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REHABILITATING FOR LIVING WELL: FROM SERVICE MANAGEMENT TO CARE

REABILITAR PARA O BEM VIVER: DA GESTÃO DOS SERVIÇOS AOS CUIDADOS

REHABILITAR PARA EL BUEN VIVIR: DE LA GESTIÓN DE LOS SERVICIOS AL CUIDADO

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RESUMO

Introdução: A diferenciação profissional entre enfermeiros generalistas e especialistas constitui um desafio para a gestão de serviços e de cuidados de reabilitação. Através de um enquadramento inovador que articula gestão, diferenciação profissional e bem-viver, este estudo explora como gerir serviços e cuidados de reabilitação no contexto desta diferenciação profissional, visando a articulação entre cuidados gerais e especializados para a promoção do bem-viver das pessoas.

Metodologia: Reflexão teórico-prática baseada em revisão narrativa da literatura científica e normativa sobre gestão de serviços de saúde e processos de reabilitação. A análise incluiu 38 artigos científicos e 15 documentos normativos, seguindo os princípios da análise temática.

Resultados: Identificaram-se cinco eixos de gestão: serviços de internamento não específico com necessidades de reabilitação; serviços especializados de internamento de reabilitação; gestão de cuidados continuados; gestão de serviços na comunidade; e gestão de cuidados de reabilitação. A análise evidenciou a diferenciação entre gestão de serviços e gestão de cuidados, destacando competências específicas em supervisão, liderança clínica e articulação interprofissional.

Discussão: O bem-viver através da reabilitação exige modelos de gestão inovadores que articulem múltiplos contextos assistenciais. Persistem desafios como envelhecimento populacional, escassez de profissionais e barreiras arquitetónicas. As perspetivas futuras apontam para modelos baseados em valor, tecnologias digitais, como telereabilitação e inteligência artificial, e participação ativa das pessoas como co-gestores do processo de reabilitação.

Conclusão: A gestão eficaz dos serviços e dos cuidados de reabilitação é estruturante para promover o bem-viver, exigindo articulação entre contextos assistenciais e complementaridade de competências profissionais.

Descritores: Enfermagem em Reabilitação; Gestão em Saúde; Assistência Centrada no Paciente; Bem-viver; Qualidade da Assistência à Saúde.

ABSTRACT

Introduction: The professional differentiation between generalist and specialist nurses constitutes a challenge for the management of rehabilitation services and care. Through an innovative framework that articulates management, professional differentiation, and well-being, this study explores how to manage rehabilitation services and care in the context of this professional differentiation, aiming to articulate the balance between general and specialized care to promote people's well-being.

Methodology: Theoretical-practical reflection based on a narrative review of scientific and normative literature on health service management and rehabilitation processes. The analysis included 38 scientific articles and 15 normative documents, following the principles of thematic analysis.

Results: Five management axes were identified: non-specific inpatient services with rehabilitation needs; specialized rehabilitation inpatient services; continuing care management; community service management; and rehabilitation care management. The analysis highlighted the differentiation between service and care management, emphasizing specific supervision, clinical leadership, and interprofessional coordination competencies.

Discussion: Well-being through rehabilitation requires innovative management models that articulate multiple care contexts. Challenges persist, including population aging, professional shortages, and architectural barriers. Future perspectives point to value-based models, digital technologies such as telerehabilitation and artificial intelligence, and active participation of people as co-managers of the rehabilitation process.

Conclusion: Effective rehabilitation services and care management are fundamental to promoting well-being, requiring coordination between care contexts and complementarity of professional competencies.

Descriptors: Rehabilitation Nursing; Health Management; Patient-Centered Care; Living Well; Quality of Health Care.

RESUMEN

Introducción: La diferenciación profesional entre enfermeros generalistas y especialistas constituye un desafío para la gestión de servicios y cuidados de rehabilitación. A través de un marco innovador que articula gestión, diferenciación profesional y bienestar, este estudio explora cómo gestionar servicios y cuidados de rehabilitación en el contexto de esta diferenciación profesional, con el objetivo de articular el equilibrio entre cuidados generales y especializados para promover el bienestar de las personas.

Metodología: Reflexión teórico-práctica basada en una revisión narrativa de la literatura científica y normativa sobre gestión de servicios de salud y procesos de rehabilitación. El análisis incluyó 38 artículos científicos y 15 documentos normativos, siguiendo los principios del análisis temátic.

Resultados: Se identificaron cinco ejes de gestión: servicios hospitalarios no específicos con necesidades de rehabilitación; servicios hospitalarios especializados en rehabilitación; gestión de cuidados continuos; gestión de servicios comunitarios; y gestión de cuidados de rehabilitación. El análisis resaltó la diferenciación entre la gestión de servicios y la gestión de cuidados, enfatizando competencias específicas de supervisión, liderazgo clínico y coordinación interprofesional.

