

Profile of speech therapy in oncology and palliative care residency program at an oncology referral hospital

Perfil da atuação fonoaudiológica na residência oncológica e em cuidados paliativos em um hospital de referência em oncologia

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ABSTRACT

Introduction: Hospital environments are among the different professional contexts in which speech therapists can work. Patients with cancer or at their final stage of life are eligible for speech therapy intervention. Based on this premise, a program called *Residência Multiprofissional em Saúde* was created focusing on Oncology-Palliative Care.

Objective: This study aimed to analyze the assistance provided by speech therapists in the scope of a multiprofessional residency program at an oncology referral hospital.

Methods: The documentary research was based on a retrospective qualitative-quantitative approach. A sample of 344 medical records were analyzed using a form containing open and closed questions as part of the study.

Results: All data were organized in spreadsheets and submitted to statistical treatment using the chisquared test and the G-test. Only 67 patients were evaluated by speech therapists, and among these only 16 underwent rehabilitation. Functional evaluation of swallowing was the most frequent evaluation method found in the analyzed medical records (9.30%), tactile-thermal-stimulation was the most used therapeutic method in speech therapy (2.03%), and most patients had no clinical evolution with speech therapy (1.74%).

Discussion: It is possible to observe a variation in the types of evaluation performed, which makes the evaluation an even more subjective process, increasing the risks of diagnostic confusion. Health services managed based on quality management advocate standardized care, with the implementation of protocols, forms, indicators and care flows; features that have not yet been implemented or developed in current palliative practice.

Conclusion: Results suggest that there is a fragmentation in the structure of the Speech Therapy Service, which is directed especially towards swallowing disorders, thus evidencing the need for a systematization of speech therapy assistance provided to PC patients.

Keywords: Speech Therapy; Palliative Care; Medical Oncology.

RESUMO

Introdução: Dentre os diversos contextos em que o profissional de Fonoaudiologia pode atuar, um é o âmbito hospitalar. Pacientes com câncer ou em fase final de vida também se configuram como indivíduos elegíveis para a intervenção fonoaudiológica. Com base nesta premissa, surgiu a Residência Multiprofissional em Saúde com foco em Oncologia-Cuidados Paliativos.

Objetivo: Este estudo teve como objetivo analisar a assistência prestada pelo profissional fonoaudiólogo na Residência Multiprofissional em Saúde de um hospital de referência em oncologia.

Métodos: A pesquisa documental foi de abordagem qualitativa-quantitativa, de caráter retrospectivo. Para tanto, fizeram parte do estudo a amostra com 344 prontuários analisados por meio um formulário, contendo perguntas abertas e fechadas.

Resultados: Após os dados serem organizados em planilhas os mesmos foram submetidos ao tratamento estatístico pelo Teste Qui-quadrado e Teste G. Apenas 67 pacientes foram avaliados por fonoaudiólogos, sendo que, destes, somente 16 foram submetidos à reabilitação. A avaliação funcional da Deglutição foi o método avaliativo mais frequente encontrado nos prontuários analisados (9,30%), a Estimulação Tátil-Térmica foi o método terapêutico mais utilizado em fonoterapia (2,03%) e a maioria dos pacientes não teve evolução clínica com o atendimento fonoaudiológico (1,74%).

Discussão: É possível observar uma variação nos tipos de avaliação realizada, o que torna a avaliação um processo ainda mais subjetivo, aumentando os riscos de confusão diagnóstica. Os serviços de saúde geridos com base na gestão da qualidade preconizam atendimento padronizado, com implementação de protocolos, fichas, indicadores e fluxos assistenciais; recursos que ainda não foram executados ou desenvolvidos na prática paliativa atual.

Conclusão: Assim, há uma fragmentação no serviço de Fonoaudiologia, sendo este direcionado especialmente para os distúrbios de deglutição. Fica evidenciado a necessidade de uma sistematização da assistência fonoaudiológica prestada aos pacientes em cuidados paliativos.

Palavras-chave: Fonoaudiologia; Cuidados Paliativos; Oncologia.

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INTRODUCTION

Speech Therapy is among the various professional categories found in a hospital environment. It is a professional area that can contribute to the good evolution of patients' clinical condition and to their hospital discharge.

As professionals who are part of a hospital environment, speech therapists have to adapt themselves to a new reality, starting to deal with death and life, and having in mind that the intervention they provide can lead to one situation or another¹.

