Operational Guidelines
On
Palliative Care

Directorate of Health Services
Government of Maharashtra

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Background :

Life with an incurable and debilitating disease is often associated with lot of sufferings. In addition to physical symptoms, there are social, emotional, financial and spiritual issues which can dramatically decrease quality of life and place a burden on the family's economy and on health care system. Cancer has become one of the leading causes of death in India, with approximately 28 lakh cancer cases at any time and more than 10 lakh Indians being diagnosed with cancer each year. 80% of the patients with cancer are diagnosed in advanced stage and more than 1 million cancer patients are estimated to be suffering from moderate to severe pain every year. Also along with cancers, 2.7 million people are living with HIV in India and about 1.89 million suffer from pain. The elderly population (aged 60 years or above) would be 12.17 % of overall population by 2026 with many of them suffering from NCD as well as degenerative diseases and requiring palliative care.

According to UNICEF India, there are 220,000 children are infected by HIV/AIDS in India. Around 80000 children are suffering with Cancer and 55 to 60000 children are suffering with Thalassemia. The exact number of other life limiting conditions like Cerebral Palsy, Mental Retardation, and Sickle Cell Anaemia is unknown. Less than 1% of these children are getting the required care.

Palliative care is an approach that improves the quality of life of people with life-threatening or debilitating illness by providing relief from pain and other physical symptoms and care for psychosocial needs. To ensure the most effective care for patients, palliative care begins at the point of diagnosis, continues throughout treatment, and bereavement support is offered to the family after the patient's death. If cure is possible, palliative care provides essential care to provide pain relief, control symptoms, and minimize suffering.

The word 'Palliative Care' is derived from a Latin word 'Pallium' which means a cloak which protects oneself from distressing symptoms.

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;

is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

Components:

1. Physical: Assessment of symptoms and treatment, appropriate analgesics, care of wounds, nursing care, improving mobilization, ensuring comfort in dying patient.

2. Psychological: Communicating with the patient and families, giving appropriate information at the appropriate time, providing emotional support, empowering patients to make choices about their treatment.

3. Social : Helping patients to live as normal life as possible, dealing with problems like social stigmatization, providing support to family members to earn a living.

4. Spiritual: Helping patients and families cope with spiritual issues that may come up in the face of life limiting situations.

Overview:

In India it is estimated that the number of patients who require Palliative Care is 10 million, 1 million with cancer and 9 million with other life limiting conditions. Approximately 1 million patients in Maharashtra would require Palliative care at some stage. Most of them reside in the rural areas where, basic Palliative Care along with Morphine availability would alleviate their suffering and allow them to die in the place of their choice with dignity.

The Ministry of Health and Family Welfare (Maharashtra) along with National Rural Health Mission and mentorship of Tata Memorial Hospital has already taken the initiative to implement palliative care programme at rural centres in Jawhar and Igatpuri block. (Annexure 3)

Public Health Department of Government of Maharashtra has taken the decision to implement Palliative Care in State of Maharashtra in phases, wide GR dated 15th June 2013. (Annexure 1) In phase 1, it will be implemented at 40 PHCs from 8 districts. The overall structure would be a Community Based Model of Palliative Care as a service delivery approach implemented by a Multi – Disciplinary team.

Who would need Palliative care?

Palliative care is provided to people of all ages who are suffering with life limiting/life threatening conditions. The need for palliative care does not depend on any specific medical diagnosis, but on the person's needs. Some of the common medical conditions of people requiring palliative care include:

1. Malignancies: Cancer
2. Non - Malignant conditions:

- Chronic Cardiac diseases
- Chronic Neurological diseases(MND, Multiple Sclerosis, Parkinson’s and Hemiplegia)
- Chromosomal disorders
- Chronic Respiratory diseases

- Genetic blood diseases
- Chronic Nephrological Disease
- Infectious disease like HIV, MDR/XDR TB
- Geriatric Care: Dementia, Parkinsonism, Diabetes Mellitus, Complicated Hypertension
- Paediatric Care: Cerebral palsy, Sickle Cell Anemia, Thalassemia major, epilepsy, mental retardation, metabolic syndromes like diabetes, taysachs disease etc.

Families and caregivers also receive support from palliative care services. Families provide much of the care for people who are dying, and practical and emotional support for them in this role is critical.

Where will the Palliative care services be provided?

Palliative care services will be provided at all levels of health care system. The focus of palliative care at Community level will be on Home based care, along with Palliative care services on OPD basis and home visits at Sub Centre and Primary Health Centres. At Sub-District Hospital (SDH), Rural Hospitals (RH), the services will be provided through dedicated OPD. The pattern of care will be different for every individual, and may depend on factors like: needs and desires of the person, family members and friends, geographical location of the residence and health care facility and the services in the area. In general, palliative care is best provided within close proximity to the person's local environment.

Who would be involved to provide Palliative care services?

Palliative care involves coordination of the skills and disciplines of many service providers. Those involved in palliative care may include:

- Medical professionals working in the health system, from all disciplines that have been trained in palliative care.
- Nursing staff who have been trained in palliative care
- Multipurpose Health workers, ASHA and other volunteers who are trained in palliative care.

- NCD staff, RNTCP, ICTC staff of National AIDS control programme, link workers and other related health care providers.
- Family members and caregivers of the patient who provide daily care.
- Voluntary workers interested in the field of palliative care and trained to provide PC at the community level.
- Private practitioners of any discipline trained in palliative care,
- NGOs and CBOs working in the field of NCD or Geriatric Medicine.

Goal:

Availability and accessibility of rational, quality, pain relief and palliative care to the needy, as an integral part of health care at all levels in alignment with the community requirements.

Objectives:

- Improve the capacity to provide Palliative Care service delivery by integrating NCD health program (Cancer, Cardiovascular diseases, Diabetes, Stroke, Care of Elderly, AIDS Control)
- Provide Morphine for medical and scientific use.
- Encourage Attitudinal Shifts among health care professionals.
- Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief.

Guiding Principles:

1. Pain relief and Palliative care are recognised as essential components of health care
2. Involvement of Public, private as well as non-profit systems of health care should be basic to fulfil the requirements of reach, quality and sustainability
3. Multidisciplinary team approach inclusive of person and family as necessary to fulfil the diverse care needs in an individual situation

4. Recognise the role and facilitate the integration of Alternative Systems of Medicine in providing for a holistic care
5. Systematic planning, implementation and monitoring of the program
6. Field level health workers and their supervisors should be able to incorporate the principles of palliative care into their routine activity at the household level. For this purpose the existing manpower and institutions in health need to be oriented and equipped adequately
7. Systematic integration of program planning, implementation and monitoring into the existing health care delivery system. Research into the field and identification of newer and better ways in improving the palliative care services is a must.

Expected Outcomes:

1. Provision of Palliative care services in the PHC through the Medical Officer and start Palliative care clinic on fix days of week,
2. Provision of Home based care through PHC and sub centre
3. Provision of Palliative care ward (10 beds) at District Hospital and appointment of 1 doctor (MBBS) and 4 Nursing staff.
4. The staff at various levels should be trained in palliative care.
5. Provision of palliative care through private practitioners and AYUSH professionals throughout Maharashtra.
6. Development of continuous monitoring and evaluation of the programme.
7. Conducting Research in the field of Palliative care.

Service Package:

The service provided would depend on the level of health facility and may vary from facility to facility. The range of services will include providing physical symptom control, psychosocial, spiritual support and rehabilitative services in an outpatient and inpatient basis, with focus on home based care. Districts will be linked to Tertiary Hospital (Medical or super- speciality hospital) for providing tertiary level care. The services under the programme would be integrated

below district level and will be integral part of existing primary health care delivery system and vertical at district and above as more specialized health care.

Roll of each Level Health Facility:

1.	Cancer Hospital & palliative care centre referral centre.	• Training • Conducting Palliative Medicine CMEs and Courses • Research
2.	District Hospital Medical Officer Palliative care-1 GNM-4	• Palliative care centre. • Palliative care OPD(two days in a week) • Palliative care IPD • Counselling • Training • Home Visit/field visit (3 days in a week to the identified blocks for palliative care services by MO Palliative care. Out of 4 GNMs one will attend Palliative care OPD and IPD at District Hospital. 3 GNMs will be allotted one block each from the identified blocks for Home based palliative care services.) This will be done in rotation every 6 monthly. • Implementation of the programme as per the operational guidelines • Attending referrals • Integration of the programme with the other stakeholder department • Integration with the related national health programmes • Monitoring • Timely Reporting • Follow Up • IEC of the programme
3.	RH/ SDH	• NCD clinic, registration by MO-NCD • Councelling by NCD councellor • Provide Home based care by NCD-GNM and councellor. • Collaborate with the local NGOs and CBOs • IEC of the programme

4.	THO	• Monitoring of 3 blocks of PHC • Training of PHC staff MO, ASHA • Maintain PHC level Records • Reporting to Medical Supritendent • IEC of the programme
5.	PHC Level (MO-NCD)	• Confirmation of Patient identified by ASHA • OPD and Registration • Treatment and follow up. • Home visit and reporting.
6.	Community Level/Village Level ANM ASHA	• Supervising the Home based care by ASHA • Provide care and support to patients at home visits • Capacity building of the patients and caregivers • Networking with the local representatives to form a community support group. • Identify potential patients needing palliative care • Registering and notifying the patients to MO, PHC • Assessing the patients and provide appropriate support • Home visit and follow up of the patients • Empowering patients and caregivers towards sharing the responsibility of care • Provide bereavement support • Collecting and distribution of logistics • Interpersonal Communication/ IEC of the programme

Management Structure:

District Hospital:

A palliative care clinic will be established at the district hospital, which will have a dedicated contractual staff of a palliative care. Medical Officer Palliative care ,GNM and a Medical Social Worker (trained in palliative care at Centre of excellence).

