

Acquired brain injury rehabilitation – Dilemmas in neurological physiotherapy across health care settings

ABSTRACT

Persons with acquired brain injuries (PwABI) are usually hospitalized for emergency care and often require both specialist health care (SpHC) and primary health care (PrHC) long-term follow-up. Higher intensity rehabilitation featuring early intervention is recommended. This study investigated how implementation of redistributed responsibilities in Norway affects neurological physiotherapy practice within and across health care levels and how physiotherapists experience and address these changes. We performed qualitative research interviews with physiotherapists (PTs), complemented by non-participatory field observations of PT treatments, during the rehabilitation of 10 PwABI from SpHC to PrHC. We performed a content analysis of the interviews connected to perspectives on professionalism. Physiotherapy services for PwABI seem to be constrained, as reforms shift responsibilities for rehabilitative work between health care levels. Earlier hospital transfer, structural limitations and resource insufficiencies challenge the ability to provide good quality and intensive physiotherapy services for PwABI, especially in primary care. Furthermore, traditional division of responsibilities and organizational boundaries appears to limit expectations of future treatment and influence the delivery of recommendations across health care levels. This study draws attention to the possible unintended consequences of reform initiatives, which should be considered during further development and efficiency improvements in rehabilitative work across health care levels.

Keywords: Brain injury, Physiotherapy, Practice/service settings, Rehabilitation services, Norway, Qualitative study

INTRODUCTION

Persons with acquired brain injuries (PwABI) are usually hospitalized for emergency care and often require long-term follow-up from both specialist health care (SpHC) and primary health care (PrHC). Higher intensity rehabilitation featuring early intervention is recommended for optimal outcomes following ABI (1), and treatment in a specialized unit with a multidisciplinary team is recommended before transfer to a rehabilitation unit if ongoing inpatient rehabilitation is required (2). Hospital services should ensure the safe transfer of care upon discharge, including relevant and adequate information to PrHC services for optimal community rehabilitation. In Norway, municipal authorities administer the primary health care level, whereas the state is responsible for specialist health care services, mainly offered in local, regional and national hospitals.

The environmental context of rehabilitation might be a contributing factor for different choices of treatment approaches, and variety in PrHC settings allows for different opportunities and limitations regarding treatment. In Norway, recent reform initiatives and regulations attach more importance and priority to neurological rehabilitation (3-5) and transfer more responsibility for provision of rehabilitation services to municipal authorities. The Coordination Reform in Norway, approved in 2012, focuses upon improved collaboration between providers of PrHC at the municipal level and SpHC in hospitals (6). The aims of this reformative work in Norway are to simultaneously improve service quality as well as reduce costs. The reformative work in Norway is inspired by, and share similarities with health care reforms both in neighboring countries such as Sweden and Denmark (7, 8), and other western countries, e.g. England (9), Scotland and Australia (10). A common feature is to provide equal and universal access to health care services for all citizens and furthermore, to solve challenges of fragmentation of health services in primary care and

unsustainable long-term costs (11). Knowledge is needed regarding how these reforms affect physiotherapy services for PwABI at the PrHC level.

Professionals are delegated the authority to judge and act, according to given rules, based on discretionary reasoning (12, 13). They are often described as street-level bureaucrats (14-16), being the final link in the chain of democratic governance. In the Norwegian context, Vike (17) has questioned whether dilemmas of gate-keeping are increasingly individualized at the professional level, and how street level bureaucrats are potentially overburdened as treatment responsibilities are delegated within the care system. The need for individualized physiotherapy treatment calls for discretionary judgement from professionals, while laws, measures and structural boundaries limit the discretionary space. Nalette (18) advocates a skepticism of status quo practices in physiotherapy to modify conventional individual, organizational and societal practices for the benefit of patients. This moral aspect calls for reflective attitudes of professionals towards practice and clinical reasoning in a changing health care setting. These aspects of professional practice constitute our framework for examination of physiotherapy services in neurological rehabilitation.

Studies on health care pathways and smooth care setting transitions are increasing (19, 20), and several studies have focused more specifically upon neurological rehabilitation and collaboration across health care settings for PwABI (21-25). However, knowledge on physiotherapists' perceptions of service delivery to PwABI in transition from SpHC to PrHC is sparse. The aim of this study was to investigate how the implementation of redistributed responsibilities affects physiotherapy practice within and across health care levels and how physiotherapists experience and address changes arising from this situation.

