

Original Article

Contributions of occupational therapy in health care of users with chronic renal insufficiency in hospital context¹

Contribuições da terapia ocupacional no atendimento a usuários com insuficiência renal crônica no contexto de hospitalização

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Abstract

Introduction: Chronic renal insufficiency (CRI) and its treatment cause restrictions and damages to the physical, mental, functional and social health of the affected users. The attention developed by Occupational Therapy with this population from the perspective of integral care during the period of hospitalization contributes to improve the setting, qualification of hospitalization time, functional recovery and emotional support. **Objective:** To identify and analyze the contributions of Occupational Therapy in health care of users with CRI in hospital context. **Method:** Qualitative study of descriptive type that used documentary analysis of the occupational therapy reports referring to the appointments made by this professional from April 2015 to April 2018. **Results:** 42 occupational therapy reports were analyzed, the majority of users were male, aged 60 or over and with some degree of functional dependence. The interventions of the Occupational Therapy were categorized in four main themes: initial contact and reception of the needs; support for resignification of the health-disease process; assistance to adapt to the new health condition and preparation for hospital discharge and the new routine of care. **Conclusion:** The Occupational Therapy allowed that aspects of patients' life altered by the CRI, hospitalization and changes in lifestyle due to the disease, were approached through different therapeutic techniques aimed at the reception of needs, stimulation of functional capacity, promotion of independence, (re) organization of daily life and insertion into the service network.

Keywords: Renal Insufficiency, Chronic, Hospitalization, Humanization of Assistance, Occupational Therapy, Patient Care Team.

¹ To carry out the study, all ethical procedures were followed, and it was approved by the Research Ethics Committee, protocol n° 365/2013.

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Resumo

Introdução: A insuficiência renal crônica (IRC) e o tratamento a ela relacionado causam restrições e prejuízos à saúde física, mental, funcional e social dos usuários acometidos. A atenção desenvolvida pela terapia ocupacional com essa população na perspectiva da integralidade do cuidado durante o período de hospitalização contribui para melhorar a ambientação, qualificação do tempo de internação, recuperação funcional e confere apoio emocional. **Objetivo:** Identificar e analisar as contribuições da terapia ocupacional no atendimento a usuários com IRC no contexto de hospitalização. **Método:** Estudo qualitativo do tipo exploratório e descritivo que utilizou análise documental dos relatórios de terapia ocupacional, referentes aos atendimentos realizados por este profissional no período de abril de 2015 a abril de 2018. **Resultados:** Foram analisados 42 relatórios, sendo a maioria de usuários do sexo masculino, com idade igual ou maior de 60 anos e com algum nível de dependência funcional. As intervenções da terapia ocupacional foram categorizadas em quatro principais temáticas: contato inicial e acolhimento das necessidades; apoio para ressignificação do processo saúde-doença; auxílio para adaptação à nova condição de saúde e preparo para a alta e a nova rotina de cuidados. **Conclusão:** A terapia ocupacional permitiu que aspectos de vida dos usuários alterados pela IRC, pela hospitalização e pelas mudanças no modo de vida decorrentes da doença fossem abordados por meio de técnicas terapêuticas diversas voltadas ao acolhimento das necessidades, estímulo à capacidade funcional, promoção da independência, (re) organização do cotidiano e inserção na rede de serviços.

Palavras-chave: Insuficiência Renal Crônica, Hospitalização, Humanização da Assistência, Terapia Ocupacional, Equipe de Assistência ao Paciente.

1 Introduction

Chronic diseases have received greater attention from health professionals in recent decades due to the important role they play in the morbidity and mortality of the world population (Goto, 2017; Organização Mundial da Saúde, 2003). Among these diseases, chronic renal failure (CRI) is considered a condition with no prospect of rapid improvement, with progressive evolution and a high prevalence of frailty that causes medical, social and economic problems (Sheshadri & Johansen, 2017).

CRI has an alarming growth and therefore constitutes a serious public health problem worldwide (Sheshadri & Johansen, 2017). In recent years, this growth is mainly due to the population ageing and the increase in the number of users with hypertension and diabetes mellitus, which are currently the main causes of CRI in Brazil (Sesso et al., 2017). In line, it is a fact that population ageing is one of the factors responsible for the increase in the number of users undergoing hemodialysis today (Goto, 2017).

It is noteworthy that, among the treatments for CRI, the most used is hemodialysis (HD) (89.4%), which consists of dialysis made by a machine that performs extracorporeal filtration of blood (Sesso et al., 2017). The prescription of treatment is,

on average, three weekly sessions, for a period of three to five hours per session (Lins et al., 2018).

The progression of the disease, as well as the treatment, causes restrictions and losses in physical, mental, functional health state, general well-being and social interaction (Martins & Cesarino, 2005). The limitations of users undergoing HD treatment tend to increase with advanced age, since the elderly tend to present frailty due to the aging process itself and are more subject to the occurrence of multiple comorbidities, functional decline and a decrease in social participation (Goto, 2017).

Some authors have found an impairment of the functional capacity for work activities of people with kidney diseases, especially those aged between 18 and 59 years, considered economically active by the society (Lara & Sarquis, 2009). Due to the physical impairment and the time allocated to HD, these people have difficulties working after the beginning of the treatment (Martins & Cesarino, 2005) and are subject to finish their professional activities. This situation generates significant economic impact (Lara & Sarquis, 2009).

HD users have limitations in their daily lives and experience numerous losses and biopsychosocial changes that interfere with their quality of life, such as: loss of employment, changes in body image, food and liquids restrictions (Martins & Cesarino, 2005), psychological impact and repercussions on family and social relationships. Besides, HD causes side effects such as nausea, headache and hypotension. Because of these changes, many people submitted to HD become depressed and anxious (Coutinho & Costa, 2015). HD treatment is responsible for a restricted daily routine of activities, favoring sedentary lifestyle and a functional deficit (Silva et al., 2011). Changes in the user's routine and the need for a companion and transportation makes the treatment difficult to realize and quite exhausting (Madeiro et al., 2010).

Thus, the treatment causes changes in the user's daily life and requires the support of the multidisciplinary team (MT), the machine and the family for the necessary care (Santi et al., 2012).

These complications are aggravated when the person with CRI is in the hospital context since this context generates a break in daily life (Santos & De Carlo, 2013). However, hospital routine is underestimated as a stress generator and the individual is exclusively expected to develop and overcome the conflicts, which aggravates their clinical condition (Santos & De Carlo, 2013). Therefore, it is necessary to be concerned with the restructuring of this individual's the daily life and propose actions of hospital humanization that can be performed by the occupational therapist together with MT.

It is recognized that the work of the occupational therapist in hospital contexts favors the maintenance of daily life, the exercise of capacities and skills (Santos & De Carlo, 2013), the reduction of re-hospitalizations, length of hospitalization and complications resulting from diseases (Galheigo & Tessuto, 2010).

Psychological and social problems arising from CRI and treatment decrease when HD programs encourage the individual to be independent and to resume their previous interests (Madeiro et al., 2010).

Thus, the MT care service to HD users requires attention and empathy to recognize the main problems faced by them in treatment adherence.