- There will be a morning, evening palliative care OPD on 2 fix days of week.

- District hospital will have 10 beds dedicated to Palliative care distributed in wards of various departments with few beds reserved for paediatrics.
- Supportive services will be provided by General Medicine, Paediatric discipline, physiotherapy, laboratory services from the District Hospital.
- The team of Palliative clinic will provide support to the Medical officers and paramedical staff of sub district/rural hospital and PHC's.
- Complicated cases will be referred to tertiary level hospitals for specialist advice. And treatment.
- Civil Surgeon/ Medical Superintendent of various health institutes will be responsible for procurement, and disbursement of morphine.
- District hospital will also be responsible for conducting supervisory visits and maintaining compiled data, regularly sending reports to the State NCD cell.

SDH/Rural Hospital:

- Palliative care Medical officer will visit identified blocks/taluka and will pay visit to the patients needing palliative care with NCD staff.
- This will be the first medical referral unit for patients from PHCs and below.
- Physiotherapist/ Multi-task worker will provide physiotherapy and medical rehabilitation at SDH/CHC. Medical officer, GNM, Physiotherapist/ Multi-task worker are supposed to conduct home visits to all the registered patients in a scheduled manner. The services of physiotherapist should be made available either from DH or 100 bedded SDH.
- Referral for further investigations and treatment to District Hospitals/Medical Colleges as per need.
- Medical officer Palliative care will compile data received from all the PHCs and forwarding the same to the District Palliative care Co-cordinator.

Primary Health Centres:

- The MO PHC will be assisted by a nurse under NPCDCS programme.

- Home visits will be conducted by the MO-PHC along with the nurse and multitask workers in a scheduled manner or if needed in case of emergencies.
- Transfer of the patient to the referral institute will be done by the MO-PHC.
- Morphine will be stored and dispensed as per the need.
- Individual case records and follow up records will be maintained at the PHC.
- Supervisory visits will be conducted by the MO
- Review meetings along with refresher sessions for ANM, MPW and ASHA will be regularly conducted.

Sub Centre Level:

- The ANM at the sub centre will do the home visit to the patients for palliative care and will guide the ASHA to provide Home based care to patients with life limiting diseases.
- She will supervise the ASHA, will guide her in capacity building of the patients and caregivers
- Maintain village wise updated records of the patients under palliative care.
- She will guide the ASHA in increasing the community awareness by conducting awareness camps.
- She will be responsible for initiating the ASHA to network with the local representatives to form a community support group.
- Palliative care services will be given by MO PHC with the help of ANM and ASHA. Palliative care cases will be identified by ASHA & registered by MO-PHC.

Roles and Responsibilities:

District Programme Co-ordinator/Program Officer-NCD:

- They are responsible for the planning, implementation and supervision of the programme under control and guidance from Civil Surgeon.
- To set up and manage palliative care clinic with the help of Nodal Officer (Additional civil surgeon).
- He is responsible for regular supply of logistics and medicine kits to ASHA.
- He should collect the report from field officers and submit through the civil surgeon.
- Review the programme at district and below district level.
- Organizing training for Medical Officers and paramedic staff.
- Collaborating with States, Medical colleges, NGOs, and other related services.

- In the absence of MO-Palliative care District Programme Co-ordinator will look after the responsibilities of Palliative care MO for smoothly running of Palliative care services.
- Medical officer-Palliative care has to visit RH/SDH/PHC in the identified blocks and provide technical and administrative support.

Palliative Care Medical officer (PC Clinic):

- He/she will be responsible for conducting morning and evening OPD on fixed days twice a week, He is also responsible for examination of IPD patients in the afternoon , & referral of patients if needed to higher centres.
- He/she should visit the patients requiring palliative care on community basis (Home visits) along with GNM and Multi-task worker, and arrange for follow up palliative care to the patients.
- He/she will conduct supervisory visits to CHCs / PHC /SC as per priority.
- He/she will be responsible for smooth and proper functioning of palliative care clinic
- He/she will work under control and guidance of head of the Institute.

- He/she will be responsible for maintaining updated records of the clinic and Reporting.
- Monitoring and reporting of the program
- Any other Job assigned by concerned officer.

Palliative care Nurse:

- She will be assisting Palliative care physician in palliative care clinic.
- She will be responsible for complete nursing care of the patient in the PC clinic &IPD patients.
- She will also conduct home visits along with Medical Officer and Multi-task worker.
- She will maintain updated records of the individual patients and reports
- She will provide guidance to the field staff including ASHA and others.

Multi-task Worker:

- He will be assisting Palliative care Medical Officer in their work.
- He will provide Counselling in palliative clinic as well as during home visits.
- He will network with the local NGOs and CBOs to provide community support to the patients.
- He will also maintain records and do the reporting

Physiotherapist:

- The services of physiotherapist should be made available in the PC clinic as well as for home visit specifically for bedridden patients.
- He Will Provide the services as per Guideline given by State and district Office

PHC- MO:

- He will register those patients referred by the ASHA who fit into the criteria of chronic life threatening illness. With the help of GNM-NCD and social worker/counsellor, he will provide physical symptom assessment and management, psychosocial and spiritual support (Annexure 6). He will fill the details of the patients in a case record sheet at the first visit and will update the record and maintain it.

1. He will provide Palliative care to the patients reffered by subcenter health worker in OPD at the PHC.
2. He will also provide domiciliary care to the patients and if needed will do the referral to the RH/SDH/DH.
3. Providing logistic support to ASHA and ANMs: The MO will provide logistic support in the form of drugs, equipment and stationary. He will maintain the record and copy of the same will be provided to ASHA and ANM. A monthly report of the record will be maintained and will be submitted to the higher centres for procurement of drugs and equipments.
4. Collaborate with the local NGOs and CBOs: He will coordinate with the ASHAs and ANMs to empower the local NGOs and CBOs in order to provide social support to the patients and generate awareness in the community on palliative care.
5. Periodic Evaluation and Refresher training: The medical officer is in charge of the overall activity in the PHC and the community. He will supervise the work of the ASHA and ANMs and provide monthly refresher training to them. He will keep stock of the drugs, equipments and register and submit monthly reports to the district NCD cell.

PHC Nurse, ANM and MPW:

- The PHC Nurse will be responsible for giving Palliative Care Services in PHC as well as by Home visit under Guidance & supervision of PHC Medical Officers
- She will responsible for Nursing Care at PHC and in Home visit
- She will also be providing Counselling if required to the PC Care Patients
- ANM/ASHA will visit and Identify patients for Palliative Care and prepare line listing of the patients for Palliative care services.
- She will be giving Technical Support to ANM MPW of Sub centre and ASHA and other village level worker.

- She will also be responsible for Maintaining all PHC register, Case record Form.

ANM and MPW at the Sub centre:

1. They will provide domiciliary Palliative Care under the guidance of PHC Nurse and Medical Officers.
2. Provide domiciliary care: The ANM will provide domiciliary care in collaboration with the ASHA. In the visit, she will do wound management, assess and manage tubes, provide education to patients and caregivers on wound and tube care, morphine use and counsel the patients and relatives as and when needed.
3. Supervising the domiciliary care by ASHA: During home visits, the ANM will assess the care and support provided by the ASHA. Scrutinise the records maintained by the ASHA and provide corrective measures.
4. Provide appropriate referral to the higher centres.
5. In coordination with the ASHA and MO PHC link the patients and caregivers to local support groups and NGOs.

ASHA:

ASHA will be an important link between the community and the health system.

1. Identify potential patients needing palliative care:

   ASHA will be given a questionnaire (checklist of symptoms defining a disease). Based on this checklist she will identify potential patients and refer them to the MO, PHC where the patient will be registered.
2. Providing Domiciliary care: ASHA will provide domiciliary care to the registered patients. She will provide at least two visits in one month to one patient and as and when there will be a need. In each visit she will provide the following services:
   - Counselling support

- Basic wound and tube care
- Check drug compliance
- Also provide appropriate referral to the MO PHC
- Organise visit by MO PHC and ANM in difficult cases
- She will assess the social environment in the house and with the help of the MO PHC and ANM will liaison the local NGO and CBOs for support.

3. Empowering patients and caregivers towards sharing the responsibility of care: This will include wound care, tube care, nutrition education and hygiene.
4. Provide bereavement support: The ASHA will provide bereavement support to relatives within 15 days of the death of the patient. With the help of the MO PHC and ANM she will liaison with the local NGO to provide appropriate support to the family.
5. Collecting and distribution of logistics: She will keep record of the drugs and equipments used from the ASHA kit and produce a monthly report of the same to the ANM and MO PHC. She will procure the drugs and equipments from the PHC on a timely basis.
6. Sensitisation of the community by different media: She will organise regular community education programmes with the help of the MO PHC and ANM in order to create awareness about palliative care. This will be done through pamphlets, posters, role plays etc.
7. Monitory benefits:

- GOI sanctioned Rs. 500/- per visit for counselor.&GNM
- Currant practice to pay visit charges 50% to GNM and 50% to MSW.
- ASHA incentives Rs25/- per new case detection
  Rs20/- per visit per week for Homecarefrom miscellaneous expenditure.
  <u>Proposed- Rs/-40/- for first visit@20 for subsequent visits per patient to ASHA, Rs/-200 to GNM +Rs/-200 to MTW</u>

Implementation Strategy:

Capacity building:

1. Identification of Blocks:

In Palliative Care districts along with headquarter block (taluka) two other blocks will be Identified for the Palliative Care Program. MO-Palliative care will render his services on priority basis to the patients in the identified blocks regularly with Multi-task worker and GNM and if required services of Physiotherapist (NCD) will be utilised for the home based care.

