ORIGINAL ARTICLE

Occupational repercussions of oncology palliative care patients assisted by a home care service

Ana Catarina das Neves Chagas, Tatiana Barbieri Bombarda

ABSTRACT

This study sought to describe the main occupational repercussions experienced by people undergoing palliative cancer care. This is a multiple case study carriedout with people aged 18 or over, affected by different types of neoplasm, and monitored while undergoing palliative care by a home care service of a reference hospital in the city of Belém. Data was collected using a characterization form and a questionnaire developed by the researchers, as well as the Memorial Symptom Assessment Scale (MSAS-br), the MD Anderson Symptom Inventory (MDASI-Core), and the Palliative Performance Scale (PPS). The instruments were applied in the home environment in a single meeting and the information was systematized descriptively, based on simple quantifications. Six patients took part, and the repercussions that were present in all cases refer to changes in activities of daily living (eating, dressing, mobility and bathing), changes in instrumental activities of daily living (managing the home, caring for others and shopping), and changes occupations of work and health management. The presence of physical and emotional symptoms was identified as the main limiting factor for performance. It was concluded that the participants during their cancer journey carry out a routine focused on the adapted performance of basic activities, experiencing an occupational imbalance that is triggered by the presence of multifactorial aspects.

Keywords: Palliative care, Activities of daily living, Neoplasms, Occupational therapy.

INTRODUCTION

Care in the oncological context is supported by the basic pillars of prevention, diagnosis, and treatment, with palliative care also being part of this framework[1]. When curative therapy is no longer effective, considering the unlikely prognosis of full recovery at a given point in the care process, palliative care for oncology becomes more relevant and thus assumes an exclusive therapeutic nature[2].

Palliative care is recommended from the beginning of treatment, with the objective of a better quality of life throughout the patient's therapeutic journey[3]. Furthermore, it is recommended that this care development be carried out by professionals from different categories[4]. Specifically, regarding the role of occupational therapy, it is stated that given the uniqueness and complexity of human occupation, each individual diagnosed with cancer will experience different limitations in their multiple occupations and functions, with restrictions on participation throughout the course of the disease, based on lifestyle choices.

It is emphasized that "occupations are central to a person's health, identity, and sense of competence, having particular meaning and value for each individual." However, cancer and its treatment can cause disruptions in daily routines, affecting how individuals perform self-care, work, leisure, or social activities. Occupational

Federal University of São Carlos, Department of Occupational Therapy, São Carlos, (SP), Brazil.

Este é um artigo publicado em acesso aberto (Open Access) sob a licença Creative Commons Attribution, que permite uso, distribuição e reprodução em qualquer meio sem restrições, desde que o trabalho original seja corretamente citado.

https://doi.org/10.11606/issn.2176-7262.rmrp.2025.226218

Therapy intervention methods can remediate, compensate, or adapt a patient's abilities to promote better levels of independence and quality of life[5].

It is understood that the occupational impacts of people with cancer are potentially sources of suffering for the individual and, therefore, have been the focus of international research[5,7-12]. Seeking to promote research with this focus in the national setting, this study aimed to describe the main occupational impacts experienced by people undergoing palliative care for cancer.

METHOD

This is a multiple-case study developed in the Home Care Service (HCS) of a referral cancer hospital in the city of Belém, State of Pará, Brazil. Participants in this study were patients registered with the institution's Home Care Service. The inclusion criteria were 18 years of age or older and patients diagnosed with any type of neoplasm and receiving palliative care. Exclusion criteria included patients with cognitive impairments and those being monitored by the HCS but hospitalized during the data collection period.

The HCS coordinator invited patients who met the aforementioned criteria to participate in the study. Upon expressing interest, the researcher contacted them by phone to schedule a home visit. Upon arrival, the researcher provided a written informed consent form (ICF) and, subsequently, the data collection instruments.

The Memorial Symptom Assessment Scale (MSAS-br), designed to identify symptoms in people with cancer, was administered for data collection[13]. The MD Anderson Symptom Inventory (MDASI-Core) was used for data collection to assess symptom intensity and its impact on activities of daily living[14]. The Palliative Performance Scale (PPS) was used to assess functional performance[15]. In addition, a participant characterization form was used to systematize clinical and sociodemographic data and a questionnaire, composed of closed questions, developed by the researchers based on the Occupational Therapy Practice Framework: Domain and Process 4th Edition[6].

The questionnaire developed by the researchers was structured in two parts: the first presented a list of 23 occupations for the participant to indicate the presence/absence of changes in each of the occupations based on the illness/treatment process, as well as to classify such changes as positive or negative, assigning the level of importance ("None", "A little", "More or less", "Considerably", and "Very") to the modified occupation. The second part of the instrument presented six factors (Physical symptoms; Emotional symptoms; Lack of future prospects/Hopelessness; Environmental barriers; Weaknesses in social support; and Overprotection from family/friends), with the addition of the option "others" to identify the presence or absence of these factors in the subject's daily life and their level of interference in their occupations (Likert scale 0-10). In this article, we chose to present data related to the identification of modified occupations and their interfering factors.

