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Palliative Rehabilitation for Occupational Therapists

Introduction

Many lay persons may assume occupational therapists and other rehabilitation providers don't have a place in a practice area such as palliative care. And, even within the healthcare field, the work OTs do within palliative care is often misunderstood. However, OTs have an essential role in palliative care: improving quality of life and continuing to promote independence as well as occupational engagement for individuals with life-limiting conditions. Occupational therapists may use remediatory and compensatory approaches for individuals who receive palliative care OT services. Interventions may include environmental modifications, task adaptation, education, leisure participation, spirituality exploration or practice, coping skills, emotion regulation, and pain management as well as keeping control of other persistent symptoms. With support from occupational therapy providers, an individual receiving palliative care services can identify, prioritize, and carry out what is most important to them at the end of their life.

Section 1: Definitions & Background

References: 1, 2, 3, 4, 5, 6, 7

Palliative care is technically defined as any specialized medical care provided to individuals with serious illnesses. Palliative care is often administered alongside other treatments intended to cure these same medical conditions. The aim of palliative care is to ease a person's discomfort and/or pain, lower the stress and overall burden of their illness, and assist them in achieving the highest quality of life possible at the time. Someone may seek palliative care if they:

- Receive a new, life-limiting diagnosis
- Are receiving medical care that does not aim to cure a life-limiting illness

- Had a now-cured life-limiting illness but are now left with residual symptoms
- Are pursuing curative treatment for a life-limiting condition
- Decline treatment for a life-limiting illness but want to remain comfortable

Palliative care is a term often confused with hospice care, but the two are not the same. While they may both be referred to as comfort care since they are equally used to ease someone's pain, each has different long-term intentions. Hospice care aims to offer comfort to someone with a serious illness **without** the intention of curing their condition. This means the patient has either declined curative treatment (due to personal reasons or feeling the risks/side effects of that treatment outweigh the benefits) or there are no curative options available. Palliative care also aims to comfort someone with a serious illness, but may or may not be paired with services that have a curative intent.

Another distinction between hospice care and palliative care is the length of time they can be provided. Hospice care is only recommended when an individual's physician expects them to pass away within 6 months. If that patient does not pass away within the 6-month time frame, they are removed from the hospice program and their care team should discuss other options. Palliative care, on the other hand, is much more open-ended and can be provided as long as the program is benefitting the patient's quality-of-life and helping manage their symptoms.

Insurance coverage for these two services is mostly the same. Hospice and palliative care are both covered by Medicare, Medicaid, and most private insurers. Some individuals decide to pay out-of-pocket (also known as self-pay) for palliative services and hospice care. It's more common for individuals to go the self-pay route for palliative services, especially if they choose non-traditional care options since those are rarely covered by standard health insurance plans. Individuals who opt for palliative care earlier in the course of their condition may have more financial resources to pay out-of-pocket. Since hospice programs have a stricter timeframe, it is less likely someone will be able to pay out-of-pocket for those services, but it still may happen.

Regardless of how these medical services are paid for, the need for palliative care must be demonstrated through documented medical necessity. This is primarily required for insurance purposes, but clinical justification also helps manage service utilization for palliative care programs. Palliative care is considered highly patient-centered as it is chiefly recommended based on the patient's needs rather than their prognosis. This means that someone can opt for palliative care measures at any point in their illness regardless of their age and doctor's guidance. In fact, in the case of cancer and other conditions that spread, it's best to request palliative care earlier in the course of the disease to assist with managing discomfort and related symptoms.

While symptom management is a large part of palliative care, these services have several other benefits. One such benefit is enabling someone to play a more active role in their care. Most people think someone opts for palliative care and then passively receives a range of treatments to make them more comfortable. However, individuals who receive palliative care often have a greater understanding of the choices as part of their medical care due to how organized and structured palliative care is. Each palliative care service is presented to someone individually, not as a package. Just as someone would consent to other medical services, individuals are given the option to accept or decline each aspect of the comfort care they wish to have and exercise control over when and how they want it.

The goals of palliative care programs include:

- Aligning a person's treatment outcomes with their preferences and values
- Improving the patient's quality of life at all points during the plan of care
- Mitigating physical pain and discomfort
- Offering spiritual counseling according to the patient's spiritual or religious practices and beliefs
- Working together with all doctors, therapists, and other allied health professionals involved in the patient's care to offer additional support
- Easing emotional distress, anxiety, or depression
    - These feelings may be directly due to disease symptoms, indirectly stem from concerns over prognosis and well-being, or a combination of both
- Assisting with adaptive equipment, mobility devices, and safety (pertaining to that equipment and in a general sense)
- Empowering patients and caregivers to actively take part in their care and make decisions they are comfortable with
- Providing support to the patient and their family during the patient's illness as well as to the family and other loved ones after the patient passes

A range of studies show that palliative care yields improvements in health-related quality-of-life on behalf of patients when compared to regular care. Additional outcomes of palliative care include reduced burden of patient symptoms and increased patient satisfaction with care. There are mixed results on the efficacy of palliative care on pain compared to pain levels following regular care. There is some evidence that palliative care positively affects caregiver burden.

Other evidence shows that patients receiving palliative care for non-cancer-related illness (chiefly, organ failure) experienced fewer emergency room visits, fewer hospital admissions, and fewer admissions to the intensive care unit compared with individuals who did not receive palliative care. This same study showed that patients receiving palliative care were more likely to die at home or in a nursing facility than patients who did not receive palliative care. Most of the research reports similar outcomes for palliative care programs regardless of location, as these services can be provided in hospitals, inpatient facilities, and patients' homes.

As a whole, there is also research to support that palliative care is associated with greater symptom management, more accurate prognostic understanding, improved caregiver outcomes, enhanced mood management, less aggressive end-of-life care, improved survival rates, and improved healthcare resource utilization. Studies also show that initiating palliative care earlier in the course of a life-limiting disease is correlated with a more positive impact on patient and family satisfaction with care, increased survival rates, and better patient perception of pain.

Individuals may seek palliative care for a variety of life-limiting health conditions, including but not limited to:

- Alzheimer's disease and other forms of dementia
- Amyotrophic lateral sclerosis (ALS)
- Bone marrow transplant
- Cancer (most specifically breast, colon, lung, ovarian, pancreatic, and prostate cancer as well as leukemia and lymphoma)
- Cerebrovascular accident (CVA)

- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- COVID-19 and its variants
- Diabetes mellitus
- End-stage renal disease (ESRD)
- Eosinophil-associated Diseases (EAD) and other immune system conditions
- HIV/AIDS
- Huntington's disease
- Liver disease
- Lupus
- Multiple myeloma
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's disease
- Pulmonary fibrosis
- Scleroderma
- Sickle cell anemia

The majority of adults who utilize palliative care do so for the following conditions: cardiovascular diseases (38.5%), cancer (34%), chronic respiratory conditions (10.3%), AIDS (5.7%), and diabetes mellitus (4.6%). Someone may also seek palliative care for a combination of reasons, such as multiple and/or lengthy hospitalizations, medical frailty, or a significant functional decline.