Discusión: El buen vivir a través de la rehabilitación requiere modelos de gestión innovadores

que articulen múltiples contextos de atención. Persisten desafíos, incluyendo el envejecimiento poblacional, la escasez de profesionales y barreras arquitectónicas. Las perspectivas futuras apuntan a modelos basados en el valor, tecnologías digitales como la telerehabilitación e inteligencia artificial, y la participación activa de las personas como co-gestores del proceso de rehabilitación.

Conclusión: La gestión efectiva de los servicios y cuidados de rehabilitación es fundamental para promover el buen vivir, requiriendo coordinación entre contextos de atención y complementariedad de competencias profesionales.

Descriptores: Enfermería en Rehabilitación; Gestión en Salud; Atención Dirigida al Paciente; Buen vivir; Calidad de la Atención de la Salud.

INTRODUCTION

The notion of well-being transcends the absence of disease, incorporating dimensions of quality of life, social inclusion, and dignity [1]. In this context, rehabilitation emerges as a process that aims to restore or maximize functionality, promoting the active participation of people in community life and configuring itself as a new paradigm of rehabilitation care [2].

Care for well-being is based on an intersubjective perspective grounded in mutual recognition, where love, respect, and solidarity emerge as key elements. This approach deepens the nurse-person relationship in rehabilitation, enhancing self-esteem and recognition. It goes beyond the merely technical dimension to establish itself as a lived and meaningful care [3]. This philosophy of care is built through the dependence-independence continuum, supported by trust, respect, and esteem, central values to humanized rehabilitation [4].

The rehabilitation nursing model for well-being constitutes the central theoretical framework of this study, based on a perspective that transcends the biomedical dimension of rehabilitation. It is anchored in Axel Honneth's theory of recognition, which identifies love, law, and solidarity as essential spheres for the construction of human identity and dignity. In the context of rehabilitation, well-being translates into the promotion of autonomy, active participation, mutual recognition, and full citizenship. It is an emancipatory process that aims not only at the recovery of physical abilities, but at the reconstruction of a meaningful life, in which the person is the protagonist of their life project [2-3].

This perspective identifies practical and contextual challenges that highlight real barriers. Limitations of the physical environment and accessibility problems stand out, aspects that should be considered in service management strategies, reinforcing the need for innovation and equity. Autonomy, interpersonal relationships, and the construction of a meaningful life are determining factors for well-being; in turn, architectural barriers, negative social attitudes, and limited access to rights hinder belonging and compromise social inclusion [4].

The management of services and care are structuring elements for achieving quality and safe care. This management ensures the rational organization of resources, interdisciplinary coordination, and the implementation of person-centered models. Thus, managing the conditions and strategies for rehabilitation implies considering inseparable processes, when the ultimate goal is the well-being of the person, whether in the hospital context, continuing care, or in the community.

The analysis of service management focusing on rehabilitation reveals different perspectives. On the one hand, there are services such as surgery or medicine, in which people are admitted for other reasons but end up needing rehabilitation. On the other hand, there are inpatient, continuity of care, and community care services, whose main focus is precisely rehabilitation. This distinction influences the planning, organization, and management of human resources—both in terms of skills and the number of professionals needed—as well as the management of specific materials and equipment and how care processes are structured by nursing and other health professionals.

In all types of service, it is essential that managers reflect on the concrete meaning of the Rehabilitation Care Process, ensuring effective articulation between general and specialized care. The differentiation of roles and skills between generalist and specialist nurses constitutes the foundation of this articulation.

The guidelines of the Order of Nurses establish that all generalist nurses have the competence to intervene in rehabilitation processes, where the promotion of autonomy, the prevention of disability, and support for self-care are central components of nursing care [5, 6]. The Regulation of Common Competencies of the Specialist Nurse highlights that the generalist nurse must be able to assess the person's functionality, identify needs related to self-care deficits and implement interventions aimed at adapting, compensating for or recovering functions. However, the complexity of the case may require supervision by the specialist nurse in rehabilitation nursing (RN) [5].

Although RNs have specific skills, the intervention of generalists is considered essential. This intervention stands out especially in primary and secondary prevention, in 24-hour continuity, in supporting the hospital discharge process and in promoting self-care strategies in different contexts [6, 7]. Thus, the generalist nurse is jointly responsible for the continuity of rehabilitation care, collaborating with the multidisciplinary team and the RN. This collaboration is geared towards functional recovery and improvement of the quality of life of the person and family, through individualized plans built with the active participation of those involved [7].

The articulation between these generalist care and the specialized intervention of the RN constitutes, precisely, one of the pillars of the effective management of rehabilitation services. RNs are required to have the ability to provide highly differentiated care, focused on maximizing autonomy, functional recovery and social reintegration of the person. These professionals must possess advanced skills in functional clinical assessment, planning and implementation of personalized rehabilitation programs, as well as skills in supervision, consulting and research [6, 8].

Beyond advanced clinical practice, the RN is expected to exercise leadership and management of specialized care, promoting safe, innovative, and evidence-based environments. This professional is also responsible for guiding and supervising generalist nurses in the provision of care, ensuring performance in accordance with quality, safety, and best practice standards. This supervision covers technical, clinical, and ethical dimensions, helping generalists integrate concepts of functionality and promoting autonomy in daily care. Additionally, this specialist acts as a clinical reference in the team, supporting decision-making and ensuring that care meets the specific needs of the person [6, 9].