This reality requires rethinking user care service based on multidisciplinary practices, which can go beyond mechanic procedures, and build together with the user and their

family new meanings of the experience, giving them tools to better cope with the diagnosis and treatment, with the purpose of minimizing the impact on daily life (Silva et al., 2011). Therefore, the relevance of integrality and humanization of care in the hospital as opposed to fragmented practices not attentive to the needs of the users served. This perspective understands the hospital as a care station, in which professional actions are based on a line of care, requiring networking for its implementation (Galheigo, 2008).

In this sense, the *Política Nacional de Atenção ao Portador de Doença Renal* contemplates actions to provide autonomy and comprehensive care lines at all levels of health care. These actions involve strategies for health promotion, prevention, treatment and recovery. In the last two decades, the service has begun to value the quality of life of the user as a relevant factor in the scenario of renal treatment (Sandri & Schmitz, 2011).

The contribution of occupational therapy with people that depend on HD procedures aims to mitigate its impacts on functionality and assists in overcoming difficulties through the development of resources such as significant activities and occupations and environmental adaptation, routine organization and assistance to continue social participation (Santi et al., 2012). In hospital context, the occupational therapist considers environmental (physical, social and cultural) and temporal factors, such as age, life cycle and limitations

Thus, the performance of occupational therapy seeks to expand the autonomy and independence of these users during the hospitalization period, providing them with ways of elaborating, coping, developing autonomy, resuming capacities and life projects (Santi et al., 2012). This perspective of care involves aspects related to the suffering and anxieties of the subject and family members regarding the diagnosis and reorganization of a new context of health care (Pinto & Pontes, 2017). It is understood that the perspective of comprehensive care during the hospitalization period contributes to improve the environment, transformation of hospitalization time, functional recovery, emotional support (Santos & De Carlo, 2013) and listening to subject's needs and their relational network (Galheigo, 2008). Moreover, because it is a chronic disease, the importance of planning their discharge stands out in this context as an indispensable tool for comprehensive care during hospitalization and post-discharge (Toldrá et al., 2019).

In view of the complex aspects involving the care of users with CRI and the need for greater visibility of OT in health care in the hospital (Galheigo & Antunes, 2008), the present study seeks to identify and analyze the contributions of occupational therapy for users with CRI in hospital context.

2 Method

A retrospective study, with a qualitative approach of exploratory and descriptive type, which used documentary analysis. Exploratory research aims to improve ideas, which allow a better knowledge of empirical reality (Minayo, 2007). A documentary study is considered to be any written material used as a source of information regarding human behavior (Minayo, 2007).

The documental analysis was performed based on reports regarding care service provided to users with CRI by an occupational therapy in the Clinical Ward (CW) of the University Hospital of the *Universidade de São Paulo* (HU-USP) from April 2015 to April 2018.

Occupational therapy services were performed by residents of the Multiprofessional Residency Program in Health Promotion and Hospital Care of the Department of Physiotherapy, Speech Therapy and Occupational Therapy of the Faculty of Medicine of the *Universidade de São Paulo*, supervised by service preceptors and tutors. Residents work five periods per week in the CW. The users were served by occupational therapy in their hospital beds, in the communal areas and in the HD sector. For the follow-up, an active search was performed in the medical records considering functional, psychoemotional needs or the users' difficulty to stay in the hospital environment and MT referrals. After each service, occupational therapists made brief entries in the clinical records and in more detail in the reports that are available in the occupational therapy sector. The records and reports have the purpose of teaching and research, considering the residents training context.

For the documentary study, we selected the reports of occupational therapy visits, filed after the user's discharge. These reports were subject to documentary analysis since they are written and authentic materials that have not received an analytical treatment yet (Minayo, 2007). They contained social and demographic information, clinical information obtained from clinical records, family and professional situation, wishes, habits, behaviors, expressions and speeches of the users; therapeutic approaches performed by the professional, such as guidelines and therapeutic techniques; interaction with MT, referrals to the service network. In addition, they contained the result of the evaluation of functional independence in activities of daily living (ADL) by Modified Barthel Index, according to a score of 0-100 (Shah et al., 1989). It is composed of the following items: personal care, mobility, locomotion and controls according to the execution of ten tasks: feeding, bathing, dressing, personal hygiene, bowel control, bladder control, use of the toilet, transfer chair-bed, ambulation and stairs.

The study included users diagnosed with CRI undergoing hemodialysis treatment during the hospitalization period, treated by occupational therapy, regardless of gender and length of hospital stay. Reports of users with acute renal insufficiency or other diagnoses were excluded from the analysis. In total, 42 report records were analyzed.

The data were analyzed in their content, in the thematic modality, in which we sought to categorize the main aspects addressed in the reports. For the thematic analysis, the steps described by Minayo (2007) were followed: pre-analysis, exploration of the material, treatment of the data obtained and interpretation. Thematic analysis was chosen because it allows identifying in the reports the contribution of occupational therapy for health care users with CRI in hospital context.

The research was approved by the Research Ethics Committee of the Faculty of Medicine of the *Universidade de São Paulo*, under protocol no. 365/2013.

3 Results and Discussion

The object of the documentary analysis consisted on the reports of 42 users hospitalized at UH-USP, with an average of seven visits per user. The social, demographic and clinical data in Table 1 shows that most of the users were male aged 60 or older, with low school level, married, and retired or on leave. Most of the users had comorbidities associated with CRI, such as hypertension and diabetes mellitus, in line with the literature (Sesso et al., 2017). As for treatment, with the exception of one user, the others continued with HD treatment after hospital discharge.

Table 1. Social, demographic and clinical profile of users hospitalized in the CW at the UH-USP. São Paulo, 2018.

SOCIAL, DEMOGRAPHIC AND CLINICAL PROFILE OF USERS	n = 42	%
GENRE		
Female	16	38
Male	26	62
AGE		
20 ≤ 39 years old	5	12
40 ≤ 59 years old	13	31
60 > years old	24	57
SCHOOL LEVEL		
Illiterate	14	33
Elementary School	15	36
High School	10	24
Higher Education	3	7
MARITAL STATUS		
Single	6	14
Married	25	60
Widow(er)	8	19
Divorced	3	7
EMPLOYMENT RELATIONSHIP		
Active	18	43
Retired/Leave	24	57
COMMORBIDITIES		
Hypertension	41	98
Diabetes Mellitus	39	93
Obesity	8	19
Respiratory Insufficiency	5	12
Alcoholic Liver Cirrhosis	3	7
Lupus Erythematosus	1	2
POST-DISCHARGE TREATMENT		
Hemodialysis	41	97.7
Peritoneal Dialysis	1	2.3
TOTAL	42	100

With regard to functional characteristics, specifically related to the users' performance of ADL, obtained by the Modified Barthel Index, described in Table 2, it was observed that most users presented some level of dependence considered mild, moderate, severe or total (Shah et al., 1989).

Table 2. Functional characteristics of users with CRI treated by occupational therapy hospitalized in the CW at UH-USP. São Paulo, 2018.

LEVEL OF FUNCTIONALITY	n = 42	%
Fully independent (100 points)	13	30.9
Mild dependence (99-76 points)	12	28.6
Moderate dependence (75-51 points)	9	21.4
Severe dependence (50-26 points)	6	14.3
Total dependency (25 points or less)	2	4.8
TOTAL	42	100%

After reading and analyzing the contents of the reports related to the occupational therapy care process, four main themes were categorized: *initial contact and reception of needs; support for resignification of the health-disease process; assistance to adapt to the new health condition and preparation for discharge and the new care routine*, according to Table 3.