Palliative care services can be used to address a range of uncomfortable physical symptoms, including but not limited to sleep loss, shortness of breath, nausea, vomiting, loss of appetite, fatigue, skin discomfort, temperature sensitivity, constipation, and pain. Some individuals living with serious medical conditions may choose to stop taking medications that cause uncomfortable side effects as one of their palliative options. This may alleviate some of their symptoms, but can cause an increase in other health concerns that they then seek palliative management for. Palliative services can be easily adapted to follow the ebb and flow of symptoms a person experiences. For this reason, no two palliative care treatment plans look the same. Palliative care can also be of help for emotional discomfort or natural emotional responses to life-limiting illness, including anxiety, fear, sadness, hopelessness, helplessness, emptiness, loneliness, a lack of connection, a sense of unfulfillment, unresolved relationship concerns, and more.

There are various disciplines that may be part of the palliative care treatment team. In fact, most members of the palliative care team mirror those on a traditional interdisciplinary team. Many individuals are also not aware that someone can keep their own provider(s) when they begin receiving palliative care. Some disciplines – like pastoral care, art therapy, and music therapy – may be entirely new to the individual. But a person's physician often transitions to palliative care services along with them, as long as they are still able to offer the level of care the patient needs. There are a range of professionals who may be part of a palliative care team:

- Advanced registered nurse practitioner (ARNP), specializing in palliative care
- Art therapist

- Assistive technology professional (ATP)
- Case manager
- Chaplain or other pastoral care worker
- Dietitian or nutritionist
- Home health aide (HHA), certified nursing assistant (CNA), or personal care assistant (PCA)
- Licensed professional counselor (LPC)
- Music therapist
- Occupational therapist
- Orthotist or prosthetist
- Patient care navigator
- Pharmacist
- Physical therapist
- Physician
    - In addition to the patient's primary care physician (PCP), several specialist physicians may be part of the palliative care team, including surgeons, psychiatrists, and palliative care or pain management physicians. Depending on the patient's medical conditions, oncologists, neurologists, rheumatologists, and respiratory care physicians may also be involved in the care process.
- Psychologist
- Registered nurse, specializing in palliative care

- Social worker
- Speech language pathologist
- Volunteers
    - Volunteers may be associated with disciplines such as recreation therapy, pastoral care, child life services, and more.

Some individuals receiving palliative care opt for modalities that fall under the heading of complementary health approaches and integrative health (CHAIH). This umbrella term is broken into complementary medicine providers and alternative medicine providers. Complementary medicine providers is a term that describes any non-traditional medical practice that is used alongside traditional medical care. Alternative medicine providers is a phrase used to detail any non-traditional medical practice used in place of traditional medical care. Therefore, the same modality may be classified as complementary or alternative depending on whether or not the person is receiving other medical services. If someone receiving palliative care opts for one or more of these integrative modalities, this means additional providers are technically part of the overarching palliative care team. CHAIH for palliative care may include reiki healers, naturopathic physicians, yoga therapists, osteopathic medicine providers, homeopathic medical providers, massage therapists, chiropractors, and acupuncturists.

Section 1 Personal Reflection

How might the palliative care treatment team differ between a hospital and the patient’s home? What aspects of care should be adjusted between these two settings?

Section 1 Key Words

Child life services - A healthcare discipline that helps children better understand new or existing medical diagnoses and minimizes trauma resulting from the healthcare service delivery process; child life treatment commonly involves education, preparation, and therapeutic play

Curative treatment - Any medical service intended to cure or help someone fully recover from an urgent health condition and reattain an acceptable quality-of-life

Medical necessity - A demonstration that any given medical services are necessary, reasonable, and/or appropriate based on the current clinical care standards and basis of evidence

Neurologist - Physicians who diagnose and treat conditions of the brain, nerves, and spinal cord

Oncologist - Physicians who diagnose and treat cancer

Rheumatologist - Physicians who diagnose and treat diseases of the muscles, joints, and bones; this includes conditions that are inflammatory or autoimmune in nature, such as arthritis

Section 2: Treatment Approaches and Models for Palliative Care

References: 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19

Palliative care models are designed to structure care for all disciplines who are part of the treatment team. The key principles associated with palliative care differ slightly based on what organization or source they come from, but most of them align very closely with the benefits of palliative care outlined earlier.

Some sources discuss models of care more focused on patient care. One study denotes the 6S model for person-centered palliative care, which consists firstly of self-image. Researchers state that providers should use the patient's personal experience of their situation as a starting point. The other principles in this model include self-determination, social relationships, symptom relief, synthesis, and strategies. Any discipline can use these areas to assist in goal formation and treatment planning for those receiving palliative care services.

The International Association for Hospice & Palliative Care (IAHPC) outlines more detailed principles that healthcare providers should adhere to when offering palliative care. These include: having a caring attitude, considering a patient's individuality, factoring in caregiver support, making adjustments based on the patient's culture, obtaining consent, allowing patients to choose where they receive care, communicating effectively, offering appropriate treatment based on the clinical context, providing a high standard of excellence and interprofessional care, successfully coordinating all aspects of the patient's treatment, maintaining continuity of care at all times, being well-versed in crisis intervention, and completing reassessments on an ongoing basis.

Stages of Palliative Care Treatment Planning

Providers should also be aware of the four stages the palliative care treatment continuum is divided into. Stage 1 is when an individual is mostly medically stable, which is why the focus of palliative care during this time is on creating and implementing the care plan. We mentioned earlier that patients should begin palliative care earlier for better outcomes. So the longer patients are in Stage 1, the better chances they have for improved comfort and symptom management over time. The transition to Stage 2 takes place when the individual becomes medically unstable. This is also when the care plan is adjusted accordingly and the patient is prepared emotionally for the next steps. During Stage 3, the patient is considered to be deteriorating and the plan of care shifts more toward end-of-life care. Stage 4 is classified as terminal, as there are little to no options in the way of curative treatment. During Stage 4, the focus continues to be on symptom management with an even heavier emphasis on spiritual and emotional care. This stage continues until the individual passes. But, as we mentioned earlier, palliative care services do not stop at the time of the patient's death. Stage 5 is dedicated to bereavement, so this is when the sole focus of providers becomes supporting the decedent's loved ones, family, and caregivers. All clinicians should be mindful of the stage their patient is in when planning goals and interventions, as all the work they do in palliative care must remain person-centered.