For all cases, there was only one meeting with each participant to administer the instruments, and the information obtained was systematized descriptively, with some simple quantifications. It should be noted that for the presentation of the data, fictitious names were assigned to all participants to preserve their anonymity.

This research was conducted in accordance with Resolution No. 510/2016 of the National Health Council and was approved by the Research Ethics Committee under ruling No. 5,469,642.

RESULTS

Six patients monitored by the HCS participated. Regarding the sociodemographic profile of the participants, they represented a variety of ages, ranging from 39 to 82 years old. Most participants were female (n=4), and half of the participants (n=3) stated that they were married. Regarding education level, half of the participants (n=3) had unfinished elementary education. Regarding religion, 5 participants reported being Evangelical and 1 participant Catholic. Of the 6 participants, 4 reported receiving retirement benefits (Table 1).

Table 1. Sociodemographic profile of participants.

Participants	Age	Marital status	Education	Religion	Retired
Juliana	55	Married	Unfinished elementary education	Evangelical	No
Bruna	39	Married	Finished high school	Evangelical	Yes
Carmen	42	Married	Unfinished elementary education	Evangelical	No
Renata	61	Divorced	Finished higher education	Catholic	Yes
Manoel	60	Widowed	Unfinished high school	Evangelical	Yes
Jorge	82	Married	Unfinished elementary education	Evangelical	Yes

Source: Authors (2024).

Regarding the clinical characteristics of the participants, it was found that there was diversity among the cases regarding the type of oncological diagnosis and the time variable since oncological diagnosis, which ranged from 9 months to 13 years. However, in most cases, the participants had been in palliative care for less than 6 months, with functional status ranging from 30 to 60 in the PPS classification, as shown in Table 2.

Table 2. Clinical information of participants.

Participants	Oncological diagnosis	Time of Oncological diagnosis	Time spent in PC	Follow-up time in PC by HCS	PPS[1]	Daily support figures
Juliana	Stomach cancer	9 months	2 months	1 month	50	daughter and daughter-in-law
Bruna	Breast cancer	3 years	5 months	3 months	30	husband daughters mother-in-law
Carmen	cervical cancer	1 year and 10 months	4 months	2 months	30	husband and daughters
Renata	sigmoid colon cancer	6 months	3 months	3 months	60	daughters
Manoel	Prostate cancer	8 years	5 months	4 months	50	son
Jorge	Prostate cancer	13 years	1 year and 10 months	1 year and 5 months	50	daughter

Source: Authors (2024).

Regarding symptoms, the MSAS-Br and MDASI-Core questionnaires revealed that all participants had multiple symptoms present in the last week, significantly interfering with daily activities, as detailed in Table 3.

[1]PPS 60: Reduced ambulation; Unable to perform hobbies/housework; Occasional assistance with self-care; Normal or reduced intake; Full level of consciousness or periods of confusion.
PPS 50: Most of the time spent sitting or lying down; Unable to perform any work; Considerable assistance with self-care; Normal or reduced intake; Full level of consciousness or periods of confusion.
PPS 30: Completely bedridden; Unable to perform most activities; Complete dependence for self-care; Normal or reduced intake; Full level of consciousness or drowsiness +/- confusion.

Table 3. Descriptive summary of data from the MSAS-Br, MDASI Core, and factors recognized as limiting the performance of occupations (questionnaire).

Participant	MSAS-Br	MDASI Core	INTERFERENCE FACTORS IN OCCUPATIONS
Juliana	16 symptoms present during the last week, including: ● Present almost all the time: pain, lack of energy, dry mouth, nausea, drowsiness, diarrhea, problems with sexual desire or activity, ● Frequently present: difficulty swallowing, ● Sometimes present: nervousness, difficulty sleeping, changes in self-image, ● Rarely present: bloating, sadness, worries, lack of appetite, dizziness	Severe symptom interference with work and walking activities (score 9/10) and relationships with others (score 8/10). Moderate symptom interference with mood (5/10) and enjoyment of life (4/10). The patient does not consider symptoms to interfere with general activities (0/10).	Physical Symptoms (7/10) Emotional Symptoms (8/10) Lack of Future Prospects/Hopelessness (0/10) Environmental Barriers (5/10) Weaknesses in Social Support (10/10) Family Overprotection (0/10)
Bruna	14 symptoms present during the last week, including: ● Frequently present: problems with sexual desire or activity, constipation, changes in self-image, and skin changes; ● Sometimes present: pain, lack of energy, cough, dry mouth, drowsiness, numbness or tingling in the hands/feet, bloating, itching; ● Rarely present: dizziness and nausea	Severe symptom interference with walking (score 10/10), work (9/10), and general activities (8/10). Moderate symptom interference with mood (5/10). Symptom interference does not interfere with enjoyment of life or relationships with others (0/10).	Physical Symptoms (8/10) Emotional Symptoms (0/10) Lack of Future Prospects/Hopelessness (0/10) Environmental Barriers (0/10) Weaknesses in Social Support (0/10) Family Overprotection (0/10)