One of the areas in which speech therapists can intervene, although still little explored, is Palliative Care (PC). Within the PC philosophy, the term "terminal patient" falls into disuse because it is used in a stereotyped way, supporting an idea that "there is nothing to be done", which may lead to a process of disinvestment in patient care².

With the advancement of scientific technology, the population's life rate has increased, also increasing the morbidity rate, that is, the number of people alive grew, but so did the number of patients who are not cured³. Admitting that a treatment is useless in face of a terminal ill condition seems to be inhumane and wrongly hurts human dignity⁴.

Speech therapy in PC consists of a unique segment of very productive performance, however, not widespread and well understood by Speech-Language Pathologists (SLPs).

The practice of Palliative Care can be interpreted as a philosophy of care and protection, where the main objective is to offer a supportive atmosphere to help patients reach death as actively as possible and with quality.

As the PC philosophy has been described so far, it is important to understand cancer: Cancer is a group of diseases characterized by the abnormal growth of cells caused by internal or external agents. The transformation of the normal cell into cancer occurs through changes in its DNA with the participation of viruses, the appearance of the environment or in virtue of food or physical agents, such as some types of radiation⁶.

The difficulty or inability of the patient to eat means, in many cases, the worsening of health⁷. Loss of the ability to feed oneself often accompanies the death process⁸. The speech therapist, in this perspective, helps to minimize the feeling of failure around eating⁹, because through efficient swallowing it is possible to optimize the patient's quality of life (QL)¹⁰, developing motivation, comfort and the pleasure of eating¹¹.

Attempts to restore a patient's oral feeding function should always be done by the speech therapist, given that eating is something pleasurable for the individual, not only for the ingestion of tasty, fragrant and visually pleasant foods,

but for the social act itself and for everything it generates around that moment¹⁰.

Many of the pathologies that require PC alter swallowing and communication functions throughout their evolution, resulting in a compromised QL of the patient and their families⁸. The objective of the speech therapist in PC is to provide the possibility of communication between the patient and their family, preserving the pleasure of oral feeding in a safe way¹².

In the residency program, the speech therapist cooperates with other professionals who work at the *Clínica de Cuidados Paliativos Oncológicos* (CCPO). The multidisciplinary team does not aim to provide care regarding only the mechanical aspects of the swallowing function, but also other aspects that can have a significant impact on dysphagia, such as positioning, cervical mobility, environment, independence, nutritional support, general health and emotional state¹³.

In PC, essential care must be provided to the patient, such as nutrition, hydration and hygiene, so that death can occur in its natural course and with dignity¹⁴.

The caregiver has a feeling of anguish when the patient is not able to eat orally and, therefore, has many questions about alternative nutrition, in addition to the patient showing resistance to accepting it¹². It is up to the speech therapist professional to explain the advantages and disadvantages of each alternative feeding method, thus trying to reduce the anguish and suffering of the patient and their family⁸. Providing comprehensive care to patients and their companions is part of the practice of SLPs residents in PC.

In cases when the patient cannot ingest food orally but desires to do so, their will is prioritized as far as possible, since this patient is on PC. Offering food and liquids to the dying patient is synonymous with humanity and compassion⁷.

The fact that all professionals see the patient at different times does not exclude the effective work of an interdisciplinary team, provided that everyone is available and attentive to the close contact among them. As stated by Mello (2003, p. 18), "cada serviço tem uma dinâmica própria, mas ao interagirem entre si e devidamente ajustados, produzem um funcionamento equilibrado, cumprindo o principal objetivo do hospital, o da promoção de saúde e recuperação do indivíduo"¹⁵.

In addition to Speech Therapy, currently there are many different areas in the PC team that contemplates residency in Palliative Care, such as: Nursing, Physiotherapy, Nutrition, Psychology, Occupational Therapy and Social Service.

For the speech therapy work to be done in the best possible way in the hospital environment, it is necessary, first, to understand the dynamics of a hospital¹⁵. Based on

this aspect, it is important to understand the work of the speech therapist in a PC unit.

This study aimed to analyze the assistance provided by the speech therapist professional as part of a Multiprofessional Residency Program on Oncology and Palliative Care at an oncology referral hospital.