METHODS

Design and Methodological Approach

We selected a sociology of knowledge framework for this study as it emphasizes an interpretive approach to professional practice. The social constructionist paradigm emphasizes multiple socially constructed realities and a dialectical process between objective and subjective reality, investigating both macro- and micro-sociological aspects of social phenomena (26-28). A constructivist and contextual perspective highlights how organizational and task-oriented changes are interpreted at the individual level and gives access to a deeper understanding of how changing demands are perceived and handled. The overall study design was sequential. The materials consisted of semi-structured interviews, observational field data, field conversations, and specialist health care discharge papers to investigate aspects of neurological rehabilitation across health care settings. Individual interviews were performed to gain in-depth knowledge concerning physiotherapists' experiences and perceptions of post-reform variations in rehabilitation processes.

Study Setting

The study was conducted in northern Norway with a dispersed population of 480,000 inhabitants, covering 113,000 km² (43,630 mi²). The study includes interviews of physiotherapists and video observations of physiotherapy treatment as we followed the rehabilitation process of 10 PwABI from hospital discharge to continued rehabilitation at the municipal level. The municipalities included in this study were small and medium sized, ranging between 1000 and 70,000 inhabitants.

Recruitment and Participants

Physiotherapists in SpHC rehabilitation units in local and regional hospitals received information about the study and were asked to participate following hospital management approval. The specialist health care physiotherapists (SpPT) were asked to identify patients

who met the following inclusion criteria: admitted to in-hospital rehabilitation following ABI; considered in need of further post-discharge physiotherapy services; and ability to consent. SpPTs were asked to assess potential patient participants' cognitive abilities to ensure fully informed consent prior to invitation to participate. Staff members not responsible for each participant patients' treatment provided verbal and written information and answered any questions. Authorities and physiotherapists in the patients' municipalities (PrPT) were invited to participate following the patients' written consent. Four of the patients underwent a rehabilitation stay in a secondary SpHC institution, prior to or after arrival in their home community. Two of the patients were transferred for further in-patient municipal rehabilitation, before discharge to home. Additional data collection following the initial procedures was performed in these cases.

All ten PwABI were transferred from acute care in either intensive care units, dedicated stroke units or neurological/neurosurgical units, for continued in-hospital rehabilitation. The included patients ranged between 30-80 years of age, all suffering from acute brain injury due to a variety of causes, such as stroke, encephalitis and brain-surgery, and had an extensive loss of function. Length of stay in the rehabilitation unit varied from two to 14 weeks, depending on the severity of the disability. The patients were living in different home settings, both in terms of family circumstances and municipal characteristics. The participating physiotherapists ranged from newly qualified to highly experienced practitioners, with variable formal and informal competence in neurological physiotherapy and within different work affiliations. Further participant characteristics are outlined in Table 1.

Data Collection Procedures

Interviews of the treating SpPTs and field observations of authentic physiotherapy treatment sessions were performed by the first author at a time point close to the patient's discharge from the rehabilitation unit. Two of the SpPTs were re-interviewed, as they treated more than one of the patients included in the study. Furthermore, the treating PrPTs were interviewed, and field observations of authentic treatment sessions were carried out shortly after arrival back home. Data collection ended after a final three-month follow-up interview of the PrPT. The interviews were scheduled at the convenience of the participants in a venue of their preference and lasted from 45 to 90 minutes. The interviewer posed open-ended questions from an interview guide related to aspects of the patient's rehabilitation process (Table 2). In total, 35 interviews and 23 field-observations were recorded and transcribed successively by the first author. The results presented in this article stem mainly from interview data.

Data Management and Analysis

The first author performed a qualitative content analysis (29) using a systematic text condensation approach (30), complemented by the second and third author. Transcripts of interviews and summaries of preliminary results were critically discussed to ensure congruence and pursue emerging themes and aspects of special interest. Rich contextual descriptions and absence of novel findings in the last interviews indicated a purposive sample size (30, 31). The transcribed interviews were analyzed by identifying meaningful units and patterns related to the objectives of this study, and codes were created through a process of condensation as presented in Table 3. In the final process of abstraction, the codes were organized into categories and themes based upon commonalities and patterns appearing across the material as a whole (cf. 31), shown in Table 4.