2. Identification of Training centre:

The Centres of Excellences will be the training centres for, special training for Medical officers and other staff working under the palliative care Programme. This will be done in the phased manner. The Primary Health Centres will also be designated as a training centre for ASHA. Training can be arranged in collaboration with TATA Memorial centre and Cipla palliative care Training Centre Pune.

The training will be provided to all cadres of medical and paramedical professionals. The duration and the module of training will depend on the cadre.

3.Training of the Master Trainers

Venue: The training will be conducted in the designated COE (Centres of excellence.)

Duration: The training will comprise of 3 to 5 days lectures in palliative care

Training Module will cover the following:

- Symptom Assessment and Management principles and Emergencies in Palliative Care
- Psychological and Social Assessment and Counselling
- Domiciliary Care of patients

- Nursing care and other Paramedical care of the patients
- How to assess burn out among the employees by conducting review meeting and managing staff distress.

Teaching Methods: Didactic Lectures, Presentation, Case discussion, role plays and assignments.

Training of the ASHA workers:

Venue: The training will be conducted in the Primary Health Centre.

Duration: The training will be for duration of 1 day which will be followed by refreshers training conducted by the MO, PHC and ANM on a monthly basis.

Training Module will comprise of the following:

- Identification of potential patients who will benefit from palliative care through a Proforma (checklist of symptoms that will define a particular disease)
- Domiciliary care which will include:

1. Management of wound and tube care and drug compliance
2. Psychosocial and spiritual support though counselling
3. Social support by liaising with local NGOs, CBOs in coordination with MO PHC.
4. Self care and debriefing with the ANM and MO PHC

Training Method: Lectures, presentations, demonstrations and role plays

Training of the Medical Officers and Nurses:

Venue: The training will be conducted in the designated Centres of excellence.

Duration: The training will comprise of 3 day lectures in palliative care followed by 4 weeks of hands on practicum training in the designated specialist palliative care centres.

Training Module will cover the following:

- Symptom assessment and management principles and emergencies in palliative care
- Psychological and social assessment and counselling
- Domiciliary care of patients
- Nursing care and other paramedical care of the patients
- Self Care and debriefing session with colleagues

Teaching Methods: Didactic Lectures, Presentation, case discussion, role plays and assignments.

Training of Counsellors and Medical Social Workers:

Venue: The training will be conducted in the designated Centres of excellence.

Duration: The training will be conducted for 15 days which will include both theory and practicals.

Training Module will comprise of:

This will cover the following topics:

- Communication
- Breaking bad news
- Spirituality
- Collusion
- Bereavement
- Stages of grief and management
- principles of symptom management,
- Counseling in paediatric and adolescent patients.

This will be followed by practical training in the form of observership and hands on experience under supervision.

Teaching Methods: Didactic Lectures, Presentation, case discussion, role plays and assignments.

Integration at all Levels:

1. The palliative care programme should be integrated with the other National Programmes like the NPCDCS and NPHCE, National Mental Health programme.
2. If required in case of unfilled vacancies, Physician and nurse trained in Palliative care for 4week should be appointed on contract/fulltime basis at speciality hospitals (RH/SDH/DH).
3. Activate public-private partnerships to upscale access to palliative care across the health system.
4. Private practitioners after adequate training can be encouraged to provide home based palliative care services. This can be achieved by collaborating with the IMA bodies and emphasizing the need for the general practitioners to get trained in palliative care.
5. Involving MMC in decision making regarding the regulatory processes of license renewal.
6. Active involvement of AYUSH professionals in the provision of palliative care services by making it mandatory for them to undergo training in basic course in palliative care for the renewal of license by the MMC or their local councils.
7. Involvement of the NGOs and CBOs to design and implement community based palliative care programs with emphasis on home based and comprehensive care.
8. Collaboration with the other departments like department of women and child welfare, department of finance, department of media and broadcasting etc.

   Medicines and consumables.

   The Medicine should be made available at Medical college hospital, District hospital, SDH/ RH and PHC. The drugs required for Palliative Care at various facilities is shown in Annexure No.11

   ASHA will be provided AHSA Kit containing common Medicine and dressing material. As per Anex. No. 12

Regulation of Morphine Procurement and Dispensement:

- Obtain license for morphine from FDA as per NDPS regulations.(Annexure 5)

- Ensuring uninterrupted supply of opioids and drugs.
- Empowering PHC to achieve the status of RMI.
- Ensuring clear guidelines for procurement and storage and dispensing medicines like morphine.
- Encourage delivery of quality PC service through provision of "Clinical Establishment Act"
- Emphasize requirement of "A hospital pain policy and end of life care."
- Collaborating with the insurance companies to cover PC services.
- Encourage private and workplace sponsored reimbursement plans for PC.

Information, Education and Communication (IEC):

State in collaboration with the tertiary care will prepare prototype IEC material on Palliative care to sensitize community about holistic care and inform about services available through various electronic, print media, and other channels. These will be disseminated to the Districts for adoption and dissemination. Messages through mass media will also be organized through the state through Radio, Television, Internet and Print media.

Monitoring, Evaluation and Research:

1. Standard formats for recording and reporting will be prescribed by the State NCD cell. A Management Information System will also be developed to computerize the information.
2. Review meetings of District Programme Officers (NCD) will be organized on a quarterly progress to assess physical and financial progress and discuss constraints in implementation of the programme.
3. Evaluation of the programme will also be planned and organized by the State NCD cell.
4. Key gaps identified during implementation of the programme and innovative interventions will be addressed through planned operational research.

Level	*Person in Charge*	*Reporting to*	*Frequency of submission*
Sub-centre	ANM/MPW	MO I/c PHC	Monthly
PHC	2 MO I/c PHC	District NCD cell	Monthly
CHC	Medical Superintendent/ Palliative care co-ordinator	District NCD cell	Monthly
District	District Programme Officer/Palliative care Co-ordinator /MO I/C Palliative Medicine Clinic	State NCD Cell	Monthly

Record and Reporting:

The format of PHC registers, Patient Case record, Nursing assessment record and ASHA workers
(Annexure 7-12)

Financial Management

The budget will be provided for salary of contractual staff, their transportation, Medicine & logistic, training and for IEC. The contingency fund will be kept at every facility.

Phase Wise Action Plan:

To begin with programme will be implemented in 8 districts of Maharashtra of which 6 old districts of NCD (Washim, Amravati, Bhandara, Chandrapur, Gadchiroli and Wardha) and two new NCD districts (Satara and Nandurbar)

Financial Guidelines Under Palliative Care Programme for Year 2014-15

Financial management groups (FMG) of Programme Management support units at state and district level, which are established under NHM, will be responsible of maintenance of accounts, release of funds, expenditure reports, utilization certificates and audit arrangements. The funds will be released to States/UTs through the State Health Society to carry out the activities at different levels as envisaged in the operational guidelines. Palliative care programme would operate through NCD cells constituted under the programme at State and District levels. No separate bank account is allowed to open.

Financial assistance under the programme:

Government of India has kept budget provision for various activities mentioned in the program. Guidelines for the utilisation of funds are given below:

A) State Palliative Care Cell :

A1.Reccuring Grant

A1.1 Human Resource :

As mentioned above, the following posts & remuneration are sanctioned

1. State Palliative Co-ordinator-1 (MBBS @ Rs.50000/-pm)
2. DEO-cum-Accountant-1 (@Rs.9600/pm)

A1.2. Misc. expenditure workshop/stationery/ POL/ communication etc.:

Provision of Rs.1.00 Lakh per year is kept for this purpose for purchase of stationary, toner cartridge, TA/DA expenses and other expenses as telephone, internet expenses and maintenance of office equipment etc.

B) District Palliative Care Clinic:

B1.Non-Reccuring Grant

B1.1Renovation of pc unit/OPD/Beds/Misc. Equipments etc.:

This grant is for establishment of the Palliative Care Clinic in the District Hospital. Sufficient space is to be identified for it near NCD clinic in the District Hospital. Budget of Rs. 15.00 Lakh should be utilised as follows:

i. Renovation and civil works for sitting of four persons in District Hospital near NCD clinics. This renovation can be done by IDW Engineer or by PWD.
ii. Purchase of furniture for sitting arrangement of four persons. Furniture to be purchased either from MSSIDC rate contract or from Jail authorities.
iii. Separate stock register is to be maintained for fixed assets/dead stock. All the fixed assets are to be serially numbered.

B2.Reccuring Grant

B2.1 Human Resource :

1. Medical Officer (MBBS)-1@ Rs. 40000/-
2. Multi task worker-1 @ Rs.15000/-pm
3. Nurse-4 @ Rs. 12000/-pm
4. ? Palliative care co-ordinator

B2.2 Training :

Provision of Rs.2.00 Lakh per year is kept for this purpose

B2.3 Drugs & Consumables :

Provision of Rs.3.00 Lakh per year is kept for this purpose

The list of drugs required under palliative care programme will be provided.