METHODOLOGY

The primary focus of the residency program at the Ophir Loyola Hospital is to provide assistance to cancer patients and PC patients. In the Multiprofessional Residency program, the work takes place in particular at the *Clínica de Cuidados Paliativos Oncológicos* (CCPO). This clinic has ten beds distributed in four wards for patients with different pathologies, including those with cancer at different stages of the disease.

This documentary research consisted of a retrospective case study based on a qualitative-quantitative approach. To this end, after approval by the Ethics and Research Committee (CEP) under number 1,223,739, the Medical Archive and Statistics Division (DAME) (*Divisão de Arquivo Médico e Estatísticos*) during the period from March 2012 to October 2015 in the morning. A script was prepared to assist in the analysis of medical records ([Supplementary Material](#)).

As an inclusion criterion, we considered the medical records of patients of both sexes admitted to the CCPO from March 2012 to October 2015, regardless of color, age, creed, race or diagnosis. A total of 403 patient medical records were accessed. Among those records, 55 records were excluded because they corresponded to patients admitted to the CCPO, but who were not eligible for PC. From the remaining 348 records of PC patients admitted to the CCPO, four records corresponded to patients hospitalized in 2010, who were also excluded from the survey, because the residency program in oncology-palliative care had begun in 2012. In short, the sample consisted of a total of 344 medical records of PC patients admitted to the CCPO from 2012 to 2015.

Initially, data from medical records were tabulated and organized in Excel spreadsheets. Then, they were submitted to percentage and statistical analysis according to the research objectives, using the chi-squared test and the G-test.

RESULTS

After having evaluated 344 medical records of patients admitted to the PC clinic at the Ophir Loyola Hospital, we found that 63.37% were female (24/107) and 36.63% were male (18/93), with a mean age between both the genders of 58.02 years and the minimum and maximum ages of 18 and 107 years, respectively.

From the total sample of medical records analyzed, records of speech therapy care were found in only 67 records (19.48%).

Among the medical records in which records of speech therapy consultations were found, there were patients who had not been evaluated. We sought to identify the reason for that lack of evaluation. It can be observed in [Table 1](#) that 6 patients (13.95%) were not evaluated for not having complaints regarding dysphagia; 5 patients (11.62%) for using an open nasogastric tube at the moment; 2 patients (4, 65%) because they were drowsy; 1 patient (2.32%) for having a reduced level of consciousness and for breathing with the aid of macro nebulization; 1 patient (2.32%) for having a severe clinical picture, with the absence of justification in 27 cases (62.79%).

Table 1. Profile of the Speech-Language Pathology and Audiology service, referring to the justification of patients who were not evaluated from 2012 to 2015.

Justification	Quantity	Percentage
No complaint	6	13.95
Open probe	5	11.62
Somnolence	2	4.65
Lowered level of consciousness and macro nebulization	1	2.32
Critical patient	1	2.32
No indication	1	2.32
No justification	27*	62.79
Total	43	100.00

*p < 0.05 (G-test; p < 0.0001)

Source: Field research

[Table 2](#) shows the type of specific assessment performed. The assisted oral assessment was the most common assessment found in the medical records, being present in 31 cases (9.01%), followed by the Orofacial Motricity Assessment, present in 30 cases (8.72%), and functional evaluation of swallowing, present in 32 cases (9.30%). The types of assessments performed less frequently in the CCPO were Pain assessment, with a frequency of only 1 case (0.29%), and Blue Dye Test, with a frequency of 1 case as well (0.29%).

From the 67 patients evaluated, only 16 received speech therapy. [Table 3](#) shows the techniques used during speech therapy for these 16 patients undergoing rehabilitation. Tactile-thermal stimulation was the most used therapeutic technique in therapy, being present in the consultations of 7 patients (2.03%), followed by swallowing maneuvers (1.45%). The least used therapeutic method corresponded to vocal speech therapy, being used in only 1 case (0.29%).

Table 2. Profile of the Speech-Language Pathology and Audiology service, referring to the evaluation method from 2012 to 2015.

