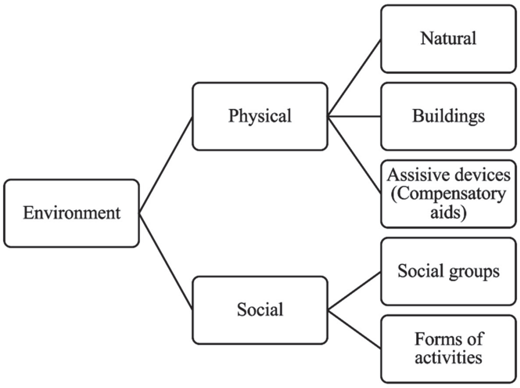


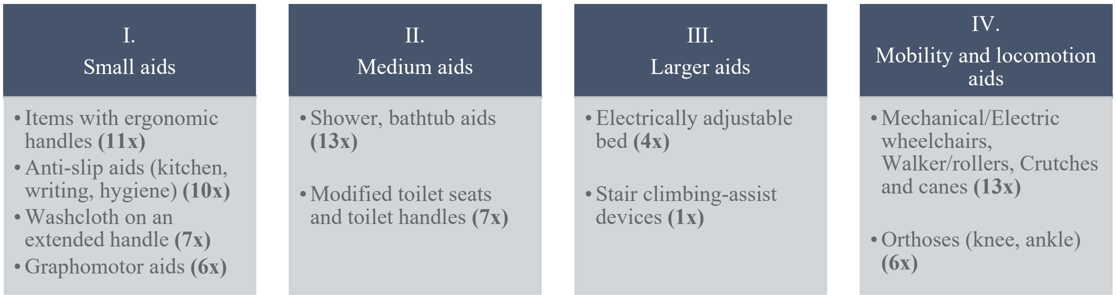
Fig. 1. The main environmental components

4. INDICATIONS FOR REHAB AIDS, BARRIER-FREE LIVING SPACE ADJUSTMENTS, AND THEIR FINANCING

A large part of home modifications and disability aids can be financed by social health services, and this is where social workers play a key role. A patient's daughter stressed the need for patients to be informed about the financing of aids: *“... we got all sorts of initial information from our social worker. I had no idea, for example, that the bed for my dad could be paid for.”* If this is addressed during the intervention itself and the OT and SW communicate with each other, the process of acquiring financing for aids or modifications can run more smoothly. The patient also benefits by being regularly informed about various financing options, for example: *“In the hospital, the social worker guided us regarding available services, although, they offered just a list of services and I still had to find out what to do and how to do it on my own. I then learned more things from the project.”* Thanks to social workers, administration is simplified, and the need for patients to interact with authorities, etc., is minimized.

In practice, we identified four basic categories of rehab aids recommended by OTs (Fig. 2).

Proper aid choice requires close cooperation, not only with a SW (particularly for “Large aids” and their financing), but also with a PT (particularly for “Mobility and locomotion aids”). It was found that categories I and III, i.e., small and large devices, were not addressed upon discharge from the hospital. For categories II and IV, in some cases the device was indicated upon



I. Small aids	II. Medium aids	III. Larger aids	IV. Mobility and locomotion aids
- Items with ergonomic handles **(11x)** - Anti-slip aids (kitchen, writing, hygiene) **(10x)** - Washcloth on an extended handle **(7x)** - Graphomotor aids **(6x)**	- Shower, bathtub aids **(13x)** - Modified toilet seats and toilet handles **(7x)**	- Electrically adjustable bed **(4x)** - Stair climbing-assist devices **(1x)**	- Mechanical/Electric wheelchairs, Walker/rollers, Crutches and canes **(13x)** - Orthoses (knee, ankle) **(6x)**

Fig. 2. Focus of occupational therapy on the indication of compensatory aids and frequency of indications ($n = 17$)

discharge from the hospital, but it was necessary to adapt the device to the conditions of the home environment, or to purchase another device.