Purchases should be made as per standard procurement guidelines.

B2.4 TA/DA/POL :

Provision of Rs.2.00 Lakh per year is kept for this purpose. Vehicle to be provided as per NRHM norms??

B2.5 Information, Education & Communication:

Provision of Rs.0.50 lac per year is kept for the IEC activities; here various Day's celebration like WHO day, Cancer Awareness Day, World Diabetes Day, World No-Tobacco Day etc, arranging press conferences to furnish the disease information, Display of Banners and posters in OPD/IPD and various public places to aware the community regarding the risk factors of NCDs and asking them to screen themselves for various NCDs.

B2.6 Misc.expenditure stationery/communication etc.:

Provision of Rs.2.50 Lakh per year is kept for this purpose for purchase of stationary, toner cartridge, expenses and other expenses as telephone, internet expenses and maintenance of office equipment etc.

ANNEXURES

Annexure 1

Government Resolution (GR) on Palliative Care

महाराष्ट्र शासन
सार्वजनिक आरोग्य विभाग
शासन निर्णय क्र.संकीर्ण २०१३/प्रक्र-१६८/आरोग्य ३(अ)
गो.ते.रुग्णालय संकुल इमारत, १० वा मजला,
नवीन मंत्रालय, मुंबई ४०० ००१.
दिनांक :-१७ जून,२०१३.

प्रस्तावना :-

शारिरीक आरोग्य ढासळल्यामुळे माणसाच्या जीवनावर बऱ्याच अंशी परिणाम झाला आहे. जागतिक आरोग्य संघटनेनुसार आरोग्याची व्याख्या म्हणजे केवळ रोगांचा अभाव नसून शारिरीक, मानसिक व सामाजिक स्वस्थता असणे म्हणजेच आरोग्य होय. जसजसे जगण्याचे सरासरी वयोमान वाढत आहे तसतसे जीर्ण आणि दुर्धर रोगांचे प्रमाणही वाढत आहे. हृदयरोग, पक्षाघात, कर्करोग, मधुमेह यासारखे असंसर्गजन्य रोग त्याचप्रमाणे एच.आय.व्ही., औषधालाही न जुगानणारा क्षय रोग (MDR/XDR-TB) अशा संसर्गजन्य रोगांमध्ये शारिरीक वेदना व अन्य लक्षणांबरोबरच या रोगांमुळे उद्भवणाऱ्या मानसीक व्यथांमुळे केवळ रुग्णांच्याच जीवनावर नव्हे तर त्यांच्या कुटुंबियांच्या आणि पर्यायाने संपूर्ण समाजावर त्याचा दूरगामी परिणाम होतो यासाठी या रुग्णांची व त्यांच्या कुटुंबियांची काळजी घेणे आवश्यक आहे.

पॅलिएटिव्ह केअर हे वैद्यकीय शास्त्रातील असे क्षेत्र आहे, जे दुर्धर आजारांवर इलाज करीत नसून अशा रुग्णांचे जीवनमान सुधारण्याचा प्रयत्न करते. वेदना व इतर लक्षणांपासून आराम पुरविण्याबरोबरच यामध्ये मानसिक वेदनांपासून मुक्ती देण्यासाठी प्रयत्न केला जातो. त्यामुळे दुर्धर आजारांनी ग्रस्त अशा रुग्णांचे व त्याच्या नातेवाईकांचे जीवनमान सुधारण्यास मदत होते. यामध्ये दुर्धर आजाराने ग्रस्त अशा रुग्णांना अखेरपर्यंत सर्व प्रकारचा आधार दिला जातो. त्याच्या कुटुंबियांनाही औषधोपचाराची माहिती, आजारा बाबतची माहिती व सल्ला दिला जातो. दुर्धर रोगांमध्ये सुरुवातीपासून ही सेवा दिली जाते जेणेकरुन केमोथेरपी, रेडिएशन किंवा अन्य उपचारांद्वारे होणाऱ्या वैद्यकीय गुंतागुंतीपासून काही अंशी आराम मिळू शकतो.

शासन निर्णय :-

राज्यातील दूर्धर रोगांनी ग्रस्त असणाऱ्या रुग्णांचे व त्यांच्या नातेवाईकांचे जीवनमान सुधारण्यासाठी व त्यांना वेदनांपासून मुक्ती देण्यासाठी पॅलिएटिव्ह केअर (उपशामक सेवा किंवा परिहार सेवा) प्रकल्प

P.O. PPP
C:-Note-Paliativecare11
17/6/13

राज्यात टप्याटप्याने राबविण्याचा निर्णय घेण्यात आला आहे. याअनुषंगाने पुढील बाबी करण्यात येणार आहेत :-

(१) पॅलिएटिव्ह केअर ही सेवा सुरु करण्यासाठी शासकीय रुग्णालयांमध्ये आवश्यक त्या वैद्यकीय साधन सामुग्री व औषधांची तरतूद करणे.

(२) मॉर्फिनसारखे प्रभावी वेदनाशामक औषध उपलब्ध करुन देण्यासाठी अन्न व औषध प्रशासनाद्वारे मॉर्फिन लायसन्स, साठवण व वितरण यामध्ये सुलभता आणणे.

(३) रुग्णांना अधिक चांगली सेवा देण्यासाठी डॉक्टर्स,परिचारीका,आरोग्य सेवक /सेविका,आशा, एम.पी.डब्ल्यू यांना प्रशिक्षण देणे. यासाठी विविध ठिकाणी शैक्षणिक केंद्र सुरु करणे.

(४) वर नमूद केलेल्या सर्व बाबींसाठी आर्थिक तरतूद करणे.

(५) पदवी व पदव्युत्तर वैद्यकीय, नर्सिंग, औषधी शिक्षण (फार्मसी) व समाजसेवा या अभ्यासक्रमात पॅलिएटिव्ह केयरचा समावेश करणे

(६) सर्वसामान्य जनतेपर्यंत ही पोहोचविणे व त्याअनुषंगाने समाजामध्ये जागृती निर्माण करण्यासाठी वर्तमानपत्र, दूरदर्शन व अन्य माध्यमांचा वापर करुन घेणे.

(७) खाजगी वैद्यकीय संस्थांमध्ये पॅलिएटिव्ह केयरची सेवा उपलब्ध करुन देणे

(८) आयुष अंतर्गत येणाऱ्या वैद्यकीय व्यावसायीकांना प्रशिक्षित करणे

(९) निमसरकारी व बिनसरकारी संस्थांचे सहकार्य घेणे.

पॅलिएटिव्ह केअर सर्वसमावेशक होण्यासाठी :-

१) कुटुंबिय, स्वयंसेवक यांना प्रशिक्षण देऊन घरी रुग्णांची काळजी घ्यायला शिकविणे गरजेचे आहे.

२) विभागीय व जिल्हा स्तरावर असणाऱ्या सरकारी रुग्णालयांमध्ये या सेवेचा समावेश करण्यात येईल. सरकारी रुग्णालयात आठवडयातून दोन दिवस तरी पॅलिएटिव्ह केअर सेवा पुरविणारी बाहय रुग्णसेवा निर्माण करण्यात येईल. उपकेंद्र, प्राथमिक आरोग्य केंद्र यामध्ये असलेल्या परिचारीका, आशा, एम.पी.डब्ल्यू, गावात घरोघरी भेटी देत असतात. अशा पॅलिएटिव्ह केअर आवश्यक असलेल्या रुग्णांचा शोध त्यांचेमार्फत घेतल्यानंतर प्राथमिक आरोग्य केंद्र, ग्रामीण रुग्णालय येथील वैद्यकीय अधिकारी अशा रुग्णांची भेट घेऊन त्यांची तपासणी करतील, त्यांना व त्यांच्या कुटुंबियांना औषधोपचार, रुग्णांचा आहार, स्वच्छता इ.बाबत माहिती देतील. त्यानंतर त्या उपकेंद्र, प्राथमिक आरोग्य केंद्रामधील परिचारीका, आशा, एम.पी.डब्ल्यू या रुग्णांना व त्यांच्या कुटुंबियांना औषधे देण्यात मदत करतील. रुग्णांना बेडसोर्स होऊ नये यासाठी नातेवाईकांना माहिती देतील व मदत करतील. त्याचप्रमाणे रुग्णांना आवश्यक असलेली इंजेक्शन देणे, कॅथेटर बदलणे ही कामे करतील. रुग्णांना आजाराच्या वेदना सुसहय व्हाव्या तसेच नातेवाईकानाही काही अंशी रुग्णांच्या काळजीपासून आराम मिळावा यासाठी त्यांचे समुपदेशनही केले जाईल. या सर्व कामात प्रशिक्षित स्वयंसेवकांची मदत घेतली जाईल. सामाजिक पातळीवर काम करणाऱ्या संस्था शोधून

त्यांचा यात समावेश करण्यात येईल जेणेकरुन गाव पातळीवर काम करणाऱ्या आशा व इतर आरोग्य सेवकांचे जाळे विणून पॅलिएटिव्ह केअर सेवा सर्वदूर पोहोचविली जाऊ शकेल.

