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Interprofessional strengths and weaknesses in the care of people with ostomies: a mixed-methods study**

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ABSTRACT

Objective: To analyze the activities of a secondary care team specialized in assisting individuals with elimination stomas, interpreting the distances and proximities with interprofessionality. **Method:** A mixed-method study conducted in a service for people with stomas in northern Brazil, involving 16 professionals. The descriptive qualitative phase was based on Émile Durkheim's Social Facts, and utilized semi-structured interviews and field notes with reflective thematic analysis. The quantitative phase used a questionnaire survey designed by experts and descriptive percentage analysis. **Results:** A total of 31 activities were described, with low expressiveness of those that foster interprofessionality, such as reception, checking family dynamics, education in the waiting room, active search for vulnerable patients' records, scheduling follow-up with social services, reviewing family dynamics, and addressing patients' rights. Two topics were developed: (1) Operational aspects of (search for) interprofessionality: registration, management, active search, and referrals; and (2) Acquiring autonomy for social reintegration and moving away from self-care: collaborative elements in the journey from beginning to "restart". **Conclusion:** Interprofessionality remains a distant work model; however, collaborative practices have begun to emerge through referrals. Emphasis on intersectionality and intersectorality is crucial to support the social reintegration of patients.

DESCRIPTORS: User Embracement. Self Care. Interprofessional Education. Enterostomal Therapy. Interdisciplinary Placement. Professional Practice.

Potencialidades e fragilidades interprofissionais na atenção às pessoas com estomias: estudo de método misto**

RESUMO

Objetivo: Analisar as atividades de uma equipe da Atenção Secundária especializada no atendimento a pessoas com estomias de eliminação, interpretando os distanciamentos e as aproximações com a interprofissionalidade. **Método:** Estudo de método misto em um serviço para pessoas com estomias do Norte do Brasil, com 16 profissionais. A etapa qualitativa descritiva foi pautada nos fatos sociais, de Émile Durkheim, em entrevista semiestruturada e em notas de campo com análise temática reflexiva. A etapa quantitativa empregou Inquérito

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**Excerpt from the thesis "*Avaliação do Programa de Assistência Especializada às Pessoas com Estomias no Sistema Único de Saúde*", qualified in the Graduate Program in Fundamental Nursing, *Universidade de São Paulo* (USP), in 2022.

por Questionário elaborado por especialistas e análise percentual descritiva. **Resultados:** Descreveram-se 31 atividades com baixa expressividade, das que estimulam a interprofissionalidade, como acolhimento, verificação da dinâmica familiar, educação na sala de espera, busca ativa de cadastros de usuários vulneráveis, agendamento de retorno ao serviço social, verificação da dinâmica familiar e abordagem sobre os direitos. Construíram-se dois temas: (1) Aspectos operacionais da (procura pela) interprofissionalidade: cadastro, gestão, busca ativa e encaminhamentos; e (2) Adquirir autonomia para a reinserção social e o afastamento do autocuidado: elementos colaborativos no caminhar do início ao "reinício". **Conclusão:** A interprofissionalidade é um modelo de trabalho distante, contudo, práticas colaborativas vêm sendo esboçadas nos encaminhamentos. É premente o enfoque na interseccionalidade e na intersetorialidade para buscar a reinserção social dos usuários.

DESCRITORES: Acolhimento. Autocuidado. Educação interprofissional. Estomaterapia. Práticas interdisciplinares. Prática profissional.

Potencialidades y fragilidades interprofesionales en la atención a personas con estomías: estudio de método mixto

RESUMEN

Objetivo: Analizar las actividades de un equipo de Atención Secundaria especializado en la atención a personas con ostomías de eliminación, interpretando los distanciamientos y acercamientos con la interprofesionalidad. **Método:** Estudio de método mixto realizado en un servicio para personas con ostomías en el norte de Brasil, con la participación de 16 profesionales. La etapa cualitativa descriptiva se basó en los Hechos Sociales de Émile Durkheim, utilizando entrevistas semiestructuradas y notas de campo con análisis temático reflexivo. La etapa cuantitativa empleó una Encuesta por Cuestionario elaborada por especialistas y análisis porcentual descriptivo. **Resultados:** Se describieron 31 actividades con baja expresividad de aquellas que fomentan la interprofesionalidad, tales como acogida, verificación de la dinámica familiar, educación en la sala de espera, búsqueda activa de registros de usuarios vulnerables, programación de retorno al servicio social, verificación de la dinámica familiar y abordaje sobre los derechos. Se construyeron dos temas: (1) Aspectos operativos de la (búsqueda de la) interprofesionalidad: registro, gestión, búsqueda activa y derivaciones; y (2) Adquirir autonomía para la reinserción social y el alejamiento del autocuidado: elementos colaborativos en el recorrido desde el inicio hasta el "reinicio". **Conclusión:** La interprofesionalidad es un modelo de trabajo distante; sin embargo, se han esbozado prácticas colaborativas en los procesos de derivación. Es urgente el enfoque en la interseccionalidad y en la intersectorialidad para promover la reinserción social de los usuarios.