In the training aspect, the RN assumes the roles of educator and facilitator of professional development. They promote teaching in a practice context, scientific updating, and continuous training of teams, functioning as a link between clinical practice, service management, and pedagogy. They are expected to contribute to the transmission of specialized knowledge, supporting generalist nurses, nursing students, and other health professionals in a multidisciplinary context. Their formative role is based on lifelong learning and the need to consolidate a culture of rehabilitation care based on evidence, innovation and co-responsibility for the development of the discipline [10, 11].

The intervention of the RN is distinguished by its technical and scientific depth, focus on functionality and quality of life, and commitment to professional excellence, responding to the complex needs of people in the rehabilitation process from their recognition, their social and family context, and promoting citizens' rights through relationships based on affection.

The differentiation between generalist nurses and rehabilitation specialists is not limited to the distinction of technical skills, but implies different ways of managing services and care. If, on the one hand, the presence of specialist nurses enhances more complex and integrated management models, focused on clinical supervision, leadership of multidisciplinary teams and the implementation of personalized rehabilitation programs, on the other hand, their absence or scarcity can result in more fragmented management models, where the continuity and depth of the intervention are compromised.

These different management configurations have a direct impact on the quality of care provided and, consequently, on promoting people's well-being. The central issue is not only recognizing that different levels of competence exist, but understanding how the management of this differentiation can enhance or limit the achievement of the ultimate goals of rehabilitation for well-being: autonomy, dignity and full social participation [12].

In this context, the thesis is proposed that professional differentiation between generalist and specialist nurses constitutes a determining factor for the promotion of well-being, provided that it is supported by management models that articulate complementary skills and ensure continuity between care contexts. The objective of this study is to reflect on management models of rehabilitation services and care that enhance the articulation between generalist and specialist nurses, analyzing their implications for the quality of care and for the achievement of well-being in different care delivery contexts.

METHODOLOGY

This article results from a theoretical-practical reflection based on a narrative review of the scientific and normative literature on health service management and rehabilitation processes, carried out between January and July 2025. This methodological design allows for the critical integration of theoretical knowledge, empirical evidence, and regulatory framework, facilitating a multidimensional analysis and the development of perspectives applied to the context of professional practice.

The bibliographic research included international databases, namely CINAHL (Cumulative Index to Nursing and Allied Health Literature), PubMed/MEDLINE, Scopus, and Web of Science, as well as grey literature consisting of documents from the World Health Organization (WHO), and documents from national regulatory bodies through research in the Official Gazette and websites of regulatory bodies. The search strategy was based on the combination of terms related to "health service management," "rehabilitation nursing," and "care management."

Inclusion criteria considered articles in Portuguese, English, and Spanish, published between January 2005 and July 2025, whose relevance focused on service management, rehabilitation nursing, and person-centered care management. Studies without direct relevance to the study objectives, publications prior to 2005, documents without access to the full text, and literature in languages other than those specified were excluded.

The selection of documents followed an interactive process based on thematic relevance and contribution to the study objectives, favoring an exploratory approach that would allow capturing the conceptual and practical diversity of the area under

study. For this study, 38 scientific articles and 15 normative documents were considered, totaling 53 documents for analysis. The analysis and synthesis of the data followed the principles of thematic analysis by Braun & Clarke [13], a widely used and recognized qualitative method for its theoretical flexibility and accessibility, organizing the findings into three main axes: service management, rehabilitation care management processes, and future perspectives.

The analytical process was developed in six phases: 1) Familiarization with the data – exhaustive reading of articles and documents, with recording of notes and initial ideas; 2) Generation of initial codes – systematic identification of relevant aspects in all articles, organizing excerpts according to each code; 3) Search for themes – grouping of codes into potential themes, gathering all pertinent data; 4) Review of themes – verification of the internal coherence of each theme in relation to the excerpts and the entire body of documents, elaborating a thematic analysis map; 5) Definition and naming of themes – conceptual refinement, assignment of clear definitions and precise designations of the themes; 6) Production of the report – integration of the results into this article, with illustration through examples, analysis of the selected excerpts in relation to the initial question and critical discussion based on the literature.

RESULTS

The analysis of the evidence allowed the construction of a thematic map that organizes the findings into five main axes: Management of non-specific inpatient rehabilitation services; Management of inpatient rehabilitation services; Management of continuing care; Management of community services; Management of rehabilitation care (Figure 1).

Figure 1 – Thematic map of the analysis of the themes management and rehabilitation.

From the interaction between the various documents under analysis, the need for strategic planning emerges, particularly in defining priorities according to epidemiological needs, age distribution, and social conditions. The articulation of care and responses available in the various regions of the country is also highlighted, in accordance with the Basic Health Law and the National Health Plan 2020–2023 [21, 22]. The organization of services should value the integration between hospital care, differentiated units, community and home care, ensuring continuity of care [23, 24].