यासाठी आवश्यक असलेल्या कर्मचारी वर्गासाठी पुढील बाबी करणे गरजेचे आहे :-

(१) मान्यताप्राप्त केंद्रांमधून किमान ६ आठवडयांचे प्रशिक्षण घेतलेला पॅलिएटिव्ह केयर सेवेमध्ये पात्र असलेला एक चिकित्सक विशेष सेवा रुग्णालयांमध्ये नियमित/कंत्राटी तत्वावर नियुक्त केला जावा.

(२) ६ आठवडयांचे प्रशिक्षण घेतलेली एक परिचारीका रुग्णाच्या संख्येच्या १:३ या प्रमाणात विशेष सेवा रुग्णालयामध्ये नियमित /कंत्राटी तत्वावर नियुक्ती केली जावी. एन.पी.सी.डी.सी.एस. (National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular disease, Stroke) अंतर्गत नेमलेल्या दोन समुपदेशकांना पॅलिएटिव्ह केअरचे ६ आठवडयांचे प्रशिक्षण देण्यात यावे. त्याचप्रमाणे वेदनाशमन, दीर्घ मुदतीची काळजी तसेच पॅलिएटिव्ह केअरचे प्रशिक्षण सर्व विशेष सेवा रुग्णालयांमधील वैद्यकीय व परिचारक कर्मचाऱ्यांना व निवडक शासकीय वैद्यकीय महाविद्यालयातील कॅन्सर सेवेतील कर्मचाऱ्यांना देण्यात यावे.

(३) जिल्हा रुग्णालय :- पॅलिएटिव्ह केअरमध्ये प्रशिक्षित असलेला चिकित्सक, रुग्णांच्या संख्येशी १:३ या प्रमाणात मान्यताप्राप्त केंद्रांमधून किमान ६ आडवठयांचे प्रशिक्षण झालेल्या परिचारीका व एक समुपदेशक/सामाजिक कार्यकर्ता यांचा समावेश करण्यात यावा.

(४) शासकीय वैद्यकीय महाविद्यालय :- पॅलिएटिव्ह केअरमध्ये प्रशिक्षित असलेला चिकित्सक, मान्यताप्राप्त केंद्रांमधून किमान ६ आठवडयांचे प्रशिक्षण झालेल्या परिचारीका व एक समुपदेशक/सामाजिक कार्यकर्ता यांचा समावेश करण्यात यावा.

(५) उप जिल्हा रुग्णालय/ग्रामीण रुग्णालये व प्राथमिक आरोग्य केंद्रामध्ये एन.पी.सी.डी.सी.एस. व एन.पी.एच.सी.ई. कार्यक्रमांतर्गत नियुक्त केलेले सध्याचे कर्मचारी याकरिता वापरण्यात येतील.

(६) प्राथमिक आरोग्य केंद्र :- १ प्रशिक्षित डॉक्टर, १ नर्स व एक समुपदेशक/ सामाजिक कार्यकर्ता यांच्याद्वारे घरगुती काळजी सेवा पुरविण्यात येईल.

(७) निवडक जिल्हयांमध्ये पॅलिएटिव्ह केअरचा अंतर्भाव " आशा " च्या जबाबदाऱ्यांमध्ये केला जावा. आशा च्या मोबदल्याकरिता एक योजना आखली जावी. प्रशिक्षित आशा ला प्रशिक्षित स्वयंसेवकाशी जोडले जावे.

(८) आशा करिता समुदायस्थित पॅलिएटिव्ह केअरचा तीन दिवसीय प्रशिक्षण कार्यक्रम व त्यानंतर दर महिन्यास एक दिवसाचा उजळणी अभ्यासक्रम आखण्यात यावा. याकरिता केरळमध्ये उपलब्ध असलेल्या ३ महिन्यांच्या कार्यक्रमाचा अभ्यासक्रम योग्य ते फेरबदल करुन वापरावा.

(९) आशा च्या नेतृत्वाखाली चालविण्यात येणारा समुदायस्थित पॅलिएटिव्ह कार्यक्रम जिल्हयातील प्राथमिक आरोग्य व्यवस्थेशी जोडण्यात यावा.

(१०) खाजगी चिकित्सकांना पुरेसे प्रशिक्षण देऊन घरगुती पॅलिएटिव्ह केअर सेवा पुरविण्यास उत्तेजन द्यावे.

(११) स्थानिक आय.एम.ए. च्या मदतीने सर्वसामान्य चिकित्सकांकरिता सीएमईद्वारे जाणीव जागृती कार्यक्रम घेण्यात यावा. तसेच सर्वसामान्य चिकित्सकांनी पॅलिएटिव्ह केअरमध्ये प्रशिक्षित होण्याच्या गरजेवर भर देण्यात यावा.

C:-Note-Paliativecare13

(१२) आयुषच्या व्यवसायिकांकरीता त्यांच्या व्यावसायिक संघटनांच्या मदतीने सीएमईद्वारे जाणीव जागृती कार्यक्रम घेण्यात यावा व पॅलिएटिव्ह केअरचे महत्व व त्यातील प्रशिक्षण यावर भर देण्यात यावा.

(१३) आयुष व्यवसायिकांच्या पॅलिएटिव्ह केअर सेवा पुरविण्यातील कृतिशील सहभागाकरिता एमएमसीद्वारे त्यांच्या परवाना नुतनीकरणाकरिता पॅलिएटिव्ह केअरमध्ये प्राथमिक प्रशिक्षण घेणे आवश्यक आहे.

(१४) पॅलिएटिव्ह केअर क्षेत्रामध्ये आधीच कार्यरत असणाऱ्या बिगर शासकीय व समुदायस्थित संस्थांचा शोध घेणे.

(१५) पॅलिएटिव्ह केअर क्षेत्रामध्ये आधीच कार्यरत असणाऱ्यांना सहाय्य व प्रोत्साहन देणे.

(१६) बिगर शासकीय व समुदायस्थित संस्थांच्या पॅलिएटिव्ह केअर क्षेत्रामधील नवीन समुदाय स्थित प्रयत्नांना सहाय्य व प्रोत्साहन देणे.

(१७) काळजीवाहक कुटुंबामधून स्वयंसेवक निवडणे व त्यांना घरगुती पॅलिएटिव्ह केअर पुरविण्याचे प्रशिक्षण देणे.

(१८) स्वयंसेवक, काळजीवाहक, आशा, पॅलिएटिव्ह केअर चिकित्सक व परिचारीका यांच्यामध्ये जाळेबांधणी करणे व त्यांना पुढे पाठवणूक करण्यायोग्य केंद्रांशीदेखील जोडून देणे.

पॅलिएटिव्ह केअर प्रकल्पाच्या अंमलबजावणीसाठी अपर मुख्य सचिव (आरोग्य) यांच्या अध्यक्षतेखाली पुढीलप्रमाणे राज्य सुकाणू समिती गठीत करण्यात येत आहे :-

१.	अपर मुख्य सचिव (आरोग्य)	अध्यक्ष
२.	सचिव, वैद्यकीय शिक्षण व औषधी द्रव्ये विभाग	उपाध्यक्ष
३.	आयुक्त, अन्न व औषध प्रशासन	सदस्य
४.	आयुक्त व अभियान संचालक, राष्ट्रीय ग्रामीण आरोग्य अभियान	सदस्य
५.	प्रकल्प संचालक, महाराष्ट्र राज्य एड्स नियंत्रण सोसायटी	सदस्य
६.	संचालक, आरोग्य सेवा संचालनालय, मुंबई	सदस्य
७.	संचालक, वैद्यकीय शिक्षण व संशोधन, मुंबई	सदस्य
८.	विभाग प्रमुख, पॅलिएटिव्ह केअर वैद्यक, टाटा मेमोरियल सेंटर	सदस्य
९.	सह संचालक, असंसर्गजन्य रोग कक्ष, आरोग्य सेवा, आरोग्यसेवा संचालनालय	सदस्य-सचिव.

पॅलिएटिव्ह केअरचे उपक्रम हे मुख्यत: आरोग्य विभागाद्वारे अंमलात आणले जातील. याकरिता आरोग्य, वैद्यकीय शिक्षण, महिला व बालकल्याण, अन्न व औषध प्रशासन तसेच अन्य संबंधित विभागामध्ये पॅलिएटिव्ह केअर संदर्भात जाणीव जागृती व संवेदनशिलता निर्माण करावी लागेल.

राज्यामध्ये पॅलिएटिव्ह केअरचे उपक्रम यशस्वीरित्या अंमलात आणण्याकरिता धोरणे, संसाधने व निधीविषयक तरतुदीबद्दल स्पष्टता असणे अत्यंत आवश्यक आहे. ज्यायोगे संरचना व निधी यांचे योग्य

पध्दतीने वाटप व वापर केला जाऊ शकेल. सदर समिती पॅलिएटिव्ह केअर संदर्भातील शासनाचे धोरण, कर्मचारी प्रशिक्षण व स्वयंसेवी संस्थांचा सहभाग, निधीचा वापर यावर योग्य अंमल बजावणी व नियंत्रणाचा वेळोवेळी आढावा घेऊन शासनाकडे अहवाल सादर करणे तसेच संबंधित विभागांशी व स्वयंसेवी संस्थांशी वेळोवेळी सल्लामसलत करुन याबाबत शासनाला माहिती देईल.

संचालक, आरोग्य सेवा यांनी याअनुषंगाने तातडीने आवश्यक कार्यवाही करावी.

महाराष्ट्राचे राज्यपाल यांच्या आदेशानुसार व नावाने.