Table 3. Themes addressed and actions of occupational therapy with users hospitalized in the CW at HU-USP. São Paulo, 2018.

THERAPEUTIC PROCESS THEMES		ACTIONS OF OCCUPATIONAL THERAPY WITH THE USER, CAREGIVERS/FAMILY MEMBERS AND TEAM PARTICIPATION.
<i>1st Theme</i>	<i>Initial contact and reception of needs</i>	<ul style="list-style-type: none"> - Establishment of therapeutic bond - Needs survey - Identification of the social support network
<i>2nd Theme</i>	<i>Support for resignification of the health-disease process</i>	<ul style="list-style-type: none"> - Valuing psychoemotional aspects - Interaction with family members/caregivers - Rescue and discovery of new interests
<i>3rd Theme</i>	<i>Assistance to adapt to the new health condition</i>	<ul style="list-style-type: none"> - Need for health management and maintenance - Facilitate self-care performance
<i>4th Theme</i>	<i>Preparation for discharge and the new routine of care</i>	<ul style="list-style-type: none"> - Guidance to (re) organize routine after hospitalization - Reinforcing the continuity of care in the health network

The themes and actions, in Table 3, in line with Martins & Cesarino (2005), indicate that the particularities and challenges related to the health-disease process of the users with CRI require self-care reorganization and generate professional impact, which can weaken the user, their family and social context.

Occupational therapy explores a range of therapeutic possibilities, including those related to physical, psychoemotional and social aspects (Santi et al., 2012), which are

commonly undermined due to hospitalization and discovery and/or exacerbation of CRI. This situation allows identifying the diversity of demands involved in the user's health-disease process and its transformations throughout the visits.

1st Theme: Initial contact and reception of needs

The first theme addressed the *initial contact and reception of the user's needs*, which favored the *establishment of therapeutic bond*, the *needs survey* and the *identification of the social support network*. In this process, it was present the with the MT (nurses, physicians, physiotherapists and speech therapists) who often mediate the contact between the occupational therapist and the user, through the request for care and partnerships in the case discussions and joint actions.

- Establishment of therapeutic bond

According to the reports, at the beginning of the care process, the occupational therapist sought to provide an environment of active reception and listening for the *establishment of therapeutic bond*. The American Occupational Therapy Association (2015) refers to the therapeutic bond as an exchange between the occupational therapist and the user, to enable open communication and the establishment of an empathic relationship, as observed in the following statements: “[...] *in the middle of all this, you sat beside me to hear me [...]*”; “*I was so lost, you managed to explain things to me, you always bring an answer [...]*”. Thus, these professionals used narrative and clinical reasoning to help users make sense of the information received in the intervention process (American Occupational Therapy Association, 2015).

The bond is pointed out by occupational therapists as essential in care, since the hospital can be a hostile environment for the user, requiring listening and reception (Galheigo & Tessuto, 2010). Moreover, the reception, necessary for the establishment of bonds, is considered in the Guidelines for the Care of People with Chronic Diseases. It is a way to operate the health work processes, in order to meet all users, listening to their requests and assuming a posture capable of accepting expectations, listening to complaints and fears and providing adequate answers to their needs (Brasil, 2004). Reception involves all professionals and demands the exercise of listening with accountability and resolution (Brasil, 2004). This can be observed in the following excerpt, in which the MT identifies the relationship established between the occupational therapist and the user who favored the relationship between the latter and the team: “[...] *the nurse and resident physicians mentioned during the discussion of the clinical case the bond created (by the OT and the user)*”. “[...] *the professionals requested our intervention as a way of access to the user [...]*”.

Thus, it was possible to identify in the reports that the therapeutic bond established with the occupational therapist and users was recognized, both by the users and by the MT itself. This fact was strongly related to the development of a welcoming environment, which favored confidence in the therapist and facilitated sharing the difficulties faced by the user.

- Needs survey

Among the different *needs* recognized by the occupational therapist, one of them was related to the greater knowledge and understanding of the user and family/caregiver about the diagnosis, the complications caused by the disease and the clinical treatment. The following excerpts exemplify this experience: “[...] *the user comes without information about their clinical condition, “it was just to give me a medicine to reduce swelling, but I am here so far” [...]; [...]* *the user said they did not understand what the doctor said about the diagnosis [...]*”.

The difficulty in obtaining information about the clinical picture by the user and family/caregiver may be related to cultural, social and emotional factors that sometimes make it impossible to meet and assimilate resources to understand the orientations offered by the professionals (Jorge & Toldrá, 2017). Furthermore, it can be related to aspects of the service and work dynamics, such as professional workload, high user turnover, which can undermine the communication between the MT and users and family/caregivers (Jorge & Toldrá, 2017).

The following record illustrates this aspect:

[...] *“The doctors came here, they said some things, but I didn't understand anything, girl”* (sic) [...] *the user said not to understand the function of the hemodialysis machine, but felt embarrassed for it and embarrassed to ask [...]* *“After you started to visit me I understood a lot, I learned that I have the right to ask, that I have to know what is happening to me” [...]*.

Thus, the strategies used by occupational therapy stimulated the sense of self-advocacy. To this end, self-advocacy involves efforts to defend rights made by the client, which the professional must promote and support (American Occupational Therapy Association, 2015).

Another need identified referred to the importance of adapting activities in the hospital context, for energy facilitation and conservation, as described: “[...] *the user states that they were already tired to perform the activities, especially which needed to be stood up for a long time [...]*”.

Furthermore, it was identified the need for greater appreciation of subjective experiences related to the hospitalization process of the users to the extent that the rupture of their daily and significant activities may be related to the difficulty in accepting the hospital treatment, as follows: *“they says they are in no mood to continue [...], I do nothing here, I lie here in bed [...]*”. Thus, the user's perspective on the hospital experience has the potential to favor the proposition of significant activities in the daily life of the user, which should be valued by health professionals.

- Identification of the social support network

The records enabled to identify that many family members found it difficult to organize the support to the hospitalized person due to the work routine and the distance from their house to the hospital. The following report is an example of this aspect: “[...] *the user has a well-established social support network, however, due to the family dynamics of work only the husband can come visit [...]*”. It also happened

that family members did not accompany the hospitalized person since they did not realize the severity of the user's clinical condition or because a lack of communication between the professionals and the family, due to their low presence in the hospital, as in the example: “[...] *the child reported not having accompanied the user in recent weeks because he thought the hospitalization would be short and soon they would be discharged* [...]”.

Sandri & Schmitz (2011) point out that social support directly influences the clinical treatment of individuals with CRI, since it can provide the means for adherence to medication and nutrition, leading to better clinical results. These authors point out that lower level of social support were associated with higher risk of mortality and lower adherence to treatment. Nevertheless, patients with renal problems with a social support network that is present indicated greater satisfaction with treatment and quality of life related to general health (Sandri & Schmitz, 2011). The occupational therapy records also revealed that those professionals favored the organization and distribution of care tasks among caregivers and the routine time of each one. In addition, they encouraged caregivers to be present along the hospitalization period. For this, the different difficulties presented by the family members were welcomed and discussed together, to both welcoming them and stimulating them to provide different types of care support to the user. The literature indicates two categories of social support: instrumental and emotional. The first category refers to the provision of help to the other, to the management or resolution of practical or operational situations of daily life, such as financial support or in daily activities. Emotional support consists of behaviors such as listening, attention or companionship, which make the person feeling well cared and/or estimated (Silva et al., 2016).