Carmen	18 symptoms present during the last week, including: ● Present almost all the time: difficulty concentrating, pain, lack of energy, dry mouth, nausea, numbness in hands/feet, sadness, problems with sexual desire or activity, lack of appetite; ● Frequently present: difficulty concentrating, sadness, drowsiness, weight loss, changes in self-image, edema in the upper and lower limbs; ● Sometimes present: constipation, change in taste, and vomiting.	Intense interference of symptoms in all activities: walking (score 10/10), pleasure of life (score 10/10), work (10/10), activities in general (score 10/10), mood (9/10), relationships with other people (score 8/10).	Physical Symptoms (10/10) Emotional Symptoms (10/10) Lack of Future Prospects/Hopelessnes s (8/10) Environmental Barriers (7/10) Weaknesses in Social Support (3/10) Family Overprotection (0/10)
Renata	18 symptoms present during the last week, including: ● Present almost all the time: pain, dry mouth, drowsiness, numbness or tingling in the hands/feet, bloating, trouble urinating, sweating, problems with sexual desire or activity, itching, lack of appetite, change in taste, hair loss, and change in self-image, ● Sometimes present: difficulty concentrating, sadness, nausea, and vomiting, ● Rarely present: lack of energy.	Severe symptomatic interference with general activities, work, walking, and enjoyment of life (10/10). Moderate symptomatic interference with mood (5/10). No interference with interpersonal relationships (0/10).	Physical Symptoms (10/10) Emotional Symptoms (7/10) Lack of Future Prospects/Hopelessnes s (10/10) Environmental Barriers (0/10) Weaknesses in Social Support (0/10) Family Overprotection (0/10)
Manoel	18 symptoms present during the last week, including: ● Present almost all the time: pain, nervousness, dry mouth, numbness or tingling in the hands/feet, difficulty sleeping, change in food taste, weight loss, constipation, and changes in self-image.	Severe interference of symptoms with general activities, work, mood, walking (score 8/10), and enjoyment of life (score 9/10). No interference with interpersonal relationships (0/10).	Physical Symptoms (8/10) Emotional Symptoms (8/10) Lack of Future Prospects/Hopelessnes s (8/10) Environmental Barriers (8/10)

	● Frequently present: bloating, sweating, problems with sexual desire or activity. ● Sometimes present: irritability, nausea, and lack of energy. ● Rarely present: difficulty concentrating, coughing, vomiting.		Weaknesses in Social Support (0/10) Family Overprotection (5/10)
Jorge	6 symptoms present during the last week, including: ● Present almost all the time: drowsiness, numbness or tingling in the hands/feet, problems with sexual desire or activity, irritability, and changes in taste. ● Rarely present: sadness.	Severe interference with mood, work, walking, and relationships with others (score 10/10). No interference with general activities or enjoyment of life (score 0/10).	Physical Symptoms (10/10) Emotional Symptoms (8/10) Lack of Future Prospects/Hopelessnes s (0/10) Environmental Barriers (0/10) Weaknesses in Social Support (9/10) Family Overprotection (0/10)

Source: Author (2024).

The information presented in Table 3 shows that aspects related to sexual problems were reported by all participants, while changes in self-image, pain, dry mouth, drowsiness and tingling in the extremities, nausea, and lack of energy were reported by almost all participants (n=5), constituting the most common symptoms experienced by participants in their daily lives.

It is also clear that the presence of multiple symptoms significantly interferes with daily activities. This finding is reinforced by the information collected via the questionnaire, which presented 23 occupations for each participant to indicate changes that have occurred and barriers associated with performance. This application found an average of 18 occupations modified by the illness process, ranging from 15 to 22 occupations considered modified by the participants, either due to the experience of disruptions or changes in performance patterns. Regarding the altered occupations identified via the questionnaire, common to all cases were changes related to daily living activities such as eating, dressing, mobility, and bathing, functional activities of daily living related to home management, caring for others, and shopping, changes in health management (specifically in the activity of promoting and maintaining social and emotional health), and changes in work, as illustrated in Table 4.

Table 4. Occupational impacts experienced by participants.