DESCRIPTORES: Acogimiento. Autocuidado. Educación interprofesional. Estomaterapia. Prácticas interdisciplinarias. Práctica profesional.

INTRODUCTION

Currently, interprofessionality emerges as an evolutionary process that reconfigures collaborative practices in healthcare, while multiprofessionality still encourages each professional to work privately with specific moments of collaboration. Interprofessionality focuses on valuing patients, exchanging knowledge and skills for clinical and therapeutic management, and redefining joint work, previously multidisciplinary, based on intercommunication in workflows and collaborative practices among workers[1].

The Brazilian National Guidelines for Healthcare for People with Ostomies within the Brazilian Healthcare system (In Portuguese, *Sistema Único de Saúde* - SUS) state that level I and level II care services must be composed of "health teams" that take into account "multiprofessional" care, terms cited in the policy[2]. However, more recent official Brazilian documents, such as the Brazilian National Policy for Specialized Healthcare (In Portuguese, *Política Nacional de Atenção*

Especializada em Saúde - PNAES) and the Brazilian National Policy for Comprehensive Healthcare for People with Disabilities (In Portuguese, *Política Nacional de Atenção Integral à Saúde da Pessoa com Deficiência* - PNAISPD), already address the term "interprofessional" in synergy with "intersectionality" and "intersectorality".

These centers are considered to be intended for the prevention of injuries, complications such as prolapse and parastomal hernia, and the correct removal and application of the collection device. Furthermore, when such procedures are definitively indicated, incontinent diversion is necessary. After patients' hospital discharge, specialized follow-up will also be required, as traditional perioperative training has been insufficient, generating critical postoperative demands for patients[3].

Knowing that a purely biomedical foundation does not meet psychosocial needs, such as engaging educational processes in support groups,[4] it is believed that longitudinal secondary care can be enhanced by various care management models. This is the case with interprofessional work, a topic little explored in the literature on stomatherapy, considering that the Brazilian National Guidelines for the Healthcare of People with Ostomies[2] do not clearly define the types of interprofessional activities.

Consequently, the quantitative research question was: What is the scope of professional activities developed in a service specializing in the care of people with elimination stomas? The qualitative research question addressed the question: How is interprofessionality being used in the activities of a specialized care team for people with elimination stomas? Recommended in mixed-method studies, the integrative question was: What activities encourage interprofessionality in a service specializing in the care of people with elimination stomas?

OBJECTIVES

To analyze the activities of a secondary care team specialized in caring for people with elimination stomas, interpreting the distances and approaches with interprofessionality.

METHODS

Since this is a mixed-method study, it is asserted that the quantitative and qualitative approaches allow for a greater number of objects to be analyzed. Regarding notation, it is noted that capital letters define the greater emphasis given to one stage—in this investigation, the qualitative stage—and the plus sign (+) indicates a convergent and merged integration of data collection when data are collected simultaneously[5]. Due to the primacy of the qualitative stage, the Consolidated criteria for reporting qualitative research (COREQ) checklist, adapted to Portuguese, was used for writing[6].

In the qualitative interpretative phase, narratives were required, situating the research in contexts of production and the processes of legitimization of different discourses in social contexts—memories, situations, and narrative "performances." The framework used was Émile Durkheim's sociology of health, with a focus on social facts[7]:

1. Public awareness;
2. Habits; and
3. Ways of doing and ways of being.

In the descriptive and quantitative phase, a questionnaire survey was used, which consisted of a percentage of perceptions, in order to contribute to the understanding of people's conceptions of reality[8]. In this study, priority was given to the activities developed in the program.

Setting

This is a type I specialized care service in northern Brazil, located in a Specialized Reference Unit (SRU). The service has four operating rooms, with morning and afternoon appointments.

Participants and inclusion and exclusion criteria

The sampling was purposeful, consisting of deponents intentionally selected for the research purposes. Care and administrative workers who had been working for at least six months were selected. Sixteen professionals from the center's staff participated, including two nutritionists, one psychologist, four nurses, four nursing technicians, two social workers, one general practitioner, and two administrative assistants, who manage requests, schedules, and workflows. Only one member of the team declined to participate, as they declined to be interviewed for personal reasons.

Negotiation, instrument and techniques for collection

The project was first presented to the coordinator and later to the team by the lead researcher responsible for the data collection. Therefore, data collection between August 2023 and January 2024 was carried out, without affecting the service, when both indicated that they were free, in the administration room, with only the researcher (nurse) and participants present.

According to the convergent approach, quantitative and qualitative data collection occurred simultaneously. The average duration with each professional was 18 minutes, and combined, over four hours. To integrate the stages, a mixed instrument was used that combined 12 closed-ended questions, one multiple-choice question, and four open-ended triggers, obtaining predominantly qualitative information and complementary quantitative information[8].

