

Development and validation of a booklet with physiotherapy guidelines for the care of individuals who are homebound and/or bedridden

Desarrollo y validación de un folleto con pautas de fisioterapia para el cuidado de personas confinadas en casa y/o en cama

Elaboração e validação de cartilha com orientações fisioterapêuticas para o cuidado do indivíduo domiciliado e/ou acamado

Lucélia Souza Martins¹

ORCID: 0009-0000-6407-770X

Samoel Mariano^{2*}

ORCID: 0000-0002-8395-2685

Fábio Luiz Mialhe²

ORCID: 0000-0001-6465-0959

Joyce Silva Duarte Assis²

ORCID: 0009-0004-2277-6894

¹Divisão de Educação em Saúde da Prefeitura de Sorocaba. São Paulo, Brazil.

²Universidade Estadual de Campinas. São Paulo, Brazil.

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*Corresponding author:

samoel.mariano@gmail.com

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Abstract

The aim was to produce educational material to guide informal caregivers in the care of individuals who are homebound and/or bedridden. This research addresses the process of developing and validating the content of an educational booklet. Initially, a literature review was conducted to support the development of the content and the criteria for its construction. Subsequently, the content was evaluated by 10 professionals and seven informal caregivers. The Content Validity Index (CVI) was used to assess these criteria. Most respondents indicated that the content and face validity items were representative, making the material's content suitable for the target audience. It is concluded that the booklet's content demonstrated great potential to assist in decision-making in the daily lives of informal caregivers. Future studies are recommended to evaluate and improve this type of material.

Descriptors: Primary Health Care; Multiprofessional Team; Physiotherapy; Home Care; Content Validation.

Resumén

El objetivo fue producir material educativo para guiar a los cuidadores informales en el cuidado de personas confinadas en casa o en cama. Esta investigación aborda el proceso de desarrollo y validación del contenido de un folleto educativo. Inicialmente, se realizó una revisión bibliográfica para respaldar el desarrollo del contenido y los criterios para su elaboración. Posteriormente, el contenido fue evaluado por 10 profesionales y siete cuidadores informales. Se utilizó el Índice de Validez de Contenido (IVC) para evaluar estos criterios. La mayoría de los encuestados indicó que los elementos de contenido y validez aparente eran representativos, lo que lo hace adecuado para el público objetivo. Se concluye que el contenido del folleto demostró un gran potencial para ayudar en la toma de decisiones en la vida diaria de los cuidadores informales. Se recomiendan estudios futuros para evaluar y mejorar este tipo de material.

Descriptores: Atención Primaria de Salud; Equipo Multiprofesional; Fisioterapia; Atención Domiciliaria; Validación de Contenido.

Resumo

Objetivou-se produzir um material de caráter educativo para orientar cuidadores informais no cuidado do indivíduo domiciliado e/ou acamado. Trata-se de uma pesquisa que trata do processo de elaboração e validação de conteúdo de um material educativo, do tipo cartilha. Inicialmente, foi realizada uma pesquisa bibliográfica para subsidiar a elaboração do conteúdo e os critérios para construção. Em seguida, o conteúdo foi avaliado por 10 profissionais e sete cuidadores informais. Utilizou-se o Índice de Validade de Conteúdo (IVC) para avaliar tais critérios. A maioria das respostas dos respondentes apontou como representativos os itens de validade de conteúdo e aparência, tornando o conteúdo do material adequado ao público-alvo. Conclui-se que o conteúdo da cartilha demonstrou-se como de grande potencial para ajudar na tomada de decisões no dia a dia de cuidadores informais. Recomendam-se futuros estudos para avaliação e aprimoramento desse tipo de material.

Descriptores: Atenção Primária à Saúde; Equipe Multiprofissional; Fisioterapia; Atenção Domiciliar; Validação de Conteúdo.



Introduction

The historical milestone for the consolidation of Primary Health Care (PHC) occurred through the Alma-Ata Declaration, the result of the International Conference on Primary Health Care, held on September 12, 1978, in the city of Alma-Ata (Union of Soviet Socialist Republics - USSR), located in the southern region of Kazakhstan. The declaration affirms that health is a fundamental human right and that its promotion and protection are important for the social and economic development of states. Furthermore, the declaration highlights the importance of social participation and the responsibility of governments in providing these services to guarantee comprehensive care, the quality of life of individuals, and, consequently, world peace. Since then, numerous studies on the subject have been conducted worldwide^{1,2}.