Palliative Care Service Delivery Models

In some countries and even in parts of the United States, palliative care services are not integrated with other healthcare services. Therefore, models of service delivery for palliative care may be any of the following: consultation teams (where specialists travel to community settings, hospitals, and patients' homes to see palliative care patients), adult day care facilities, assisted living facilities, inpatient palliative care units and hospices, and outpatient services.

Other research notes specific models to be used in various settings, including the integrated model, the consultation model, the liaison model, the shared care model, the pop-up model, the team-based model (also known as the multidisciplinary model), and the trajectory model. The integrated model is viewed as the most ideal since it encompasses case management and skill building with patients as well as specialist inreach and outreach. This model is endorsed by the World Health Organization (WHO), as it extends across primary, secondary, and tertiary care. The consultation model involves having specialists support complex decision-making for palliative care patients in need of care planning and coordination. In this model, the specialists' role is to offer advice, and they are not necessarily directly involved in the patient's treatment. The liaison model for palliative care combines patient education with clinical support for primary care providers and educational outreach. This model is most often utilized when a patient's primary provider(s) are less skilled in managing chronic, life-limiting conditions. The shared care model involves collaborating to monitor palliative care patients and sharing pertinent information about their treatment in order to fulfill joint responsibilities. This model was initially devised to offer palliative care in remote or rural areas and also involves a rapid-needs response. The pop-up model for palliative care is a common occurrence in rural areas with a lack of permanent infrastructure for palliative care services. This model is often sought out when certain geographic areas cannot develop more lasting programming for palliative care, which may be the case if they lack funding or have too few specialty providers in their area. The team-based model involves many disciplines working together to meet the wide range of health needs presented by people with life-limiting conditions. This model involves providers working between various sectors for the primary, social, and palliative care of sick individuals. The trajectory model of palliative care aligns quite closely with the overall aim of these services, as its intent is to offer support over a long period of time. The trajectory model can be used to assist with simple or complex needs on an ongoing basis with an emphasis on early intervention and family support. Each of these models is well suited for various situations, but all have a shared purpose of offering palliative care services to those who need them.

As you can imagine, there are advantages and downsides to each model. Some research has compared the efficacy of services provided through some of these approaches. Specifically, one study looked at outcomes from specialist palliative care initially provided in the home to the patient, their next-of-kin, and doctor or nurse and specialist palliative care offered initially in the hospital. Results showed no significant differences in terms of quality-of-life, communication, or satisfaction with care. While this is simply a snapshot of one comparison, the results indicate that palliative care can be effective in a range of settings.

OT’s Role in Palliative Care

All of this information is used to inform the work OTs do in palliative care. OT’s role in palliative care encompasses:

- Optimizing quality-of-life by promoting occupational performance at all points during the disease progression
- Encouraging adaptation and healthy coping, which may be done in part by reframing occupational goals based on disease-related changes
- Supporting someone’s ability and desire to leave a legacy while still playing an active role in attending to their affairs, if they choose to do so
- Assisting with symptom management through modalities such as education, task modification, durable medical equipment prescription, assistive technology recommendation and training, and counseling
- Supporting the person’s choice to carry out their remaining days in a certain setting with the help of those involved in care coordination
- Connecting patients with community supports and resources to help both the patient and their family
- Offering home safety assessments and environmental modification recommendations, particularly for individuals who choose to continue aging in place

- Serving as a liaison for various purposes within the care team
- Training and educating the patient’s family and caregivers (formal or informal) to reduce their risk of injury, aid in the bereavement process, and minimize negative emotional or physical experiences
- Providing individuals with a continued sense of autonomy over their time, health, and social engagement
- Acknowledging and incorporating spirituality, a search for meaning, and a sense of purpose into a person’s daily routines during all palliative care services

Some research has looked at how and why individuals seek out rehab-based palliative care services (OT and PT). In particular, palliative care patients most often reported fatigue (81%), impaired participation in physical activity (77%), difficulty carrying out daily activities and work duties (77%), persistent pain (72%), and anxiety or worry about their condition (58%). The same study also found that palliative care patients receiving OT and PT reported wanting services focused on engagement in physical activity (79%), participation in daily activities and work duties (77%), fatigue management (70%), pain management (65%), ability to concentrate (51%), and resolution or greater control over anxiety and worry related to one’s condition (51%). Of all the patients surveyed, 50% of the patients felt their symptoms were severe. This data cements some of the leading areas rehabilitation providers should assess and treat when working with someone through palliative care.

Overall, there is a lack of research on the intersection of OT and palliative care. The American Occupational Therapy Association (AOTA) has set forth general scope of practice information for OT’s work in end-of-life care, which encompasses both hospice and palliative care. This content is based directly on the most recent edition of the Occupational Therapy Practice Framework: Domain & Practice. However, there aren't many actual research studies conducted in the United States, since there are few OTs working in end-of-life care compared to other practice areas. The research that does exist overwhelmingly recommends that more OTs be involved in this specialty.

One study showed that OTs most commonly offered palliative care interventions in the areas of transfers, functional mobility, and hygiene. Their focus within these ADLs was on optimizing comfort and safety while enabling participation. As is common within the field as a whole, OTs working in palliative care reported one of the biggest barriers to their work was patient unfamiliarity with their role. They also faced many organizational obstacles that limited their work, which may point toward a need for greater integration of services within palliative care programs.

Another study, which was led by OTs, found that OT's role in end-of-life care (including both hospice and palliative care) was understandably most effective from a provider and patient standpoint when it focused on occupational performance. However, there is a lack of generally accepted outcome measures for OTs to use in end-of-life care, which can hinder therapists' ability to demonstrate the efficacy of the work they do.

Research on the work palliative care OTs do in other countries can be used to inform American practice. For example, a study on German OTs working in palliative care showed that 74% of therapists in this area offered interventions using the needs-based therapy model, 69% of OT providers trained family, caregivers, and other loved ones, 69% of OTs offered assistance with positioning through various means, and 66% of clinicians engaged their patients in relaxation-based modalities. Needs-based therapies are interventions based on the fulfillment of a patient's needs. The underlying principle of needs-based therapy is very much in alignment with the principles of palliative care and therapy as a whole: when a person's needs are met, they not only feel well, but also do well. Therapy using the needs-based framework goes beyond symptom management/relief and helps support patients in forming connections, expressing themselves creatively, being free, and finding meaning in life.