OCCUPATION CLASSIFICATION	MODIFIED OCCUPATION	N (6)
Activities of Daily Living (ADL)	Bathing	6
	Food	6
	Clothing	6
	Mobility	6
	Personal Care	4
Instrumental Activities of Daily Living (IADL)	Caring for Others	6
	Home Management	6
	Shopping	6
	Meal Preparation	5
	Financial Management	5
	Pet Care	4
	Involvement in Religious/Spiritual Activities	3
	Communication Management	2
Health Management	Promoting and maintaining social and emotional health (managing emotions, expressing needs effectively, pursuing occupations and social engagement to support health and well-being, making choices to improve quality of life and participation)	6
	Symptom and medication management	5
	Physical activity	3
Work	Job maintenance	6
Rest and Sleep	Restorative rest and sleep to enable engagement in other occupations	5
Leisure	Participation in leisure activities	5
Social Participation	Family Involvement	5
	Friendships	4
	Community Involvement	2
Education	Participation in formal learning activities	1

Source: Author (2024)

Rest and sleep, leisure, meal preparation, financial management, family involvement, and symptom and medication management were also presented as altered occupations in almost all cases (n=5).

It is important to highlight that the aforementioned occupational changes were classified by participants predominantly as negative changes, that is, associated with perceptions of impaired performance. However, it is noteworthy that changes in performance patterns were sometimes mentioned as being perceived as positive, namely:

- Juliana - expressed positive changes regarding participation in family and friendships
- Bruna - expressed positive changes in eating, clothing, and personal care
- Carmen - expressed positive changes in sleep and rest

- Renata - expressed positive changes in financial management
- Manoel - expressed positive changes in symptom and medication management
- Jorge - does not recognize any positive changes in occupations experienced after the illness and treatment

The presence of physical and emotional symptoms was identified by all participants as the main factors interfering with the performance of occupations, limiting occupational performance. However, it is important to note that environmental barriers, weaknesses in social support, and lack of future prospects/hopelessness were also highlighted by half of the participants as influential aspects, although with different levels of interference in each participant's experience (Table 3).

DISCUSSION

Based on the cases presented, it was found that, although there are discrepancies related to the time of cancer diagnosis (between 6 months and 13 years), the majority of individuals began receiving palliative care less than 6 months ago.

It is noteworthy that there was a variation of more than six months between the time of cancer diagnosis and the moment the participant entered palliative care, reaching a maximum interval of approximately 11 years and 2 months. This factor diverges from the recommendation that palliative care be initiated from the diagnosis of a life-threatening illness, concomitantly with disease-modifying treatment.

Regarding the timing of initiation of palliative care in cancer, researchers[16] point out that palliative care is available in the late stages of cancer treatment, near the end of life, resulting in suffering faced by cancer patients with insufficient treatment. It is clear that part of the life-threatening illness trajectory is not attended to by a specialized palliative team, with this referral being more likely to occur at the end of life. However, it is important to emphasize that with early referral to palliative care, attention to symptom management and patient satisfaction tend to be positive[17]. The reverse of this relationship was observed in our study, namely the presence of late referral to palliative care services and the presence of various physical and emotional symptoms, which affect the performance of activities.

Patients with progressive disease and at a stage where the disease is no longer modifiable face a variety of symptoms and stressors. Assessing these symptoms in palliative care is essential to minimize symptom burden and improve patient quality of life. Therefore, obtaining accurate information on symptom severity is essential to ensure effective management[18]. This study observed dozens of physical and emotional symptoms experienced by participants, with particular emphasis on symptoms such as sexual problems, pain, changes in self-image, dry mouth, and numbness in the upper and lower limbs.

Specifically, regarding pain, it is important to emphasize that it is a global health concern. The prevalence of pain among cancer patients is high, and for this reason, guidelines have been created for effective pain management using accessible and safe medications[19].

In addition to pharmacological measures, non-pharmacological strategies should be considered for the relief and control of pain and other symptoms, which represent potential multidisciplinary resources. A systematic review[20] identified different strategies used by people with advanced cancer for non-pharmacological symptom control, including physical exercise to manage fatigue, relaxation techniques, and adherence to some form of complementary and alternative medicine, such as acupuncture or homeopathy.

Some patients chose to engage in

leisure activities or explore new hobbies as a way to distract themselves from disease symptoms and worries. Patients' seeking support from family and friends, and information regarding their disease and treatment, were also characterized as highly effective strategies for symptom management. However, it is important to highlight that the majority of studies found in the review were from developed countries[20].

It is known that an individual's condition, due to oncological treatment in palliative care, can undergo changes and directly influence their occupations. Numerous factors can compromise occupational management, but this study found physical and emotional symptoms to be the main factor.

The burden of cancer symptoms can interfere with participation in everything from simple activities to more complex functions, and patients with advanced cancer may experience a greater combination of complications[21,22]. Another study[10] highlights that a number of women with metastatic breast cancer were unable to perform their ADLs, IADLs, leisure activities, and work, which is consistent with the findings of our study.