QUALITATIVE stage

The instrument was administered individually, with only the principal investigator and participants present at the time of data collection. Data collection was audio-recorded. During completion, the sociological problematization strategy was employed, asking the hidden "whys" after each closed-ended response, allowing for free-form narration: Why do you believe this? How do you perceive self-care being developed? How does this flow/route/process occur? Finally, the trigger questions were used: How do you perceive this service? How do you think patients perceive this service? How important is your work? What is the greatest challenge in your work?

Each transcript was decoded as "P" for "professional" and the interview number. The pilot test was conducted with participant P1, and it was found necessary to insert the "why" at the end of some open-ended questions, problematizing them, in order to expand the responses. The test interview was considered to compose the *corpus*.

To achieve interprofessionality, the movements established a denaturalization of what is said, making debatable what is evident and silted up by care practice, linking social facts to this denaturalization. According to Durkheim, every social fact has a purpose, and such inquiries targeted the external behaviors established in routines due to the coercion[7] of the policy that underpins the program.

Sociological research relies on notes on situations, interruptions, appearances, and reflections by the researcher, based on immersion and problematization of what has become commonplace in practice. Thus, the field diary is instrumental in refining observation questions and improving hypotheses by recording recurring "categories of thought"[9]. This triangulation with the notes elucidated aspects of the statements, being among the symbols, namely: for {reflective notes} and [descriptive notes]. Data saturation occurred respecting: the principle of representativeness of the chosen location and questions that enabled the mapping of multiple perspectives, adding volume to the corpus and the triangulation of techniques. After each interview, journal entries with new ideas for subsequent questions facilitated attempts to approach previously unexplored topics, allowing for the progressive inclusion of data.

Quantitative stage

A questionnaire developed by experts in stomatherapy was used, consisting of: characterization variables and position in the program; dichotomous "Yes" or "No" responses to taking courses in the area or not (name of course); previous experience in caring for people with ostomies; whether self-care is perceived to be supported by the program; and whether rehabilitation is practiced with the help of the program. Furthermore, the questionnaire consisted of multiple marking options, addressing the types of activities performed, with space for the professional to recall any activities outside the instrument.

QUALITATIVE + quantitative analysis

The qualitative data were coded without the aid of software, with validation by the researchers, two of whom are PhD with expertise in oncology and clinical-qualitative research. Each statement was transcribed using Transkriptor and converted to Microsoft Word, then reviewed for possible spelling errors by the artificial intelligence. Feedback was not provided from the interviews with the deponents, but rather from their diary notes. Furthermore, the researcher regularly reported on the progress of the findings during visits to the SRU. Quantitative data were organized in Excel 2020 spreadsheets, with subsequent analysis using simple descriptive statistics in relative and absolute frequencies (n=16/100%).

After reading each statement, the documents were merged into a single Word file, considered the matrix for the six-stage inductive thematic-reflective analysis, namely[10]:

1. Familiarity with data, transcribing it immediately after collection and noting recurrences in a diary;
2. Generating initial codes systematically in individual files;
3. Searching for similar codes among each participant;
4. Common topics after grouping codes in the matrix;
5. Interpreting and naming topics, considering interprofessionality as a guiding principle in this study, with the understanding of social facts (activities that have a broader purpose, operationalizing the policy of care for people with ostomies at the microsocial level); and
6. Report production. Chart 1 shows the codes found.

Therefore, this study is an excerpt from the report of a thesis entitled "*Avaliação do programa de assistência especializada às pessoas com estomias no Sistema Único de Saúde*".

Ethical aspects

There was approval under CAAE 68649123.1.0000.5393, and participants became aware by reading and signing the Informed Consent Form (ICF).

RESULTS

Concerning professional characteristics, 15 participants were female and 1 was male. As for the *lato sensu* and/or *stricto sensu* specialization courses, the areas of interest were specialization in family health, public health, hospital administration, intensive care, family therapy, psychopedagogy, obstetric nursing, human resource management, and oncology. It is noteworthy that three professionals have a master's degree, and 14 have completed ostomy training courses in the last six

Chart 1. Correspondence of codes with topics

Codes (occurrence in the matrix)	Topic
Aspects of service operationalization (n=11); internal and external referrals to the service to enhance comprehensive care (n=07); active search for patients (n=13); attention to prison inmates (n=01).	Topic 1 – Operational aspects of (search for) interprofessionality: registration, management, active search, and referrals.
Distancing from self-care (n=04); acquiring autonomy for social reintegration (n=13).	Topic 2 – Acquiring autonomy for social reintegration and moving away from self-care: collaborative elements in the journey from beginning to "restart".

Source: Data analysis.

months. Nine believe that the program's participants have developed self-care skills, six believe they have not, and one participant stated "maybe".

It was reported that the main referrals are psychological and medical. Self-care education is provided by 87.5% of these professionals, while addressing rights is the most neglected element during ostomy care, with 6.2% performing it. The bureaucratic and organizational aspects are initially handled through patient registration. The first contact is mediated by interprofessional consultations and filling out a form, carried out by 75% of those involved. Requesting supplies, scheduling follow-up appointments in case of urgent social needs, and actively searching the registry each account for 6.25% of these professionals.