Qualitative research also shows that a therapist's personal experiences with loss play a large part in their decision to enter palliative care. This also influences the type of work palliative care therapists do, as this sort of connection with their work helps therapists continually develop the role and enables them to build patient skills during such a sensitive time. When a therapist gets a strong sense of fulfillment from their work, this has a notable impact on treatment outcomes. For this reason, most of the palliative care therapists surveyed validated the work they did and derived satisfaction from their job. Critical self-reflection has proven especially essential in this practice area, as it can solidify OT's role in palliative care as well as increase its utilization by those who need it.

Section 2 Personal Reflection

What impact might life-limiting illnesses have on occupational engagement? How can OTs minimize the negative effects and encourage participation?

Section 2 Key Words

Bereavement - The actual process of losing a loved one; this differs from grief, which is used to describe the cognitive, emotional, behavioral, and functional responses to the death of a loved one

Specialist in-reach - Members of a care team offering specialist care for patients they are already seeing, and the specialist comes to the patient (e.g. they go to the hospital if the patient is already admitted)

Specialist outreach - Members of a care team referring their patients to a specialist at another location for more concentrated care

Section 3: OT Evaluation for Palliative Care

References: 20, 21, 22, 23, 24

An occupational therapy evaluation within the palliative care realm serves several purposes. Firstly, evaluations of this nature involve in-depth functional and risk assessments. These two aspects should be central to the OT evaluation process. This not only ensures for patient safety, but helps therapists facilitate the patient's transition to their preferred location while making accommodations for medical, emotional, spiritual, and social needs. An OT evaluation should also help identify the complexities related to each patient's condition(s) as well as their caregiving situation and ability to engage in desirable activities.

As you can imagine, the occupational profile is an essential part of the OT evaluation process in palliative care. Since palliative care is especially holistic and patient-centered, the occupational profile will offer a wide breadth of information to guide a therapist in formulating the treatment plan. There are also a range of standardized assessment tools to supplement this information. Some of these assessments are specifically geared toward general well-being within the palliative care population while others assist with functional deficits and skill areas commonly impacted by life-limiting diagnoses.

Some of the main assessment areas covered by palliative care OT services include case management, symptom management, emotional responses to disease or disability, caregiver quality-of-life and caregiver burden or strain, spiritual participation, patient quality-of-life, and patient experience.

- Caregiver quality-of-life and caregiver strain or burden

  - Caregiver Impact Scale (used with caregivers of patients who have advanced cancer)
  - Caregiver Quality of Life Index – Cancer (used with caregivers of patients who have cancer)
  - Caregiver Reaction Assessment (used with caregivers of patients who are receiving palliative care)
  - Caregiver Strain Index (used with caregivers of patients who have symptomatic advanced cancer)
  - Caregiver's Burden Scale in End-of-Life Care (used with family caregivers of patients who have terminal cancer)
  - Family Appraisal of Caregiving Questionnaire for Palliative Care (used with caregivers of patients who are receiving palliative care)
  - NAT-CC – Needs Assessment Tool for Caregivers (used with caregivers of patients with chronic conditions)
  - Quality of Life in Life-Threatening Illness - Family Carer Version (used with caregivers of patients who are receiving palliative care for cancer)
  - Zarit Burden Inventory (used with caregivers of patients who have advanced conditions)
- Case management
  - Supportive and Palliative Care Indicator Tool (used with any person whose health is deteriorating and might benefit from palliative care planning, regardless of the services they may or may not already be receiving)

- Emotional responses to disease or disability
    - Beck Depression Inventory - Short Form (used with patients who have metastatic breast cancer)
    - Brief Edinburgh Depression Scale (used with patients who are receiving palliative care and have 6 months or less to live)
    - Brief Symptom Inventory (used with patients who have advanced diseases)
    - Distress Thermometer (used with patients who have advanced diseases)
    - General Health Questionnaire (used with patients who have advanced diseases)
    - Hospital Anxiety and Depression Scale (used with patients who are receiving palliative care and have 6 months or less to live)
    - Mental Adjustment to Cancer (used with patients who have a first-time diagnosis of breast cancer)
    - Two Single Items: "Are you depressed?" and "Have you lost interest?" (used with patients who are receiving palliative care)
- Environmental modifications
    - Community Health Environment Checklist - Mobility (CHEC-M)
    - Cougar Home Safety Assessment
    - Home Environment Lighting Assessment (HELA)
    - Home Falls and Accidents Screening Tool (Home FAST)

  - Home Occupation-Environment Assessment (HOEA)
  - Home Safety Self-Assessment Tool (HSSAT)
  - In-Home Occupational Performance Evaluation (I-HOPE)
  - In-Home Occupational Performance Evaluation for Providing Assistance (I-HOPE Assist)
  - Safety Assessment of Function and the Environment for Rehabilitation - Health Outcome Measurement and Evaluation (SAFER-HOME)
  - Westmead Home Safety Assessment (WeHSA)
- Patient experience
  - After Death Bereaved Family Member Interview (used with close relatives, surrogates, and caregivers who recently lost a loved one who received palliative care)
  - End of Life in Dementia- Satisfaction with Care & Comfort Assessment in Dying (used with dementia patients who are receiving palliative care or their healthcare proxies and caregivers after they have passed)
  - Family Assessment of Treatment of End-of-Life Survey (used with family members of patients who are receiving palliative care)
  - Family Satisfaction in the ICU (used with family members of ICU patients who are receiving palliative care)
  - Family Satisfaction with Advanced Cancer Care (used with caregivers and family members of patients with advanced cancer who are receiving palliative care)

  - Quality of Dying and Death (used with family members of patients who received palliative care before their death)
  - Quality of End-of-Life Care and Satisfaction with Treatment (used with patients who are receiving palliative care and their family members)
- Quality-of-life
  - Brief Hospice Inventory (used with patients who are in hospice)
  - Cambridge Palliative Audit Schedule (used with patients who are receiving palliative care)
  - Condensed Memorial Symptom Assessment Scale (used with patients who have cancer)
  - Demoralization Score (used with patients who have cancer)
  - Edmonton Functional Assessment Tool (used with patients who have cancer)
  - Edmonton Symptom Assessment Scale (used with patients who are receiving palliative care)
  - Emanuel and Emanuel Medical Directive (used with patients who are seriously ill)
  - European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire – Gastric Cancer Module (used with patients who have adenocarcinoma of the stomach)
  - European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire – Oesophageal Cancer Module (used with patients who have esophageal cancer)