Some authors[23] classify the disease trajectory into three dynamic stages: initial, intermediate, and final. In the initial stage, patients can perform their usual activities of daily living, work, and leisure activities without significant impairment. In the intermediate stage, functions are more restricted and displaced due to the increasing demands of the disease, which involve occupations related to health management and ADLs. In the final stage, cancer progression can cause interruptions in several occupations, and the promotion and maintenance of comfort and supportive relationships become a priority. The demands of advanced-stage cancer patients are highly diverse, influenced by the nature of the cancer, symptoms, and their functional and personal needs[24]. Decreased functionality is an indicator associated with a higher likelihood of chemotherapy toxicity and shorter survival in these individuals, as well as patient and disease characteristics, clinical factors, and therapy-related factors[25].

The analysis of the cases in this study reveals that the participants presented functional statuses ranging from 30 to 60 on the PPS classification, which can be considered a low to fair average. This data reveals that all participants had reduced and/or absent ambulation and a disability that compromises essential occupations, such as ADLs.

To delay functional losses and preserve occupational capabilities, the literature suggests prehabilitation—the provision of rehabilitation services immediately after diagnosis, in the pre-surgical period—to prevent and mitigate the effects of treatment, promoting more effective functional recovery. It has been demonstrated that patients with lung, colorectal, and breast cancer who received prehabilitation before surgery experienced improvements in functional mobility for ADLs and IADLs, as well as reduced hospital stays[25-27].

Another recommended indication is the early implementation of palliative care, which results in significant benefits, such as improved quality of life and survival, and reduced adverse effects of treatment[28]. In this sense, an interdisciplinary approach to symptom management can help patients restore their performance and resume their daily routines in a more satisfying and normalized manner[29].

Affordable and reliable measures to address self-care capabilities during cancer treatment are essential[30]. Physical and existential adaptation to functional loss is believed to depend on active participation, and providing opportunities for participation is essential to maximize performance in meaningful and essential occupations, as chosen by the individual[31].

In this sense, early access to

Occupational Therapy allows for an individualized assessment of functional needs and a care plan to facilitate continued engagement in meaningful occupations. Functional assessments and occupational interviews can be used to develop a comprehensive profile and adapt devices, aiming for functional independence[24-25].

It is important to emphasize that the occupational repercussions identified in this study were significant in terms of the number of occupations altered and the amount of importance given to them. It was found that participants tended to completely discontinue functional activities of daily living related to home management, meal preparation and cleaning, community mobility, and religious and spiritual expression, as well as occupations associated with work and education.

Participants reported having a routine focused on activities of daily living, such as bathing, personal hygiene and personal care, dressing, eating, rest and sleep, and health management, demonstrating an imbalance in the occupational repertoire caused by the illness and treatment process.

Townsend and Wilcock[32] state that occupational imbalance can affect people's health and well-being through inappropriate and disproportionate variation in occupational involvement. To promote occupational balance, it is crucial to provide patients with the opportunity to develop satisfying personal occupational projects and ensure access to the human, technological, physical, and social resources necessary for their participation, including the implementation of comprehensive activity programs that address various occupational areas, developing time management skills, and promoting freedom of choice according to the importance attributed to each occupation[33].

As influential factors in occupational repercussions, in addition to physical symptoms, emotional symptoms and environmental barriers were also identified as factors that interfere with the performance of occupations.

Regarding emotional symptoms, it is known that these can vary significantly in patients with advanced cancer[34]. In these cases, there is a cultural and social influence on cancer as a disabling and suffering disease, which can result in social and family isolation, as well as emotional disorders such as anger, sadness, and depression. These complications require a multidisciplinary approach for comprehensive care for the patient, family, and caregiver[35].

Regarding environmental barriers, occupational therapy approaches can be proposed primarily regarding the allocation of priority resources, prescription and provision of assistive technology, orthosis prescription, and modification of the home environment. These interventions are mostly compensatory in nature, aiming to adapt environmental factors to facilitate occupational performance, without necessarily improving the individual's abilities[36].

In light of the above, it is essential in the palliative oncology care process to identify specific demands regarding the most important occupations of the patient, promoting grades of intervention whenever necessary, given the challenges imposed by the cancer symptoms[10,37]. Considering occupations as one of the elements of care enables greater occupational participation of patients in the context of their process of living and dying.

CONCLUSIONS

This study sought to explore aspects related to the occupational impacts of people undergoing palliative care for cancer and assisted by a home care service. It was found that the occupations most frequently reported by participants as being affected by the process of illness and cancer treatment were bathing, dressing, eating, mobility, caring for others, shopping, home

management, promoting and maintaining social and emotional health, and work.