As shown in Table 1, 62.5% reported assessing social needs both during registration and in subsequent consultations, although the qualitative findings indicate that these data are often not further processed by the team, and 56.25% make exchanges. Both assessment and psychological consultation were low, as only one psychologist performs them, as well as the follow-up consultation scheduled by a medical professional.

Activities that foster interprofessionality and support health education, such as "reception", "family dynamics assessment", and "group guidance and waiting room education," received little attention. However, there was a positive highlight, considering that within the interprofessional and intersectional framework, "social needs assessment" is primarily performed. Other interprofessional activities that offer excellent contributions to intersectionality, but are rarely performed, include "actively searching for records of children and older adults with ostomies", "scheduling social service visits in cases of social needs", and "family dynamics assessment". Intersectoral collaboration should be better encouraged, with more actions focused on explaining the rights of people with ostomies, something carried out (consistently) by a single participant. Qualitative categories will allow for a deeper understanding of aspects that are not one-dimensional, such as self-care and the flows of care.

Topic 1 – Operational aspects of (search for) interprofessionality: registration, management, active search and referrals

There was reflection on the program's progress, when epidemiologically rectal cancer was not significant, and on when the program was initiated by the Ostomy Association.

> *There was no Ostomy Care Program. The Association, which operated here in the building, provided the bags. The association received, dispensed, and assisted patients. In 2005, they did everything, and we had no contact with them. Despite being a social center, it was a service separate from the SRU. There were few patients; they were volunteers, who came three or four times a week and dispensed the bags. After the Health Department took over, they added a nurse, and it evolved, reaching what it is today, with a multidisciplinary team. It could have had more professionals, but we've already achieved a lot.* (Synthesis P10 and P15)

Comprehensive, longitudinal, and equal care is operationalized through several fronts. The management and development of the standard that serves as a reference for materials returned to patients were mentioned. The importance of nurses as coordinators or within the coordination team was also cited. The management of equipment and adjuvants dispensed is handled by a company in the same building, but external to the service. Reception is another strategy within this operationalization.

> *Here, the coordination team handles the bidding process, the requests, and the part that really has to be done within the year. For instance, we're closing now, and we have to submit any questions. I think it has to be a nurse. At the last meeting* [on ostomies in São Paulo, where the service was presented], *there were several people in the coordination team who weren't nurses, like physical therapists. In ostomy care, a nurse is required to be the coordinator. They have to be aware of it, they have to know the regulations, they have to understand the nursing aspect. Even if professionals study everything, it's different.* (P6)

Table 1. Survey of professional activities by area. Belém (PA), Brazil, 2024

	n	%	N	%
Professional activities related to demand access and organization				
Ostomy Program registration	12	75	16	100
Reception	2	12.50	16	100
Scheduling monthly follow-up appointments for reassessment and provision of collection equipment	11	68.75	16	100
Actively seeking registration for children and older adults with ostomies	1	6.25	16	100
Scheduling follow-up appointments with social services in cases of social need	1	6.25	16	100
Ordering materials, preparing reference standards, and verifying requests from the state's countryside	1	6.25	16	100
Activities in multidisciplinary consultations and assessments				
Nursing consultation	3	18.75	16	100
Changing the collection device	9	56.25	16	100
Medical consultation for follow-up	1	6.25	16	100
Requesting routine tests	2	12.50	16	100
Nutritional assessment and dietary guidance	2	12.50	16	100
Psychological assessment	1	6.25	16	100
Assessment of social needs	10	62.50	16	100
Checking family dynamics	1	6.25	16	100
Online care and video call assessment (teleconsultation)	2	12.50	16	100
Psychological consultation with ostomy patients and their families	1	6.25	16	100
Professional activities related to teaching, such as guidance and recommendations on equipment and products				
Indication of collection equipment and adjuvants	11	68.75	16	100
Teaching patients and families about self-care with the ostomy and collection equipment	14	87.50	16	100
Providing written instructions on care	7	43.75	16	100
Teaching patients and families about the main complications and how to recognize them	11	68.75	16	100
Patient and family education on storage of collection equipment	7	43.75	16	100
Guidance for patients and families in the event of complications	11	68.75	16	100
Indication of treatment in cases of stoma and peristomal skin complications	7	43.75	16	100
Offers written guidance on nutrition	3	18.75	16	100
Discussion of the rights of people with stoma	1	6.25	16	100
Group guidance and education in the waiting room	2	12.50	16	100
Professional activities related to referrals made (internal to the service)				
Referral to other medical specialties	12	75	16	100
Referral for nutritional counseling	10	62.50	16	100
Referral for psychological counseling	12	75	16	100
Referral to a social worker	11	68.75	16	100
Referral to the Ostomy Association	9	56.25	16	100

Source: Data collection.