- FACIT-Pal Functional Assessment of Chronic Illness Therapy-Palliative Subscale (used with patients who have life-limiting illnesses)
- Hospice Quality of Life Index (used with patients who are in hospice)
- Life Closure Scale (used with patients who are terminally ill)
- Life Evaluation Questionnaire (used with patients who have incurable cancer)
- McCanse Readiness for Death Instrument (used with patients who are terminally ill)
- McGill Quality of Life Questionnaire (used with patients who have life-threatening illnesses)
- McGill Quality of Life Questionnaire - Cardiff Short Form (used with patients who are terminally ill)
- McMaster Quality of Life Scale (used with patients who are receiving palliative care)
- Memorial Symptom Assessment Scale (used with patients who have cancer)
- Memorial Symptom Assessment Scale- Global Distress Index (used with patients who have cancer)
- Missoula-VITAS Quality of Life Index (used with patients who are terminally ill)
- Needs Assessment for Advanced Cancer Patients (used with patients who have advanced cancer)

  - Palliative Care Outcome Scale (used with patients who have advanced cancer)
  - Patient Autonomy Questionnaire (used with patients who are receiving palliative care for cancer)
  - Patient Dignity Inventory (used with patients who are nearing the end of their lives)
  - Problems and Needs in Palliative Care Questionnaire (used with patients who are receiving palliative care)
  - Problems and Needs in Palliative Care Questionnaire- Short Version (used with patients who are receiving palliative care)
  - Quality of Life at the End of Life (used with patients who are seriously ill)
  - Spiritual Needs Inventory (used with patients who are near the end of their lives)
- Spiritual participation
  - Beck Hopelessness Scale (used with patients who are receiving palliative care)
  - Bereavement Experience Questionnaire (used with bereaved adults)
  - Brief Grief Questionnaire (used with recipients of crisis counseling and bereaved community-dwelling adults)
  - Core Bereavement Items (used with bereaved adults)
  - Grief Evaluation Measure (used with bereaved adults)
  - Grief Experience Questionnaire (used with bereaved spouses)

  - Hogan Grief Reaction Checklist (used with parentally bereaved people)
  - Inventory of Complicated Grief (used with bereaved spouses)
  - Inventory of Traumatic Grief (used with elderly widowed residents and bereaved adults)
  - Ironson-Woods Spirituality/Religiousness Index (used with patients who have life-limiting conditions)
  - Marwit–Meuser Caregiver Grief Inventory (used with caregivers of people who have dementia, acquired brain injury, or cancer)
  - Marwit–Meuser Caregiver Grief Inventory - Short Form (used with adult caregivers of people who have dementia)
  - Prolonged Grief–12 (used with caregivers of hospice patients or people who have dementia)
  - Prolonged Grief–13 (used with bereaved caregivers who have prolonged grief disorder)
  - Revised Grief Experience Inventory (used with hospice caregivers following the death of a loved one)
  - Texas Revised Inventory of Grief (used with bereaved psychiatric outpatients and bereaved adults)
  - Two-Track Bereavement Questionnaire (used with bereaved adults)
  - Two-Track Bereavement Questionnaire - CG30 (used with bereaved adults whose loved one experienced a traumatic death)
- Symptom management

- Abbey Pain Scale (used with patients who have dementia and are non-verbal)
- ALS Functional Rating Scale (used with patients who have motor neuron disease)
- American Thoracic Society Division of Lung Diseases 1978 Dyspnea Scale (used with patients who have COPD or asthma)
- Braden Scale for Predicting Pressure Sore Risk (used with patients who are non-ambulatory, minimally ambulatory, or cannot independently shift weight)
- Breathlessness, Cough, and Sputum Scale (used with patients who have COPD)
- Cardiovascular Limitations and Symptoms Profile (used with patients who have ischemic heart disease)
- Chronic Heart Failure Questionnaire - Dyspnea Subscale (used with patients who have heart failure)
- Chronic Lung Disease Severity Index (used with patients who have chronic lung diseases)
- Chronic Respiratory Questionnaire - Dyspnea Subscale (used with patients who have COPD, interstitial lung disease, cystic fibrosis, motor neuron disease, or alpha antitrypsin deficiency)
- Confusion Assessment Method (CAM) (used with patients who are suspected to have delirium for any reason)
- Dyspnea Assessment Questionnaire (used with patients who have cancer)

- Dyspnea Descriptor Questionnaire (there are two separate versions: one to be used with patients who have heart failure and one for use with patients who have COPD)
- European Organization for Research and Treatment of Cancer Quality of Life Questionnaire - Lung Cancer supplement and breathlessness subscale (used with patients who have lung cancer)
- Faces Scale (used with patients who are ventilator dependent)
- Global Short of Breath Questionnaire (used with patients who have COPD)
- London Chest Activity of Daily Living Scale (used with patients who have COPD)
- Medical Research Council Dyspnea Scale (used with patients who have COPD, interstitial lung disease, asthma, and other conditions that cause dyspnea)
- Mini-Nutritional Assessment Short-Form (used with patients who are malnourished or are at risk of being malnourished)
- Modified Borg Breathlessness Scale (used with patients who have COPD, restrictive lung disease, or asthma)
- Modified Residents Verbal Brief Pain Inventory (M-RVBPI) (used with patients who are non-verbal)
- Motor Neuron Disease Dyspnea Rating Scale (used with patients who have motor neuron disease)

- Norton Pressure Sore Risk Assessment Scale (used with patients who are non-ambulatory, minimally ambulatory, or cannot independently shift weight)
- Numeric Rating Scale or Dyspnea Numeric Scale (used with patients who have cancer or COPD)
- Oxygen Cost Diagram (used with patients who have respiratory disease, COPD, or heart failure)
- Pulmonary Function Status and Dyspnea Questionnaire - modified (used with patients who have COPD)
- Rand Instrument (used with patients who have heart failure or respiratory disease)
- St. George's Respiratory Questionnaire (used with patients who have COPD, asthma, or bronchiectasis)
- University of Cincinnati Dyspnea Questionnaire (used with patients who have asthma, sarcoidosis, COPD, or cystic fibrosis)
- University of California San Diego Shortness of Breath Questionnaire (used with patients who have COPD, asthma, cystic fibrosis, or are post lung transplant)
- Visual Analog Scale (used with patients who have asthma, COPD, or are ventilator dependent)

A cultural assessment is another important aspect of an OT evaluation within palliative care settings. It's especially crucial for therapists to address culture during palliative care evaluation and treatment, as this allows diverse individuals to receive the care they are most comfortable with. In fact, research shows that non-white patients are far less likely to participate in palliative care measures and pain management during end-of-life. This further highlights the need for this part of an OT evaluation.

Cultural competence is key to understanding patients as well as their backgrounds, motivations, and beliefs, all of which impact the therapy process. Within palliative care, therapists must be aware of how individuals and their loved ones view pain, pain management, death, and where they spend the most time at the end of their lives.