Although environmental barriers, weak social support, and a lack of future prospects and hopelessness were cited by half of the participants as factors causing occupational impacts, the main influencing factors were related to physical and emotional symptoms. The presence of multiple physical and emotional symptoms, the most common being problems with sexual desire or activity, changes in self-image, drowsiness, numbness or tingling in the hands/feet, dry mouth, pain, nausea, lack of energy, sadness, and difficulty concentrating, demonstrates that the guiding principle of palliative care—providing relief from pain and other symptoms—is lacking in practice, considering that participants generally reported the presence of dozens of symptoms that negatively impact occupational performance. This situation reflects the patients' experience of a routine focused on the adapted performance of basic activities, an indicator of an occupational imbalance that generates suffering.

It is believed that the findings of this study enable an understanding of the magnitude of the influences of the illness process and cancer treatment on the occupational repertoire, scientifically reinforcing the importance of occupations as a care axis, given the importance attributed these functions and their direct influence on quality of life and relief from suffering.

Although scarce, positive occupational changes were singled out by participants, a factor that could be considered a coping strategy and a topic for future research.

REFERENCES

1. World Health Organization. Palliative care cancer control: knowledge into action: WHO guide for effective programs [Internet]. Module 5. Geneva: World Health Organization; 2007 [accessed on 2021 July 16]. Available at: http://apps.who.int/iris/bitstream/10665/44024/1/9241547345_eng.pdf.
2. Kirby EEF, Jung IEFS, Gregório APA, et al. O desafio de comunicar más notícias nos cuidados paliativos oncológicos: perspectiva dos trabalhadores. Rev Bras Pós-Grad. [Internet]. 2020 [accessed on 2021 July 31]; 16 (36):1-17. Available at: https://rbpg.capes.gov.br/index.php/rbpg/article/view/1718/931.
3. Neves LML, Gouvêa MV, Souza EEF. Cuidados paliativos oncológicos ou cuidados ao fim de vida? o desafio de uma equipe multiprofissional. Saúde Redes. [Internet]. 2020 [accessed on 2021 Aug 18]; 6 (3):25-37. Available at: http://revista.redeunida.org.br/ojs/index.php/rede-unida/article/view/2566
4. Rodrigues GGF, Duarte MCS, Mamede RS, et al. Cuidados paliativos direcionados ao cliente oncológico: estudo bibliométrico. Rev Enferm UFPE On Line. [Internet]. 2017 [accessed on 2021 Aug 7]; 11(supl. 3):1349-1356. Available at: https://periodicos.ufpe.br/revistas/revistaenfermagem/%20article/view/13976/16824.
5. Longpré S. Fact sheet: Role of Occupational Therapy. Bethesda: The American Occupational Therapy Association; 2011.
6. American Occupational Therapy Association. Occupational therapy practice framework: Domain and process (4th ed.). American Journal of Occupational Therapy. [Internet]. 2020 [accessed on 2021 Sept 19]; 74 (Suppl. 2):7412410010. Available at: https://doi. org/10.5014/ajot.2020.74S2001.
7. Wæhrens EE, Brandt A, Peoples H, Cour K. Everyday activities when living at home with advanced cancer: A cross-sectional study. European Journal of Cancer Care. [Internet]. 2020 [accessed on 2022 Nov 07]; 29 (5). Available at: https://pubmed.ncbi.nlm.nih.gov/32489002/.
8. Brekke MF, Cour K, Brandt Å, et al. The association between ADL ability and quality of life among people with advanced cancer. Occupational Therapy International. [Internet]. 2019 [accessed on 2022 Nov 07]. Available at: https://pubmed.ncbi.nlm.nih.gov/31531007/.
9. Peoples H, Brandt Å, Wæhrens EE, Cour K. Managing occupations in everyday life for people with advanced cancer living at home. Scandinavian Journal of Occupational