Research Team and Reflexivity

Two of the researchers (xx and xx) are experienced PTs with knowledge of PT services in both health care levels, which may strengthen the relevance of the interpretations. The third researcher (xx) is a sociologist with shared interests in the field of study and contributed to the applied theoretical framework and rigor in the analytical process (cf. 32).

Ethical Considerations

The study followed the principles of The Declaration of Helsinki (33) and was approved by The Data Protection Official for Research, Norwegian Social Science Data Services (NSD).

RESULTS

Two main themes emerged from the analysis: 1) Rehabilitation contexts in change and 2) Challenges in the transition to municipalities. Table 5 presents an overview of the final step of the analytical process, organizing the identified categories in two themes that we elaborate on in the following sections, exemplified by quotations.

Rehabilitation Contexts in Change

Prioritizing and resource inequality

The informants described differences between SpHC and PrHC levels concerning both structure and available resources. Most of the physiotherapists working in SpHC described a situation characterized by defined settings with adequately sized resources available. The sizing and number of different health professionals were adjusted according to the number of beds within the rehabilitation unit and were overall considered sufficient to offer qualitatively good services for admitted patients, as one of the hospital PTs stated:

“We are quite well set here with regard to resources. [...] Here, it’s possible to offer therapy with two physiotherapists, and we can offer treatment twice a day when needed...” (SpPT2)

In the PrHC setting, the physiotherapists generally described an undersized service and a challenging environment, characterized by waiting lists, prioritizing and lack of coherence between resources and responsibilities:

“So I have to make space for her in my already full days, and someone has to go. It’s like pressing a sardine into a box, and another one pops up in the other end.” (PrPT5)

In spite of the variety in population size, PrPTs’ work affiliation and PT coverage among the municipalities, they all described challenges concerning prioritizing. One of the physiotherapists working in a medium sized municipality stated the following:

“According to a national average, we are reasonably well set. But, if we had two more (PTs), we would still have more than enough work for them as well... I feel that we have time to prioritize rehabilitation in cases with extensive needs. That is, we find time at the expense of others, but that’s just the way it is.” (PrPT0)

Most of the physiotherapists in the PrHC prioritized and planned the service either alone or between colleagues, with little or no involvement from municipal authorities. The larger municipalities used fixed criteria to prioritize patients on waiting lists, while the individual physiotherapist in most of the smaller municipalities made these judgements.

Alteration in rehabilitation pathways

Hospital physiotherapists emphasized a change in time of admittance in the rehabilitation unit as patients were now transferred earlier from acute care. The SpPTs indicated negative consequences for the overall rehabilitation process and the patients’ functional levels upon arrival in the regional level rehabilitation units. One PT explained:

“We also experience a greater pressure on us, to admit patients earlier, which gives us patients in a poorer state. They are actually not receptive for rehabilitation. So they use the first period with us to become medically stable, and we have the knife on our throats because they are supposed to be discharged again soon.” (SpPT2)

The SpPTs highlighted the need to assess and treat the patients thoroughly to be able to provide information and recommendations with regard to expected potential for recovery, progress and needs when transferring from SpHC to PrHC. Several PrPTs supported the SpPT’s point of view and problematized the combination of less functional ability and earlier municipal rehabilitation, as the following primary care PT explained:

“It’s becoming more complex anyhow... In my opinion, it’s necessary first to finalize the primary rehabilitation, to achieve a certain level of function, before they are going home.” (PrPT7)

Challenges in the Transition to Municipalities

Home rehabilitation and everyday life

Resuming an everyday life after hospitalization was a theme several PrPTs reflected upon in relation to delivery of physiotherapy services. The patients were discharged earlier and with less functional ability, and the PrPTs saw this as unfavorable:

“The patients have somewhat more basic challenges now than earlier, so we simply have to start on a lower level than we used to, and... then there is the home situation... It is difficult to achieve good enough conditions to offer adequate treatment when they are in as poor condition as some of them are.” (PrPT6)

Most of the working age patients had extensive networks of family and friends at home and, according to their PrPTs, experienced trouble balancing their social life and

rehabilitative efforts. The following PTs explained various aspects of balancing everyday life and rehabilitation:

“So he has become very tired. I have a feeling it’s full speed from early morning till late night. We have discussed whether he should think a little rehabilitation still. He is after all still in rehabilitation...” (PrPT0)

“He is training a lot and has so for a long time, so he’s not able to do much more that day. It’s draining when it comes to energy and vigor, so balancing is an issue.” (PrPT8)