Human resources management focuses on valuing multidisciplinarity and invests in specialized skills, also considering motivation and resources [25, 26]. Financial and technological management refers to the rational use of equipment, assistive technologies, and digital innovation, namely telerehabilitation and integrated records [27-29].

MANAGEMENT OF INPATIENT SERVICES, NOT REHABILITATION SERVICES, WITH REHABILITATION CARE NEEDS

Managing services that cater to people with rehabilitation care needs involves planning, organizing, and evaluating specific responses for individuals with temporary or permanent functional limitations. This approach requires person-centered integration, focusing on the early identification of needs, interprofessional coordination, and the integration of human, technical, and social resources to optimize the recovery and adaptation process. To achieve this, it is essential to implement strategies that ensure continuity of care 24 hours a day and throughout hospitalization, the prevention of secondary disabilities, and the promotion of quality of life.

The health service manager faces the challenge of aligning organizational policies with the principles

of rehabilitation, ensuring accessibility, equity, and sustainability of responses. This involves ensuring that, from the moment of hospitalization or the occurrence of a functional limitation, there is a clear care plan adapted to the clinical, social, and family situation of each person [14, 30].

The organization of the service must provide resources that ensure continuity of care, which implies creating hospital-to-community transition protocols, linking hospital discharge with home-based rehabilitation care or in outpatient units [31]. A person with a femur fracture undergoing orthopedic surgery benefits from continuous rehabilitation: first in an inpatient setting, then in a rehabilitation center and, finally, through home visits by nursing and physiotherapy, ensuring home adaptation and fall prevention.

Another example of effective management occurs in the area of preventing secondary disabilities. People with spinal cord injuries need specialized care to avoid complications such as pressure ulcers, recurrent urinary tract infections, or muscle contractures. The nurse manager must ensure team training, acquisition of appropriate equipment, and implementation of clinical monitoring systems [14].

Promoting quality of life is equally central. For people with multiple sclerosis or neurodegenerative diseases, the manager must create responses that are not limited to clinical treatment, but also integrate psychological support, mutual aid groups, and community social support networks [32]. Thus, not only physical functionality is promoted, but also emotional well-being and social inclusion.

Assessment processes are fundamental in these services, allowing for the guarantee of quality rehabilitation care and identifying factors that contribute to the excellence of rehabilitation nursing care in inpatient units. In this context, instruments that support decision-making by managers stand out, such as the Instrument for Assessing the Quality of Rehabilitation Nursing in Inpatient Units (IAQERUI) [33].

In short, managing services with people and families with rehabilitation care needs means coordinating human and technical resources efficiently, promoting interprofessional integration and ensuring a response that goes beyond the hospital dimension, involving the community and families. Effective management translates into improved health outcomes, reduced disabilities and the construction of more humane and inclusive services, so monitoring specific indicators becomes a real need for management.

MANAGEMENT OF INPATIENT REHABILITATION SERVICES; MANAGEMENT OF CONTINUING CARE; MANAGEMENT OF COMMUNITY-BAS D REHABILITATION SERVICES

These three management axes – specific inpatient rehabilitation services, continuing care, and community-based rehabilitation services – although distinct in their characteristics, share the principle that rehabilitation is a continuous process that does not end with the inpatient period, requiring coordination between different levels of care to ensure safe and effective transitions and promote the well-being of individuals throughout the rehabilitation process. Thus, it was decided to develop these three management axes in an integrated way in this subsection, highlighting their articulation.

The management of rehabilitation services must be aligned with the principles of accessibility, equity, and sustainability, which implies ensuring that all people, regardless of their socioeconomic status, have access to rehabilitation programs [14, 30]. An example is the implementation of telerehabilitation consultations, which allow monitoring of people in rural areas or with mobility difficulties, reducing inequalities in access to care and facilitating continuity between specialized inpatient care, continuing care, and community support [34].

In hospital inpatient care, management focuses primarily on the organization of multidisciplinary teams, ensuring that doctors, physiatrists, nurses, RNs, physiotherapists, occupational therapists, social workers, and other health professionals work in an integrated manner on individualized care plans [35]. The adequate allocation of RNs is also crucial, since insufficient human resources can compromise both clinical safety and the functional outcomes of the person undergoing rehabilitation [36, 37]. Another relevant aspect concerns the adoption of assistive technologies, such as early mobilization devices or telemonitoring systems, which allow for improved autonomy and reduced complications associated with immobility [16, 34].

Leading the teams in these services is a real challenge for nurse managers, particularly in promoting a team spirit, in which each professional contributes their specific knowledge to the success of the person and family being assisted. However, it was observed that strategies to enhance multidisciplinary integration in rehabilitation care were still insufficient.

In the community context, management prioritizes proximity and continuity of care, coordinating strategies between primary health care teams, families, and social support networks [38]. The use of home visit programs and rehabilitation nursing consultations in family health units are examples of practices that allow supporting the person in readapting to home and preventing avoidable readmissions [39]. The articulation between hospital

and community, based on integrated management, proves to be crucial to ensure safe and efficient care transitions, being decisive in preventing readmissions, reducing costs, and promoting the social reintegration of people with functional dependence [16].

