




ORIGINAL


**Clinical and sociodemographic profile of adults hospitalized in palliative care**

Perfil clínico e sociodemográfico de adultos hospitalizados em cuidados paliativos  
Perfil clínico y sociodemográfico de adultos hospitalizados en cuidados paliativos


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ABSTRACT

**Objective:** to characterize the clinical and sociodemographic profile of adults hospitalized and monitored by a consulting team in palliative care. **Method:** a quantitative and descriptive study, of the retrospective type. The sample consisted of 53 patients followed-up between October 2018 and December 2019 by a team from a hospital in southern Brazil and by an extension project. The data were extracted from the project assessment instruments and organized in *Microsoft Excel*. The analysis was performed using descriptive statistics. **Results:** low schooling and income levels were identified. Lung neoplasm was the most frequent diagnosis, related to smoking, a prevalent habit. Pain was the main complaint. Tiredness, well-being, sleep, anxiety and depression were worse self-rated. Opioids were more prescribed for pain control, but laxatives were not in equal proportion. Regarding the use of health devices, respiratory devices predominated. Death was the main outcome. **Conclusion:** the sociodemographic profile should be identified by the teams and considered in the planning of hospital discharge in palliative care. Physical symptoms seemed to be better controlled, with the use of pharmacological measures standing out. Psychological and comfort-related symptoms deserve a comprehensive evaluation and more specific interventions by the health teams.

**Descriptors:** Hospice Care; Hospitals; Palliative Care; Critical Illness.

RESUMO

**Objetivo:** caracterizar o perfil clínico e sociodemográfico de adultos hospitalizados e acompanhados por equipe de consultoria em cuidados paliativos. **Método:** estudo quantitativo, descritivo, do tipo retrospectivo. A amostra foi constituída por 53 pacientes acompanhados, entre outubro de 2018 e dezembro de 2019, por equipe de um hospital do Sul do Brasil e por um projeto de extensão. Os dados foram extraídos dos instrumentos de avaliação do projeto e organizados no programa *Microsoft Excel*. A análise se deu por meio de estatística descritiva. **Resultados:** identificou-se baixo nível de escolaridade e renda. A neoplasia de pulmão foi o diagnóstico mais frequente, relacionado ao tabagismo, hábito prevalente. Dor foi a principal queixa. Cansaço, bem-estar, sono, ansiedade e depressão foram pior autoavaliados. Opióides foram mais prescritos para o controle da dor, entretanto não estiveram em igual proporção os laxativos. Quanto ao uso de dispositivos de saúde, os respiratórios predominaram. O óbito foi o principal desfecho. **Conclusão:** o perfil sociodemográfico deve ser identificado pelas equipes e considerado no planejamento da alta hospitalar em cuidados paliativos. Sintomas físicos pareceram melhor controlados, sobressaindo-se para tal o uso de medidas farmacológicas. Sintomas psíquicos e relacionados ao conforto merecem avaliação abrangente e intervenções mais específicas das equipes de saúde.

**Descritores:** Cuidados Paliativos na Terminalidade da Vida. Hospitais. Cuidados Paliativos. Estado Terminal.

RESUMÉN

**Objetivo:** caracterizar el perfil clínico y sociodemográfico de adultos hospitalizados acompañados por un equipo de consulta en cuidados paliativos. **Método:** estudio cuantitativo, descriptivo, retrospectivo. La muestra estuvo compuesta por 53 pacientes seguidos entre octubre de 2018 y diciembre de 2019, por un equipo de un hospital del sur de Brasil y por un proyecto de extensión. Los datos se extrajeron de los instrumentos de evaluación de proyectos y fueron organizados en el programa *Microsoft Excel*. El análisis se realizó mediante estadística descriptiva. **Resultados:** se identificó un bajo nivel de escolaridad e ingresos. El cáncer de pulmón fue el diagnóstico más frecuente, relacionado con el tabaquismo como hábito prevalente. El dolor fue la queja principal. El cansancio, el bienestar, el sueño, la ansiedad y la depresión fueron los síntomas peor evaluados. Los opiáceos fueron más prescritos para el control del dolor, advirtiéndose que los laxantes no lo fueron en igual proporción. En cuanto al uso de dispositivos médicos, predominaron los respiratorios. La muerte fue el principal resultado. **Conclusión:** el perfil sociodemográfico debe ser identificado por los equipos y considerado en la planificación del alta hospitalaria en cuidados paliativos. Los síntomas físicos parecen estar mejor controlados, destacándose el uso de medidas farmacológicas. Los síntomas psíquicos y los relacionados con el confort requieren una evaluación integral e intervenciones más específicas por parte de los equipos de salud.