(थॉ. चे. बेंजामिन) १५/६/२०१३
अपर मुख्य सचिव, महाराष्ट्र शासन.

प्रति :-

सचिव, वैद्यकीय शिक्षण व औषधी द्रव्ये विभाग
आयुक्त, अन्न व औषध प्रशासन
आयुक्त व अभियान संचालक, राष्ट्रीय ग्रामीण आरोग्य अभियान
प्रकल्प संचालक, महाराष्ट्र राज्य एड्स नियंत्रण सोसायटी
संचालक, आरोग्य सेवा, आरोग्य सेवा संचालनालय, मुंबई
संचालक, वैद्यकीय शिक्षण व संशोधन, मुंबई
विभाग प्रमुख, पॅलिएटिव्ह केअर वैद्यक, टाटा मेमोरियल सेंटर
सह संचालक, असंसर्गजन्य रोग कक्ष, आरोग्य सेवासंचालनालय
सर्व उपसंचालक,
सर्व जिल्हा आरोग्य अधिकारी / जिल्हा शल्य चिकित्सक
मा.मुख्यमंत्री महोदय यांचे खाजगी सचिव
सर्व मंत्री महोदयांचे खाजगी सचिव
सर्व राज्यमंत्री महोदयांचे खाजगी सचिव
सर्व मंत्रालयीन विभाग
सर्व उपसचिव/अवर सचिव/ कक्ष अधिकारी, सार्वजनिक आरोग्य विभाग,
निवड नस्ती कार्यासन आरोग्य-३ अ,

C:-Note-Paliativecare.lwp15

Annexure 2

Work Group Committee

Under the able guidance of Hon'ble Dr Satish Pawar, Director of Health Services, Maharashtra and Hon'ble Dr Archana Patil, Joint Director (NCD), Health Services, Operational guidelines for Palliative Care was prepared on 5th and 6th June 2013 at HFWTC, Nashik.

Working Committee Group:

Sr. No.	*Name of the officers*	*Designation*	*Dept.*
1.	Dr. N.J. Rathod	Senior Consultant PPP	PPP Cell, NRHM Mumbai
2.	Dr. Chaturvedi	Professor and Head	Department of PSM, LTMMC
3.	Dr. Lalit Sankhe	Assistant Professor	Department of PSM, Grant Govt. Medical College, Mumbai
4.	Dr. Chhaya Rajguru	Assistant Professor	Department of PSM, Grant Govt. Medical College, Mumbai
5.	Dr. Pradnya Talawadekar	Country Coordinator	CPC, India
6.	Dr. R Marad	Medical Superintendent	Sub-district Hospital, Jawhar, district Thane
7.	Dr. Shrikant Atreya	Post-Doctoral Fellow	Tata Memorial Center, Mumbai

Acknowledgements:
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Dr. Rukmini Lobo, Snehaanchal Hospice, Nagpur
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Mr. Kiran Kadam, Programme Officer, PPP Cell, NRHM, Mumbai
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Dr. Amol Gaikwad (DPO -NCD Dist. Gadchiroli
Dr. S.D. Shiwankar, Medical Officer, NCD, Rural Hospital, Nagbid
Ms. Tara D. Sharma, Nursing Tutor, District Hospital, Gadchiroli

Annexure 3

Data on Project Implementation

The Government of Maharashtra initiated to implement the Palliative care programme in the rural and tribal areas of Maharashtra in the year 2011. Thus National Rural Health Mission with the technical guidance of Tata Memorial Hospital implemented the pilot project on Palliative care in the Jawhar and Igatpuri blocks of Maharashtra with a vision that every patient with chronic life limiting conditions will be provided physical symptom control, psychosocial support and spiritual support, a holistic care towards improving the quality of life of patients and caregivers.

This was achieved under the following heading:

1. Capacity building of medical and paramedical staff:

Human Resources	2011-12	2012-13	Total
Medical Officers	8	21	35
Medical Social Workers	01	01	02
ANM/Nurses	45	38	83
ASHA	239	188	427

2. Number patients benefitted:

Year	Jawhar Block	Igatpuri Block	Total
2011-12	271	-	271
2012-13	178	265	443
2013 (April-May)	28	45	73
Total	477	310	787

Following diseases were commonly notified: MR/CP, Epilepsy, Cancer, Hemiplegia, COPD, MDR/XDR TB, HIV/AIDS

3. Ensure availability of Morphine at block level: Both Jawhar and Igatpuri have successfully obtained the morphine license and have been dispensing morphine for the needy patients.

4. Community Awareness: The ASHA with the help of ANM and MO, PHC conducts community awareness programs.

Annexure 4

Palliative Care centres in the State of Maharashtra

Palliative Care Centres	Location	Type of Institution
Tata Memorial Center	Parel, Mumbai	Government
Govt Medical College	Nagpur	Government
LTMMC Hospital, Sion Mumbai (Pediatric and Adult Palliative Care)	Mumbai	Municipal Corporation
MGM Medical College, Mumbai (Pediatric Palliative Care)	Mumbai	Private
Cipla Foundation	Warje, Pune	Trust
Krishna Institute of Medical Sciences	Karad	Trust/ Private Medical College
Shanti Avedana Ashram	Bandra, Mumbai	Trust
Walawalkar Hospital	Derwan, Chiplun	Trust
Snehanchal Hospice	Nagpur	Trust
Rashtriya Santh Tukadoji Hospital	Nagpur	Trust
Cottage Hospital/Sub-district Hospital	Jawhar	Government
Rural Hospital	Igatpuri	Government
Raheja Hospital	Mumbai	Private
Bhakti Vedaanta Hospital	Mumbai	Trust

Annexure 5

Special provisions relating to the use etc. of Morphine by recognized medical institutions (Govt. of India Draft)

The state will adopt approved provisions of the Govt. of India and State Govt. regulations while amending the NDPS Rules for easy availability of Morphine and its usage for the Palliative Care on the below mentioned lines.

Special provisions relating to the use etc of Morphine by recognized medical institutions

1. Notwithstanding any provisions to the contrary in these Rules, possession, transport, purchase, sale, import inter-state, export inter-state or use of morphine or any preparation containing morphine in respect of a recognized medical institution shall be as per the following provisions.

2. Definitions –In this chapter, unless the context otherwise requires:-
   i. 'morphine includes any preparation containing morphine
   ii. 'Recognized medical institution' means a hospital or medical institution recognized for the purposes under this chapter facilities and . It is the responsibility of the institution so recognized to ensure that morphine obtained by them is used for medical purposes only.
3. Recognition of medical institutions:-
   i. Every medical institution which intends to be recognized for the purpose under this chapter shall apply in the format at Annexure 1 to the Drug Controller appointed by the State Govt who shall convey his decision within three months of the receipt of the application.
   ii. If it comes to the notice of the Drug Controller that morphine obtained by recognized institution was supplied for non-medical use or that any of the Rules under this Chapter is not complied with, for reasons to be recorded in writing, the Drug Controller may revoke the recognition accorded under these Rules.

4. Duties of Recognized Medical Institution:-

Every recognized medical institution shall

i. Designate one or more qualified medical practitioner who may prescribe morphine for medical purposes. When more than one qualified medical practitioner have been designated, one of them shall be designated as over-all in charge:

ii. The designated medical practitioner or the overall in charge, as the case may be, shall-

a) Endeavour to ensure that the stock of morphine is adequate for patient needs,

b) Maintain adequate security over stock of morphine ,

c) Maintain a record of all receipts and disbursements of morphine in the format enclosed as Annexure 2. And

d) Ensure that estimates and other relevant information required to be sent by the recognized medical institution under this chapter are sent to the authorities concerned

5. Sending of Estimates of requirement of morphine by the recognized medical institution

Every recognized medical institution shall send their annual requirement of morphine in the format at Annexure III by 30th November of the preceding year along with the name and address of the supplier from whom they intend to buy it to the drug controller.

311 Approval of estimates by the Drug controller

Drug Controller who received the Annual requirement shall consider it, who may if necessary call for necessary clarification. A reply on approved estimates or not accepting the estimates shall be sent before 21st of December of the preceding year. A copy of the communication shall be sent each to the supplier whose name has been given in the estimate, if the supplier is located in another state, the Drug controller of that state, the Drug Controller General of India and the Narcotics commissioner of India

6. Supplementary estimates:

If the requirement of the recognized Medical Institution exceeds the annual estimate approved by the Drug Controller, the recognized medical institution may send a supplementary estimate at any time to the Drug Controller which shall be considered and dealt with by the Drug Controller in the same manner as the annual estimates.