In Brazil, Primary Health Care (PHC) was established approximately 10 years after the Conference, with the promulgation of the Federal Constitution (CF) and, soon after, in the 1990s, with the implementation of the Unified Health System (SUS). The SUS is a health system that offers free and universal access to the entire population, especially the most vulnerable, to guarantee the principles of equity, universality, and comprehensiveness, seeking to resolve any health problems that may arise²⁻⁴.

The Ministry of Health (MH) treats the terms Primary Health Care and Basic Care as equivalent terms, and in this study, we will use the first term. Therefore, the MH defines PHC as:

"[...] the set of individual, family, and collective health actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care, and health surveillance, developed through integrated care practices and qualified management, carried out by a multidisciplinary team and directed to the population in a defined territory, over which the teams assume sanitary responsibility"⁵.

PHC is the gateway to accessing the Brazilian Unified Health System (SUS), coordinating care and serving as a point of communication with the Health Care Network (RAS). It is considered fundamental for the reorganization and effectiveness of the SUS, seeking to guarantee continuity of care and comprehensive assistance for the population of that territory^{3,5,6}.

Seeking its consolidation and expansion, PHC prioritizes the Family Health Strategy (FHS) as its care model. This model aims to fulfill the principles and guidelines of the Brazilian Unified Health System, which are: 1) Universality, enabling universal access to effective and high-quality health services; 2) Equity, where the provision of care is based on recognizing the conditions and needs of each individual; and 3) Comprehensiveness, ensuring that the health care of each individual is provided holistically, from the promotion and prevention of illnesses to cure or palliative care. Among the guidelines are regionalization and hierarchical organization, territorialization and registration, the registered population, person-centered care, effectiveness, longitudinality of care, coordinating care, organizing networks, and community participation^{5,7}.

To guarantee this comprehensive care, the Family Health Support Center (NASF) was created in 2008, later renamed in 2017 as the Expanded Family Health and Primary Care Center (NASF-AB), and currently, according to Ministry of Health Ordinance No. 635 of May 22, 2023, Multiprofessional Teams in Primary Health Care (eMulti) exist¹. Regarding these teams, according to the Ministry of Health:

"[...] the term "eMulti" refers to teams composed of health professionals from different areas of knowledge who work in a complementary and integrated manner with other Primary Health Care (PHC) teams, sharing responsibility for the population and the territory, in intersectoral coordination and with the Health Care Network (HCN)"¹.

The eMulti team is comprised of professionals from various categories, such as physiotherapists, psychologists, occupational therapists, pharmacists, physical education professionals, nutritionists, speech therapists, social workers, doctors, and other professionals. According to the Ministry of Health, this team is responsible for: individual, group, or home-based care (shared with other professionals and teams); matrix support; collective activities; case discussions; health actions and projects in the community; and intersectoral practices⁸.

Multiprofessional teamwork is fundamental, as it ensures a comprehensive approach considering the determinants and conditioning factors of an individual's health, always acting within the principles of the SUS, despite daily challenges⁹. Within this context, the physiotherapist seeks to promote care focused on the individual's functionality. For a long time, physiotherapy was conceived as an exclusively rehabilitative profession; however, this is changing, as this professional is playing an important role within primary health care, further strengthening comprehensive care. According to these authors¹⁰:

"[...] among the numerous responsibilities of physiotherapy in primary care, the following stand out: identifying the presence of kinetic-functional disorders, providing postural guidance, encouraging community participation in health-related issues, continuing education, as well as guidance on healthy environments and lifestyles"¹⁰.

In addition to these responsibilities, the physiotherapist, within primary health care, also conducts home visits, which can be individual or in conjunction with a multidisciplinary team¹⁰. A home visit is essential when an individual is unable to travel to work due to a functional disability that confines them to their home environment¹¹. According to the Ministry of Health, Home Care (HC) is characterized as a set of actions aimed at promoting, preventing, recovering, or providing palliative care within the home to guarantee continuity of care. It is classified as HC1, HC2, and HC3, according to the clinical condition of each user, frequency of visits, and even the use of equipment. HC1 is the responsibility of PHC, since it involves individuals who require fewer multidisciplinary interventions and, consequently, fewer visits, as their



condition remains stable and they are cared for by a caregiver, whether a family member or a contracted professional¹².