**Descriptor:** Cuidados Paliativos al Final de la Vida. Hospitales. Cuidados Paliativos. Enfermedad Terminal.

## INTRODUCTION

Chronic Non-Communicable Diseases (CNCDs) account for approximately 70% of all deaths worldwide.<sup>(1)</sup> With the increase in CNCDs and population aging, Palliative Care (PC) emerges as an approach to chronic diseases that no longer respond to the modifying treatment.

Carried out by a multidisciplinary team, PC is intended for people with life-threatening diseases and their families. It is not exclusively intended for terminal situations, but people in these situations can benefit from this approach to relieve health-related suffering.<sup>(2)</sup> The professionals' objective is to identify and control physical, psychological, social and spiritual symptoms in advance, respecting the beliefs and culture of all those involved in the care provided.<sup>(2-3)</sup>

In Brazil, there are 191 palliative care services, which are mainly located in the Southeast (55%) and South (17.2%) regions, in outpatient clinics or hospitals through the Palliative Care Consulting Team (PCCT) (82.7%), also called interconsultation teams. These teams are minimally comprised by a physician and a nurse with clinical experience, specialization or improvement in the area of palliative care. They provide support to the teams that directly assist patients and families in the different hospitalization units.<sup>(4)</sup>

The PCCT assists other professionals in the elaboration of individualized care plans, which include management of symptoms and organization of socioeconomic aspects, in addition to the psychological and spiritual approach of issues that emerge with the possibility of life finitude. These plans may be accepted and implemented by the assistant teams or not, depending on the agreements between such teams and the PCCT.<sup>(4)</sup>

Research studies on the profile of patients followed-up by the PCCT are scarce in the national literature. The studies in the area deal with experience reports about the implementation of specific hospitalization units in palliative care or about the patients in these units.<sup>(5-6)</sup>

Among those that approach the PCCT, we identified a study conducted with young patients in which it was verified that hospitalizations happen to control symptoms. The hospitalization time varied from 15 to 20 days between follow-up initiation and death or hospital discharge, when possible, respectively. A delay regarding the request for follow-up by the palliative care team was also identified.<sup>(7)</sup> Another study compared the effectiveness in relieving symptoms of cancer patients hospitalized and monitored by the PCCT and care team. Pain, dyspnea and depression were better controlled by the PCCT.<sup>(8)</sup>

Thus, the need is identified to characterize the profile of patients who are followed-up under the philosophy of Palliative Care, but who are not in specific units for PC, in order to identify priority interventions and adapt them to the socioeconomic context of patients and families. In view of the above, this study aimed at characterizing the clinical and sociodemographic profile of adults hospitalized and monitored by a consulting team in Palliative Cares.

## METHOD

A study with a quantitative, descriptive and retrospective approach. Retrospective studies involve collecting data on a result in the present time and

then turning the eyes to the past in search of possible causes or to characterize a situation.<sup>(9)</sup>

The study scenario was a Teaching Hospital in southern Brazil that has 175 hospitalization beds and is a reference in care, especially in Oncology, for 28 municipalities. A differential of the institution is the presence of a Palliative Care Consulting Team, comprised by two physicians and a nurse as permanent members. Social workers, chaplains and psychologists are triggered according to demand, that is, they are not part of the team.

This team guides professionals who directly assist adults hospitalized in the three hospitalization units that are part of the urgency and emergency network, a medical clinic hospitalization unit, a surgical hospitalization unit and the intensive care unit, as well as their formal and informal caregivers.

The consulting team also plays an educational role with the professionals regarding guidance on PC and also with Nursing and medical students, through voluntary internships and teaching, research and extension projects.

The study participants were hospitalized patients due to advanced stage diseases. The sample was intentionally constituted, through the indication of patients by the PCCT, considering the following as inclusion criteria: being in follow-up with the PCCT, being over 18 years old and having been evaluated by the extension project called "Nursing consultation as a care instrument for people with life-threatening diseases and their families". Patients who refused to be evaluated by the extension workers were excluded.