> *The material order, the development of the standard terms of reference. All materials that arrive here are acquired by the state through a bidding process. To do this, a term of reference, a standard, must be developed, and I support the coordination and nursing team in developing them. I usually place material orders once they're already in the system. It's important to emphasize that the materials are received and managed by a state-owned company. They arrive at the state distribution center and, from there, are requested here, to the service pharmacy. So the flow is more or less like this regarding materials.* (P8)

> *Reception can be done by any professional. It's not the responsibility of* [names category expressing discontent], *I've already made that clear to the entire team. Anyone with the necessary skills can provide reception, because reception is a posture, and you look at people differently.* (P10)

Registration is essential because it is the first observation of reality. It is often conducted only with the family member, based on non-participant observations, whether due to their clinical condition or difficulty reaching the center. Assessments and reassessments are impacted by difficulties such as patients' geolocation and lack of equipment. Photos sent via WhatsApp, as the service has its own mobile phone, have been used to infer assessments.

> {Field note P12 – Depending on who does the registration, the approach is different: *"Social workers focus on social issues; nutritionists do the nutritional assessment; nurses focus on management and care issues; and psychologists take their turn"*}.

> *When we do the registration, generally when it doesn't come with an indication, it indicates* [in relation to adjuvants]. (P6)

> *We always try to schedule appointments within a month of registering, but we encounter difficulties. We lack supplies, patients live far away, and we can't always get them to come back. But if they're from Belém and having difficulties, we send them. Since they now have cell phones, they send photos via WhatsApp, and we continue to guide them, but when people can come, we schedule them.* (P1)

Even with the wide range of activities they can cover, they cannot take on other demands and procedures, either due to staff shortages, such as a surgeon in the event of complications, or due to physical infrastructure constraints. Reassessment remains a controversial point, as others claim it occurs even with shortages, unlike P7.

> *No, we don't have one. We can't handle* [reassessments] (P7).

> *We have a procedure called lavage. Irrigation—I'm against it being an outpatient procedure, as it is. But if we had better infrastructure, a team of doctors, a surgeon, all within a larger space, with quality, sterilized care—then yes.* (P6)

> *We don't see these complications. Unfortunately* (P16).

> *Sometimes they get very confused. Some complications and where they should go. Most of the time, they think they need to come here for some of these complications. We advise that many of these complications are not emergencies; in these cases, they should see the surgeon who performed the surgery. We emphasize those issues that are important and urgent. Whether it's necrosis, prolonged absence of bowel movements even when patients are eating, stoma collapse, or active bleeding that won't stop*. (P7)

Active record searches, mentioned by two interviewees, show the need to understand why patients do not visit regularly after registering and what difficulties they're facing. Another aspect of active record searches is always having a record of how many people are from the countryside of the state and are seeking material in the capital. This allows municipal departments to be contacted and a representative to collect the funds, avoiding long trips.

> *Actively searching for records, especially for at-risk groups* (children, older adults). *We have medical records, which include the previous date, where they came from, and their status. I'm always searching through the files. For instance, a patient who came to pick up, usually a month old, went four months without showing up, six months without showing up. I call mainly when it's a child or an older adult. There are cases of an older adult who was kept in a plastic bag for more than eight months because their family couldn't come, couldn't come pick up...* [says they're from a city near the capital, which should theoretically make it easier for them to come]. *So, we're always actively searching, "Oh, six months without coming*

> *to pick up." In theory, they're already listed as absent. I put them in the most absent category, because if they show up here, knock, and come to social services, we'll have to have a conversation, "Why is this happening?". Often, people don't want to come, they just put up a bag because they refuse, sometimes it's far away and they don't have the money for travel.* (P2)

> *Checking requests from the countryside, where many patients can't travel to the service, a responsible person from the municipality, usually from health or social services, creates a list and contacts us to request the request, separate the materials, and forward them.* (P8)

Internal and external referrals were found to be essential to enhance comprehensive care. This factor, in addition to providing resolution to serious complications, encourages interprofessionalism and connects the specialized service to the Healthcare Network. Referrals are made based on the identification of problems (P3 and P6), which is often confused with mere guidance.

> *We refer patients because there's a doctor in the afternoon. We also refer them outside when we detect serious changes, such as necrosis. I've already referred them to the emergency room or to Ophir, in cases of prolapse, when they're almost unfit.* (P1)

> *I schedule an appointment with the doctor. Before she approaches a patient, I tell them about the need, and she makes the referral* (or used to, as it's been a while since I've been sending them). *We refer them to the team members. For instance, I'm talking to a patient. I asked how patients' mental state was, even now that their family came, if they were accepting the use of the bag. When there's any acceptance issues, we suggest they schedule an appointment with the psychologist.* (P12)

> *The room is separate* [the equipment distribution and self-care guidance room is what "matrixes" patients]. *So, we identify a patient who needs a psychologist. We can direct them, but it's not in writing, either with the nutritionist or the* [psychologist], *to get guidance. "You're entitled to a referral. Is your stoma permanent? You're entitled." When there's a complication regarding the dressing or a hernia problem, we "refer" them, provide guidance. So, they can see the surgeon who performed the operation. Regarding nutrition, this patient needs to be referred for nutrition. Sometimes, even we, depending on what we eat, feel unwell.* (Synthesis P3 and P6)

Referrals are necessary and are included from the first contact with patients. Thus, diagnostic impressions are present in the ostomy service.