We identified in the records that the occupational therapists through their actions sought to mediate with the nursing team the possibility of alternative visiting hours that contemplated other family members in the care rotation. The *identification of the social support network* assumes the availability of significant people, such as spouse, friends and groups (American Occupational Therapy Association, 2015), who can be requested to support the hospitalization process, either with visits, alternation of care to reduce the workload of a single caregiver or as emotional support.

Part of the users assisted by occupational therapy had a single caregiver and the influence of this factor in the health-disease process of the caregiver and the user was remarkable in the records of the reports. Sometimes, the caregivers reported emotional and physical overload, and mentioned the concern with their own health, as illustrated: “[...] *the only caregiver is the wife, who is overwhelmed and distressed by hospital staying and home care, stating that he does not have time to take care of herself* [...]”.

The concept of workload related to care can be understood as a set of responsibilities and feelings arising from care that is often interpreted as a burden in the caregivers' lives, a task or risk condition to which they are exposed (Sandri & Schmitz, 2011). In these cases, occupational therapists provide moments of self-care for the caregiver offering resources such as massage, relaxation techniques and listening to them to diminish the anxieties. They also had conversations with

family and friends who were not involved in this process, but who could be triggered to assist in care at some point, aiming to reduce the workload of the primary caregiver.

For users without family ties, the social support network was more fragile, as follows: “[...] *they have no children or a wife, no contact with relatives. The only visit on weekends is from a neighbor [...] the user reports having left some medical treatments, because they do not have physical conditions or somebody to go with to health services [...]*”. These users reported family helplessness due to the physical and affective distance from family members and because of coexistence problems.

However, belonging to friends, religious, neighbors or work groups, partly provided an affective space and showed concern with the health-disease process of the user, as said: “[...] *the main social support network is the religious community, which they visit frequently and show interest and participation in their care [...]*”. In these cases, visitors were informed about their health status and how they could help the user. In situations of users in greater vulnerability, the occupational therapist requested the evaluation and guidance of the social worker, who looked for, found and informed relatives, through telephone contact.

Other families were overprotective and had more difficulty in understanding behaviors that created barriers to the users' performance in their daily activities, even preserving cognitive and physical conditions to perform them. Furthermore, records showed that caregivers interfered in the user's choice to accept or not the interventions of professionals, as exemplified: “[...] *the wife is overprotective, interfering in the active participation of the user in the ADL and decisions on the acceptance of MT interventions [...]*”. These families were guided by the occupational therapy about the importance of follow-up and care and not to restrict the possibility of performing the proposed activities, as well as the user's choices. However, other records indicate that families more informed about the disease process and the comorbidities of the user were more organized in terms of care.

Beside the records enabled to identify that the social support network appreciate occupational therapy to mediate the possibilities of greater support during and after hospitalization. It was noticed that including the caregivers in the user's treatment context, favored the support provided by the support network, helping in the adherence to the care process. In line with this, the literature understands that collaborative and centered attention on the person and the family, replacing prescriptive and disease-centered care, transforms the relationship between users and health professionals, from mere spectators they become the main social producers of their health (Organização Mundial da Saúde, 2003).

2nd Thematic: Support 9-for resignification of the health-disease process

The thematic category *support for resignification of the health-disease process* was related to *valuing psychoemotional aspects, interaction with family members/caregivers* and *rescue and discovery of new interests of the users*. The occupational therapist developed actions due to psychoemotional difficulties

related to hospitalization, treatment and acceptance of temporary or permanent limitations arising from the disease.

- *Valuing psychoemotional aspects*

As stated in the care records, *valuing psychoemotional aspects* was an important component of the interventions. The following excerpts exemplify how users referred emotional distress conditions to occupational therapists: “[...] *the user refers feelings of sadness and frequent crying “I would like to jump out of the window” [...] “now will I be connected to the machine until death?” [...]*”

According to Coutinho & Costa (2015), users with CRI are constantly exposed to adverse factors inherent to diagnosis and therapy, such as the long time dedicated to HD sessions, constant laboratory tests, restrictive diets and the expectation of waiting for a vacancy in the HD clinic after discharge. These factors, associated with the long period of hospitalization, contribute to the onset of depressive symptoms. The authors indicate in their studies that the rate of depression in this population is from 56% to 68% (Coutinho & Costa, 2015). In view of this problem, the occupational therapist prepares the users from the moment they are admitted and discover the diagnosis and/or symptoms exacerbation, to promote greater support and adherence to clinical treatment after hospital discharge with lower psychoemotional impacts.

The records in the reports showed that the interventions related to *valuing psychoemotional aspects* consisted mainly of clarifications about the clinical picture, treatment and prognosis, since often, the concerns were because there was little understanding of the reason for hospitalization and lack of space for the expressing their anguish. So, as stated in the following report: “*an acquaintance told me that a neighbor started this treatment and passed away soon after, other people told me that this machine (HD) does not help at all [...] I thought I was going to die and refused to treat myself [...]*”. The therapeutic action priority was to lessen the state of anxiety and agitation of the user in the face of diagnosis and hospitalization period, since many were hospitalized for long periods until stabilization of the clinical picture and waiting for dialysis clinics in their community.

During hospitalization, the users are included in the waiting list for a vacancy in a hemodialysis clinic and receive information on how follow-up is performed there. The waiting time for the vacancy varies according to the availability in the regions close to the user's home and directly influences the length of hospitalization, since the user is only discharged from the hospital when he/she has a guaranteed vacancy and has performed an evaluation for treatment in the service.

According to Madalosso & Mariotti (2013), improvement in the user's psychoemotional state may be related to the sense of ability and feeling of empowerment towards themselves. As follows: “[...] *the user refers being tired of the routine of treatments, says they feel like being “thrown from one place to*

another” (sic) [...]”. Thus, the occupational therapist, together with the user, tried to identify strategies to manage the anxiety, the incorporation of attitudes of co-responsibility for the treatment process and stimulus to measures that minimize complaints and provide support to suffering, such as the inclusion of leisure activities, relaxation techniques and opening spaces for joint care with other users to favor exchanges.

It is understood that the communication skills of occupational therapists contributed to this qualified listening. An Australian study aimed to identify the perception of occupational therapists about attributes required for an excellent performance with adults in the context of hospitalization. This study identified that the ability to communicate effectively was the professionals most valued attribute, as it allowed, among other aspects, the construction of the relationship with the user, a greater understanding of the activities performed and a greater understanding of the needs of the subject served (Swan et al., 2019).

- Interaction with family members/caregivers

The *valorization of psychoemotional aspects* in the context of occupational therapy involves *interaction with family members/caregivers*, who, like the users, bring the difficulties and doubts of how to deal with the new health condition of the hospitalized family member. In this sense, it is necessary that professionals consider the inclusion of caregivers in the scope of care (Jorge & Toldrá, 2017). Omura et al. (2018) highlight it is important that the teams, as far as possible, know the caregivers, their network of friends and family, to identify the needs of the hospitalized family members, to favor a greater understanding of the characteristics of the disease and to provide guidance for the user’s care, as illustrated in: “[...] *the fiancée brings questions related to lack of information and doubts about the clinical picture [...] –“we are researching on the Internet, but I wanted to talk to you (MT), I saw there is a possibility to do dialysis at home”*”.