It is emphasized that, after the evaluation request, the PCCT monitors the patient during the remainder of the hospitalization period. During the study period, a mean of 15 new patients were evaluated monthly. It is noteworthy that this number varied, upwards or downwards, according to the period of the year. For example, in March, the start of a new team of medical residents in the Institution, or during the PCCT professionals' vacations, who were not replaced by other professionals, the number of requests was reduced.

Similarly, it is important to clarify that Nursing consultations (extension activity) were performed at the bedside of the units in which the patients were hospitalized by students attending the Undergraduate Nursing course. All the students previously performed an internship of academic experiences with the PCCT professionals, lasting at least 20 hours, with a maximum of 40 hours.

The consultations were aimed at patients and their family members and generally occurred in two or three days, which could be on weekdays or during the weekends, depending on the students' availability and also on the patients' clinical conditions. Each patient was evaluated at least twice. In the consultations, a standardized assessment instrument was used and elaborated by the extension project members (teachers, students and health professionals). This instrument is detailed below. In addition to the assessment, the students elaborated Nursing diagnoses and prescriptions, based on the North American Nursing Diagnosis Association-

International (NANDA-I) and Nursing Interventions Classification (NIC) taxonomies, respectively, which were verbally instructed to the patients and to the professionals working in the units.

However, it is worth noting that there is no estimate of the duration of consultations and that this was never an objective of the project, as each patient and family are unique. Considering the PC philosophy, each person takes some time in the approach, some more, others less. Thus, the approach during the physical examination and the application of assessment scales were longer with some individuals than with others. Especially with patients who presented reduced functionality, fatigue, presence of some symptom or sadness, the consultations were shorter, and guidance was provided to the students, in order to respect the time, comfort and dignity of each person followed-up.

Data collection occurred between May and July 2020 and was performed with assessment instruments completed by students who were part of the extension project, between October 2018 and December 2019. The assessment instrument was structured as follows: 1) Anamnesis; 2) Physical Examination - in this block the students used the propaedeutic techniques and the measurement of vital signs to collect and evaluate data regarding the vital signs (pain was evaluated using the verbal numerical scale, understanding the absence of pain as the zero answer, mild pain when the answer is between one and three, moderate pain when the values assigned are between four and six, and severe pain when they are between seven and ten) and the symptoms - through the Edmonton Symptom Assessment Scale (ESAS); and 3) Basic Human Needs (BHNs), Nursing Diagnoses and Prescriptions. It is worth noting that, to fill out some information of the instrument, the students could also consult the patient's medical record.

In this article, the study variables chosen to be presented and analyzed were the following: age, gender, income, marital status, origin, reason for hospitalization, medical diagnosis, main complaints, habits, score obtained with the evaluation by the Palliative Performance Status (PPS), disease evolution phase, medications, support network, pain assessment, symptom intensity based on ESAS, use of medical device and main outcome. The data were organized in a database created in the *Excel* 2010 spreadsheet editing program and analyzed through descriptive statistics, specifically by the use of absolute frequency, relative frequency and mean value.

This study was approved by the Research Ethics Committee under opinion No. 4,339,013 and Certificate of Presentation for Ethical Appreciation (*Certificado de Apresentação para Apreciação Ética*, CAAE) 13634719.2.0000.5316.

## RESULTS

The sample consisted of data from 53 patients. The mean age was 62.58 years old, varying from 23 to 91. The majority, 60.38% (n=32), were female,

with marital status indicated as married in 43.39% (n=23), and 71.69% (n=38) had the city of Pelotas as their place of residence. Regarding schooling, 54.72% (n= 29) of the patients had completed elementary school. In relation to family income, all (n=53) reported incomes from one to five minimum wages, which came from retirement in 54.72% (n=29). Regarding the support network, the children were mentioned as the main support by 71.69% (n=38) of the participants, followed by the partner in 41.5% (n=22).