> *When patients arrive, what we do right away is the anamnesis. It's about gathering basic information and listening deeply, because they come with a lot of pressure, a lot of need for therapy. We also do it right away, getting a diagnostic impression, because even if we're not certain about the diagnosis, if I can help patients who have behavioral changes or symptoms of a disorder early on, I can already refer them for parallel psychological and psychiatric treatment.* (P11)

One unexpected finding was the mention of criminal detainees. Two issues are the lack of reliable numbers for this demand and the registration of false documents. Finally, P1 says, "*and we don't know what happens to them…*".

> *I don't know why... we only find out when they arrive at the prison with the bag, which is empty. They come here with minimal documentation for that inmate; they enter with false documents. We treat them here; it's happened before. So, I have no way of knowing. The prison population isn't small; there are several with ostomies. Some people have never used a bag, and when they get there, they worry about coming back. They leave that place and never come back. We already have that file on file. Other times, the family comes, but the material doesn't arrive there. Their problem is that they change a lot, they go to other prisons, and during this transfer, things get complicated, because they don't always keep coming back for it. And we don't know what happens to them.* (P1)

Topic 2 – Acquiring autonomy for social reintegration and moving away from self-care: collaborative elements in the journey from beginning to "restart"

The difficulty in "being used to the idea" is initial, and upon arrival at the program, people feel "hurt" and "offended." These are barriers the team must overcome.

> *They come here without any preparation, like, "Look, you're going to need surgery," "You're going to use the bag this way, the equipment this way." So, their first reaction is to reject it, to not even look at it, to not want to handle it. They don't want to clean it, they don't want to perform hygiene. They need to get used to the idea first. My work will permeate all other specialties. Sometimes, I reinforce some of the nutritionist's and nurses' initiatives regarding patients. This difficulty is more initial.* (P11)
>
> *There are a lot of taboos, a lot of prejudice involved. Especially socially, people feel very offended when they arrive here and feel very hurt. How will they deal with this later?* (P8).

P4 reflects that a minority arrives at the center with this knowledge, enabling reflection on how crucial this secondary care point is. P15, on the other hand, reports that the service helps them "use themselves" in public spaces again through self-care instruction. Some patients even consider the benefits of having an elimination stoma.

> *Most of our patients already have this knowledge: "I don't need this," "I still have this here," "I need this and that." Many of our patients are able to go through this process by recommending it, because we've spent years working with them. Of course, we have those who really are; today one comes and tomorrow another comes* [to seek it]. *But we've always tried to work with them. It's very repetitive because we're always talking, demanding things from them, those kinds of things.* (P3)
>
> *Most don't* [manage to perform self-care before going to the service]. *They start learning self-care after they come here. They arrive very lost in the new situation, and they don't know how to perform self-care, eat, use equipment, or maintain hygiene. It's very difficult for a patient to come here with all this knowledge; they're the minority.* (P4)
>
> *Because they accept themselves when they start to self-care, they begin to be free from other people and go out. They can use themselves; they can go out; they can date because we give them guidance on how to act. Some people say, "I even think it's better to have a stoma than not", saying it's better because they have that little bag to hold it;* [if] *they don't have one, they're constantly going to the bathroom. Depending on the person, there are exceptions. This self-care is 100% helpful.* (P15)

Independence is linked to self-care, and the secondary level is characterized as a support point for diverse knowledge, for reintegration into work and daily life.

> *It's the main factor that leads to their inclusion, perhaps self-care, because before they have a certain level of autonomy... in the care process, they avoid leaving the house, going out to birthday parties, going to work as much as possible. They feel completely insecure about finding themselves in an embarrassing situation. So, the moment they feel free from another person to do this, to empty themselves, to change, they feel more confident leaving the house, carrying their changing kit and more aware that something could happen. They need to go to the public restroom or at work to change, so this independence from other people is what truly restores their confidence.* (P7)
>
> *The goal is to reach a point where a patient has the autonomy to do it, because that's our service. Some people don't like cleaning, some don't like seeing feces, so when they actually get involved in this, most refuse; they don't want to. We talk and explain until they feel ready to no longer be dependent on another person. They have to do their own self-care.* (Synthesis P12 and P15)

Professionals report how they assess patients' knowledge upon first contact with the service. Based on just one self-care component that patients can develop, teaching strategies are outlined for resumption.

> *When I see a patient who already has a certain ease, that's already an open door to work. When I have this self-care, I can look at the ostomy, and I don't reject it. Patients may not have complete technical mastery of removing the equipment, of knowing how to change it, because it's all new, but they already participate in some part of that process. They already clean, they already do something that makes it easier for the family member who's helping. This helps not only their confidence, autonomy, and freedom, because for them to be reintegrated into society, into the activities they did before, they need to have this mastery. Otherwise, they'll feel insecure about starting over. How will I fill the bag, how will I change it, how will I handle it? It's crucial, therefore, in terms of the freedom they'll have socially. Even for their self-esteem, it changes a lot, because the person learns to do everything and cope, knowing they won't run the risk of leakage, they know they won't run any other risk, because they've already mastered the technique.* (P11)

One of the deponents offers explanations based on the experience in the service that impacts reintegration, the degree of cleaning and the use of adjuvants such as barrier paste, reporting differences in a person's sex in terms of acceptance.