The frequency of PT treatments varied in the municipalities. The oldest patients (>60 years) received the fewest number of treatments (≤ 3 per week), but treatment of working age patients showed the greatest variation (2-5 per week). The majority of PrPTs considered 3 sessions per week as intensive and related low frequency treatment to lack of PT resources, long travel distances and the patient’s participatory ability and level of function, as a PT explained:

“Usually, if I work intensively with someone, it’s three times a week. Yes. And it’s really enough for most of them because it is.... You have to live a little in between, you know. So, if the therapist comes every day, it’s not so good. Then, you have to be in an institution, in my opinion.” (PrPT6)

Low prospects for continued municipal rehabilitation

The resources in the municipalities were considered limited, and most of the SpPTs had low expectations for future follow-up. The SpPTs expressed concerns, as they perceived the professional environments too small at the municipal level and not able to provide sufficient treatment frequency, and one PT described:

“Well, usually our patients are offered services maximum two times per week when they arrive in the community. That’s not enough for many of them....I rarely recommend five times a week because I’m aware of the limitations.” (SpPT0)

Some of the most experienced PTs contributed to the adjustment of the expectations of patients and their next of kin to arrange the preconditions for future treatment at the primary care level. One of the SpPT explained:

“We try to state clearly that it’s not given that they will receive the same intensity in the municipality as they receive here. [...] We are after all trying to build confidence to the service they will receive after discharge, so that the future collaboration will be good. (SpPT9)

DISCUSSION

The main findings in this study are that both SpPTs and PrPTs articulated challenges in performing high quality rehabilitation following the change in the transfer policy between hospital units and across service levels. According to SpPTs, hospitals transfer patients to active rehabilitation units before they are receptive to active rehabilitation, and furthermore, they are discharged to municipalities at a stage where PrPTs find it difficult to start home-based rehabilitation. Anticipation of municipal constraints influences information given upon hospital discharge, and transfer of rehabilitation responsibilities affects prioritizing for the PrPTs.

The physiotherapists in this study described challenges balancing professional judgments with the lack of resources. Limitations in service delivery combined with increased responsibility can lead to dilemmas, as the appropriate course of action cannot be achieved because of external barriers (34); this can create tension between political

governance and the professional accountability of street-level bureaucrats (35). Recent studies show that influence of contextual factors and external circumstances such as economy, duration of stay, organization and culture affect physiotherapists' and other professionals' clinical reasoning and decision-making (36-41). The results from our study reveal that these factors also affect the quality of rehabilitative work and the process of patient transition from SpHC to further PrHC follow-up. Shorter hospital stays result in a decreased ability to predict future outcomes and further needs in the continuation of the rehabilitation process and complicate the rehabilitative work at the municipal level.

These results somewhat contrast with the promising results from studies on early supported discharge (ESD) and home rehabilitation programs, which show similar or better outcomes of patient treatment when the length of specialist health care stay is reduced (23, 42-46). However, particular ESD studies presuppose extra SpHC effort in patient transition, performed in the PrHC setting, offering close collaboration and support in the homecoming phase (21, 22). Additionally, neurological injuries in addition to stroke are included in ESD studies to a lesser degree, and several studies on strokes conclude that the positive benefits of ESD is primarily applicable for minor-to-moderately disabled stroke patients (21, 47, 48). All patients included in this study were considered in need of further in-hospital rehabilitation, and none of the rehabilitation pathways involved extra SpHC effort upon discharge, as conditioned in the ESD trials. This indicates a discrepancy between the positive results of ESD in randomized controlled trials and the current circumstances in the municipalities. Thus, changes in rehabilitation pathways, to further develop the health care system and reap the benefits of earlier hospital discharge in accordance with recent research results, might prove disadvantageous for PwABI with extensive rehabilitation needs, if

principal features of ESD such as cooperation, extra SpHC support and resources are not provided.