One of the purposes of a physiotherapist's home visit is to guide patients and caregivers on how to adapt the environment to make it conducive to the individual's care, providing greater safety for both the caregiver and the person being cared for. In the case of bedridden patients, it is essential that the caregiver possesses the knowledge and skills to perform this task in the best possible way. Thus, it is crucial that the physiotherapist develops health education activities during home visits to promote autonomy and improve the quality of life of individuals. However, due to the heavy workload of caregivers, some may forget information acquired only verbally, and the availability of educational materials can help them recall the most important information for health care. Educational materials serve as a facilitator for the development of care, provided they are clear and practical, as they help in recommending daily tasks, in addition to serving as a tool to answer questions. The availability of this material does not replace the guidance and in-person monitoring by the physiotherapist. Furthermore, the physiotherapist must clearly explain the guidelines contained in these materials, as well as train the caregiver and make them aware of the importance of following the instructions in the materials^{13,14}.

Given the above, this study is justified by the understanding that adequate guidance for informal caregivers can provide greater safety in the daily lives of families and improve the care of bedridden patients. The objective was to produce an educational booklet with physiotherapy guidelines to orient caregivers of individuals who are homebound and/or bedridden.

Methodology

This is a methodological research study to produce educational material, which was carried out between July 2023 and January 2024. This study was conducted in the territory of the Dr. Osmar Guimarães Family Health Unit (USF), in the Vitória Régia neighborhood, located in the North Zone of the municipality of Sorocaba/SP.

The study was developed following these steps: 1. Bibliographic survey on the topic; 2. Identification of homebound and bedridden patients registered at the Family Health Unit; 3. Production of educational material in booklet format; 4. Validation of the content and appearance of the material by professionals working in the field of home care and by the target audience.

In the first step, a bibliographic survey was conducted using the Virtual Health Library (VHL) platform, through the following databases: MEDLINE, LILACS, SciELO, and BDNF. The keywords used were: "Primary health care," "Multiprofessional team," "Physiotherapy," "Home care," and "Content validation." In this phase, articles addressing the care of bedridden patients within the scope of Primary Health Care were sought to provide a theoretical basis for the development of the booklet's content.

Next, all homebound and bedridden patients classified by the Family Health Strategy teams of the health unit were identified, totaling five teams.

In step 3, texts were developed that addressed the content based on Maslow's hierarchy of needs, focusing primarily on the individual's physiological needs, specifically in the areas of food, sleep and rest, and physical comfort. The material was constructed considering the language, illustration, and layout guidelines for educational materials in the health field, aiming for simplicity, conciseness, effectiveness, and relevance for user¹⁵.

Step 4 dealt with the validation of the content and appearance of the material produced, both by USF professionals and by users.

In this stage, the researcher submitted the booklet to professionals from the Family Health Unit to act as judges. The professionals were chosen through convenience sampling, selecting those with the longest service time at the health unit and who practiced home visits.

Regarding the target audience, informal caregivers of individuals who were homebound or bedridden, registered at the health unit, and who were available to answer the questionnaire were selected through non-probabilistic sampling. The inclusion criteria were informal caregivers of individuals over 18 years of age registered at this health unit, classified as homebound or bedridden according to the Family Health Strategy teams, and who were available to answer the questionnaire. The exclusion criteria were caregivers of homebound or bedridden individuals under 18 years of age or who were being monitored by the Home Care Service (SAD).

To collect data in this stage, two instruments were used: the first was submitted to professionals for content validation, and the second was also submitted to professionals and the target audience for face validity. The first instrument, which measured content validity, consisted of eight items corresponding to the topics covered in the educational material: "What is the difference between a homebound and a bedridden individual?", "What is the importance of physiotherapy for these individuals?", "Tips for correct positioning in bed", "How to position a homebound or bedridden individual in bed in dorsal and lateral decubitus positions?", "Tips for transfers", "Activities of daily living", "Physiotherapeutic exercises", and "Caregiver, you also need care!". Each item was evaluated using a four-point Likert scale, where: 1. Not relevant or not representative; 2. Item needs significant revision to be representative; 3. Item needs minor revision to be representative; 4. Item relevant or representative¹⁶.