5. LINKING HEALTH AND SOCIAL ISSUES

Suppl. Fig. S3 of the overlapping interventions of OTs and SWs shows the overall interconnection of health and social services. The importance of cooperating with a physiotherapist cannot be omitted.

However, when a SW has the role of case manager, they can greatly facilitate successful communication between health and social services, as confirmed by the research. Mutual awareness within the team is indispensable, as patients confirm, specifically: *"It's nice that when I ask you something, you're connected and willing to help me."*

Based on the interventions used in our study cases, four basic areas were identified where OTs can make important contributions to the home environment of people with ABI: (1) evaluation of living spaces and identification of facilitators, (2) training and education about activities of daily living (ADL) and daily routine, (3) influencing impaired functions through specific targeted occupational therapy and self-therapy education, and (4) education of family members and caregivers. The most frequent individual specifics within these four focus areas are shown in Suppl. Fig. S3, based on the interviews and case reports analysis.

These areas are foundational and are applicable to all our ABI patients. The role of occupational therapy for ABI patients is very broad and includes both health and social areas.

Discussion

In rehabilitation, we face daily problems related to the lack of connection between the health and social spheres of patient services. In practice, we resolve these issues through cooperation between OTs and SWs. There is an absence of similarly focused studies that specifically deal with the cooperation between these two professions, although the importance of linking these disciplines or the educational strategies of SWs for support in their involvement in the health sphere are pointed out in the context of interprofessional education (Held et al., 2019). A scoping review (Freymueller et al., 2024) focuses on social work practice and outcomes in rehabilitation, including collaboration with a rehabilitation team and the mutual conduction of interventions involving cooperation with OTs. As part of a study focused on people with chronic lower back pain returning to work after rehabilitation, Michel et al. (2018) describes the cooperation between an OT and SW, especially when collecting occupational information. We consider cooperation to be very desirable due to the many overlapping areas and the broad role of occupational therapy. According to Hughes et al. (2016), up to 200 different daily activities are associated with occupational therapy. In our study, we focused on the role of the OT in the home environment of those with ABI. One specific area of OT and SW overlap, and potential cooperation involves the best choice of compensatory aids. For example, aids related to barrier-free accessibility, such as stair climbers, may be recommended by an OT. However, the aid may be financed by social services, thus close cooperation with a SW can be effective in cutting through administration and helping the patient to receive the aid in a timely manner.

We worked in accordance with the philosophy of the International Classification of Functioning, Disability, and Health (ICF), in which the environment is described as a contributing factor. This prevents people with disabilities from being perceived as isolated individuals with a disabling diagnosis. Instead, patients should be seen as a dynamic interaction between their diagnosis, their treatment, and the environment in which they live (WHO, 2008). Therefore, we focused on the functional health of the patient and those other situations where the functional limitations of the patient manifest, with the aim of achieving the maximum QoL.

In cooperation with a PT, occupational therapy focused on the functional abilities of patients associated with impaired motor, sensory, or, in some cases, cognitive functions. The OTs, in cooperation with SWs, mainly deal with the financing of compensatory aids, modifications to patient living space, or the arrangement of barrier-free housing. Additionally, they help with arranging rehabilitation and helping families adjust to a family member with ABI, for example, by assessing follow-up services and support and mediating communication with authorities and various medical and non-medical professionals.

We noted that a vital role of SWs was to coordinate team responsibilities in addressing the needs of individual patients. Other goals for SWs included social counselling regarding social benefits, and helping patients navigate the maze of paperwork to get funding for compensatory aids or living space modifications to meet their special needs. Finally, SWs were also an important source of psychological support for patients.

Study strengths and limitations

The initial input of the interprofessional team made it possible for patients to quickly gain an understanding and awareness of available services and assistance. Regarding counselling by social workers, one patient noted – *"I think* [they] *did everything well, they gave my family and me clear directions, which helped us a lot"* (Patient 13). However, once our intervention ended, patients faced a lack of any coordinated assistance, leaving them dissatisfied with their situation and prompting unproductive desires to return to life before their stroke or brain injury. It is obvious that the lack of coordinated rehabilitation services leads to feelings of frustration and hopelessness.