Knowledge of a patient’s culture informs the work that a patient’s care team does. For example, in order to best do their job, nurses need to know whether or not patients want any pain medication and whether or not a patient is willing to spend time in an institution. If a patient declines all pain medication, this means the entire interprofessional team should focus on the education of alternative pain management strategies. Therefore, the entire team should be asking some of the following questions:

- How important is it that you remain mentally aware at the end of your life?
- What pain level are you willing to endure?
    - This question should be paired with any of the above pain assessments.
- What non-pharmacological pain management techniques are you willing to try or use?
    - This can be used to inform the next step in the treatment plan. Based on a patient’s answer to this question, the therapist may need to review all of the possibilities with the patient and make potential selections from there. If the patient has a few techniques in mind, but needs help implementing or scheduling them, the therapist can make goals accordingly.

- What are your preferences regarding how your medical information is shared – specifically with whom it is shared and what is shared with you?
- Is there anything you'd like me to know about how you and your family view serious illness?
- Would you prefer to make medical decisions yourself, would you like to collaborate with loved ones for this, or do you want your loved ones to make all decisions for you?
- Assess the need for a translator
- In your own words, can you repeat back to me what you just learned from your time with me?
- Are there certain medical or therapy treatments you would like to decline due to your cultural beliefs?
- Are there any practices or instructions you'd like your care staff to follow at the time of your death and immediately afterwards?
- Are there specific treatments you prefer to have in your own home rather than the hospital? If so, which ones?

While some individuals may decline pain medications for cultural or personal reasons, they should still receive education about pharmacological management. While always remaining sensitive and understanding of others' beliefs, therapists should inform individuals and their families about the ripple effect that pain can have. Many individuals may not be well-versed in the mind-body connection and may be unaware that decreasing physical pain with medication can assist in managing other manifestations of physical stress within the body as well as psychological discomfort. This type of education should be part of the evaluation process and can also extend throughout the treatment plan, if needed.

Kleinman and Campbell's Patient Explanatory Assessment Model allows therapists to better understand the beliefs their patients hold surrounding pain. This model asks the following questions:

- How severe is your pain?
  - Again, this should be paired with any of the above standardized assessments that address pain.
- What are the main concerns your pain has caused you?
- What do you believe caused this pain?
- What does your pain do to you in a functional, spiritual, emotional, mental, and physical sense?
- What do you fear the most about the pain you experience?
- What kind of treatment do you think you should receive?
- What kind of treatment do you want to receive?
- Why do you think your pain started when it did?

The Explanatory Model Interview for Pain Assessment is a structured interview for assessing cultural considerations. There is some overlap in questions when compared to the above outcome measure. However, since these are models and not standardized assessments, therapists can mix and match according to their patient's needs. This assessment includes the following questions:

- Do you have any fears about your pain? If so, what do you fear the most about your pain?
- Do you have family and friends that help you because of your pain? If so, who?

- Have you seen a traditional healer for your pain? Do you want one?
- How severe is your pain? Does it last a long or short time?
- What are the chief problems that your pain causes you?
- What cultural remedies have you tried to help address your pain?
- What do you call your pain? Have you given it a name? If so, why do you call it this?
- What does your pain mean to your body?
- What sort of treatment do you think you should receive? What results are the most important for you to see as a result of this treatment?
- Why do you think you have this pain?
- Within your social circle (family and friends), who do you talk to about your pain? What do they know about your pain? What do you want them to know about your pain?

Section 3 Personal Reflection

What combination of assessments might be most appropriate for a palliative care patient who is living with late-stage cancer and COPD?

Section 4: OT Interventions for Palliative Care

References: 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47

Occupational therapists are well-suited to address a range of concerns that palliative care patients may experience. OT intervention in the palliative care arena can cover any of the following areas:

- Cognitive exercises
    - OTs can offer cognitive exercises to help patients improve executive functions such as attention, memory, and comprehension. These exercises can be used as preparatory activities for functional training during sessions.
    - OTs can also provide patients with a range of cognitive activities as part of a home program, either to be completed on their own or with the help of caregivers.
    - There is little to no research on cognitive retraining for palliative care patients. Much of the literature in the broader realm of cognition and palliative care covers the use of cognitive behavioral therapy (CBT) for palliative care patients. This literature outlines the efficacy of CBT in improving pain management and regulating distressing emotions related to death and the end-of-life period.

- Coping strategies
    - Therapists may need to assist patients with both identifying and using coping strategies, so this type of intervention may range from education on potential strategies to using routines to assist with habit formation and adherence.
    - This can include simple coping strategies such as affirmations and distractions or more complex, interactive strategies such as productive leisure.
    - A systematic review found that home-based palliative care treatment has proven beneficial in improving problem-solving and coping in

    both patients with advanced cancer and their families.

    - A separate systematic review found that palliative care treatment was most effective when patients and their family members supported one another through mutual acknowledgment of shared challenges, positive thinking, and joint adaptation to shifting roles over time.

- Energy conservation
    - Some of the central aspects of energy conservation include the 4 Ps: prioritizing, planning, pacing, and positioning.
    - From there, therapists can help patients learn and employ specific energy conservation techniques to aid in each functional task they complete.
    - As part of energy conservation, therapists should emphasize body awareness and mindfulness principles. This will help patients recognize signs of fatigue or exacerbation so they can take rest breaks before those occur. Therapists should also encourage a greater frequency of rest breaks depending on the patient's condition, self-reported energy levels, and functional abilities.
    - An exploratory study looked at palliative care professionals' ability to manage fatigue in patients. Results found that, while there are no systematic approaches to fatigue management, professionals have found a high degree of value and efficacy in education, exercise, and energy conservation techniques.
    - A practice review looked at the efficacy of fatigue management strategies for patients with advanced cancer. Results showed that physical exercise was most effective in this realm, but that energy conservation techniques yielded similar benefits.