> *I see them complaining. I don't know if it's a lack of cleanliness or that they don't know how to clean it. Sometimes it gets inflamed, red, they don't know when to apply the powder, they don't know when to apply the barrier cream. But as ostomy patients, having their ostomy inserted, I see that many have no problem. After cleaning, they come out normally. They have a working life. This ostomy situation is more difficult for boys than for girls. I don't know if it's because of their own emotional, physical, and feminine structure; women end up accepting it more. I don't see as many complaints about the girls' lack of care. But boys are even more difficult. I think it's because of their own acceptance that they arrive and are upset, because of the ostomy, because it's taking so much time to reconstruct. But I see some of them working, having a good family life, and I don't see as much resentment, as much disappointment. But there are some who arrive already irritated...* (P14)

For some, the program's power must be so great that people with ostomies no longer see themselves as disabled, pejoratively, as common sense sees them, even though ostomies are a disability. Paradoxically, P12 says this, but asks to recognize themselves as someone who uses a bag. Reintegration involves beginning to accept themselves as they are—disabled—but without the stigmatization that people with disabilities suffer.

> {Reflective field note on P2's statement – *"They have ostomies, not disabilities": I think about the impact of this statement when the professional tells me that she asks patients to take photos of themselves for promotional material for the service and noticed that they always take photos from the abdomen up, without demonstrating that they are living with a bag that collects fecal effluent. She tells me that she always says, "No. You can try to recognize yourself as a person with an ostomy. Why not take photos showing the bag?"*}

They observe a withdrawal from self-care due to psycho-emotional aspects. Self-care is relegated to family members, seeing the surgery as something "imposed".

> *Often, it's not the difficulty with the stoma itself; it's an emotional difficulty the person is experiencing. A difficulty with acceptance. It's not a difficulty with the equipment itself, or with replacement. It's a difficulty stemming from the emotional aspect.* (P11)

> *It would facilitate breaking some taboos that we need to emphasize during consultations, but another key pillar would be mental healthcare. These two cornerstones. Most of the time, it's due to the stoma, the initial clinical picture, and the change in reality.* (P7)

> *Many are unable to do so and also try to withdraw from self-care, leaving more responsibility to family members or caregivers. First, because they're still trying to cope with the new situation they've been forced into. It's a situation that ends up being caused by illness or an accident, somewhat outside their usual reality.* (P8)

DISCUSSION

It was analyzed that interprofessionality, materialized in professional activities, is not yet a reality in the service in question; however, some minority practices have been trying to implement it. Similar results were found in research conducted at the primary level, where workers were willing to establish collaborative practices; however, care management and patient flow prevented this type of shared care, generally prioritizing the unidirectional (biomedical) flow of care[11].

Punctual and spontaneous dialogue in referrals, for instance, already paves the way for the exchanges necessary for interprofessionality. However, without meetings to discuss cases or critical aspects of the work, automatic decisions will be made, favoring uncollaborative and strictly programmatic actions. Interprofessionality is under the aegis of the complementarity of dialogical actions[1,11].

It was found that referrals to the service's psychologist were the most frequent internal referral, while referrals to the Ostomy Association were relatively insignificant. Associations for people with ostomies in Latin America are relatively new, and patient engagement for policy formulation and control is limited; patients are only visible within the SUS through an associative focus. Only the union of these social actors would generate some kind of joint action, as well as the assessment of benefit packages, technologies, and other aspects of the services they use[12].

One positive aspect was the assessment of social needs, performed by 62.5%; however, receiving and assessing family dynamics are performed by few. Historically, in Brazil, the secondary level has been seen as a point of care for medium-complexity procedures[13]. However, currently, due to the guarantee of return to this care point, light technologies and shared care must be used more frequently.

The scenario highlighted, further obstacles, the presence of only family members during the assessment and the need to conduct the assessment by sending photos, given the financial and travel difficulties for people from rural areas to reach the capital. Actively searching for medical records to assess patients from rural areas or those who missed appointments is urgent. It is confirmed that, for this service to be maintained, not only medical and nursing consultations must be provided, but they must coexist with group activities, health promotion, and complication prevention. This also improves follow-up. The proposal is that patients should receive treatment plans from the team with referral flows and guidance, encouraging a link with primary care[14].

The secondary level of care for people with ostomies must be connected to their territory. The service in question is level I; however, its transition to level II is essential for effective referral to emergency services, polyclinics, or even tertiary[13] care in cases of serious complications.