Effective management in this area also implies coordination with social structures, such as day centers and Residential Structures for the Elderly, to ensure support in activities of daily living. In this way, it is possible to reduce costs, avoid readmissions, and promote social reintegration, central objectives of contemporary rehabilitation.

We have identified a lack of specific studies on the management of continuing care units for rehabilitation, however we recall that the objectives of these units are to provide continuous and integrated health and social support to people who, regardless of age, are in a situation of dependency and are focused on the overall recovery of the person, promoting their autonomy and improving their functionality, within the context of the dependency situation in which they find themselves, guided by their fundamental values that underpin the rehabilitation intervention [40].

REHABILITATION CARE MANAGEMENT

This identified axis – rehabilitation care management – differs from the previous ones by focusing on the direct care process and not on the organization of services. This axis is transversal to the four previous ones, being operationalized in all care contexts through the specialized clinical practice of the RN.

The analysis of the evidence revealed that the promotion of the well-being of people in the rehabilitation process critically depends on the articulation between different levels of professional differentiation: generalist nurse and rehabilitation specialist, each contributing in a specific but complementary way to health outcomes and quality of life [6,42]. This professional differentiation directly impacts people's well-being through multiple mechanisms.

The presence of RN is associated with significant gains in functional autonomy, reduced length of stay, prevention of secondary complications, and greater empowerment of individuals and families for self-management of their health condition [16, 36, 37]). While generalist nurses ensure the continuity of basic care and clinical monitoring, RN introduces specialized interventions that enhance functionality, autonomy, and social participation. This complementarity translates into concrete results, such as greater health literacy, social and labor inclusion for the person's well-being [11, 16].

In this context, well-being goes beyond the absence of disease or functional recovery, translating into the ability to live with meaning, dignity and quality despite physical capacity. This requires the articulation between general care, which ensures maintenance and safety, and specialized care, which promotes transformation and empowerment. When this articulation fails, ruptures in the continuity of care are observed, less effective interventions, less response to the complex needs of people in rehabilitation and consequent compromise of health outcomes and well-being [6, 11, 16, 42].

Ensuring well-being therefore implies management structures capable of integrating this complexity. Rehabilitation care management is a dynamic process that involves the planning, implementation, and evaluation of clinical interventions by nursing and other professionals, aimed at people undergoing rehabilitation, but also promoting a successful life within their remaining health, physical, and intellectual conditions. This level of management is closer to clinical practice, encompassing the definition of individualized plans, the monitoring of health outcome indicators, and the use of functional, social, and environmental assessment tools for well-being, hence the importance of family, social, and work integration [41].

Three levels of nurses involved in rehabilitation can be identified: beginners, nurses with little experience and limited mastery of rehabilitation principles, who demonstrate basic skills under supervision, focusing on compliance with protocols; the intermediate level - nurses capable of adapting interventions, with greater autonomy and consistent integration of scientific evidence; and finally, the advanced level - highly specialized practice, transformational leadership, innovation in care management, and contribution to the development of the profession [6, 42].

The care management process begins with the collection of objective data (whenever possible using specific scales), followed by nursing diagnoses, the care plan, the execution of care and its evaluation [43]. The RN plays a central role in coordinating person-centered care, oriented towards autonomy, safety and quality of life. Its practice requires constant articulation with the multidisciplinary team, which may include physiotherapists, occupational therapists, psychologists and doctors, in order to ensure integrated and coherent interventions with the objectives defined for urban rehabilitation [11].

Care management differs from service management in that it is directly linked to clinical execution and personalized monitoring of the rehabilitation process, but also in that it requires the RN to invest in leading the teams with whom they work, delegating some activities and supervising the progress of the people cared for and the professionals to whom they delegate [6, 11, 42].

The Association of Rehabilitation Nurses sought to enhance the management of rehabilitation care by publicizing the Competency Model for Professional Rehabilitation Nursing, which constitutes a structuring reference for defining the competencies of rehabilitation nurses [42]. The

model is organized into four central domains: professional practice, leadership, health and well-being promotion, and person-centered care delivery. It describes expected behaviors and capabilities at three proficiency levels: beginner, intermediate, and advanced. This framework allows for guiding the continuous professional development of RNs, but also offers objective criteria for performance evaluation and for the construction of educational programs aligned with the contemporary demands of clinical practice. By systematizing technical, ethical, and relational competencies, the model underlines the importance of evidence-based, interdisciplinary practice focused on maximizing the functionality and quality of life of people undergoing rehabilitation [42].

The outlined competencies are particularly relevant, since professional practice is based on the nursing process, clinical judgment, evidence-based practice, ethics, and safety. Leadership translates into the ability to coordinate teams, manage resources, influence health policies, and promote the quality of services. Promoting health and well-being involves health education, preventing complications, supporting self-management of the condition, and maximizing functionality. Finally, providing person-centered care requires a holistic approach, respect for individuality, therapeutic communication, and family/caregiver involvement [42].