- Environmental modifications
    - Studies show that environmental design is crucial in end-of-life care. Therapists should ensure that environmental modifications encourage social interaction (e.g. improvement of visibility and line of sight to individuals around them), privacy, creation of a home-like environment and maximum personalization (e.g. optimization of natural and artificial light as well as temperature), an ambient environment (e.g. hiding medical equipment whenever possible and offering the patient a view of nature), and positive distractions.
    - For individuals with dementia who are also receiving palliative care, considerations such as low noise levels and careful use of contrasting colors within the physical environment should also be accounted for. In particular, these adjustments are associated with lower rates of verbal and physical aggression, restlessness, and wandering.
    - Environmental modifications should also focus on ease of access as well as reducing a person's fall risk.
    - There is a lack of research regarding environmental modifications in a general sense for patients receiving palliative care. However, existing research does focus on the use of environmental modifications to improve outcomes such as fall risk, fear of falling, and independence with patients who have late-stage dementia. These studies state that environmental modifications are most useful in this population and for these outcomes when combined with physical activity.
- Equipment recommendations
    - Individuals receiving palliative care may benefit from devices in several categories to help during the end-of-life period. OTs can

recommend durable medical equipment (DME) such as 3-in-1 commodes, rollators, front-wheeled walkers, and wheelchairs to assist with positioning, seating, and mobility during functional tasks. Patients receiving palliative care may also benefit from assistive technology to compensate for motor, sensory, or cognitive deficits they may be experiencing. Each of these devices can help maintain independence and preserve quality-of-life. Depending on the patient's financial status, medical condition, and cognitive abilities, therapists may recommend low-, mid-, or high-tech devices.

- A cross-sectional study looked at the topic of assistive devices and individuals with advanced cancer. Results showed that most individuals with advanced cancer used assistive devices for the sake of improving rest and facilitating proper positioning. More than 25% of the participants demonstrated the need for additional assistive devices and had lower ADL function as a result.
- A qualitative study looked at factors that impacted someone's use of assistive devices at the end of life. Participants (most of which had cancer or COPD) expressed more motivation to use equipment when it assisted with function, supported their interests, and enabled better participation. However, some participants associated equipment with their personal deterioration, which led to a disconnect from the devices. Caregivers viewed devices positively and found it improved the work they did. These are all factors therapists should address when recommending and training patients on assistive devices.
- Another study analyzed equipment requests made within home-based palliative care programs. Results showed the median time

between equipment implementation and patient death is 35 days. This suggests the timeliness of equipment recommendation should be expedited to maximize its benefit and usage.

- Joint protection
    - Joint protection strategies have a similar purpose as energy conservation techniques, which is to preserve someone's remaining abilities.
    - Joint protection strategies include body mechanics education. Some patients receiving palliative care may be unable to adhere to these recommendations on their own, so it's important to include caregivers in the training to encourage adherence. Proper lifting techniques also fall into this category and should be part of caregiver education. By using an ergonomic posture and technique, caregivers will avoid injuring themselves when assisting patients who cannot transfer or reposition independently.
    - There is little to no research regarding the use or effectiveness of joint protection strategies in the palliative care population. However, this is within an OT's scope of practice. Joint protection strategies can be beneficial not only to patients receiving palliative care but also their family, caregivers, and anyone else who is involved in their care.
- Pain management
    - While therapists cannot administer or recommend any type of pain medication (prescription or over-the-counter), they can educate patients on intended benefits of these drugs as well as side effects and mechanisms of action.
    - If patients decline traditional pain relief methods like medication or

    simply want additional ways to manage their pain, therapists can utilize physical agent modalities (PAMs) or complementary health approaches and integrative health (CHAIH). Some examples of PAMs include transcutaneous electrical nerve stimulation (TENS), iontophoresis, moist heat, and ice packs. CHAIH may include acupuncture, guided imagery, meditation, and more, most of which double as relaxation techniques. Some PAMs may be contraindicated with certain conditions and health concerns, so they may not be appropriate for all palliative care patients.

    - Some patients may opt to receive certain CHAIH modalities from dedicated professionals, such as Reiki healers. A few CHAIH modalities (such as acupuncture) require specialized training, so OTs should feel comfortable making referrals as needed.

- Patient and family advocacy
    - Many palliative care patients may have personal or medical difficulty speaking up if and when their needs are not being met. They may also struggle to verbalize their needs or recall the wishes they once had for end-of-life care. Therapists can assist in advocating for patients during this process and, again, making referrals to other team members such as care managers and social workers.
    - Advocacy is important in the palliative care arena, as the therapist serves as an expert, helps the patient become one with their care team, and can ascertain the value of palliative care and its essential place in someone’s health during the end-of-life period.
    - In addition to direct advocacy for people within patient care settings and related organizations, therapists can also engage in palliative care

advocacy on a larger scale. By gathering data related to unmet palliative care needs, identifying gaps in public policy, referencing existing legislation that pertains to palliative care, and getting involved in organizations that advocate for palliative care, therapists can indirectly impact accessibility of these services. Therapists can also encourage their supervisors or anyone else responsible for professional development at their organization to embed advocacy into their training efforts.

  - In order to effectively advocate for palliative care, therapists should know the influence that palliative care has on health inequities.

- Patient and family education
  - Patient and family education can cover any of the above areas. However, there is a wide range of topics therapists might educate patients and their families on. Community resources is one area that can help patients and their families. This may include suggesting respite care programs in the area, lending libraries with used durable medical equipment if insurance coverage or wait times are an issue, and support groups for patients and/or their families.
  - In addition to referral-based resources, therapists should also educate patients on home programs to preserve function, sleep hygiene, nutrition, positioning tips, and other strategies that can assist with safety and quality-of-life.
  - One randomized controlled study found that use of a palliative care educational video did not necessarily improve patients' knowledge or acceptance of palliative care services, but this learning medium did lead to triple the referral rate for palliative care programming. This

shows that, while educational videos may need to be customized based on the individual patient’s needs, they still show promise in terms of expanding palliative care services.

  - A systematic review was also conducted on educational videos and showed the content positively impacted patients’ care preferences, care planning, sense of emotional support, and ability to make informed decisions.
  - A different systematic review looked at palliative care education as a whole and discovered that most programs helped improve patient attitude, knowledge, and confidence in palliative care as well as patient satisfaction. This lends support to the idea that palliative care education should be all-encompassing in nature.

- Physical activity recommendations
  - Depending on the patient’s level of function, the best exercises part of their home program may be active range-of-motion or passive range-of-motion. Therapists should also take caregiver presence and assistance into consideration when recommending exercises.
  - A systematic review of non-pharmacological fatigue treatments found that physical exercise is one of the leading fatigue management techniques for patients with advanced cancer. There were many variations of physical activity studied, so this review did not identify clear guidelines for exercise in this population.
  - Another piece of research looked at physical activity benefits for individuals with advanced cancer. Results showed improvements in areas such as functional performance, quality of life, and fatigue management along with improvements in objective testing for

  physical function and fitness levels. While there are no clear guidelines to govern exercise in this population, literature lauds the benefits of activity versus inactivity to prevent deconditioning.

  - A different study looked more so at the impact of specific types of exercise on those with advanced cancer. Participants engaged in aerobic, resistance, mixed-mode, or other exercises for between 2 weeks and 6 months. When the results were compared to usual care, researchers found no significant differences in risk of adverse events related to exercise. Retention rates were the highest in the resistance exercise group, and members in all groups demonstrated positive results in the areas of fatigue, quality of life, aerobic fitness, and lower-body strength.