Therapy. [Internet]. 2016 [accessed on 2023 Mar 19]; 24 (1):57-64. Available at: https://www.tandfonline.com/doi/abs/10.1080/11038128.2016.1225815.
10. Pilegaard MS, Cour K, Oestergaard LG, et al. The 'Cancer Home-Life Intervention': a randomised controlled trial evaluating the efficacy of an occupational therapy–based intervention in people with advanced cancer. Palliative Medicine. [Internet]. 2018 [accessed on 2023 Mar 19]; 32 (4):744-756. Available at: https://journals.sagepub.com/doi/pdf/10.1177/0269216317747199.
11. Yeh H, McColl MA. A model for occupation-based palliative care. Occupational Therapy in Health Care. [Internet]. 2019 [accessed on 2023 Mar 19]; 33 (1):108-123. Available at: https://www.tandfonline.com/doi/abs/10.1080/07380577.2018.1544428.
12. Chow JK, Pickens ND. Measuring the efficacy of Occupational Therapy in end-of-life care: A scoping review. The American Journal of Occupational Therapy. [Internet]. 2020 [accessed on 2023 Mar 19]; 74 (1):7401205020p1-7401205020p14. Available at: https://research.aota.org/ajot/articleabstract/74/1/7401205020p1/6659/Measuring-the-Efficacy-of-Occupational-Therapy-in.
13. Portenoy RK, Thaler HT, Kornblith AB, et al. The Memorial Symptom Assessment Scale: An instrument for the evaluation of symptom prevalence, characteristics and distress. Eur J Cancer. [Internet]. 1994 [accessed on 2023 June 18]; 30 (9):1326-1336. Available at: https://www.sciencedirect.com/science/article/abs/pii/0959804994901821.
14. Kolankiewicz ACB, Domenico EBL, Lopes LFD, Magnago TSBS. Validação do Inventário de Sintomas do M.D. Anderson Cancer Center para a língua portuguesa. Rev Esc Enferm USP. [Internet]. 2014 accessed on 2022 Nov 7]; 48 (6):999-1005. Available at: https://www.scielo.br/j/reeusp/a/pfVMNVXJ9Fxhgh8Ws5SxZ8m/?format=pdf&lang=pt.
15. Harrold J, Rickerson E, Carroll JT, et al. Is the palliative performance scale a useful predictor of mortality in a heterogeneous hospice population? J Palliat Med. [Internet]. 2005 [accessed on 2022 Nov 7]; 8 (3):503-509. Available at: https://www.liebertpub.com/doi/10.1089/jpm.2005.8.503?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed.
16. Tewes M, Rettler T, Wolf N, et al. Predictors of outpatients' request for palliative care service at a medical oncology clinic of a German comprehensive cancer center. Supportive Care in Cancer. [Internet]. 2018 [accessed on 2023 June 17]; 26:3641-3647. Available at: https://link.springer.com/article/10.1007/s00520-018-4245-7.
17. Alves JM, Marinho MLP, Sapeta P. Referenciação tardia: barreiras a referenciação de doentes adultos oncológicos e não oncológicos para serviços de cuidados paliativos. Revista de Cuidados Paliativos. [Internet]. 2023 [accessed on 2023 April 14]; 6 (1):13-26. Available at: https://smartcms.boldapps.pt/publicfiles/Uploads/Files/91/SubContent/4dfd3b56-ff85-41ddbe47-2788ef860dce.pdf#page=13.
18. Zloklikovits S, Andritsch E, Fröhlich B, et al. Assessing symptoms of terminally-ill patients by different raters: a prospective study. Palliat Support Care. [Internet]. 2005 [accessed on 2023 April 08]; 3 (2):87-98. Available at: https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/abs/assessing-symptoms-of-terminallyill-patients-by-different-raters-a-prospective-study/8864BADF9F6E9F02A18337EF79B95AFB.
19. Hamieh NM, Akel R, Anouti B, et al. Cancer-related pain: Prevalence, severity and management in a tertiary care center in the Middle East. Asian Pac J Cancer Prev. [Internet]. 2018 [accessed on 2022 Nov 07]; 19 (3):769-775. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5980854/
20. Dongen SIV, De Nooijer K, Cramm JM, et al. Self-management of patients with advanced cancer: A systematic review of experiences and attitudes. Palliat Med. [Internet]. 2020 [accessed on 2023 Mar 14]; 34 (2):160-178. Available at: https://journals.sagepub.com/doi/full/10.1177/0269216319883976
21. Yokoo M, Akechi T, Takayama T, et al. Comprehensive assessment of cancer patients' concerns and the association with quality of life. Jpn J Clin Oncol. [Internet]. 2014 [accessed on 2023 Mar 19]; 44 (7):670-