As far as evaluating QoL and self-sufficiency is concerned, we are aware that spontaneous recovery after ABI can result in functional status improvement and changes in patient perception of QoL. However, further research on a larger set of probands is needed to draw unambiguous conclusions. At the same time, rehabilitation programs focused on patient goals and an interprofessional approach have an indisputable effect on the QoL in the long term, not only for patients but also for caregivers, as evidenced by other studies (Markovic et al., 2024; Vešligaj-Damiš et al., 2023). Vogler et al. (2014) found that after a mean time post-injury of 18 years, health related QoL and perceived health status in caregivers show lower values compared to the age-matched control. The monitored values were lower in patients with ABI than in caregivers. In Europe, there is still a lack of extensive research focusing on these areas of community practice. The available studies are more concerned with early neurorehabilitation, early discharge, and outpatient rehabilitation, e.g., a Danish study published by the authors Krogager Mathiasen et al. (2020). In Germany, a randomized study was conducted on 53 people with acquired brain injury, focusing on long-term coordinated and continuous rehabilitation on outpatient intervention (Bender et al., 2016).

Also, the results of OT or SW intervention cannot be separated from the coordinated intervention. Therefore, on the basis of the research, it is not possible to accurately evaluate the success of the intervention of individual experts, including PT. Due to the essence of the article, PT is not evaluated and discussed in detail. However, the results are evaluated and interpreted in a coordinated interprofessional approach, with an emphasis on the importance of cooperation between OT and SW, as this cooperation is often neglected or downplayed in practice. In the Czech Republic, this is a significant problem due to the absence of interconnection between the health and social spheres. Very few OTs perform interventions in a patient's home environment, and financing these services is problematic.

Within the research of individual cases, a large amount of quantitative and qualitative data was collected. Therefore, annotating was also used (Hendl, 2016). Open, axial, and selective coding was used in the qualitative analysis. The article contains the most important information and outputs in connection with the presented topic. Due to the scope and focus of the research, other specific outputs are included in several publications (Bendová et al., 2021; Kuželková et al., 2024).

Hughes et al. (2016) state that occupational therapist intervention in the patient's home environment is important for improving and maintaining the physical functions, independence, and QoL of a wide range of people. The authors divided the work of an occupational therapist into direct care, indirect care, teamwork, and service development. Mentioned components can also be found in the OT, SW, and PT intervention within our research. We also found inconsistencies in the terminology used to describe patients and clients. In healthcare, the term "patient" is more commonly used, while in social work and similar services, the term "client" is preferred. Soklaridis et al. (2017) reported encountering difficulties in consistently using a single term in their research, which also involved team members from diverse professional backgrounds.

Rehabilitation teams also use some continuous terminology. Specifically, the terms multidisciplinary, interdisciplinary, and interprofessional are often confused or used interchangeably (Körner, 2010). Due to the excellent cooperation among the various professionals working on this project, we have used the term interprofessional approach in our research.

Despite the systemic lack of a structural or administrative connection between the health services and social services in the Czech Republic, we were able to establish excellent working relationships between the OTs and SWs participating in our study. We consider cooperation between these two specialties to be very desirable in daily practice.

Conclusion

Regarding the duties and responsibilities defined in current legal documents and based on the research, we have defined five basic areas for cooperation between occupational therapists and social workers when they work together in the home environment of ABI patients: (1) Quality of life, (2) Self-sufficiency, (3) Evaluation of the patient's home, physical, and social environment, (4) Indications for rehab aids, barrier-free living space adjustments and their financing, (5) Linking health and social issues.

Based on interviews and using objective instruments FIM and WHODAS 2.0, our research showed that by emphasizing the above-mentioned interconnections and overlaps between health services and social services and stressing close cooperation between OTs and SWs, we can (1) greatly improve the knowledge and understanding of patients with regard to the availability of critical services, (2) increase the timeliness and effectiveness of accessing important social services and support, and (3) facilitate the speediest return of the patient to their normal life. Termination of the coordinated process leads to stagnation or deterioration of patients' states, and the influence of physiotherapy within the coordinated rehabilitation cannot be omitted.