The second instrument, used to assess the face validity of the material, consisted of six items: "material title," "material colors," "clarity of subject matter," "clarity of language," "illustrations," and "relevance of information." Each item was evaluated using a four-point Likert scale, with the following response options: 1. Not representative; 2. Slightly representative; 3. Representative; 4. Fully representative. This scale allowed for verification of the evaluators' degree of agreement regarding the adequacy of the formal and content elements of the proposed material.



The term “representative” refers to how faithfully and adequately each evaluated item reflects the objectives and purpose of the booklet, effectively contributing to its communicative and educational function. For sociodemographic characterization of the target audience, a simple questionnaire was added to the instrument, seeking information on sex, age, education level, degree of kinship with the individual being cared for, and length of time as a caregiver¹⁶.

Regarding content and appearance validation, the Content Validity Index (CVI) was used, which measures the proportion or percentage of raters who agree on certain aspects of the instrument and its items. This method employs a Likert-type scale with scores from “1” to “4”. To assess relevance, the authors recommend the responses used in this study, as mentioned above. Items rated “1” or “2” were revised or eliminated. The score was analyzed by summing the agreement of items rated “3” and “4”. Therefore, the formula for evaluating each item was as follows¹⁶:

$$CVI = \frac{\text{number of responses} \\ \text{“3” or “4”}}{\text{total number of responses}}$$

According to researchers¹⁷, in evaluating each item, the number of evaluators must be considered. In this research, where 10 professionals were used to evaluate the content of the material, the CVI should have a result greater than 0.78. To assess the agreement of the instrument in general, the average of the values of the items calculated separately was used; that is, all the CVI values calculated separately were added together and divided by the number of items considered in the evaluation. In this case, the authors recommend a minimum agreement of 0.90 or more for the material to be considered validated.

The study was submitted to the Research Ethics Committee of the University of Sorocaba (CEP/UNISO) - Sorocaba/SP -, through the Plataforma Brasil platform. After analysis, the research was approved on June 30, 2023, under opinion No. 6.155.936 and CAAE No. 70151323.8.0000.5500. All participants, professionals, and caregivers signed the Informed Consent Form (TCLE). The confidentiality and anonymity of the participants were maintained, as ensured in accordance with Resolution No. 466/12 of the National Health Council.

Results

The results of this study will be presented in two stages: development of the booklet and validation of the booklet.

Preparation of the booklet

Firstly, the content aimed to correspond to the bibliographic basis and information gathering on the subject. Then, the text was developed, in which the booklet was subdivided into eight topics: “What is the difference between a homebound and a bedridden individual?”, “What

is the importance of physiotherapy for these individuals?”, “Tips for correct positioning in bed”, “How to position a homebound or bedridden individual in dorsal and lateral decubitus positions?”, “Transfer tips”, “Activities of daily living”, “Physiotherapeutic exercises”, and “Caregiver, you also need care!”. The aim was to use clear and objective language, yet rich in information, without the use of technical terms to adapt to the target audience.

Regarding the layout/design, configuration, and diagramming of the booklet, the online platform CANVA Pro[®] was used, as well as for the illustrations, in addition to images extracted from Google Images[®]. The booklet was produced on A4 paper (21x29.7 cm), consisting of 20 pages, using analogous colors in shades of green and blue. It includes a cover, back cover, cataloging data sheet, table of contents, introduction, the body of the booklet containing the titles mentioned above, references, and notes. Finally, the booklet was titled “Physiotherapeutic Guidelines for the Care of Individuals Living at Home and/or Bedridden”.

Validation of the booklet's content and appearance

The booklet was evaluated by professional judges and a sample of the target audience. Ten active healthcare professionals working directly with home visits at the health unit were selected: five nurses, one occupational therapist, and four nursing technicians. Regarding the judges, 90% were female (9) and 10% (1) were male. The average age of the professionals was 47.2 years, with the youngest being 38 years and the oldest 58 years. Their years of experience since graduation ranged from 8 to 38 years, and their length of service at the health unit ranged from 3 to 17 years. Regarding specialization, five of the six graduate judges have a specialization in Family Health. The content of the booklet was validated using the CVI. The booklet received a score of 1.0 on the CVI, indicating a high level of agreement among the judges.