At the time of the evaluation, 45.28% (n=24) of the patients had advanced stage diseases and 41.51% (n=22) were in the final stage of life. Such data converges with the scores identified during the evaluation with PPS, in which there was predominance of patients with low functionality, that is, 24.52% (n=13) had PPS=30, 16.98% (n=9) obtained PPS=50 and 11.32% (n=6) scored PPS=40. The time between admission and the request for the PCCT evaluation varied from 1 to 155 days. Thus, a mean of 18.64 days is observed from the time of hospitalization to the beginning of the follow-up by the PCCT. In relation to the time between the evaluation request and its completion, this occurred a mean of 1.13 days after the request, with six days being the longest time recorded.

Among the 53 patients, the most recurrent reason for hospitalization was clinical research with 26.23% (n=14). In addition to that, 11.48% (n=6) were hospitalized for the treatment of community-acquired pneumonia. 89% (n=47) of the patients had a medical diagnosis of neoplasm, predominantly lung cancer, with 28% (n=13), followed by breast cancer, with 11% (n=5). It is worth considering the fact that the patients affected by lung neoplasms are the most closely monitored by the Palliative Care team because the Pulmonology team is the most helpful in consulting.

In relation to the patients' habits, 62.26% (n=33) were smokers, 16.98% (n=9) made abusive use of alcohol, 9.43% (n=5) used illicit drugs and 11.32% (n=6) preferred not to answer. Regarding the main complaints, the following stood out: pain, with 47.16% (n=25); nausea, constipation and other digestive problems, with 24.52% (n=13); dyspnea, with 18.86% (n=10); and lack of appetite, with 7.54% (n=4).

Among the 29 patients who were able to answer the question about pain, 48.3% (n=14) did not report pain at the evaluation instance, 24.1% (n=7) reported mild pain, 20.7% (n=6) reported it as severe and 6.9% (n=2) described it as mild.

As for the ESAS, Table 1 presents the frequency with which the level of symptoms was manifested by the patients. It is emphasized that, in the ESAS Scale, 0 represents absence of the symptom and 10 corresponds to the worst possible sensation in relation to it. It is also noteworthy that, although all 53 patients were eligible for application of the scale, as they were in palliative care, not everyone answered all the items when asked due to fatigue, lack of lucidity, torporous state or not wanting to answer. In these cases, respect for the patient's desire prevailed, even acknowledging that this

becomes a limiting factor of the data presented, as researching in palliative care is, first of all, recognizing the other's limits and territory. In other

words, recognizing the fragilities of the body in all its dimensions and privileging dignity.

**Table 1 - Result of the evaluation with the Edmonton Symptom Assessment Scale (ESAS). Pelotas, RS, Brazil, 2020.**

Symptom and number of respondents	Evaluation - ESAS							
	Self-assessment % respondents							
	0		1-3		4-6		7-10	
	n	%	n	%	n	%	n	%
Pain (n=34)	14	41.17	3	8.82	8	23.52	9	26.47
Tiredness (n=28)	8	28.57	-	-	7	25	13	46.42
Drowsiness (n=28)	5	17.85	1	3.57	9	32.14	13	46.42
Nausea (n=28)	21	75	-	-	4	14.28	3	10.71
Appetite (n=28)	9	32.14	2	7.14	7	25	10	5.71
Shortness of breath (n=28)	14	50	1	3.57	6	21.42	7	25
Depression (n=26)	4	15.38	2	7.69	7	26.92	13	50
Anxiety (n=27)	3	11.11	1	3.70	10	37.03	13	48.14
Well-being (n=23)	5	21.73	3	13.04	9	39.13	6	26.08
Other problems (n=0)	-	-	-	-	-	-	-	-

Source: Research data (2020).

Regarding the medications used to control symptoms, all patients filled out the instrument. Due to the large number of drugs, it was decided to gather the most frequent ones and separate them by pharmacological class. Thus, with regard to the pain control medications, opioid analgesics were found in 50 prescriptions, non-opioid analgesics in 49 and anti-inflammatory drugs in 29. It is noteworthy that laxatives and antispasmodics were prescribed less frequently than opioids, being identified in 29 prescriptions.

As for the other medications and the frequency with which they were prescribed, antiemetics were for 49 of the patients, anticoagulants for 26, antiulceratives for 23, bronchodilators for 23, antibiotics for 17, antiallergics for ten, antifungals and diuretics were administered in five. In addition, 17 prescriptions of antidepressants, 15 of antipsychotics and seven of benzodiazepines were identified.