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Ethical aspects and conflict of interest
The authors have no conflict of interest to declare.

References

1. Act No. 108/2006 Coll., zákon o sociálních službách. In: Sbírka zákonů České republiky, částka 37/2006.
2. Arnoldová A (2015). Sociální péče, part 1. Praha: Grada Publishing, 240 p.
3. Bender A, Adrion C, Fischer L, Huber M, Jawny K, Straube A, Mansmann U (2016). Long-term Rehabilitation in Patients With Acquired Brain Injury. Dtsch Arztebl Int 113(38): 634–641. DOI: 10.3238/arztebl.2016.0634.
4. Bendová M, Hartmanová M, Vacková J, Míková M, Kuželková A (2021). Longitudinal study of postural and locomotor function development in clients with brain damage. Kontakt 23(3): 170–177. DOI: 10.32725/kont.2021.023.
5. Chen L, Xiao LD, Chamberlain D, Newman P (2021). Enablers and barriers in hospital-to-home transitional care for stroke survivors and caregivers: A systematic review. J Clin Nurs 30(19–20): 2786–2807. DOI: 10.1111/jocn.15807.
6. Chumney D, Nollinger K, Shesko K, Skop K, Spencer M, Newton RA (2010). Ability of Functional Independence Measure to accurately predict functional outcome of stroke-specific population: systematic review. J Rehabil Res Dev 47(1): 17–29. DOI: 10.1682/jrrd.2009.08.0140.