Assessment performed	Answer				Total	%	*p-value
	Yes	%	No	%			
Assisted Oral	31	9.01	313	90.99	344	100.00	< 0.0001
Orofacial Motricity	30	8.72	314	91.28	344	100.00	< 0.0001
Swallowing	32	9.30	312	90.70	344	100.00	< 0.0001
Voice	16	4.65	328	95.35	344	100.00	< 0.0001
Cervical Auscultation	8	2.33	336	97.67	344	100.00	< 0.0001
Blood Saturation	12	3.49	332	96.51	344	100.00	< 0.0001
Respiratory frequency	15	4.36	329	95.64	344	100.00	< 0.0001
Cardiac frequency	6	1.74	338	98.26	344	100.00	< 0.0001
FOIS** scale	5	1.45	339	98.55	344	100.00	< 0.0001
DOSS*** scale	2	0.58	342	99.42	344	100.00	< 0.0001
Mallampati classification	1	0.29	343	99.71	344	100.00	< 0.0001
KPS**** scale	2	0.58	342	99.42	344	100.00	< 0.0001
Pain scale	1	0.29	343	99.71	344	100.00	< 0.0001
Blue dye Test	1	0.29	343	99.71	344	100.00	< 0.0001

*p < 0.05 (chi-squared test).

Functional Oral Intake Scale; *Dysphagia Outcome and Severity Scale; ****Karnofsky Performance Status.

Table 3. Profile of the Speech-Language Pathology and Audiology service, referring to the therapeutic technique from 2012 to 2015.

Phonotherapy	Answer				Total	%	*p-value		
	Yes	%	No	%					
Tactile-thermal stimulation	7	2.03	9	2.62	328	95.35	344	100,00	< 0.0001
Tactile-thermal-gustatory stimulation	4	1.16	12	3.49	328	95.35	344	100,00	< 0.0001
Gustatory Stimulation	4	1.16	12	3.49	328	95.35	344	100,00	< 0.0001
Myofunctional Orofacial Motricity	3	0.87	13	3.78	328	95.35	344	100,00	< 0.0001
Swallowing maneuver	5	1.45	11	3.20	328	95.35	344	100,00	< 0.0001
Vocal phonotherapy	1	0.29	15	4.36	328	95.35	344	100,00	< 0.0001
Therapy Taping	2	0.58	14	4.07	328	95.35	344	100,00	< 0.0001
No indication	4	1.16	12	3.49	328	95.35	344	100,00	< 0.0001

*p < 0.05 (G-test).

Source: Field research.

With regard to the evolution achieved following speech therapy, it is possible to observe in Table 4 that from the number of patients submitted to speech therapy 6 (1.74%) did not present any evolution, but others presented different

types of evolutions, such as diet release by oral route (n=2), improvement in vocal intensity (n=1), decrease in the pathological reflex (n=2), decrease in the aspiration procedure by the physiotherapy team (n=1), and consistency evolution (n= 1).

Table 4. Profile of the Speech-Language Pathology and Audiology service, referring to the speech-language pathology evolution from 2012 to 2015.

Speech Therapy Evolution	Amount	Percentage
None	6	1.74
From enteral to exclusive oral diet	2	0.58
Saliva swallowing, suction, vocal intensity, absence of signs of laryngeal penetration	1	0.29
From enteral diet to mixed diet	1	0.29
Consistency evolution	1	0.29
More swallows, decreased bite reflex, and more oral manipulation	1	0.29
More swallows, decreased bite reflex and more oral manipulation, decreased aspirations	1	0.29
No registry	331*	96.22
Total	344	100.00

*p < 0.05 (chi-squared test; p < 0.0001)

Source: Field research

DISCUSSION

One of the speech therapist's technical competences in a hospital environment is the management of food consistency for patients with dysphagia. Therefore, it is through the clinical findings observed in the evaluation process that the speech therapist can suggest changes in food consistency, ensuring a safe diet and protection of the airways. Therefore, in order for the speech therapist to prescribe or manage such changes it is first necessary to carry out an evaluation¹⁶.

Contrary to what is imagined, not every PC patient has some difficulty in eating – to the point of depending on an alternative feeding route (nasogastric or nasoenteral tube, gastrostomy, jejunostomy or parenteral diet). Our data clearly show that 6 patients (13.95%) were not evaluated because they did not present complaints regarding dysphagia, that is, they did not present a speech-language pathology demand from the swallowing point of view. In a research also carried out at the CCPO, in which it was sought to analyze the swallowing of hospitalized patients, this author found that 59.9% of the individuals ate exclusively orally, but with restrictions¹⁷.

PC patients will inevitably evolve to death, which means that at some point, the swallowing impairment will be present; therefore, speech therapy intervention was necessary. Critically ill patients correspond to a group with multiple risk factors for food aspiration¹⁸. In the present study, the Speech-Language Pathology team did not see the majority of patients (80.52%).