Regarding the validation of the material's appearance, this was done by calculating the agreement between the judges regarding six aspects: the material's title, the material's colors, clarity of the subject matter, clarity of the language, illustrations, and relevance of the subject matter. Each item had four possible answers: “Not representative,” “Somewhat representative,” “Representative,” and “Completely representative.” It was found that the items were approved in 100% of the responses, with 31.66% (19) of the responses across all evaluated items classified as “Representative” and 68.33% (41) of the items classified as “Completely representative”.

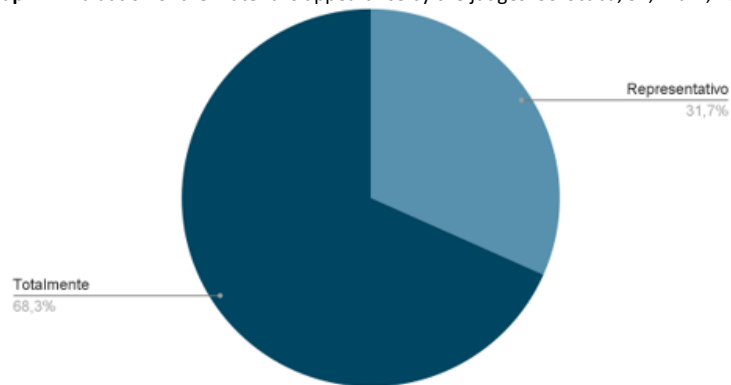
Regarding the validation of appearance by the target audience, in which seven informal caregivers from the territory were selected, the researcher conducted a home visit, together with the Community Health Agent (ACS) of the respective family. The sample consisted of 71.5% (5) female, and this same percentage is used for the classification of the degree of kinship of these individuals, being 71.5% (5) children. The average age among them was 57 years and 4 months, with the youngest age being 43 years and the oldest age being 71 years. The time these people have been informal caregivers ranged from 7 months to 32 years.



Regarding schooling (Graph 2). According to the evaluation of the target audience, the booklet was unanimously approved, with 30.93% (13) of the responses under all items

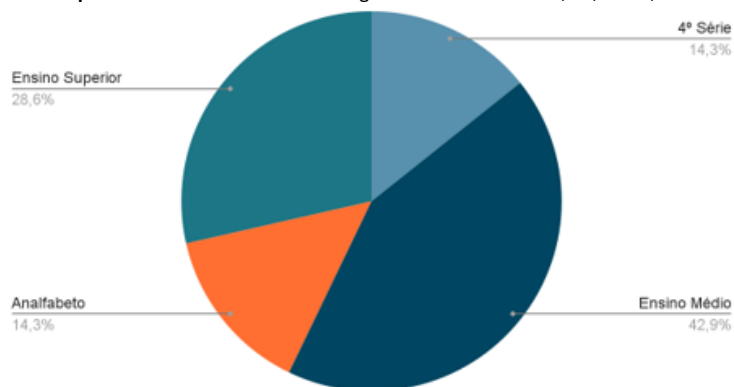
marked as "Representative" and 69.07% (29) as "Totally representative" (Graph 3).

Graph 1. Evaluation of the material's appearance by the judges. Sorocaba, SP, Brazil, 2024



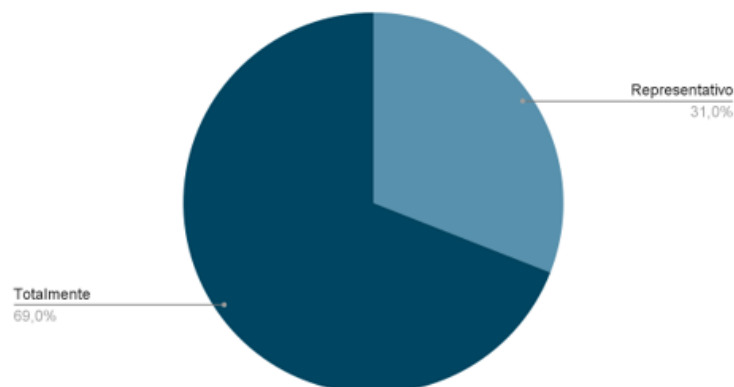
Note: Totalmente: Totally. Representativo: Representative.