676. Available at: https://academic.oup.com/jjco/article/44/7/670/866588?login=false.
22. Dong ST, Butow PN, Tong A, et al. Patients' experiences and perspectives of multiple concurrent symptoms in advanced cancer: A semi-structured interview study. Support Care Cancer. [Internet]. 2016 [accessed on 2023 Mar 19]; 24:1373-1386. Available at: https://link.springer.com/article/10.1007/s00520-015-2913-4.
23. Bye RA, Llewellyn GM, Christl KE. The end of life. In: Bonder BR, Bello-Haas VD, editors. Functional performance in older adults. Philadelphia (PA): F. A. Davis Company; 2009. p. 633-655.
24. Dolgoy N, Driga A, Brose JM. The essential role of occupational therapy to address the functional needs of individuals living with advanced chronic cancers. Seminars in Oncology Nursing. [Internet]. 2021 [accessed on 2023 May 17]; 37 (4). Available at: https://www.sciencedirect.com/science/article/abs/pii/S0749208121000632.
25. Nightingale G, Battisti NML, Loh KP, et al. Perspectives on functional status in older adults with cancer: an interprofessional report from the International Society of Geriatric Oncology (SIOG) nursing and allied health interest group and young SIOG. Journal of Geriatric Oncology. [Internet]. 2021 [accessed on 2022 Nov 07]; 12 (4):658-665. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8102651/.
26. Mayo NE, Feldman L, Scott S, et al. Impact of preoperative change in physical function on postoperative recovery: argument supporting prehabilitation for colorectal surgery. Surgery. [Internet]. 2011 [accessed on 2023 May 28]; 150 (3):505-514. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0039606011003965.
27. Minnella EM, Awasthi R, Loiselle S, et al. Effect of exercise and nutrition prehabilitation on functional capacity in esophagogastric cancer surgery: a randomized clinical trial. JAMA Surg. [Internet]. 2018 [accessed on 2023 May 28]; 153 (12):1081-1089. Available at: https://jamanetwork.com/journals/jamasurgery/article-abstract/2698681.
28. Kirkhus L, Benth JŠ, Grønberg BH, et al. Frailty identified by geriatric assessment is associated with poor functioning, high symptom burden and increased risk of physical decline in older cancer patients: Prospective observational study. Palliat Med. [Internet]. 2019 [accessed on 2023 Mar 07]; 33 (3):312-322. Available at: https://journals.sagepub.com/doi/full/10.1177/0269216319825972.
29. Sheikhalipour Z, Ghahramanian A, Fateh A, Onyeka TC. Functional status of women after cancer and its related factors: A study based on Roy adaptation model. Eur J Cancer Care (Engl). [Internet]. 2021 [accessed on 2023 Mar 19]; 30 (2). Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/ecc.13378.
30. Baumann C, Baumann R, Wedding U. The importance of a detailed geriatric functional assessment of older patients with cancer. Oncol Res Treat. [Internet]. 2021 [accessed on 2023 Mar 19]; 44 (5):221-231. Available at: https://www.karger.com/Article/Abstract/514712.
31. Morgan DD, Currow DC, Denehy L, Aranda SA. Living actively in the face of impending death: constantly adjusting to bodily decline at the end-of-life. BMJ Support Palliat Care. [Internet]. 2017 [accessed on 2023 June 19]; 7 (2):179-188. Available at: https://spcare.bmj.com/content/7/2/179.short.
32. Townsend E, Wilcock AA. Occupational justice and client-centred practice: a dialogue in progress. Canadian Journal of Occupational Therapy. [Internet]. 2004 [accessed on 2022 Nov 07]; 71 (2):75-87. Available at: https://journals.sagepub.com/doi/10.1177/000841740407100203?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.
33. Correia JCP. O papel do terapeuta ocupacional nos Centros de Atividades Ocupacionais [Specialization thesis on the Internet]. Porto: Repositório Científico do Instituto Politécnico do Porto; 2016 [accessed on 2022 Nov 07]. 19 p. Available at: https://recipp.ipp.pt/bitstream/10400.22/10321/1/PTE_JoanaCorreia_2016.pdf.
34. Vehling S, Gerstorf D, Schulz-Kindermann F, et al. The daily dynamics of loss orientation

and life engagement in advanced cancer: a pilot study to characterise patterns of adaptation at the end of life. Eur J Cancer Care (Engl). [Internet]. 2018 [accessed on 2023 Mar 19]; 27 (4). Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/ecc.12842.

35. Puerto Pedraza HM. Soporte social percibido en cuidadores familiares de personas en tratamiento contra el cáncer. Rev Cuidarte. [Internet]. 2017 [accessed on 2022 Nov 7]; 8 (1):1407-1422. Available at: https://revistas.udes.edu.co/cuidarte/article/view/345.
36. Ferreira APC, Fuly PSC, Nascimento JS. Occupational therapy interventions for activities of daily living in cancer palliative care: integrative review. Research, Society and Development. [Internet]. 2023 [accessed on 2023 Aug 29]; 12 (1). Available at: https://rsdjournal.org/index.php/rsd/article/view/39497.
37. Brandt Å, Pilegaard MS, Oestergaard LG, et al. Effectiveness of the “Cancer Home-Life Intervention” on everyday activities and quality of life in people with advanced cancer living at home: a randomised controlled trial and an economic evaluation. BMC Palliative Care. [Internet]. 2016 [accessed on 2022 Nov 07]; 15 (1):1-11. Available at: https://pubmed.ncbi.nlm.nih.gov/26801394/.

Authors' contributions:

ACNC, TBB: Substantial contribution to the study design or data interpretation, participation in writing the preliminary version, review and approval of the final version, agreement to be accountable for the accuracy or integrity of any part of the study.

Sources of support/funding: Self-funded.

This study received logistical and human resource support from the Home Care Service (SAD) of Ophir Loyola Hospital (HOL) during the data collection phase.

Corresponding Author:

Ana Catarina das Neves Chagas
catarinanevees@hotmail.com

Received: jun 13, 2024
Approved: oct 1, 2024

Editor: Prof. Dra. Ada Clarice Gastaldi