Monitoring the patient's vital signs is important to verify the most appropriate time for action, and can contribute in the best possible way, without putting the patient's life at risk, making it necessary to evaluate these parameters before and after speech therapy intervention^{19,20} since the patient's clinical status tends to worsen as death approaches²¹.

Among the patients evaluated by the Speech-Language Pathology and Audiology service, it is possible to observe a variation in the types of evaluation performed, that is, there was no standardization of the evaluation method, which makes the evaluation an even more subjective process, increasing the risks of diagnostic confusion. Quality management-based health services recommend standardized care, with the implementation of protocols, forms, indicators and care flows, resources that have not yet been performed or developed in the current palliative practice.

There is a fragmentation in the Speech-Language Pathology service at the CCPO, since not all hospitalized patients received care from this medical specialty, although there are residents and preceptors in that clinic. Against this background, relevant questions arise, such as: Why is not every patient evaluated by a speech therapist at the CCPO? What are the criteria for a patient to be considered "eligible" for speech therapy? Why not all patients who present demand for such care were submitted to speech therapy? To what extent can the condition of a PC patient improve from a speech-language pathology point of view? To what extent is it pertinent to recommend therapy to patients whose philosophy of care surrounding proposes not to evolve/treat but to control the symptoms instead?

Although not all patients have undergone speech therapy, the role of the speech therapist in the process of adapting the swallowing function of PC patients should not be ignored. Among the benefits of speech therapy is the reduction of the negative effects of muscle atrophy and reduction of oropharyngeal structures²².

The tactile-thermal stimulation can be considered an important technique for the rehabilitation of the swallowing function in the dysphagic patient. Tactile-thermal stimulation is used to stimulate intraoral sensitivity, to improve the oral

preparatory phase and to prevent extraoral leakage²³. In the present study, this technique was the most used by speech therapists at the CCPO (2,03%).

The swallowing mechanism can be modeled by sensory stimuli, such as gustatory stimuli that increase salivation, therefore facilitating swallowing²⁴. These authors also argue that foods of different consistencies, temperature and flavor excite various types of sensory fibers that innervate the oropharyngeal mucous membrane.

Regaining the ability to swallow, even in minimal volumes, can mean the recovery of health and physical and psychosocial well-being for the patient²³.

The importance of speech therapy work with PC patients is justified by providing quality of life while helping to reintroduce oral diet¹⁶. In this study, 3 patients were able to resume oral feeding, being 2 exclusively orally (0.58%) and 1 on a mixed diet (0.28%). In addition, 1 patient (0.28%) had the possibility to re-experience foods of different consistencies through the evolution of consistency, which allows us to infer that the comfort/pleasure to which food is related was possible to be guaranteed to these patients with a reserved prognosis, thus implying a better quality of life/death.

CONCLUSION

The findings of this study indicate that the speech therapy assistance provided by the professional speech therapist in the Multiprofessional Residency Program on Oncology and Palliative Care is fragmented, not standardized with regard to interventions and procedures, and not yet based on scientific evidence, implying on severe risks for a comprehensive care management and lack of good practices for end of life patients.

As the clinic residency is a program within an oncology hospital, it is necessary that the SLPs have knowledge about the peculiarities of cancer, as well as its treatment modalities and implications for communication and vital functions of the human being.

Most hospitalized patients are not treated by speech therapists, and those who are evaluated did not receive therapy. In addition to the speech therapy evolution being difficult, the Speech-Language Pathology service at CCPO is especially directed to swallowing disorders.

It is important to emphasize that this study did not propose to highlight the negative points of the Speech-Language Pathology service at the CCPO, but rather to briefly discuss the present reality of the service in this clinic. It is believed that this specialty is fundamental for the proper functioning of the CCPO, and could improve the performance of the service.

It is evident, then, the need to restructure the fragmented service of Speech-Language Pathology and Audiology currently available and to promote the construction of a systematic service of screening, evaluation, diagnosis and treatment of dysphagia and other disorders that require the competence of the SLPs. It is recommended the creation and use of a Standard Operating Protocol for the Speech-Language Pathology service in palliative care.

Perhaps the Speech-Language Pathology service is still far from an ideal model. However, with dedication and good will of professionals who always seek to improve their practice, assistance and service, it will be possible to succeed in our ultimate goal: the well-being of the patient and their family.