Jorge & Toldrá (2017) add that the emotional and organizational demands of caregivers can directly reflect on their relationship with the users, the institution and the professionals who assist them. The record demonstrates the relatives concern about the consequences of the disease: “*I am distressed by his return home, of the changes that we will have to face [...] He’s the one who keeps the house, if he can’t work anymore, I don’t know how we’re going to be*”.

It was also identified, in the records, that the actions of occupational therapy were oriented to create joint strategies with the medical and nursing team for further clarification of the family about the clinical picture, therapeutic approaches, possible side effects of the medication and to understand better the process of moving from hospital treatment to the HD clinic. To this end, joint conversations were planned involving the family member, occupational therapist and doctor and/or nurse to guide the relatives regarding the treatment process in the hospital, treatment options after discharge, to clarify indication and

contraindication of treatment types, as well as the expected changes in the physical and emotional disposition of the user resulting from the treatment. Of the 42 users in the sample, only one (Table 1) requested treatment after hospital discharge for peritoneal dialysis. The team informed this user about the hygiene conditions, home adequacy and care necessary for this treatment modality. The relevance of these team actions for comprehensive care is recognized. One study pointed out that occupational therapists have the perception of their “[...] potential to work as a team, which makes them a powerful intermediary in the construction and facilitation of communication between agents of support networks and health services” (Galheigo & Tessuto, 2010, p. 30). However, the same study also states that one of the work challenges of the occupational therapist in the hospital context is the lack of recognition of their possibilities of action by the other team members, who often judge them as unimportant in the care process (Galheigo & Tessuto, 2010). In this sense, it is possible to identify from the reports that the joint actions carried out within the scope of the MT of the UH-USP were also relevant for the strengthening of shared actions which favor the understanding of the occupational therapist actions in the hospital context.

Specifically regarding to HD, Goto (2017) identified that, after beginning the treatment, individuals with CRI underwent changes in their ADL and self-care, modifying not only their personal daily life, but also of the family members involved in their care routine. These changes implied the joint restructuring of activities planning between users and family members. These conditions are illustrated in the records of occupational therapists.

- Rescue and discovery of new interests

Another relevant action identified in the records was related to the *rescue and discovery of new interests*, used as coping resources and stimulus to the maintenance and improvement of functional and emotional aspects. In occupational therapy interventions, according to the user's repertoire, the rescue of significant activities that were no longer performed because of the illness process, as well as new possibilities, were explored. Involvement in activities helps coping with the process of illness and hospitalization as it encourages them to share experiences, favors free expression, helps stress reduce, motivates health, autonomy and quality of life restoration (Santos & De Carlo, 2013).

The records highlighted the exploitation of leisure time during hospitalization, which, according to Santos et al. (2018), should be encouraged because it is a little stimulated occupational area with the adult and elderly population during this process, as exemplified in this record:

[...] the user refers the desire to listening to the radio, her most frequent leisure activity at home [...] we talked with her grandson about the possibility of bringing a radio to the hospital [...] the user was moved and grateful when we put her CD with Sérgio Reis songs to listen to in the room [...].

Lima & Silveira (2016) point out that the use of significant activities for users during the therapeutic process can be considered as a possibility of construction and experimentation, welcoming experiences, forms of expression, sharing feelings and relieving suffering, as identified in: “[...] *the user was interested in painting and mosaic activities after seeing another user performing these activities [...] it was proposed that the user participate and both throughout the visits exchanged experiences, told life stories [...]*”.

Contrary to expectations, the hospitalization process allowed users to rescue significant activities and express interests for new activities, as described in the medical records: “[...] *refers the desire to create a garland with “fuxicos” and carried out the step by step for the construction [...] during the activity the user brought questions related to their expectations regarding the future and life projects [...]*”. Such activities favor the shift of attention from the disease towards the enhancement of new possibilities of encounter and action between professionals and users (Lima & Silveira, 2016).

It was identified in the records that leisure activities provided a more humanized environment during hospitalization and means of resignification of the health-disease process, expression and artistic communication. Occupational therapists also adapted the activities, considering relevant aspects to the user’s performance, such as comfort and adequate positioning. This adaptation of the making was singularized in each activity with guidelines aimed at facilitating the performance of significant activities after discharge, as described:

[...] the user stopped performing garden activities due to muscular strength decrease [...] activities related to plants and garden care were proposed, ways to adapt this activity in the home with energy conservation technique and types of elevated gardens for better positioning [...].

It was possible to identify that occupational therapy, guided by the logic of health promotion and the valorization of aspects such as humanization, reception and communication (Santos et al., 2018), allowed users to express feelings, desires through the therapeutic process. In addition, the activities used were resources that motivate participation, stimulate sense of competence and self-esteem through therapeutic work.

3rd Theme: Assistance to adapt to the new health condition

In the third theme, the recognition of the need of strategies for *health management and maintenance* and modalities for performing activities *to facilitate self-care performance* was addressed. MT is an important ally in these actions, since many aspects related to health management were discussed and mediated by the team.

- Strategies for health management and maintenance

As found in the documentary study, interventions were carried out to favor the recognition of the need and support to develop *strategies for health management and*

maintenance, since most of the users expressed concern with changes in their health care and with the reorganization of their routine and activities. In this process, it was essential the occupational therapist listening them about their desires and sharing information to guide strategies to facilitate care and occupational performance.

Pimentel & Toldrá (2017, p. 68) point out that the

[...] communication and information exchange role during the process, especially for chronic diseases, is fundamental, since their care process does not depend exclusively on medicines, but also on the knowledge that people have about their diseases and how they will develop the various skills necessary for their coping and care in everyday life.

In order to complement the interventions performed together with the MT, occupational therapy used educational materials developed by the professional area at UH-USP. The most mentioned materials were the manual of chronic renal insufficiency, which includes general information on the disease, therapies and diet, and the booklet of energy conservation techniques, with guidance on fatigue, pauses, fractionation of activities and organization of the routine for lower energy expenditure. The use of such resources was performed to clarify and enable the users and caregivers/family members recognition about the needs of health management and maintenance, as extracted from the records: “[...] *the user began throughout the visits to demonstrate greater understanding of the disease, the risks and to envision possible strategies to use, she began to ask further doubts regarding the activities she can perform and how to perform them* (cleaning the house; working, going out to dinner) [...]”.

The use of educational materials, which favor the teaching-learning process, is a practical resource that contributes to complement therapeutic strategies, facilitates understanding, reinforces information and guidance of the MT, and serves as a guide in situations of doubts to users and their caregivers/family members (Pimentel & Toldrá, 2017). Next, the use of this resource is identified:

[...] *the ICR Manual was used, reading by theme by the user and the caregiver and handed out for possible consultations and sharing with family [...]; [...] the Energy Conservation booklet was used and read during the service for a better understanding of the user and preparation for functional training of ADL [...] the following day bath training was performed following the guidelines of the energy conservation technique [...].*

Thus, the use of educational materials is shown as a strategy that strongly contributes to the promotion of health, autonomy and co-responsibility of the users in their care, besides assisting in the search for alternatives to improve health (Brasil, 2004).