7. The provisions of these Rules in other chapters in respect of possession, transport, sale, import, inter-state export inter-state or use of manufactured drugs shall not apply to possession, transport, purchase, sale, import inter-state, export inter-state or use of morphine in respect of a recognized medical institution. Possession, transport, purchase, sale, import inter-state, export inter-state or use of morphine in respect of a recognized medical institution shall be in accordance with the following provisions:
   a) The recognized medical institution shall place orders for purchase to a manufacturer/supplier in the format at Annexure IV along with a photocopy of the communication of the Drug Controller vide which the institution was recognized for the purpose of this chapter and a copy of the communication of the Drug Controller vide which the approved estimates were conveyed. A copy of the order for purchase shall be sent to the Drug Controller and the Narcotics Commissioner of India.
   b) Any manufacturer or supplier shall send morphine to the recognized medical institution under this chapter only on the basis of an order for purchase received in the format of Annexure IV along with copies of recognition granted by the Drug Controller and the approved estimates communicated by the Drug Controller. The manufacturer/supplier shall dispatch the morphine consignment note in quintuplicate in the format given in Annexure V. Copies of the consignment note shall be sent by the manufacturer/supplier to the Drug Controller of the State in which the manufacturer/supplier is located, the Drug Controller of the State in which the recognized medical institution is located and the Narcotics Commissioner of India. He shall also keep a copy of the consignment note.
   c) On receipt of the consignment the medical institution shall enter the quantity received with date in all the copies of the consignment note, retain the original consignment note, send the duplicate to the supplier, triplicate to the Drug Controller, the quadruplicate to the Drug Controller of the State (in cases in which the consignment originated outside the

State) in which the supplier is located and the quintuplicate to the Narcotics Commissioner of India.

8. Maintenance of Records:-

All records generated under this chapter shall not be kept for a period of two years from the date of transaction which shall be open for inspection by the officers empowered by the State Govt. under sections 41 and 42 of the Narcotic Drugs and Psychotropic Substances Act.1985.

9. Inspection of Stocks of Morphine

The stocks of Morphine under the custody of a recognized medical institution shall be open for inspection by the Drug Controller or any other officer subordinate to him or the officers of other departments of the State Govt empowered under section 41 and 42 of the Narcotic Drugs and Psychotropic Substances Act 1985.

312 Appeals

Any institution aggrieved by any decision or orders passed by the Drug Controller relating to recognition, revocation of recognition of any institution or estimates any appeal to the Secretary, Department of Health of the State Govt. within 90 days from the date of communication of such decision or order.

1998 Special provisions relating to the use etc. of Morphine by Recognized Medical Institutions – Annexure-1

1. Name of the Institution and Address :
2. Name of the Head/In-charge of the Institution :
3. Number of persons employed :
   1. Doctors
   2. Nursing Staff
   3. Others
4. Number of patients treated during the previous calendar year :

1. in patients

2. out patients

5. Whether the hospital has facility to treat cancer patients : YES/NO

6. Number of cancer patients treated during previous calendar year :

1. in patients

2. out Patients

7. Name of the qualified medical practitioner who would prescribe:

Morphine (If there is more than one qualified Medical Practitioner who would prescribe Morphine, indicate the name of the Medical Practitioner who would be overall in charge)

313 Whether the institutions recognition for the purpose was

Withdrawn earlier (If the recognition was withdrawn earlier

the details are to be given) :

Station:

Date : Signature of the Head/In Charge

of the Institution with Name

1998 Special provisions relating to the use etc. of Morphine by Recognized Medical Institutions Annexure - 2

Record of Receipt | Dispensement and Balance of Morphine

Date

Qty in hand At the beginning of the day	Details of quantity received				Details of quantity disbursed				Qty in hand at the close of the day
	Sr. No	Qty	From whom received	Consignment Note/Bill or Entry number	Sr. No	Qty	Name of the person and address to Whom disbursed	Name of the Medical Practitioner who prescribed	

Signature

Note

1. This record is to be maintained on day to day basis and entries shall be made for each day the institution functions. Entries shall be completed for each day before the close of the day. The authorized Medical Practitioner/In Charge or any person authorized by them shall initial after entry of each day with date. The pages of the register shall contain necessary number
2. This record shall be retained for 2 years from the date of last entry.
3. This record shall be produced to the authorized officers whenever called upon during the course of their inspection.

1998 Special provisions relating to the use etc. of Morphine by Recognized Medical

Institutions – Annexure -3

Estimate of Annual requirement

1. Name and address of the recognized medical institution.
2. Period for which the estimate is submitted.
3. Quantity disbursed during the previous year.
4. Quantity estimated to be disbursed during the year for which estimate is submitted.
5. Supplier who would supply the quantity.

S.No	Name and address of the supplier	Quantity

6. If this is a supplementary requirement, give details of annual requirement sent earlier and the reasons for giving a supplementary requirement.

Station
Date

(Signature of the authorized medical practitioner / In-charge with name)

1998 Special provisions relating to the use etc. of Morphine by Recognized

Medical Institutions – Annexure-4

Orders for purchase

To

(Name and address of the supplier)

1. Name and address of the recognized medical institution which places the order.
2. Description of the quantity for which the order is placed.
3. Whether the institution has been recognized by the Drug controller (A photocopy of the recognition is to accompany each order for purchase).
4. Whether this order is covered by the estimate approved by the Drug controller (A photocopy of the approved estimate is to accompany each order of purchase).
5. Details of other orders for purchase made during the year.

S.No.	Quantity	To whom order was placed

Station: (Signature of the person

Date authorized to place order with

Name and designation if any)

Note

1. A copy of this order shall be kept by the recognized medical institution which places the order.
2. This shall be retained for two years from the date of transaction.

S.No-_____

CONSIGNMENT NOTE

(To accompany a consignment of morphine)

Date and time of dispatch

of the consignment-____

1. Name and address of consignor.
2. Name and address of the consigned i.e., recognized medical institution.

3. Description and quantity of the consignment.

No. of packages	Quantity	
	Gross	Net

4. Mode of transport (particulars of the transporter, Registration number of the vehicle, RR., if the transport is by railways etc.)

Signature of the Consignor with date

(Name and Designation if any)

To be filled by consignee

5. Date and time of receipt by the consignee and his remarks.
6. Quantity received by the consignee-

No. of packages	Quantity	
	Gross	Net

Signature of the Consignor with date

(Name and Designation if any)

Note

1. This consignment note shall be serially numbered on annual basis.
2. The consignor should record a certificate on the cover page of each book containing consignment notes indicating the number of pages contained in the consignment note-book.
3. The consignor should maintain a Register showing the details of the books of consignment note brought in use during a particular year.
4. Each consignment of morphine shall be accompanied by this consignment note is quintuplicate (i.e., five).
5. This consignment note shall be retained for a period of two years from the date of transaction.
6. The records referred to at items 2 and 5 above in this note shall be produced to the authorized officers whenever called upon during the course of their inspection.

Annexure 6

Treatment Guidelines in Palliative Medicine

Index

Authors:

- Professor and Head- Dr. Maryann Muckaden
- Associate Professor- Dr. Jayita Deodhar
- Associate Professor- Dr. Manjiri Dighe
- Post Doctoral Fellow-Dr. Shrikant Atreya
- Project Officer-Dr. Sunil Dhiliwal

Introduction:

Def:- WHO definition ‘Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual’.

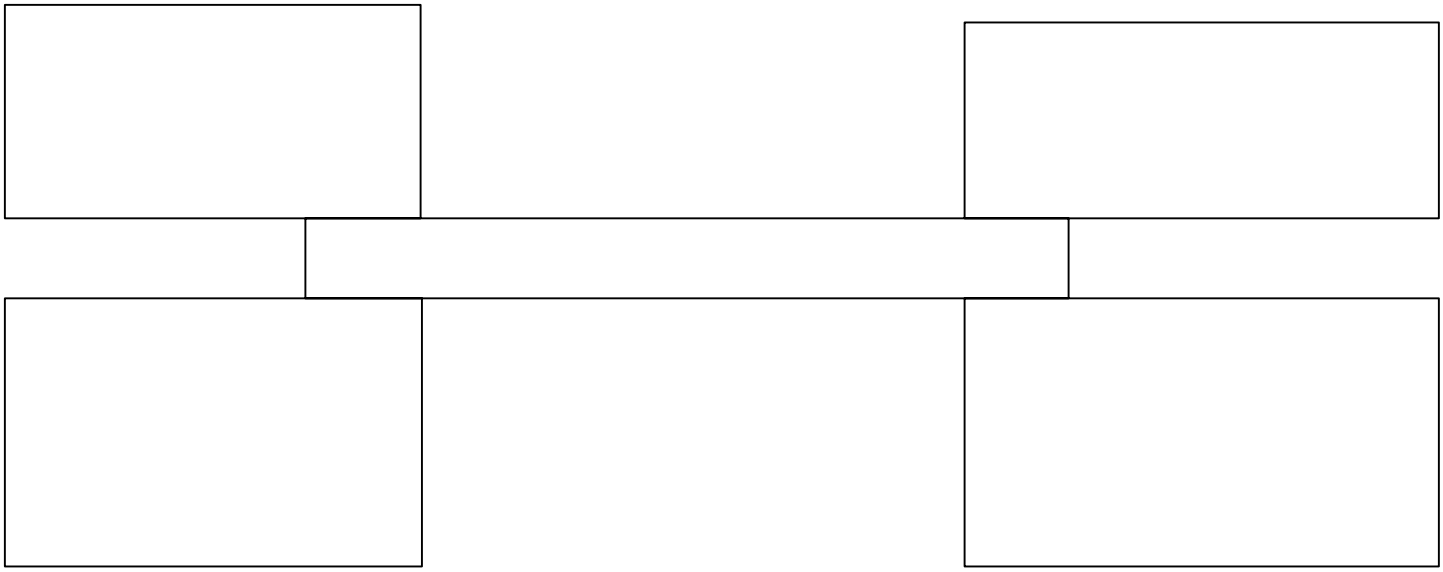
Goals:

-

Guiding Principles:

It is estimated that there is a prevalence of 2.5-3 million cancer cases in India at any point in time, who are in need of palliative care in India. A patient and family have diverse and individual suffering. These are inter-twined and experience is required to understand each unique suffering. This has to be assessed by a trained multi professional team.