- Relaxation techniques

  - One study has shown that progressive muscle relaxation yielded a significant reduction in pain levels of individuals with cancer who were receiving palliative care.

  - Another comparative study looked at the differences between relaxation groups and reflexology in terms of their effects on patients with cancer who are receiving palliative care. The study showed that both modalities were effective in decreasing depression and anxiety, but reflexology was more beneficial in increasing quality of life and managing pain than relaxation groups.

  - Some research has looked at how virtual reality interventions compare to traditional relaxation techniques for individuals in palliative care programs. Studies have found that virtual reality-based therapies have significantly reduced symptoms of distress (emotional and physical) in palliative care patients.

  - There is some research regarding the use of deep breathing, guided imagery, meditation, gentle massage and healing touch modalities, and music-based interventions for patients receiving palliative care services. However, much of the literature regarding these areas is either dated or too general to inform practice.
- Seating and positioning recommendations
  - There is not much research in the realm of seating and positioning related to palliative care. However, seating and positioning are both very much within an OT’s scope of practice.
  - Seating and positioning can both assist patients with improved comfort, injury prevention, and maintenance of range of motion.
- Task adaptation
  - Task adaptation is the crux of the OT profession. This is another area that is lacking research as it pertains to palliative care. However, task adaptation stands to improve occupational performance, feelings of independence, and quality of life in patients receiving palliative care.

Section 4 Personal Reflection

What OT intervention would be most appropriate as a first-line therapy for a 41-year-old who just got diagnosed with cancer and has not left her bed for over a week?

Section 4 Key Words

Complementary health approaches and integrative health (CHAIH) - A wide array of products and practices outside of conventional medicine; CHAIH is divided into two groups: natural products and mind-body practices

First-line therapy - The first treatment provided for any disease

Physical agent modalities (PAMs) - Any intervention that uses a physical agent (or source of energy) to address client factors; in rehabilitation therapies, physical agent modalities are used in a preparatory manner to improve circulation, movement, and edema before other interventions

Section 5: Case Study #1

An OT working in a long-term care facility is scheduled for their initial session with a 53-year-old woman who was diagnosed with mild Parkinson's disease 1 month ago. This patient was referred to palliative care 2 days ago, and OT will be the first skilled service she receives since that time. The patient is also new to the long-term care facility aside from having a brief stay in the skilled nursing portion of the building 10 years ago for a hip replacement. Prior to being admitted 2 days ago, she was living at home with her spouse, who needed to offer more and more care leading up to the patient's diagnosis. From the moment the patient saw the therapist, it became apparent that her focus was on continuing to apply makeup, put on clothing of her choice, and maintaining her skincare routine each day. The therapist started things off by discussing what products the patient uses, how they make her feel, how much help she needs with this process, and what this routine typically entails at home.

1. What will be an important part of this patient's palliative care OT evaluation?

2. When completing this patient’s occupational profile, what important questions should the OT ask?
3. What would be an appropriate client-centered goal for this patient?

Section 6: Case Study #1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What will be an important part of this patient’s palliative care OT evaluation?

   Since OT is the first skilled service this patient will receive under the heading of palliative care, the therapist should ensure education is at the forefront during the evaluation. The OT should be sure any family, caregivers, and other relevant parties are present during this session, not only to benefit from the education, but also to help with answering questions to round out the evaluation. The OT should focus on giving a robust, but comprehensible description of what palliative care is and what the patient should expect. It’s recommended that the OT use various mediums - videos, handouts with appropriate imagery, and contact information for the OT as well as other members of the palliative care team. Due to the nature of their diagnosis, the patient would also benefit from having the contact information posted somewhere visible in their room. The OT should not only offer general information about palliative care and its intent, but also describe how OTs are able to assist during this time.

2. When completing this patient’s occupational profile, what important questions should the OT ask?

Since the OT is the first member of the palliative care team to see this patient, the occupational profile will prove very important in informing other members what to expect. While the OT doesn't have the time or the need to ask questions pertaining to others' scope of practice, they can address basic, but vital information they will need to do their jobs. Some questions that would be especially beneficial as part of this patient's occupational profile include:

- What major life achievements, experiences, or milestones do you find value in?
- What activities do you most like to do?
- What roles do you find personally meaningful?
- How has your participation in these activities and roles changed over the years, if at all? How has that participation changed in the last month?
- Do you find you're still able to participate in those activities and roles? If not, what areas do you have the most trouble with?
- Are you interested in exploring other activities to participate in?
- What places do you spend most of your time? Home, friend's homes, community?
- What type of activity engagement would improve your quality of life?

3. What would be an appropriate client-centered goal for this patient?

This patient has expressed a strong preference for being highly involved and adhering to her daily beauty routine. This would be an excellent goal, as the

OT can focus on hygiene and grooming as it pertains to her daily routine. The OT can then use this as an opportunity to build rapport with the patient, learn about other areas of need, and inform the treatment process moving forward.

Section 7: Case Study #2

When working in a home-based palliative care program, an OT begins treating a 72-year-old man with advanced prostate cancer. This man lives in a two-story home and was diagnosed 3 months ago, which is when he began most palliative care services. However, he is just now seeing an OT due to staffing shortages in the area. This patient continues to be ambulatory with the help of a cane (and sometimes a walker, depending on his balance and fatigue) and is experiencing some mild cognitive impairments. He is also dealing with severe depression and difficulty coping with his condition, particularly due to fears over what will happen with his disabled adult son, who he is the primary caregiver for. His son still lives in the home with him and other family members have been pooling resources to assist with his care. His son has also demonstrated fear of seeing his father in this state, so he has not been interacting with him much since he started deteriorating.

1. What client-centered goals would be most appropriate for this patient?
2. What environmental modifications might this patient benefit from?

Section 8: Case Study #2 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What client-centered goals would be most appropriate for this patient?

   This patient has expressed a lot of concern over the care of his son, so a goal surrounding caregiving would be ideal. Since the patient is also experiencing depressive symptoms, a goal surrounding emotion regulation, use of spirituality, and/or coping strategies could be of interest.

2. What environmental modifications might this patient benefit from?

   Since this patient is ambulatory with an assistive device, is still living within his home, and is experiencing some mild cognitive concerns, environmental modifications would be a great intervention for the OT to offer. The patient would benefit from training on his new walker and cane as well as modifications to turn the house into a first-floor setup. The OT should also work with the patient to make thoughtful changes to the home to decrease the likelihood of falls, which can cause further complications and further limit his independence.

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