It is important to emphasize that care management is not limited to the physical space of the health institution; it goes beyond the physical barriers where the RNs work. It is often essential to go to the environment of the people they care for, to their workplaces, or even to intervene with local authorities to adapt accessibility and community spaces [44]. This perspective broadens the dimension of rehabilitation by incorporating social, environmental, and political factors that directly influence health outcomes.

In this way, rehabilitation care management differs from service management because it is closely linked to clinical execution, personalized follow-up, and direct support for the recovery process. The integration of family, community and social structures thus becomes an essential pillar for achieving sustainable results and promoting true well-being for people undergoing rehabilitation [6, 8].

The results allowed us to identify five complementary and interdependent axes of management in rehabilitation nursing: Axis 1 - Management of non-specific inpatient services that identifies and responds to rehabilitation needs in general hospital settings, preparing transitions; Axis 2 - Management of inpatient rehabilitation services that organizes specialized and intensive hospital rehabilitation responses; Axis 3 - Management of continuing care that consolidates gains and facilitates transitions between hospital and community; Axis 4 - Management of services in the community that promotes proximity, continuity and social reintegration in the person's natural environment; and Axis 5 - Management of rehabilitation care that operationalizes specialized clinical practice across the four previous axes.

The effective articulation between these five axes, supported by the professional differentiation between generalist nurses and RN (Specialized Rehabilitation and Rehabilitation Specialists), constitutes the foundation for promoting the well-being of people in the rehabilitation process, ensuring continuity, quality, and humanization of care throughout the entire care trajectory.

DISCUSSION

The results presented, organized into five thematic management axes, highlight the complexity and multidimensionality of rehabilitation nursing. This discussion seeks to deepen the meaning of these findings, articulating them with theoretical, ethical, and organizational perspectives that underpin the promotion of well-being as the central objective of rehabilitation.

The five management axes identified — from non-specific hospitalization to direct care management — reflect a paradigmatic evolution in the conception of rehabilitation. This is no longer understood as a mere recovery of physical functions but is configured as a process of promoting well-being, a concept that transcends the physical dimension and integrates dignity, social inclusion, autonomy, and quality of life1). This understanding positions rehabilitation not only as a clinical process but as an intersubjective paradigm, in which mutual recognition, solidarity, and the construction of trust relationships between nurse and person in rehabilitation are fundamental to promoting self-esteem and autonomy [3]. Care management (axis 5), from this perspective, is not limited to technical procedures, but requires a relational approach that recognizes the person in their entirety and uniqueness. This paradigm shift is implicit in the five identified axes, where the articulation between these axes thus materializes the transition from a disease-centered model to a well-being-centered model.

The results highlight the differentiation between generalist nurses and RNs as a structuring element of rehabilitation care management (axis 5). Generalist nurses play an essential role in promoting autonomy and preventing disabilities in general care contexts, through continuous clinical monitoring they identify rehabilitation needs early [5, 8].

RNs, in addition to intervening in more complex situations, are responsible for supervising and training generalists, ensuring standards of quality, safety and innovation, as well as leading person-centered rehabilitation programs. This clinical leadership is particularly evident in axes 2 (specialized inpatient

care) and 5 (direct care management), where specialized interventions maximize functional gains and empower people for self-management [6, 17].

The articulation between these levels of professional competence translates into greater effectiveness of the rehabilitation process and the achievement of well-being. This differentiation is not merely hierarchical, but functional and complementary: generalists ensure the basis of safety and continuity, while RNs introduce the transformation and innovation necessary to maximize the potential for recovery. The absence of this articulation compromises health outcomes and the well-being of people [3, 20].

The analysis of the five axes highlights the need for innovative management models that articulate rehabilitation services and care in multiple contexts — hospital, community and continuing care. The literature and normative references analyzed confirm that effective management depends on the synergistic integration between the five complementary axes: management of services with rehabilitation care needs (axis 1), which requires planning focused on rapid and individualized responses, early identification of needs and articulation with subsequent axes; Management of rehabilitation services in specialized inpatient care (axis 2), continuing care (axis 3) and community (axis 4), which presupposes multiprofessional coordination and continuity between levels of care, ensuring that functional gains are consolidated and maintained throughout the entire care trajectory; and the management of rehabilitation care (axis 5), where specialized clinical practice ensures personalized plans, integrating family, community and the various contexts of life, transversally operationalizing the promotion of well-being in all care contexts [16, 30].

This integration between the five identified axes is not linear, but systemic and dynamic. Each axis influences and is influenced by the others, creating a care network that must be managed holistically and in a coordinated manner. The fragmentation between axes, identified as a limitation in the results, compromises the continuity of care and, consequently, the well-being of people.

On the other hand, organizational and contextual challenges persist that condition the effective operationalization of the five identified axes. Architectural barriers, discriminatory social attitudes, and limited access to resources and technologies, which condition social inclusion and equity of care, are particularly relevant in axis 4 (community care management), in which social inclusion is a primary objective [4]. Management must therefore consider the environmental and political dimension of rehabilitation, going beyond institutional walls and promoting interventions in conjunction with families, local authorities, and the community [44]. This perspective is especially relevant in axis 5 (care management), where RNs frequently need to intervene in non-institutional contexts, which broadens the traditional concept of care management and reinforces the commitment to well-being as a social construct [44].