Graph 2. Educational level of the target audience. Sorocaba, SP, Brazil, 2024



Note: Ensino Superior: Higher Education. Analfabeto: Illiterate. 4ª série: 4th grade. Ensino Médio: High School.

Graph 3. Evaluation of the material's appearance by the target audience. Sorocaba, SP, Brazil, 2024



Note: Totalmente: Totally. Representativo: Representative.

The validation of the booklet encompassed all the steps of the initial proposal, being unanimously approved by the judges and the target audience, making the material a consistent and applicable product for the routine of informal caregivers. It was verified that the proposed construction and validation of the booklet's content and appearance were achieved. Based on the judges' evaluations, it is considered that this material can help healthcare professionals guide caregivers in decision-making, facilitating daily care, providing greater comfort and safety for them, and for those receiving care. The material's format, with its objective and

clear characteristics, and good illustrations, points to a resource with the potential to guide physiotherapy care for individuals who are homebound and/or bedridden.

Therefore, the importance of validating educational materials to guide the care of these individuals is evident, since most caregivers are informal and increasingly require appropriate guidance. Furthermore, the care of the caregivers themselves is highlighted, as they are often related to the individual being cared for and neglect their own needs in favor of caring for the homebound or bedridden individual.



Regarding the difficulties encountered in conducting this study, the scarcity of available evaluators stands out, as these professionals are embedded in services within a work process that does not allow for the reservation of time in their schedules for activities related to research or health promotion. As for the availability of caregivers for evaluation, this occurred through the researchers traveling to their homes to conduct the assessments, highlighting the overload of their work routines and further demonstrating the need to develop instruments that also address caregiver health promotion, as is the case with the validated booklet. Therefore, further studies on this topic are recommended, given the scarcity of updated scientific articles addressing physiotherapy care for this target population.

Discussion

The development and validation of a booklet with physiotherapy guidelines for caregivers of homebound and/or bedridden individuals represents a concrete response to the persistent challenges of Home Care within the Brazilian Unified Health System (SUS). Ministry of Health Ordinance No. 825/2016, in redefining Home Care, establishes caregiver training as a fundamental guideline, recognizing its centrality in ensuring the continuity and quality of care. In this context, the developed material transcends the mere compilation of techniques, configuring itself as a low-cost health technology that operationalizes the principle of comprehensiveness. By structuring specialized knowledge in an accessible format, the booklet aims to promote autonomy and safety, thereby mitigating the vulnerability inherent in situations of functional dependence and the frequent overload experienced by informal caregivers, aligning with the mission of humanization and support advocated by national policy^{1,2}.

The methodological rigor adopted, based on content validation by expert judges and the target audience, lends scientific solidity to the instrument. The application of the Content Validity Index (CVI), with a maximum score (1.0) among professionals and high agreement among caregivers, meets and exceeds the methodological excellence parameters recommended for the field. This rigor is essential because it ensures that the content is not only clinically accurate but also socially and culturally relevant to its target audience. This methodological approach aligns with studies that demonstrate the necessity of validation by multiple actors (professionals and users) for the effective adoption of educational technologies in healthcare, thereby increasing their credibility and potential impact on daily practice^{3,18}.

The role of the physiotherapist in Primary Health Care (PHC), particularly in the home setting, is being reconfigured beyond a strictly rehabilitative model, assuming a proactive role in promoting functionality and preventing complications. This guide validates and expands this role, functioning as an extension of the home visit. It does not replace the home visit, but consolidates and references verbal instructions, serving as a continuous matrix support resource that strengthens the bond and co-responsibility. This strategy is congruent with person-centered care models, in which structured health education

empowers patients and families, transforming them into active agents in the therapeutic process. In this way, the material enhances the physiotherapist's action, whose inclusion in multidisciplinary teams (eMulti) is formally recognized as essential for comprehensive care⁵⁻⁷.