The PrPTs acknowledged that insufficient resources influenced the ability to offer intensive physiotherapy for PwABI. The intensity of practice and therapy is considered a key-factor in meaningful training after ABI, as the effect seems to increase as intensity increases (44, 49). The delivery of neurological rehabilitation services has been shown to vary widely across health care levels (50), and the results from our study indicate both shorter stays in SpHC and a decrease in intensity of treatment when transferred to PrHC. In spite of reduced treatment intensity after hospital discharge, the PrPTs considered PwABI a prioritized group. They also expressed concerns regarding other groups in need of physiotherapy treatment in their municipality because of prioritizing PwABI, and it remains uncertain whether this constitutes a displacement of resource insufficiency. The informants portrayed a constrained practice, as described by Nalette (18), characterized by time pressure, lower functional level at discharge, contextual limitations and downgrading of other patient categories in PrHC. The PrPTs further experienced little involvement from municipal authorities with regards to prioritizing and deciding intensity of service provision. Increased responsibilities and patients with more extensive needs might lead to professional dilemmas in terms of providing sufficient treatment in accordance with the PT's own professional judgement. Furthermore, the lack of involvement from municipal authorities might indicate a local context whereby professional and political discourse on prioritizing issues is not present or applied. Cultural and traditional divisions of responsibilities can be seen as embedded in professional practice and are often hard to change (51). The dual focus of the reformative work seen in western countries recent years, emphasizing both improvements in service provision and economic rationalization, appear challenging to fulfill in a constrained primary health care setting.

Increased attention to and debate concerning prioritizing and resource allocation might be necessary both to identify barriers in reform implementation and facilitate modification of current practices.

The results emphasize how physiotherapists' knowledge of future external circumstances in a patient's rehabilitation pathway influenced how information and recommendations were communicated in patient transitions. Some of the SpPTs expressed a need for a change in a patient's expectations regarding the extent of municipal physiotherapy services and tended to fit recommendations to the existing situation at the municipal level. Simultaneously, PrPTs argue that both external conditions, such as treatment facilities and travel distances, and the patient's need to balance everyday life and rehabilitation efforts complicate opportunities for intensive treatment. Rehabilitation close to home, family, friends and colleagues is considered to play an important role in motivation and goal-setting for the patients (52), and participation in everyday life is the desired outcome of rehabilitation (53). Nevertheless, rehabilitation is a demanding process. The patients often have reduced capacity because of the injury and the transition between the institution and home constitutes a vulnerable phase (54, 55). The institutional rehabilitation environment allows patients to mobilize focus and energy on their physical recovery, whereas new challenges appear when discharged (56). The shift from the hospital setting to continued rehabilitation in the patients' home communities also involves additional efforts to re-establish everyday life, expanding the context in which the rehabilitation take place. This calls for attention to the timing of hospital discharge in relation to the current situation and resource incapability within PrHC settings, as a reduction in rehabilitation services might affect the PwABI's ability to reach optimal capacity and participation in everyday life.

Methodological Considerations

The results from this study stem from a limited number of participants, carried out in one region of Norway. However, variability within the material regarding PTs' professional experiences, patient categories and communities has generated rich data, and the similarities found indicate validity across different settings. The participants illustrate examples within a rehabilitation context, and patterns and commonalities may, according to Brinkmann and Kvale (31) and Malterud (32), represent features relevant to similar groups through analytical generalization. Physiotherapists' professional dilemmas in relation to available resources in our study may show transferability to similar changes in hand-off processes between health care levels in other countries. Procedures, data management and analysis are described in detail and exemplified to ensure further reliability and validity of the study (cf. 31). The recruitment procedures presupposed volunteering initially and, as such, the informants from SpHC pre-selected to participate, possibly increasing the risk of bias.

CONCLUSION

As reforms shift responsibilities for rehabilitative work between health care levels, physiotherapy services for PwABI seems to be further constrained. Earlier hospital transfer, structural limitations and resource insufficiency challenge the ability to provide good quality and intensive physiotherapy services for PwABI, especially in municipalities. Furthermore, the traditional division of responsibilities and organizational boundaries appear to limit expectations of future treatments and influence delivery of recommendations and information across health care levels in patient transitions.

IMPLICATIONS FOR PHYSIOTHERAPY PRACTICE AND FURTHER RESEARCH

This study brings attention to possible unintended consequences of reform initiatives, which should be considered in further development and efficiency improvements in rehabilitative work across health care levels. The results also call for attention to roles of the professionals as changing agents in a reorganizing health care service. Larger studies, performed in other demographic contexts and in different organizational circumstances, are required.