In relation to the health devices, in the respiratory system, 45.28% (n=24) of the patients used some at the time of the evaluation. Of these, 37.73% (n=20) made use of a nasal catheter of the glasses type, 8.33% (n=2) wore a mask with an oxygen reservoir, 4.16% (n=1) had a tracheostomy cannula, and 4.15% (n=1) had a Venturi mask.

In the vascular system, 62.26% (n=33) of the patients used a peripheral venous catheter, 15.09% (n=8) used some type of central venous catheter, and 7.54% (n=4) had hypodermoclysis. One patient was using two devices at the same time: peripheral venous catheter and fully implanted venous catheter. Regarding the digestive system, 20.75% (n=11) of the patients used some device, where 36.36% (n=4) used a nasoenteric tube, 27.27% (n=3) made use of jejunostomy, 18.18% (n=2) had a closed nasogastric

tube, and 18.18% (n=2) an open nasogastric tube in vial.

Regarding the urinary system, 30.18% (n=16) of the patients used some device. Of these, 81.25% (n=13) used an indwelling bladder tube, and 18.75% (n=3) used a device for urinary incontinence in latex. As for intestinal eliminations, 13.20% (n=7) of the patients had a colostomy. Even if diapers are not medical devices, 30.18% (n=16) of the patients used them at the time of the evaluation.

In relation to the patients' outcome, 26 evolved to death, 18 were discharged to their homes and, of these, eight went on with follow-up by a home care service. One patient was discharged from Palliative Care consulting and there was no record of the outcome for another eight subjects.

## DISCUSSION

In this research, most of the participants had completed elementary school. A study on palliative cancer care and of the doctrinal principles of the Unified Health System (*Sistema Único de Saúde*, SUS) evidenced that chronic diseases are responsible for 72% of the deaths and that they affect people from all socioeconomic layers, but mainly and more intensely those with greater vulnerability, low income and low schooling.<sup>(10)</sup> Thus, the findings of this study reiterate the literature and reinforce the importance of considering the language level used when addressing patients and family members during interventions in the hospital environment.

Regarding salary income, it varied from one to five minimum wages, mostly from retirement. This result converges with a study<sup>(11)</sup> on the sociodemographic and clinical profile of patients under palliative cancer care, which shows that most

of the patients had incomes of one to two minimum wages, usually from retirement. Nevertheless, this finding should be weighted, as the number of minimum wages per person in the family was not identified, which directly interferes with care issues and discharge planning when considering access to certain equipment, medications and devices, among others.

Although death was the most prevalent outcome in the patients evaluated, 18 subjects returned to their homes. Thus, it is important that health teams better understand how families of people in palliative care organize themselves, in social and economic terms, to welcome them in the home space, as the quality of the care offered will directly depend on these aspects.

Regarding the time from hospitalization to the time of the consulting request, it presented an important variation. A study<sup>(12)</sup> points out that the delay and difficulty in requesting consulting teams may occur because the professionals understand Palliative Care as a sign of failure, in addition to the feeling of losing control or leadership in conducting the treatment.

In relation to the patients' clinical profile, the majority was affected by some type of neoplasm. This in line with the study<sup>(10)</sup> that identified cancer patients as the most assisted by Palliative Care teams. This result can be influenced by the specific ways to evaluate cancer patients and by the fact that the hospital in which the study was developed is a reference in Oncology. In this specific area, it is more frequent to use functionality assessment instruments, such as PPS, Karnofsky Performance Status (KPS) or the Eastern Cooperative Oncology Group (ECOG), tools that help assess the patients' functionality and, indirectly, favor the identification of the need for Palliative Care and the decision-making process regarding the therapeutic options.<sup>(13)</sup>

The most recurrent neoplasm was lung cancer, and may be associated with the smoking habit presented by most of the patients. Lung cancer usually has a late diagnosis, which ends up impairing the patient's prognosis, and is strongly associated with tobacco use.<sup>(14)</sup> The data found in the current study are in line with the Australian study<sup>(15)</sup> that sought to identify the profile of patients in palliative care in the state of Queensland, between July and December 2019. Regarding the diagnoses, it was verified that, among 4,931 patients, 744 were affected by lung cancer, a condition responsible for the largest number of cancer patients in palliative care, followed by colorectal cancer, with 363. Both types of cancer accounted for 23.3% of all the palliative care cases (including all disease groups) in the Australian state.