The unanimous approval by the target audience of the items related to "clarity of language" and "illustrations" constitutes one of the most significant findings of this study. This result materializes the principle of equity in access to health information, advocated since the Alma-Ata Declaration and reaffirmed in the National Primary Care Policy. Translating technical-physiotherapeutic knowledge into vernacular language, associated with elucidative visual elements, is a powerful pedagogical strategy to overcome educational barriers and ensure universal understanding. Research in health literacy reinforces that written materials with a high level of clarity and visual appeal are crucial for the correct understanding of instructions, adherence to treatments, and consequently, for the improvement of health outcomes^{8,9,19}.

The inclusion of a section dedicated to caregiver self-care, "Caregiver, you also need care!", represents a fundamental innovation and a humanizing differentiator of the guide. This approach recognizes the informal caregiver not only as an instrument of care but as an individual who, in their dedication, often neglects their own health, becoming vulnerable to conditions such as stress, burnout, and depression. By incorporating this dimension, the material aligns with a broader vision of health and adheres to the principle of comprehensiveness more comprehensively, encompassing the support network that sustains the patient. Educational interventions that include components of psychosocial support for the caregiver demonstrate greater efficiency in improving the quality of life of the entire care unit, highlighting the relevance of this thematic choice^{11,20,21}.

The practical applicability of the booklet in the routine of the Family Health Strategy deserves highlighting. The concise format, intuitive organization, and tangible nature of the material address real logistical challenges, such as the limited time available to professionals during home visits and the potential information overload experienced by caregivers. By serving as a structured guide for quick consultation and review of procedures, the booklet can optimize professional-family interaction, leading to greater efficiency and effectiveness in action. Studies implementing similar tools in primary health care contexts highlight that portability and ease of use are critical attributes for the successful incorporation of new resources into the teams' workflow^{13,22}.

It is necessary to acknowledge the inherent limitations of this study, notably the size and convenience nature of the validator sample (10 professionals and 7 caregivers from a single health unit), which may restrict the generalizability of the results. The specialized literature is unanimous in pointing out that apparent acceptability and validation constitute only the first step. The true contribution of an educational technology is only demonstrated through controlled studies that measure its



impact on intermediate outcomes (such as increased knowledge and self-confidence of the caregiver) and outcomes (such as the reduction of complications like pressure ulcers, contractures, or falls, and improved quality of life)^{14,23}.

In this sense, the agenda for future research is clear and urgent. It is recommended that clinical trials or quasi-experimental studies be conducted comparing groups of caregivers who receive the booklet combined with standard guidance with groups who receive only standard guidance. Measurable outcomes should include, in addition to those already mentioned, indicators of caregiver burden (e.g., using the Zarit Burden Interview scale), adherence to prescribed exercises, and rates of avoidable hospital readmission. Only through this type of research will it be possible to move beyond the realm of potential and assign the booklet a value based on evidence of effectiveness.^{15,24}.

From a healthcare system perspective, the production and distribution of a validated booklet represents a potentially cost-effective intervention. Preventing a single serious complication, such as an advanced-stage pressure injury, whose treatment costs are extremely high for the Brazilian Unified Health System (SUS), would amply justify the investment in the large-scale production of a low-cost material. This logic of primary and secondary prevention is perfectly aligned with the principles of economy and sustainability of the public health system,

reinforcing the material's potential as an intelligent and efficient clinical management tool in primary health care^{16,25}.

Conclusion

It is concluded that the educational material developed achieved a high level of agreement regarding its content and appearance validity among professionals and caregivers, indicating its potential to assist caregivers in the care of bedridden patients. The booklet "Physiotherapeutic Guidelines for the Care of Homebound and/or Bedridden Individuals" emerges as a socially referenced health technology, methodologically robust in its construction and deeply adherent to the doctrinal and organizational principles of the Brazilian Unified Health System (SUS). Its development addresses a practical gap in supporting informal caregivers and consolidates the educational and preventive role of the physiotherapist within the scope of Home Care. The booklet is therefore presented not as an endpoint, but as a promising starting point for implementation and effectiveness research that consolidates health education as an indispensable pillar for safe, qualified, and truly comprehensive home care.

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