The Multiprofessional Residency routine involves an exclusive dedication and obligatory 60 hours per week split into theoretical classes and care assistance. In spite of the difficulty of flexible schedules for accessing the medical records this study aimed to provide practical knowledge on the role of speech therapists with patients with no prospects of cure, in addition to enriching the theoretical contributions of the role of speech therapists with PC patients. Thus, this research has gathered some elements for reflection on the service in palliative care, proposing a methodologically structured practice in palliative care for speech therapy, aiming at service excellence and improvement of the assistance provided, therefore contributing to the professional training of residents.

DEDICATION

In memory of Jorge Leão, and in recognition of my fellow speech therapists who are interested in the subject and who allow themselves to venture beyond the realms of palliative care and who, like me, have felt and feel doubts and insecurity when exploring this new area of activity.

REFERENCES

1. Oliveira ST. Ética e bioética na atuação fonoaudiológica em hospitais. In: Oliveira ST, organizators. Fonoaudiologia hospitalar. São Paulo(BR): Lovise; 2003. p. 29-32.
2. Kovács MJ. Comunicação nos programas de cuidados paliativos: uma abordagem multidisciplinar. In: Pessini L, Bertachini L, editors. Humanização e cuidados paliativos. São Paulo(BR): Edições Loyola; 2004. p. 275-89.
3. Chaves JHB, Mendonça VLC, Pessini L, Rego G, Nunes R. Cuidados paliativos na prática médica: contexto bioético. Rev Dor. 2011 Jul-Sep;12(3):250-5. <https://doi.org/10.1590/S1806-00132011000300011>.
4. Moreira MJ S, Guimarães MF, Lopes L, Moreira F. Contribuições da Fonoaudiologia nos Cuidados Paliativos e no fim da vida. CoDAS. 2020;32(4):e20190202. <https://doi.org/10.1590/2317-1782/20202019202>
5. Cruz FC, Williams EMO, Denuncci MAM. Atuação fonoaudiológica nos cuidados paliativos de pacientes com a doença de Alzheimer. Rev In Int Fo Odon. 2021;2(1):58-76. <http://www.revistas.uniflu.edu.br:8088/seer/ojs-3.0.2/index.php/interface/article/view/411>.