Regarding the patients' complaints, pain was prevalent. In Palliative Care, pain is a recurrent symptom and can be linked to physical aspects such as the disease, as well as it may have social, emotional and psychological backgrounds. To control this symptom, it must be evaluated regularly and the patient should be encouraged to assume the leading role at that moment. The pharmacological treatment should consider the analgesia ladder proposed by the

World Health Organization (WHO). This ladder is subdivided as follows: level 1 - not opioids; level 2 - weak opioids; and level 3 - strong opioids.<sup>(16)</sup>

In relation to the evaluation of symptoms through ESAS, it is highlighted that applicability of this scale in the clinical practice is difficult, especially regarding the patient's understanding of the aspects that it seeks to evaluate. Thus, in this study, when evaluated with ESAS, for most patients, pain was controlled at the time of the evaluation. This result can be associated with the use of non-opioid and opioid analgesics, which most of the patients were using.

Constipation is one of the side effects arising from the use of opioids. According to the medical prescriptions, 29 patients made use of laxatives. However, as already mentioned, 49 subjects were using opioids. Through this result, it is perceived that it is not a routine to prescribe laxatives whenever a patient is on opioids. However, it should be considered that the fact that many laxatives are thick and unpleasant to the palate leads to refusal of the medications. The preventive action of using a non-pharmacological laxative is fundamental, since initiation of opioid use. In addition to that, the combination of non-pharmacological and pharmacological treatments, as well as opioid rotation, can mitigate this side effect.<sup>(17)</sup>

Nausea, another symptom identified, can be present due to the disease and its complications in the last days of life. It can also be a side effect to opioid use. For this symptom, it is recommended to prescribe Haloperidol or Metoclopramide.<sup>(17)</sup> This guidance is in line with the one identified in the prescriptions analyzed in this study.

In the evaluation of drowsiness, the patients mostly presented some level of discomfort. In hospitalization, intrinsic factors can affect the sleep pattern, such as pain and emesis. A number of psychological factors can also collaborate, such as fear, worry or anguish. These intrinsic and extrinsic factors (those associated with the environment and therapy, for example) can compromise sleep quality during hospitalization.<sup>(18)</sup>

Most of the patients also presented some level of tiredness. This finding corroborates what was found in a study<sup>(19)</sup> that resorted to the Multidimensional Scale to assess pain and symptoms of aged people in Palliative Care. In it, it was observed that 60% of the participants suffered from tiredness or fatigue, which are symptoms that develop over time and have cognitive, physical and emotional implications, including increased need for rest, reduced mental concentration and disinterest in performing daily activities.<sup>(19)</sup>

In addition to that, the presence of tiredness can be related to lack of appetite. In the evaluation through ESAS, it was verified that most of the patients indicated some problem related to appetite. In the literature, it is verified that the following factors stand out among those that contribute to changes in appetite at the end of life and, consequently, increase the feeling of tiredness: pain, oral mucositis and absence of teeth.<sup>(20)</sup>

In relation to shortness of breath, half of the patients did not present this symptom in the evaluation. However, according to the evaluation of the use of medical devices, most were on oxygen by nasal catheters of the glasses type and, as already mentioned, they also used opioids and bronchodilators. This finding converges with the international recommendation<sup>(17)</sup> that suggests the use of opioids, bronchodilators through nebulization, corticosteroids and oxygen therapy to control this symptom.

In relation to well-being, most of the patients were dissatisfied, a result that is in line with a study<sup>(21)</sup> conducted with cancer patients, in which the following instruments were used for the evaluations: Karnofsky Performance Scale, Palliative Performance Scale and ESAS. It was observed that, of 100 patients evaluated, 79% were dissatisfied with well-being.<sup>(21)</sup> It is worth noting that the hospital environment exerts a psychological impact on the patients because, in addition to being away from their homes and their routine, they are living in an unknown place, with other people and with rules of an institution, in addition to the disease.