It is highlighted in the records that actions related to the clarification of health demands to users and family members were carried out, whenever possible, in a joint way with MT. In case they identified doubts regarding other professional areas, occupational therapists sought to trigger the other members of the MT and mediate the

interaction aiming at increasing the users and family members empowerment about their care process, as pointed out in the excerpt:

[...] after reading the CRI Manual, the user reported interest in talking to the nutritionist of the hospital about dietary restriction [...] we requested the possibility of a nutrition service visit to clarify the user's doubts [...].

For users better comprehend their health conditions, the interventions performed favored the need to change habits and adjust their routine. The greater access to information and communication with the team were aspects that favored the autonomy and responsibility of the users in the face of changes in health conditions, according to the excerpt:

[...] the user escaped in previous hospitalization, he mentioned difficulty in remaining hospitalized due to work commitments (self-employed musician), "I couldn't pay my bills and so I abandoned the treatment" [...]. The user was hospitalized again since his general health picture worsened [...] after several visits together with other professionals, the user says that he can now understand that he will have to reorganize his work routine, "I can no longer neglect my health" [...].

In chronic diseases, the success of treatment depends heavily on the involvement of the user as an active subject of their treatment. An attitude of self-care that leads to healthier lifestyles and life practices, as well as adherence to treatment, depends not only on a professional prescription, but also on the users, who work together with the MT to define the problem, establish the goals, monitor them, institute care plans and solve the problems that arise throughout the management process (Brasil, 2013).

Self-care means recognizing the central role of the user in relation to their health, developing a sense of self-responsibility and transforming the health professional into a user's partner (Brasil, 2013). The professional enables the client to seek and obtain resources to participate fully in their health-disease process, well-being and participation. Thus, users are encouraged to express their doubts and become active in the process through knowledge shared between the MT and the user.

- Facilitation in self-care performance

Occupational therapists frequently used adaptations and activities of daily living to recognize difficulties and possibilities for facilitating occupational performance. In this process, the self-care activities proposed the ones for which performance difficulties were identified, according to Modified Barthel Index. The following excerpt exemplifies the difficulties mentioned: *"[...] the user reports that the independence in the performance of ADL in recent months has been decreasing, refers they cannot finish the activities due to body weakness [...] difficulty in shaving, eating, bathing [...]."*

The facilitation of self-care performance becomes necessary due to the decline of physical function in users with CRI, responsible for the difficulty in performing the activities, which requires individualized evaluation that considers the factors resulting from the health condition and stage of CRI (Goto, 2017).

This study observed that, because of the decrease in participation in ADL, they often began to be performed exclusively or with great participation of the caregiver/family member. As a measure of care and protection, the caregiver/family member often begins to restrict the user's participation in the performance of self-care due to their physical decline, feeling of malaise and frequent tiredness resulting from the disease. Thus, as exemplified in the excerpt:

[...] the user reported being little satisfied with her performance in her activities, since the family overprotected her, and even infantilized her in a certain way [...] not allowing her to perform the activities and explore her potentials [...].

Also in this other record this aspect could be identified:

[...] the user and wife reported that he is dependent on all ADL, but that he has the possibility of greater participation in the activities [...] the user can perform some activities, but needs more time to finish them and the wife ends up doing for him to "go on" [...].

Self-care activities proposed to users aimed at optimizing the performance skills required in the activities, the active participation of the user and, when necessary, the introduction of resources/materials to adapt or simplify the tasks. Therefore, the intervention develop a capacity or recover a skill that has been undermined. The therapeutic use of remaining capacities to improve and maintain occupational performance in self-care activities (American Occupational Therapy Association, 2015) was also used by the occupational therapists to enhance the sense of competence and self-esteem.

The records showed that the performance and adequacy of the activities favored to carry them out with greater independence and encouraged users in the use of their potentialities. Thus, they used resources to facilitate the user's performance, such as energy conservation techniques, assistive technology, activities to stimulate body awareness, motor coordination, as well as guidance to assist and graduate the assistance by caregivers/family members. This can be exemplified in the reports:

[...] different activities were explored to enhance the sense of ability and performance skills through gross and fine motor coordination activities, with the use of games, stimulation of body awareness using a mirror [...]; [...] using cutlery adapted, the user was able to seize the utensils accurately, she was trained to open the food packaging, such as the sealed bread bag and the food tray [...].

These experiences contributed to resume activities that were no longer performed by users.

[...] during bathing, the caregiver was instructed to stimulate the active participation of the user, with verbal commands, facilitating access to hygiene products and assistance to perform activity with the use of a stretcher that facilitated the use of the sponge during the back and lower limbs hygiene [...].

The care proposals undertaken in a protected environment proved important for the acquisition of self-confidence (Pinto & Pontes, 2017), boosting users regarding the appropriation of the current health condition and recognition of their limitations and capacity.

4th Theme: Preparation for discharge and the new routine of care

The last theme corresponded to the *preparation for discharge and the new routine of care*, which aimed to *guidance to (re) organize routine after hospitalization* and the *reinforcing the continuity of care in the health care network*. These actions included joint interventions with the MT to clarify the importance of maintaining the link with the health services available in the community and adopting a routine of care and HD treatment.

- Guidance to (re) organize routine after hospitalization

It was identified from the records that relevant actions performed by occupational therapists were related to the preparation for discharge, with *guidance to (re) organize the routine after hospitalization*. Hospital discharge is considered a specific transition of health care, from hospital to home, from continuous professional care to family care, which requires hospital professionals to think a plan involving guidance directed to the needs of the user, preferences, clinical status and resources of caregivers/family members (Brasil, 2004).

The users and their family raised several issues during occupational therapy visits regarding home care after discharge, pointing to the importance of care for users with CRI during hospitalization. Since, after diagnosis and hospitalization, the user is faced with changes that involve not only the functioning of their body, but also with the need to modify their routine, the role of the occupational therapist is fundamental in the adaptation to the new condition and preparation for a new routine of care (Omura et al., 2018). Jorge & Toldrá (2017) also point out the importance of the professionals in directing the attention to continue care after hospital discharge by guiding the user and caregivers/family members, to co-responsibility for the user care at home.

Since HD treatment directly affects the physical aspect, side effects such as pain and fatigue during and after therapy are common. It is also frequent, in the days before HD, the appearance of edemas and feeling of weakness, which leads to a reduction in the physical capacity necessary to perform daily activities (Pinto & Pontes, 2017). According to Santi et al. (2012), the restrictions that the routine treatment of users with kidney disease undergo cause them to suffer occupational deprivation, which hinders their independence to participate in activities.

According to the reports, hospital discharge was reported, especially by caregivers/family members, as a challenge due to the new responsibilities and care tasks to be performed at home. In order to increase the appropriation of caregivers for better performance of these tasks at home and minimize concerns and feelings of impotence that generate suffering, occupational therapy systematically monitored the predictions of hospital discharge of the users with CRI, so they can give the necessary orientations as early as possible.