The management competence of nurses is incorporated throughout undergraduate, specialized, and postgraduate training, as well as through practice in contexts of coordination, leadership, and management of services. The results show that the management of rehabilitation nursing services, operationalized through the five identified axes, is essential to ensure integrated, effective and person-centered care, responding to the growing demands of society and health systems [20].

This management competence is not limited to administrative aspects, but integrates clinical, ethical and political dimensions. In axes 1 to 4, management focuses on the organization of services, allocation of resources, interdisciplinary coordination and ensuring continuity of care. In axis 5, management takes on distinct characteristics, focusing on clinical execution, personalization of care and leadership of teams in the direct context of practice [6, 11, 42].

The development of these management skills, adapted to the specificities of each axis, is imperative for the promotion of well-being. The continuing education of nurses, particularly RN, should integrate these multiple management dimensions, preparing them to lead the transformation of rehabilitation services and care from a perspective of promoting well-being.

Thus, the discussion points to the urgency of integrating the perspective of well-being into the management strategies of services (axes 1 to 4) and care (axis 5), consolidating a humanized, inclusive and sustainable rehabilitation nursing practice. This vision challenges professionals and managers to assume rehabilitation not only as functional recovery, but as an emancipatory process that promotes the recognition, citizenship and dignity of people in different phases of life [1, 3].

Well-being, in this perspective, is not a result to be achieved at the end of a linear rehabilitation process, but a present and structuring objective in each of the five identified axes. From the early identification of needs in general inpatient services (axis 1), through intensive rehabilitation (axis 2), consolidation in continuing care (axis 3), community support (axis 4), to the direct and personalized management of care (axis 5), well-being should guide all management decisions and all clinical interventions.

This integration of well-being as the guiding thread of the five axes constitutes the central contribution of this reflection, proposing a systemic and holistic approach to management in rehabilitation nursing that transcends the traditional fragmentation between contexts and levels of care.

CURRENT CHALLENGES IN MANAGEMENT AND CARE

Having established the conceptual and organizational framework for rehabilitation nursing management through the five identified axes, it is now important to situate this reality within the context of the contemporary challenges faced by health systems. These challenges directly impact the operationalization of the five axes and the capacity to effectively promote the well-being of people undergoing rehabilitation.

The health sector faces a set of increasingly complex and interdependent challenges resulting from demographic, epidemiological, and organizational changes. Population aging, the increased prevalence of chronic diseases, and the growing pressure for efficiency have highlighted the need for more integrated and innovative management of health services, particularly in the rehabilitation contexts identified in the five axes [45]. In this context, nursing assumes a central role, with rehabilitation nursing standing out as a strategic area in promoting the autonomy, functionality, and social reintegration of the individual [46].

Population aging and the increased burden of chronic disease are global realities that impact all identified management axes. It is estimated that, by 2050, more than 22% of the world's population will be over 60 years old, representing a significant increase in the demand for long-term and multidimensional care (45). Associated with aging, there is a rise in chronic diseases and multimorbidity, which require a reorganization of the health system focused on proximity care, prevention of disabilities and promotion of quality of life [47].

The shortage of qualified professionals constitutes a global threat, with a particular impact on axis 5 (care management), where the presence of RN is crucial for outcomes. Projections point to a gap of around 18 million health workers by 2030, compromising the response capacity of the systems [48]. In the Portuguese context, the need for safe staffing levels and work overload intensify phenomena such as burnout and turnover, harming the quality and safety of care in all identified axes [49]. This reality compromises not only clinical effectiveness, but also the ability to implement the professional differentiation that the results have shown to be essential for promoting well-being.

Inequalities in access to health persist, especially in vulnerable populations and peripheral areas, particularly impacting axes 3 (continued care) and 4 (community services). Geographic, economic, and informational barriers condition not only the use of services but also the integration of the person into family and social life [45]. Strategies such as decentralization, telerehabilitation, and community programs are fundamental to reducing these inequities and ensuring that well-being is accessible to all people, regardless of their socioeconomic status or geographic location [34, 45].

The fragmentation between the domains of administrative and clinical management compromises organizational efficiency and continuity of care, particularly in the articulation between the five management axes. Clinical governance models and the interoperability of information systems emerge as essential tools to align strategic objectives and ensure evidence-based decisions that promote well-being [49]. This need for integration is particularly relevant in the articulation between service management (axes 1 to 4) and care management (axis 5), where parallel operating logics often persist that compromise continuity and quality of care.

Health systems face strong pressure to demonstrate economic efficiency and achieve performance targets. However, the humanized dimension of care remains central, especially in rehabilitation, where proximity, empathy and recognition of the person in their uniqueness are crucial for health outcomes and well-being [43]. Health leadership must therefore balance quantitative metrics with qualitative results, ensuring that efficiency does not compromise the dignity of care. This tension manifests itself in all five axes, but is particularly critical in axis 5 (care management), where personalization and the therapeutic relationship are irreplaceable.