In the emotional questions, in relation to depression, most of the patients obtained scores greater than or equal to five. In palliative care, it is estimated that at least 25% of the patients develop depression.<sup>(17)</sup> In this study, antidepressant prescriptions were found with some patients. Despite this, there does not seem to be a good management in this aspect, considering that, at the time of evaluation, 13 patients scored between 4 and 10 points in the ESAS Scale. The presence of anxiety and depression is associated with greater expressiveness of other symptoms in situations of advanced stage diseases.<sup>(22)</sup>

In a study on the prevalence of anxiety and depression in cancer patients, it was identified that they tend to have depression during the disease and anxiety at the beginning, after the diagnosis. In addition to that, these psychiatric disorders are not frequently diagnosed in these patients, as sometimes there is no time for this or, then, these symptoms are attributed as inherent to cancer itself, underdiagnosed and undertreated conditions.<sup>(23)</sup>

There are scales translated and validated for use in Brazil that can help reduce this bias in the diagnosis and treatment of these pathologies. In relation to the assessment of depression, there is the Hospital Anxiety and Depression Scale - Depression (HADS-D) and the Patient Health Questionnaire-9 (PHQ-9). For anxiety assessment there is the Hospital Anxiety and Depression Scale - Anxiety (HADS-A) and the General Anxiety Disorder - 7 (GAD-7).<sup>(24)</sup> These instruments can be useful for the early identification of disorders and for the recognition of the priorities regarding the therapeutic courses of action.

It is worth remembering that, as already pointed out in the Method, the PCCT of the institution does not have a permanent psychologist in the team. This aspect hinders a proper approach to depression. Faced with the terminality experienced in the hospital, psychologists are professionals who offer support to patients faced with stress, depression and

suffering resulting from progression of the disease, loss of autonomy and the real possibility of death. They assists in (re)signifying the meanings of life.<sup>(25)</sup>

Anxiety was mostly classified as mild or intense. It can be related to several reasons, either due to organic problems or not. A predisposing factor is being hospitalized. In addition to that, anxiety can be related to the possibility of death and to the dying process. Death anxiety can be identified both in the person under palliative cares and in the caregivers. A study<sup>(26)</sup> with caregivers of end-of-life patients showed that most of them had anxiety related to the fear of loneliness and abandonment and death, as well as to the fear of physical degradation inherent to the dying process. The feeling of helplessness was also recurrent.

As for the devices, a relevant data was the low use of hypodermoclysis, even in patients who are followed-up by palliative care team. This medication administration route is the most recommended for the pharmacological control of signs and symptoms inherent to the dying process. It presents good rates of absorption and efficacy of the medications and can be easily handled by formal and informal caregivers.<sup>(27)</sup>

Finally, the significant number of people using diapers stands out. This piece composed of absorbent material is intended to contain excrement, such as feces and urine, wither in children or in people with some disease. In adults and older adults, it is indicated in cases of incontinence or severe mobilization restrictions, in the impossibility of using urinary and intestinal collectors.<sup>(28)</sup> In a study conducted with 105 patients admitted to a University Hospital, 60% of them used diapers. In the study, the main reasons for diaper use in the patients were impaired mobility and cognitive deficit; however, 38% of the patients had no reason to wear diapers.<sup>(28)</sup> This data reinforces the importance of analyzing the use of this technology, which sometimes constrains and confers a sensation of "indignity" to the patients, as it reinforces the situation of dependence and lack of control over the body itself.

The limitations of this research were related to the reduced number of participants, to the fact that some information is incomplete in the data collection instruments, to the patients' frailty, or to the fact that different students performed the evaluations. In addition to that, there was difficulty conducting a second evaluation to clarify any doubt that might have emerged.

However, it is believed that, as contributions, the study allowed identifying intervention priorities to be listed in the care plans by the care teams. Thus, it is possible to maintain and reinforce what has already been successfully accomplished - control of physical symptoms - by investing in what can improve the quality of life - psychoemotional symptoms - of people hospitalized in palliative care and their families.

## CONCLUSION

This research allowed characterizing the clinical and sociodemographic profile of hospitalized adults

monitored by a palliative care consulting team. The patients' low schooling and income levels were evidenced, a fact that directly interferes with the care provided, mainly in hospital discharge planning and implementation. Although the physical symptoms seem to be well-controlled, the psychological and comfort-related ones, as well as specific techniques such as hypodermoclysis, need to be better addressed by the PCCT and care teams.

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