One of the concerns most mentioned by the users and family members referred to work, as exemplified in:

[...] the user is concerned with the organization after discharge, how to maintain a routine of care, working [...] once the user was unemployed and it would be difficult to find a job due to dialysis routine, OT indicated options for free fast training courses and new job opportunities that could adapt to the schedules and physical capacity of the user [...].

In general, users with CRI retire early due to incapacity or leave work due to the disease, which leads them to social isolation, reduced self-esteem and decreased family income. Still, often in the social environment, there is a stigma that these individuals are incapable and require excessive care, which often excludes them from professional roles (Madalosso & Mariotti, 2013).

The work routine of individuals with CRI is undermined due to functional involvement, which limits their occupations, but mainly due to the time spent in hemodialysis sessions. Thus, it is important to explore with the users new possibilities of adaptation and adequacy of activities according to their possibilities. Therefore, it was necessary to mediate occupational therapy with the medical and social assistance team of the hospital to guide the possibilities of working and the social rights the users have because of their disease.

The guidance included information on the transport provided by the dialysis clinics for the sessions, the right to the free ticket for public transport and the documents necessary for the user to be discharged from the hospital and instructions on the processes of treatment follow-up, as can be seen: “[...] *clarifying the issue of the right to transport to go to the dialysis clinic [...] the need for the user to receive the right to the ticket for transport [...].*”

Another concern mentioned by the users and family members was the difficulty in traveling due to the restrictions of the disease itself and the need for some users to undergo dialysis, which would imply recurrent attendance at treatment sessions, as noted in this record: “[...] *the main concern of the user was in how to maintain the travel routine, which he has been doing with his wife for years for his second home in another state [...] “how am I going to make the trips if I have to be in the clinic three times a week” [...].*” It was clarified that the user is not prevented from making tours or trips, however, it is difficult to transport the necessary materials for the dialysis procedure at home where, in general, there is not a suitable environment for peritoneal dialysis. For this situation, users were instructed to organize

themselves in advance about the destination, ask for authorization at the reference dialysis clinic for the expected period, so that the clinic in the destination city could grant treatment. For these users, joint conversations were planned with the physician responsible for guidance, considering the needs related to travel and treatment and mediation for the reference dialysis clinic.

As observed in social, demographic and clinical data, most users with CRI were elderly and had other associated chronic diseases. It is recognized that the elderly, through the aging process itself, face functional declines (Silva et al., 2016). In addition to the various changes that the elderly face they have the consequences of renal replacement therapy. Thus, there was a direction to reconcile the treatments of the elderly and guidance to family members regarding the organization of medications and home care, use of facilitators to adapt the family routine and their children work to the treatments and to routine appointments, as observed in:

[...] we identified the recognition by the user and family members of the need for greater health care and the establishment of a new family dynamic [...] the daughter proposes for the parents go to live with her to adjust the routine of HD, medications and facilitate transportation, since the parents are elderly, and the daughter is concerned about the health of the mother, who is the main caregiver [...].

In this discharge process, especially in cases that would imply that users moved house, it was encouraged the discussion of all the family involved on the importance of autonomy and participation of the users in decision making. In the records, it was observed that users who experienced this situation agreed that the change, although challenging, would be beneficial to facilitate the provision of care.

- Reinforcing the continuity of care in the health network

Preparing the discharge, the actions carried out aimed to *reinforcing the continuity of care in the health network*. As identified in the analysis of the reports, occupational therapy reinforced the need for the participation of caregivers/family members in the treatment process and of the users becoming co-responsible for their own care and explained the importance of follow-up in the health care network. This conduct is highly valued in the literature to favor comprehensive care and co-responsibility in care (Santos et al., 2018), as exemplified in:

[...] we discussed with the user and their family members the importance of routine medical follow-up and the link with the Basic Health Unit (BHU) to monitor associated comorbidities, such as diabetes, hypertension, obesity and dyspnea, in addition to the need for a professional follow-up to start physical activities [...].

According to the Ministry of Health (Brasil, 2013), users with CRI should be accompanied by a MT in the BHU and, in cases of greater complexity, in the care units specialized in chronic kidney disease. Such follow-up favors: counseling and

support on lifestyle change, guidance on self-care, nutritional assessment, guidance on physical exercises, continuous follow-up of prescribed medications, education program on CRI and, if necessary, inclusion in the kidney transplantation program.

Countertransference, in this sense, is fundamental for the continuity of comprehensive care and for strengthening the longitudinal care of these users in primary care (Brasil, 2013). Moreover, it is more effective when it occurs based on a multiprofessional planning during hospitalization, when the user and family members become more informed about the path to be followed in the line of care (Toldrá et al., 2019), according to the passage: “[...] *the caregiver was guided to seek by the BHU to request follow-up of the family health strategy team or other forms of home monitoring, since the user is in bed [...]*”. The records identified that referrals are performed by the medical team and, in general, occupational therapy guides the services available in the reference BHU. It was also observed that occupational therapy contacted the BHU to know about therapeutic groups and actions performed that could be indicated to users with CRI. The users were informed about the services available in their reference BHU and informed about the referrals and procedures the rehabilitation team care service. Aiming at increasing the social participation of those users, therapeutic and community groups were indicated in the community, as exemplified: “[...] *the user was referred to the occupational therapy of the BHU and informed about groups of coexistence in the Community and Cooperative Center in their neighborhood [...]*”.

4 Final Considerations

This study aimed to identify and analyze the contributions of occupational in health care of users with CRI in the hospital context. The records indicated that the actions performed by occupational therapy with CW users focused on the reception of the users' needs, support for resignification of the health-disease process, assistance to adapt to the new health condition and preparation for discharge and the new routine of care. The records indicated that actions carried out resulting from the process of illness and treatment aimed at the empowerment and co-responsibility of the user as an active subject in habits and routine changes, development of limitation coping strategies, stimulus for continuity of treatment and insertion in the service network.

It was also identified the diversified use of therapeutic techniques aimed at coping with the hospitalization process and exploring activities of interest to the user as a means of rescuing self-esteem and expression of feelings. Finally, it was pointed out the use of strategies to improve functional capacity, promote independence, adaptation and (re) organization of daily activities after hospital discharge.

The importance of the study is highlighted given the social, functional and family consequences that CRI brings to the users and their closest social network. As a limitation, we point out the fact that the study was conducted through a documentary study with records of occupational therapy reports and represents

the experience in a single hospital. However, it is believed that this work can sensitize professionals who work with this population regarding the importance of comprehensive care provided during hospitalization, contributing to the expansion of knowledge in occupational therapy in the area of hospital contexts, as well as stimulate future studies on the subject.