6. Angelis EC et al. Atuação fonoaudiológica no câncer de cabeça e pescoço. In: Oliveira ST, organizator. Fonoaudiologia hospitalar. São Paulo(BR): Lovise; 2003.
7. Benarroz MO, Faillace GBD, Barbosa LA. Bioética e nutrição em cuidados paliativos oncológicos em adultos. *Cad Saúde Pública*. 2009;25(9):1875-82. <https://pesquisa.bvsalud.org/portal/resource/pt/lil-524812>.
8. Taquemori LY. Fonoaudiologia. In: Oliveira RA, organizator. Cuidado Paliativo. São Paulo(BR): Conselho Regional de Medicina do Estado de São Paulo; 2008. p. 64-66.
9. Pinto AC. Papel do fonoaudiólogo na equipe de cuidados paliativos. In: Academia Nacional de Cuidados Paliativos. Manual de cuidados paliativos. Rio de Janeiro(BR): Diagraphic; 2009. p. 234-6.
10. Moschetti MB. Disfagia orofaríngea no Centro de Terapia Intensiva – CTI. In: Jacobi JS, Levy DS, Silva LMC, organizators. Disfagia: avaliação e tratamento. Rio de Janeiro(BR): Revinter; 2004. p. 209-24.
11. Silva LMC, Jacobi JS. Disfagia orofaríngea e sua importância na pneumologia. In: Jacobi JS, Levy DS, Silva LMC, organizators. Disfagia: avaliação e tratamento. Rio de Janeiro(BR): Revinter; 2004. p. 163-80.
12. Calheiros AS, Albuquerque CL. A vivência da fonoaudiologia na equipe de cuidados paliativos de um hospital universitário do Rio de Janeiro. *Rev Hosp Univ Pedro Ernesto*. 2012;11(2):94-8. <https://www.e-publicacoes.uerj.br/index.php/revistahupe/article/view/8950>.
13. Santana PPC, Silva JR, Matias TF, Silva GCA, Ribeiro WA, Andrade M. Atuação fonoaudiológica a pacientes em cuidados paliativos: uma revisão integrativa. *Res Soc Dev*. 2020;9(8):e108985464. <https://doi.org/10.33448/rsd-v9i8.5464>.
14. Jacinto-Scudeiro LA, Ayres A, Olchik MR. Tomada de decisão: papel do fonoaudiólogo em cuidados paliativos. *Distúrbios Comun*. 2023;31(1):141-6. <https://doi.org/10.23925/2176-2724.2019v31i1p141-146>.
15. Mello MC. O hospital e sua organização. In: Rios IJA, organizator. Conhecimentos essenciais para atender bem em fonoaudiologia hospitalar. São José dos Campos(BR): Pulso; 2003.
16. Barreto LPP. Protocolo de consistências alimentares e dietas hospitalares da clínica de cuidados paliativos e oncológicos de um hospital referência em câncer [monography]. Belém(BR): Hospital Ophir Loyola, Universidade do Estado do Pará; 2015.
17. Silva RP. Avaliação fonoaudiológica do processo de deglutição de pacientes em uma clínica de cuidados paliativos e oncologia [monography]. Belém(BR): Hospital Ophir Loyola, Universidade do Estado do Pará; 2014.
18. Santos LB dos, Mituuti CT, Luchesi KF. Atendimento fonoaudiológico para pacientes em cuidados paliativos com disfagia orofaríngea. *Audiol, Commun Res*. 2020;25:e2262. <https://doi.org/10.1590/2317-6431-2019-2262>.
19. Mendes BNN, Christmann MK, Schmidt JB, Abreu ES. Percepção de fonoaudiólogos sobre a atuação na área de cuidados paliativos em um hospital público de Santa Catarina. *Audiol, Commun Res*. 2022;27:e2565. Available from: <https://doi.org/10.1590/2317-6431R-2021-2565>.
20. Nascimento N. Cuidados paliativos e fonoaudiologia [monography]. Goiânia(BR): Escola de Ciências Sociais e da Saúde; Pontifícia Universidade Católica de Goiás; 2021. <https://repositorio.pucgoias.edu.br/jspui/bitstream/123456789/3424/1/tcc.pdf>.
21. Alves JCD, Souza JLA. Enfermagem no cenário da unidade de terapia intensiva. In: Furkim AM, Rodrigues KA, organizators. Disfagias nas unidades de terapia intensiva. São Paulo(BR): Roca; 2015. p. 9-37.
22. Rodrigues KA, Gonçalves MIR. Avaliação fonoaudiológica de pacientes disfágicos internados na unidade de terapia intensiva. In: Furkim AM, Rodrigues KA, organizators. Disfagias nas unidades de terapia intensiva. São Paulo(BR): Roca; 2015. p. 300-10.
23. Peixoto CAS. Efeitos da estimulação térmica gelada intra-oral em pacientes de uma clínica de cuidados paliativos oncológico[monography]. Belém(BR): Hospital Ophir Loyola, Universidade do Estado do Pará; 2014.
24. Steele CM, Miller AJ. Sensory input pathways and mechanisms in swallowing: a review. *Dysphagia*. 2010 Dec;25(4):323-33. <https://doi.org/10.1007/s00455-010-9301-5>.

SUPPLEMENTARY MATERIAL

SCRIPT FOR ANALYSIS OF MEDICAL RECORDS



Participant:

Gender: Age: City:

Period of hospitalization: from to Time of hospitalization:

Left the hospital due to: () discharge () death

Diagnosis:

Medical treatment performed:

SPEECH-THERAPY ASSESSMENT

Type of Assessment:

- () Phonoarticulatory Organs
- () Swallowing
- () Communication
- () others:

Complementary assessment:

- () Blue Dye Test
- () Cervical Auscultation
- () Pulse oximetry
- () Scale. Which one?
- () Assessment not performed. Why?

THERAPEUTIC CONDUCT

What was performed?

- () Myofunctional orofacial stimulation
- () consistency management
- () tactile-thermal stimulation
- () tactile-thermal-gustatory stimulation
- () alternative communication
- () others:

SPEECH THERAPY EVOLUTION

- () tone of phonoarticulatory organs
- () mobility of phonoarticulatory organs
- () intra-oral sensitivity
- () extra-oral sensitivity
- () laryngeal elevation
- () consistency evolution
- () interpersonal communication skill
- () others:
- () did not evolve

REBL worked in the final writing and field research, whereas FCRSA worked on the concept and methodology.