Another category refers to teaching self-care as a "walk through the program." Only this training, combined with assessing patients' knowledge, can alleviate fear and allow them to regain control of their lives. Peristomal skin complications are often underestimated by newly registered patients, who may use skin barrier products incorrectly if not properly instructed. Active management—especially preventive management—of these complications by stoma therapists and dermatologists would allow patients' knowledge to be assessed and adapted educational strategies implemented[15].

The central role of nursing as a coordinator in developing the standard for such services was revealed. Skin integrity is crucial for the system's sealing. Otherwise, leaks occur. Specialized nursing considers three main factors in its consultation: individual (body profile, social situation); healthcare system (standard of care and health education); and products. Because of this last element, when directed toward managing such services, it can encompass practice by considering, in developing the standard: the equipment's ability to follow body movements; adhesive strength; the need for adjuvants to aid fixation; the potential for skin adhesion/removal; the level of effort required for the plate to adhere to the skin; and immediate adhesion is preferable[16].

As proposals, it is clear that the development of shared care plans is important. Expanded care is a micropolitical endeavor, and the care plan proposes a conversation about the uniqueness of health conditions. This approach, frequently observed in public health and mental health, is segmented into: understanding the case and problematizing its singularities, which requires an expanded history and diagnosis; developing a care plan for situations involving accountability and goals; reassessing the case and whether or not goals are met at the next appointment; and making observations about the case, to be discussed as a team[17].

A gender difference is evident: women are more resilient to the condition, while men tend to take longer to accept it. A recent systematic review of gender differences in people with intestinal ostomies suggests that women's emotional aspects, social, psychological, and sexual functioning, are more affected than men's. However, women choose more assertive coping strategies than men after having an intestinal ostomy[18].

It is clear that another contingency for care could consider human rights treaties, which have considered historically marginalized categories, following intersectionalities, such as female gender and age of the person with a disability. Making disabilities visible is the way to address social markers of difference. According to human rights, relying on these regulations, such as those of the United Nations (UN), allows us to recognize "multiple discriminations" in the fields of health and social services[19]. Another difficulty is overcoming the geolocal difference marker, as the northern state covered in this study has a considerable territorial extension, meaning that assessments are carried out with the help of WhatsApp.

The PNAES calls for specialized care to enable the implementation of monitoring practices for people with disabilities, with diagnostic groups, diagnostic support actions for rehabilitation, and matrix support to ensure they can return to primary care, something still in its infancy in Brazil. To this end, intersectionality is not just rhetoric; it would help understand factors linked to people with disabilities, escaping the pathologization by recognizing the positive and negative aspects of their identities, which change throughout the care program, as interprofessionalism helps them understand the new situation—of a person with an imposed disability—while emphasizing that a person is not incapacitated[20].

A recent scoping review highlighted challenges in providing timely access to secondary care services for people with disabilities, highlighting fragmentation, lack of team training, poor communication among professionals, and physician-centered care designs. As in this study, economic, territorial, and infrastructure constraints hinder self-care education and coverage of this area of care[21].

Finally, public health theorists argue that closer patient participation alone can reconfigure practices. It is asserted that one of the reasons for the difficulty in implementing Interprofessional Collaborative Practices is their immaterial focus, such as reception, communication, information exchange, and other unstructured knowledge. Thus, lines of care, therapeutic projects, and matrix support are lost in the face of the strictly biophysical modulation that healthcare has been taking[22].

The research's contributions included interprofessionality in the care of people with ostomies and the possibility of pursuing collaborative practices in these specialized settings. Listing these (inter)professional activities will guide future research and training by identifying critical points of care, highlighting the urgency of an intersectional and intersectoral approach for people with disabilities.

This study is limited by the limited contact with participants in the qualitative phase and the data collection conducted during work shifts. Furthermore, the lack of continuing training and education on interprofessionality among the team often resulted in perspectives that differed from the subject matter in the interviews. A future qualitative research agenda of the participatory or action type is recommended, addressing interprofessionality education in a proactive manner at the specialized level. This allows for the establishment of more flexible and collaborative workflows and therapeutic projects in routine practice.

CONCLUSION

It was found that collaborative interprofessional practices already partially exist, although this model is far from being achieved. Activities such as internal referrals and active search for vulnerable individuals are the initial stages toward achieving a secondary level focused on social rehabilitation. However, there was little expression of the rights of people with ostomies and health education in the waiting room.

It is important to emphasize that interprofessionality does not aim to eliminate the scope of exclusive activities, but rather to broaden the conduct of each category, expanding subjectivities in patient-centered care. It is important to emphasize that autonomy, self-care, and independence are fostered by teachings that convey safety in equipment handling and guidance on how patients should reintegrate into society.

Difficulties in providing care from the patient-family dyad perspective were identified, hindering longitudinality, and the use of WhatsApp to ensure assessments/reassessments were barriers to program operation. Participants understood that the program needs to advance, identifying social markers of difference and intersectionality in consultations and assessments. This supports the creation of an action plan for the interprofessional care network for people with disabilities, focused on ostomies, structured based on a regional epidemiological analysis and the characterization of services available for this profile.

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