References

- American Occupational Therapy Association – AOTA. (2015). Estrutura da prática da Terapia Ocupacional: domínio & processo. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 26(esp), 1-49.
- Brasil. (2004). *HumanizaSUS: Política Nacional de Humanização: a humanização como eixo norteador das práticas de atenção e gestão em todas as instâncias do SUS*. Brasília: Ministério da Saúde.
- Brasil. (2013). *Diretrizes para o cuidado das pessoas com doenças crônicas nas redes de atenção à saúde e nas linhas de cuidado prioritárias*. Brasília: Ministério da Saúde.
- Coutinho, M. P. L., & Costa, F. G. (2015). Depressão e insuficiência renal crônica: uma análise psicossociológica. *Psicologia e Sociedade*, 27(2), 449-459.
- Galheigo, S. M. (2008). Terapia ocupacional, a produção do cuidado em saúde e o lugar do hospital: reflexões sobre a constituição de um campo de saber e prática. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 19(1), 20-28.
- Galheigo, S. M., & Antunes, J. R. (2008). A caracterização da produção bibliográfica nas práticas hospitalares em terapia ocupacional no Brasil: uma revisão da literatura de 1990 a 2007. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 19(2), 91-99.
- Galheigo, S. M., & Tessuto, L. A. A. (2010). Trajetórias, percepções e inquietações de terapeutas ocupacionais do Estado de São Paulo no âmbito das práticas da terapia ocupacional no hospital. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 21(1), 23-32.
- Goto, Y. (2017). Renal rehabilitation in occupational therapy for patients with chronic kidney disease. *Physical Medicine and Rehabilitation Research*, 2(5), 1-3.
- Jorge, C. F., & Toldrá, R. C. (2017). Percepção dos cuidadores sobre a experiência de cuidar dos familiares. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 28(3), 271-280.
- Lara, E. A., & Sarquis, L. M. M. (2009). O paciente renal crônico e sua relação com o trabalho. *Cogitare Enfermagem*, 9(2), 99-106.
- Lima, L. J. C., & Silveira, N. D. R. (2016). Atividades artísticas como promoção de qualidade de vida no envelhecimento. In A. C. V. Campos, E. M. Berlezzzi, & A. H. M., Correa (Orgs.), *Teorias e práticas socioculturais no envelhecimento ativo* (pp. 103-128). Ijuí: Unijuí.
- Lins, S. M. S. B., Leite, J. L., Godoy, S., Tavares, J. M. A. B., Rocha, R. G., & Silva, F. V. C. (2018). Adhesión de enfermos de insuficiencia renal crónica al tratamiento establecido. *Acta Paulista de Enfermagem*, 31(1), 54-60.
- Madalosso, F. D., & Mariotti, M. C. (2013). Terapia Ocupacional e qualidade de vida de pessoas com insuficiência renal crônica em hemodiálise. *Cadernos de Terapia Ocupacional da UFSCar*, 21(3), 511-520.
- Madeiro, A. C., Machado, P. D. L. C., Bonfim, I. M., Braqueais, A. R., & Lima, F. E. T. (2010). Adesão de portadores de insuficiência renal crônica ao tratamento de hemodiálise. *Acta Paulista de Enfermagem*, 23(4), 546-551.
- Martins, M. R. I., & Cesarino, C. B. (2005). Qualidade de vida de pessoas com doença renal crônica em tratamento hemodialítico. *Revista Latino-Americana de Enfermagem*, 13(5), 670-676.

- Minayo, M. C. S. (2007). *O desafio do conhecimento: pesquisa qualitativa em saúde*. São Paulo: HUCITEC.
- Omura, K. M., Alencar, C. N., Cavalcante, S. M., Marques, M. S. P., & Campos, C. F. (2018). Intervenções terapêuticas ocupacionais com pacientes renais crônicos no contexto hospitalar: uma análise da prática. *Revista Interinstitucional Brasileira de Terapia Ocupacional*, 2(1), 204-211.
- Organização Mundial da Saúde – OMS. (2003). *Cuidados inovadores para condições crônicas: componentes estruturais de ação: relatório mundial*. Brasília: OMS.
- Pimentel, P. P., & Toldrá, R. C. (2017). Desenvolvimento de manual para orientações básicas do dia a dia para pessoas com esclerose múltipla. *Cadernos de Terapia Ocupacional da UFSCar*, 25(1), 67-74.
- Pinto, S. C. A., & Pontes, L. M. (2017). Quality of life of the patients in hemodialytic treatment: occupational therapy intervention. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 28(1), 79-85.
- Sandri, J. V. A., & Schmitz, J. (2011). Trajetória da família de portadores de insuficiência renal crônica: desafios e a emergência familiar. *Nursing*, 13(154), 138-143.
- Santi, A., Mariotti, M. C., & Cordeiro, J. R. (2012). Lista de identificação de papéis ocupacionais em um centro de tratamento de hemodiálise: contribuições para a intervenção de terapia ocupacional – estudo piloto. *Revista de Terapia Ocupacional da Universidade de São Paulo*, 23(3), 289-296.
- Santos, C. A. V., & De Carlo, M. M. R. P. (2013). Hospital como campo de práticas: revisão integrativa da literatura e a terapia ocupacional. *Cadernos de Terapia Ocupacional da UFSCar*, 21(1), 99-107.
- Santos, L. P., Pedro, T. N. F., Almeida, M. H. M., & Toldrá, R. C. (2018). Terapia ocupacional e a promoção da saúde no contexto hospitalar: cuidado e acolhimento. *Revista Interinstitucional Brasileira de Terapia Ocupacional*, 2(3), 607-620.
- Sesso, R. C., Lopes, A. A., Thomé, F. S., Lugon, J. R., & Martins, C. T. (2017). Inquérito Brasileiro de Diálise Crônica 2016. *Brazilian Journal of Nephrology*, 39(3), 261-266.
- Shah, S., Vanclay, F., & Cooper, B. (1989). Improving the sensitivity of the Barthel index for stroke rehabilitation. *Journal of Clinical Epidemiology*, 42(1), 703-709.
- Sheshadri, A., & Johansen, K. L. (2017). Prehabilitation for the frail patient approaching ESRD. *Seminars in Nephrology*, 37(2), 159-172.
- Silva, A. S., Silveira, R. S., Machado, G. F. F., Lunardi, I. V. L., & Backes, V. M. S. (2011). Percepções e mudanças na qualidade de vida de pacientes submetidos à hemodiálise. *Revista Brasileira de Enfermagem*, 64(5), 839-844.
- Silva, S. M., Braidó, N. F., Ottaviani, A. C., Gesualdo, G. D., Zazzetta, M. S., & Orlandi, F. S. (2016). Social support of adults and elderly with chronic kidney disease on dialysis. *Revista Latino-Americana de Enfermagem*, 24(e2752), 2-7.
- Swan, J., Carr, S. E., & Fisher, C. (2019). What are the attributes of excellence in an acute practice occupational therapist? *Australian Occupational Therapy Journal*, 66(1), 52-60.
- Toldrá, R. C., Ramos, R. R. E., & Almeida, M. H. M. (2019). Em busca de atenção em rede: contribuições de um programa de residência multiprofissional no âmbito hospitalar. *Cadernos Brasileiros de Terapia Ocupacional*, 27(3), 584-592.

Author's Contributions

Jaqueline Barbosa Pereira: Main author. She contributed to the research design, performed data collection and

preliminary analysis and discussion of the results. She elaborated the preliminary version and manuscript writing and contributed to critical review. Maria Helena Morgani de Almeida: She mainly contributed in the introduction design and justification of the work, and in the discussion of the data. She contributed to the manuscript writing and critical review. Marina Picazzio Perez Batista: she mainly contributed in the design of the introduction and justification of the work, and in the discussion of the data. She contributed to the manuscript writing and critical review. Rosé Colom Toldrá: Responsible for coordinating, designing, conducting the research. She contributed in all stages of the research, introduction design, justification, discussion of the data. She contributed to the manuscript writing a critical review of the text. All authors approved the final version of the article.

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