7. Connor EO, Dolan E, Horgan F, Galvin R, Robinson K (2023). A qualitative evidence synthesis exploring people after stroke, family members, carers and healthcare professionals' experiences of early supported discharge (ESD) after stroke. PLoS One 18(2): e0281583. DOI: 10.1371/journal.pone.0281583.
8. Decree No. 505/2006 Coll., vyhláška, kterou se provádějí některá ustanovení zákona o sociálních službách. In: Sbírka zákonů České republiky, částka 164/2006.
9. Decree No. 55/2011 Coll., vyhláška o činnostech zdravotnických pracovníků a jiných odborných pracovníků. In: Sbírka zákonů České republiky, částka 20/2011.
10. Freymueller N, Knoop T, Meyer-Feil T (2024). Social work practice and outcomes in rehabilitation: a scoping review. Front Rehabil Sci 5: 1348294. DOI: 10.3389/fresc.2024.134829.
11. Held ML, Black DR, Chaffin KM, Mallory KC, Milam Diehl A, Cummings S (2019). Training the Future Workforce: Social Workers in Integrated Health Care Settings. J Soc Work Educ 55(1): 50–63. DOI: 10.1080/10437797.2018.1526728.
12. Hendl J (2016). Kvalitativní výzkum: základní teorie, metody a aplikace. Praha: Portál, 496 p.
13. Hughes J, Wilberforce M, Symonds E, Bowns I, Challis D (2016). Occupational therapy roles and responsibilities: Development of a standardised measure of time use for staff working with adults in community settings. Br J Occup Ther 79(6): 336–344. DOI: 10.1177/0308022616640298.
14. Jellema S, van Erp S, Nijhuis-van der Sanden MWG, van der Sande R, Steultjens EMJ (2021). Activity resumption after acquired brain injury: the influence of the social network as described by social workers. Disabil Rehabil 43(8): 1137–1144. DOI: 10.1080/09638288.2019.1652855.
15. Karol RL (2014). Team models in neurorehabilitation: structure, function, and culture change. NeuroRehabilitation 34(4): 655–669. DOI: 10.3233/NRE-141080.
16. Karpa K, Pinto C, Possanza A, Dos Santos J, Snyder M, Salvadia A, et al. (2018). Stroke Simulation Activity: A Standardized Patient Case for Interprofessional Student Learning. MedEdPORTAL. 14: 10698. DOI: 10.15766/mep_2374-8265.10698.
17. Körner M (2010). Interprofessional teamwork in medical rehabilitation: a comparison of multidisciplinary and interdisciplinary team approach. Clin Rehabil 24(8): 745–755. DOI: 10.1177/0269215510367538.
18. Krogager Mathiasen M, Bastrup Jørgensen L, From M, Aadal L, Pallesen H (2020). The temporality of uncertainty in decision-making and treatment of severe brain injury. PLoS One 15(10): e0238506. DOI: 10.1371/journal.pone.0238506.
19. Kuželková A, Vacková J, Ptaková S, Podzemná D, Pechoušková K, Angerová Y (2024). Ergoterapie osob se získaným poškozením mozku se zaměřením na bariéry a facilitátory v domácím prostředí. [Occupational therapy of people with acquired brain injury in the home environment focusing on barriers and facilitators]. Rehabilitace a fyzikální lékařství 31(3): 134–143. DOI: 10.48095/ccrhfl2024134.
20. Markovic G, Bartfai A, Schult ML, Ekholm J (2024). Rehabilitation with intensive attention training early after acquired brain injury promotes better long-term status on health-related quality of life, daily activities, work ability and return to work. J Rehabil Med 56: jrm5308. DOI: 10.2340/jrm.v56.5308.
21. Michel C, Guêné V, Michon E, Roquelaure Y, Petit A (2018). Return to work after rehabilitation in chronic low back pain workers. Does the interprofessional collaboration work? J Interprof Care 32(4): 521–524. DOI: 10.1080/13561820.2018.1450231.
22. Mokrusch T (2021). The team in neurological rehabilitation. Neurol Rehabil 27(4): 215–222. DOI: 10.14624/NR2104001.
23. Ponsford J (2004). Rehabilitation following traumatic brain injury and cerebrovascular accident. In: Ponsford J. (Ed.). Cognitive and behavioral rehabilitation: From Neurobiology to Clinical Practice, New York (NY): Guilford Press, pp. 299–342.
24. Přibyl H (2015). Lidské potřeby ve stáří. Praha: Maxdorf, 96 p.
25. Sládková P, UZIS (2016). WHODAS 2.0 (Czech Translation). Praha: Institute of Health Information and Statistics of the Czech Republic. [online] [cit. 2024-11-12]. Available from: https://www.uzis.cz/index.php?pg=registry-sber-dat--klasifikace--who-disability-assessment-schedule
26. Soklaridis S, Romano D, Fung WL, Martimianakis MA, Sargeant J, Chambers J, et al. (2017). Where is the client/patient voice in interprofessional healthcare team assessments? Findings from a one-day forum. J Interprof Care 31(1): 122–124. DOI: 10.1080/13561820.2016.1233393.
27. Švestková O, Angerová Y, Druga R, Pfeiffer J, Votava J (2017). Rehabilitace motoriky člověka: fyziologie a léčebné postupy. Praha: Grada, 320 p.
28. Üstün TB, Kostanjsek N, Chatterji S, Rehm J (Eds), WHO (2010). Measuring health and disability: manual for WHO Disability Assessment Schedule WHODAS 2.0. Geneva: World Health Organization. [online] [cit. 2024-11-12]. Available from: https://iris.who.int/handle/10665/43974
29. Vešligaj-Damiš J, Vošinek T, Gorišek V, Holnthaner R (2023). The effects of goal-oriented long-term rehabilitation of persons with acquired brain injury on quality of life after injury. Brain Inj 37: 96.
30. Vogler J, Klein AM, Bender A (2014). Long-term health-related quality-of-life in patients with acquired brain injury and their caregivers. Brain Inj 28(11): 1381–1388. DOI: 10.3109/02699052.2014.919536.
31. WHO (2008). Mezinárodní klasifikace funkčních schopností, disability a zdraví: MKF [International Classification of Functioning, Disability and Health: MKF]. Translated by Pfeiffer J, Švestková O. Praha: Grada, 280 s.