FUTURE PERSPECTIVES IN REHABILITATION CARE MANAGEMENT.

Given the challenges identified, and recognizing the complexity of rehabilitation nursing management across the five axes, it is important to project future perspectives that allow for the consolidation and deepening of the promotion of well-being as the central objective of rehabilitation.

Future management models should be based on the concept of value-based healthcare, prioritizing outcomes for individuals over volume or cost metrics. The concept of creating value in healthcare means measuring gains in functionality, autonomy, and quality of life, favoring decisions focused on the real impact on the individual [47, 50].

This perspective implies transforming management indicators across all five axes, incorporating dimensions of well-being (social participation, perceived quality of life, satisfaction, employment) in addition to traditional clinical and efficiency indicators. The evaluation of management effectiveness should, therefore, focus on the value created for individuals and not just on costs avoided or the number of interventions performed.

Digital technologies represent one of the greatest vectors of transformation, with the potential to strengthen the articulation between the five axes. Telemonitoring allows for continuous monitoring at home (axis 4), promoting therapeutic adherence and preventing complications. Artificial

intelligence applied to rehabilitation paves the way for personalized plans and monitoring of functional evolution, across all five axes [51, 52]. However, it is essential to ensure that these technologies are implemented in a logic of proximity and humanization, and not of distancing or depersonalization. Technology should be an ally of the therapeutic relationship, facilitating the continuity and personalization of care, and not a substitute for the human contact essential to promoting well-being.

The co-responsibility of citizens in the rehabilitation process is essential, in all the axes identified. The person should be a co-manager of their health process, participating in the definition of objectives and monitoring of their progress. This active participation promotes empowerment, increases adherence and improves results, constituting a fundamental dimension of well-being [53, 54]. This perspective requires a cultural transformation in health services, abandoning paternalistic models to embrace an effective partnership with people and families. Care management (axis 5) should operationalize this vision through practices of shared decision-making, negotiation of objectives, and recognition of the person as an expert in their own life.

The continuing education of teams must go beyond technical skills, encompassing leadership and management applied to rehabilitation, preparing professionals for coordination and decision-making roles in the different identified areas [36]. Continuing education adapted to the digital reality and new care demands ensures practices supported by scientific evidence and aligned with the goal of promoting well-being [55]. This training should include a systemic understanding of the five management areas, empowering professionals to promote the articulation between them and to lead the necessary transformation in rehabilitation services and care.

Sustainability and equity should be pillars of any future strategy, across the five management areas. Rehabilitation care is a universal right and should be accessible to all people, regardless of their socioeconomic status, geographical location, or stage of life and illness. Simultaneously, efficiency must be ensured through preventive models that reduce long-term costs, such as readmissions and institutionalizations, promoting effective articulation between the five areas [49, 56].

The management of rehabilitation care is at a turning point. The five identified axes highlight the complexity and multidimensionality of rehabilitation nursing management, from the early identification of needs in general contexts to the maximum personalization of specialized care. Current challenges—aging, chronicity, shortage of professionals, and inequalities in access—demand innovative and sustainable responses that effectively articulate these five axes.

Future perspectives, based on value models, humanized technology, citizen participation, continuous training, and a commitment to equity, offer a path to reposition rehabilitation as a central element of health systems. The integration between the critical analysis of challenges and the projection of future solutions allows for the consolidation of a rehabilitation paradigm that balances efficiency and humanization, strengthens people's autonomy, and ensures the sustainability of organizations.

Rehabilitation care, operationalized through the effective articulation of the five identified management axes, should be understood not only as a clinical intervention, but as an essential social strategy to promote dignity, inclusion and quality of life – that is, to promote well-being as the ultimate and structuring objective of all management processes and all rehabilitation nursing care interventions.

CONCLUSION

The articulation between management and rehabilitation is an essential condition for health services to effectively promote well-being. Rehabilitation is not limited to physical recovery, but involves creating organizational, social, and human conditions for the full and dignified participation of individuals. Thus, the management of services and care should be understood not only as a technical dimension, but as an ethical commitment to quality of life.

The analysis carried out allows us to affirm that rehabilitation, when oriented towards well-being, goes beyond the biomedical dimension and establishes itself as an integrative process, centered on functionality, dignity, and social inclusion. The management of rehabilitation services and care is crucial to ensure continuity, quality, and safety of care, with the articulation between inpatient, community, and continuing care contexts being decisive. The differentiated role of generalist nurses and rehabilitation specialists, as defined by the Order of Nurses, reinforces the complementarity of skills, where supervision, continuous training, and clinical leadership assumes particular relevance.

However, challenges related to architectural, organizational, and social barriers persist, requiring innovation in management models and greater integration of environmental, technological, and political dimensions in rehabilitation. The reflection points to the need to consolidate person-centered management practices oriented towards well-being, mobilizing specialized human resources, assistive technologies, and interprofessional collaborative strategies. In short, rehabilitation should be understood as an emancipatory process, capable of promoting not only functional autonomy but also active participation, recognition, and citizenship.

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