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TABLE LEGENDS

Table 1 Participant characteristics

Table 2 Topic guide

Table 3 Example of the analytical process from meaningful units to condensation and codes

Table 4 Example of the analytical process from codes to category and theme

Table 5 Overview of categories and themes

TABLES

Table 1

Patients, n=10			
Diagnosis	Cerebral infarction, cerebral hemorrhage, tumor, encephalitis. Surgical interventions (craniotomy, shunt, biopsy, brain surgery) in 6 of 10 patients.		
Independent walking with or without aids	Upon admittance to primary rehabilitation unit: 1 (using aids)	Upon discharge from primary rehabilitation unit: 4 (2 using aids)	
Gender	Male: 8		Female: 2
Age	<40 years: 3	40-60 years: 4	>60 years: 3
Social/Family relations	Living alone: 3	Live-in partner: 7	Parental responsibility for under-aged: 2 Adult children (>18 years): 5
Physiotherapists in specialist health care, n=8			
Education	Bachelor's degree: 6		Master's degree: 2
Experience	0-9 years: 5		10+ years: 3
Specialization in neurology	Post-experience neurology courses: 4		Specialist in neurological PT: 4
Work affiliation	Rehab. unit: 6		Private hospital: 2
Physiotherapists in primary health care, n=12			
Education	Bachelor's degree: 12		Master's degree: 0
Experience	0-9 years: 6		10+ years: 6
Specialization in neurology	Post-experience neurology courses: 3		Specialist in neurological PT: 2
Work affiliation	Employee: 10		Self-employed: 2
Municipalities, n=9			
Community population	0-4,999 inhabitants: 4 municipalities	5,000-20,000 inhabitants: 3 municipalities	More than 20,000 inhabitants: 2 municipalities

Table 1 Participant characteristics

Table 2

Physiotherapist's background and description of patient	<ul style="list-style-type: none"> - Age - Education - Postgraduate studies and courses - Description of practice and patient categories - Patient and rehabilitation process
Professional practice environment	<ul style="list-style-type: none"> - Resources - Venues - Time - Treatment approach, possibilities and constraints
Collaboration	<ul style="list-style-type: none"> - Physiotherapists - Other health professionals - Interaction - Communication of information
Role in rehabilitative work	<ul style="list-style-type: none"> - Physiotherapists' responsibilities - Expectations of patient, next of kin, other collaborating health professionals - Alterations in roles and work tasks
Transfer of knowledge	<ul style="list-style-type: none"> - From who - What - Missing information - Own role in communication of information regarding the patient: PT, other health professionals, next of kin, etc.
Prioritizing of the patient	<ul style="list-style-type: none"> - High priority - Downgrading - Who sets the priorities - Other solutions
Responsibilities within different health care levels	<ul style="list-style-type: none"> - SpHC - PrHC - Changes - Potential changes - Level of knowledge
Further patient follow-up	<ul style="list-style-type: none"> - What is important - Expectations - Possibilities - Promotive and restrictive elements

Table 2 Topic guide

Table 3

Meaningful units	Condensation	Codes
<i>What type of rehabilitation can you expect with such small units, when the professionals are supposed to attend to a variety of tasks: elderly, children, musculo-skeletal, neurology, cancer and so on.</i>	Small units and task diversity reduce expectations for further rehabilitation	Low expectations
<i>Well, in general, if the patients get physiotherapy three times a week the first period after discharge, we think it's very good, and the municipality has made an effort.</i>	A good effort to offer physiotherapy three times a week	Settle for less
<i>However, more often it's two times a week, you know, and sometimes it's one, and that's a bit scarce.</i>	Frequency of physiotherapy interventions is often too low	Reduced service delivery
<i>So what I'm saying is: What can we expect, considering what we know and what we're told?</i>	Knowledge of the premises reduces expectations	Negative presumptions

Table 3 Example of the analytical process from meaningful units to condensation and codes

Table 4

Codes	Category	Theme
Low expectations	Low prospects for continued municipal rehabilitation	Challenges in the transition to municipalities
Settle for less		
Reduced service delivery		
Negative presumptions		
Time pressure		
Undersized service		
Tailored recommendations		
Downscaling of expectations		
Ensure patient-carer relationship		

Table 4 Example of the analytical process from codes to category and theme

Table 5

Acquired brain injury rehabilitation – Dilemmas in neurological physiotherapy across health care settings				
Themes	Rehabilitation contexts in change		Challenges in the transition to municipalities	
Categories	Prioritizing and resource inequality	Alteration in rehabilitation pathways	Home rehabilitation and everyday life	Low prospects for continued municipal rehabilitation

Table 5 Overview of categories and themes