Some common types of suffering are:-

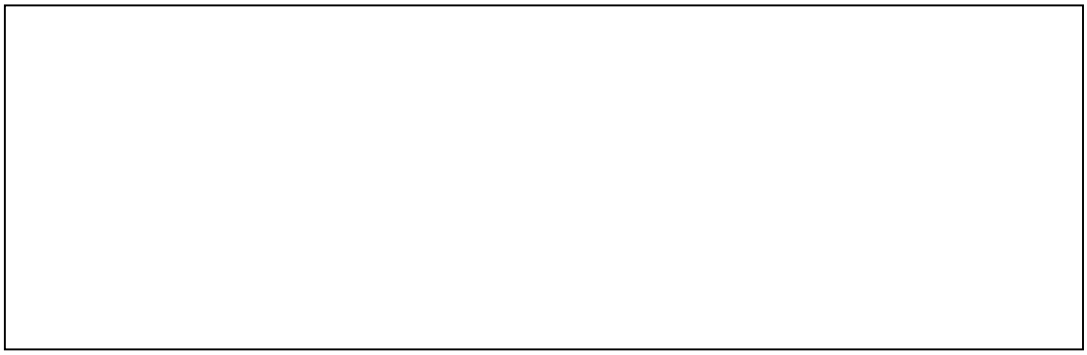


Care is offered for each suffering by a multi professional team in the hospital, home or hospice – the choice of patient and family in concurrence with treating physician

MANAGEMENT OF COMMON SYMPTOMS

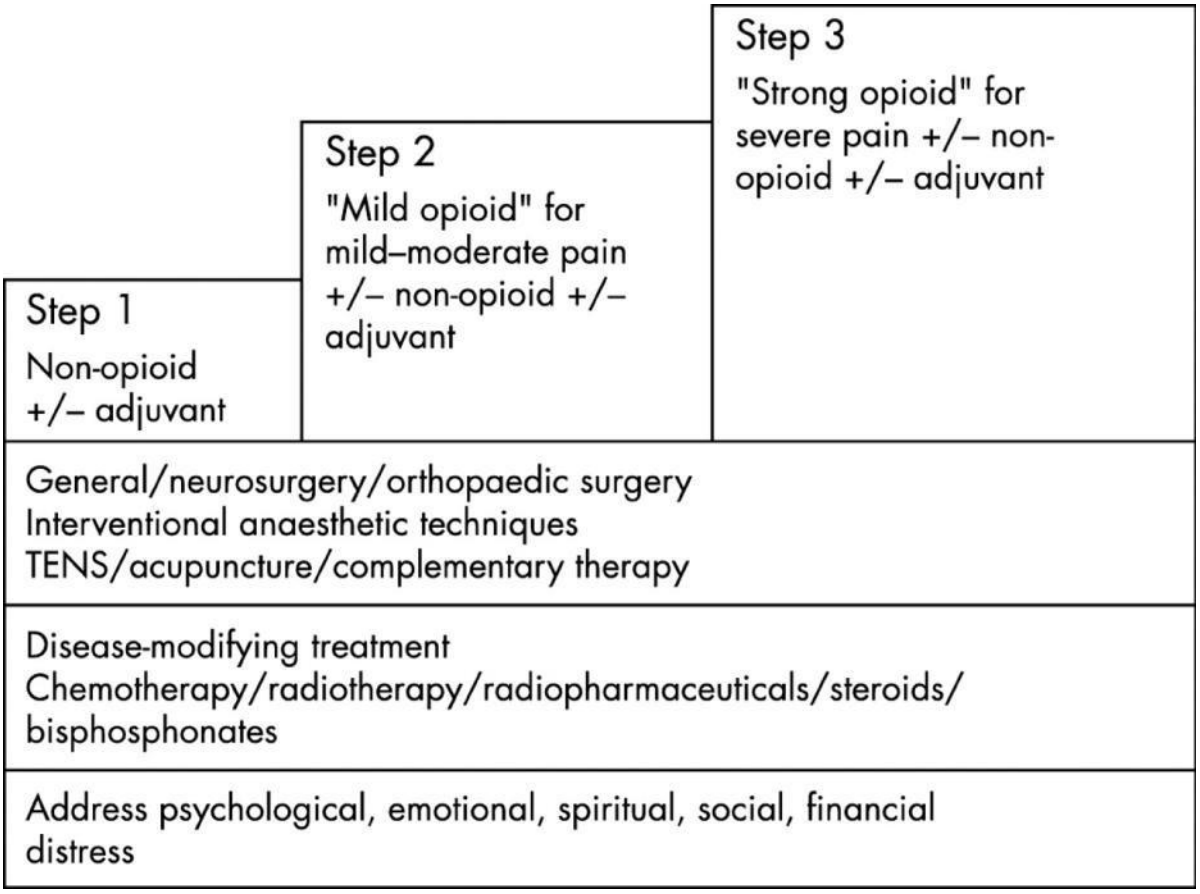
PAIN

Assessment



Use relevant clinical examination and investigations to determine cause of pain

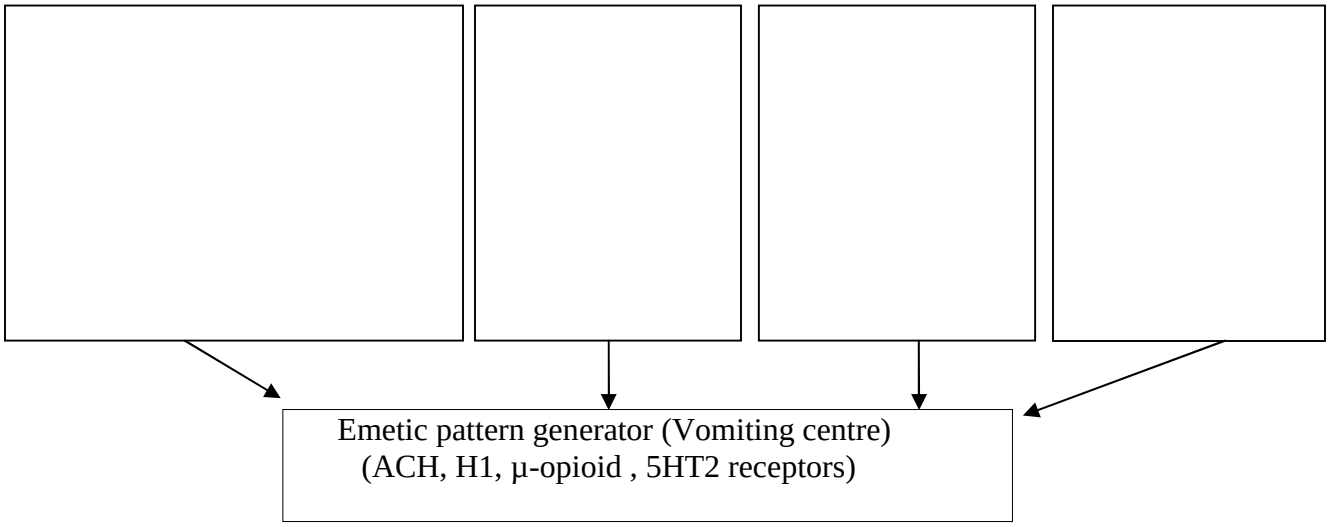
Management : WHO ANALGESIC LADDER



Modified analgesic ladder (reproduced with permission from *The palliative care handbook*. 5th Ed. Forest Holme and Wessex Specialist Palliative Care units. Dorset Cancer Network).

NAUSEA AND VOMITING

Important to assess cause of vomiting, to be able to treat accurately
Comprehensive history and physical examination
Minimum investigations
The receptors as shown below are stimulated to induce vomiting; drugs chosen for specific receptor



Commonly used drugs acting on specific receptors

Drug	Dosage	D2	H1	ACHm	5HT2	5HT3	5HT4
Metoclopromide	10-20mg q4-6h PO/SC/IV	++	0	0	0	+	++
Domperidone	10-20mg q4-8h PO	++	0	0	0	0	0
Haloperidol	0.5-2mg q6-12h PO/SC/IV	+++	0	0	0	0	0
Ondansetron	4-8MG Q8-12	0	0	0	0	+++	0
Chlorpromazine	25-50mg q6-8h PO/IV	++	++	+	0	0	0
Diphenhydramine	50-100 mg q4-6h PO/IV	0	++	++	0	0	0
Prochlorperazine	10-20mg q6h PO/IV or 25mg q6hPR	++	+	0	0	0	0
Olanzapine	1.25-2.5mg PO OD	+	++	++	++	+	0
Dexamethasone	4-20mg q AM PO /IV/SC	0	0	0	0	?	0

Non drug measures include small tasty meals, variety, cold food, break from cooking, ventilation of home etc.

MALIGNANT BOWEL OBSTRUCTION

If there is single level of obstruction surgically resection can be considered. This will also depend on the performance status of the patient.
If there are multiple levels of obstruction, surgery not an option, there in symptomatic management is essential to relieve the obstruction.

- Sub-acute and potentially reversible- bowel sounds hyperactive

- Complete and irreversible- bowel sounds absent (terminal care)

- Minimal hydration using SC route, sips of fluid and ice or pineapple chunks

CONSTIPATION

Commonly due to drugs, reduced oral intake, vomiting, lack of exercise

General measures

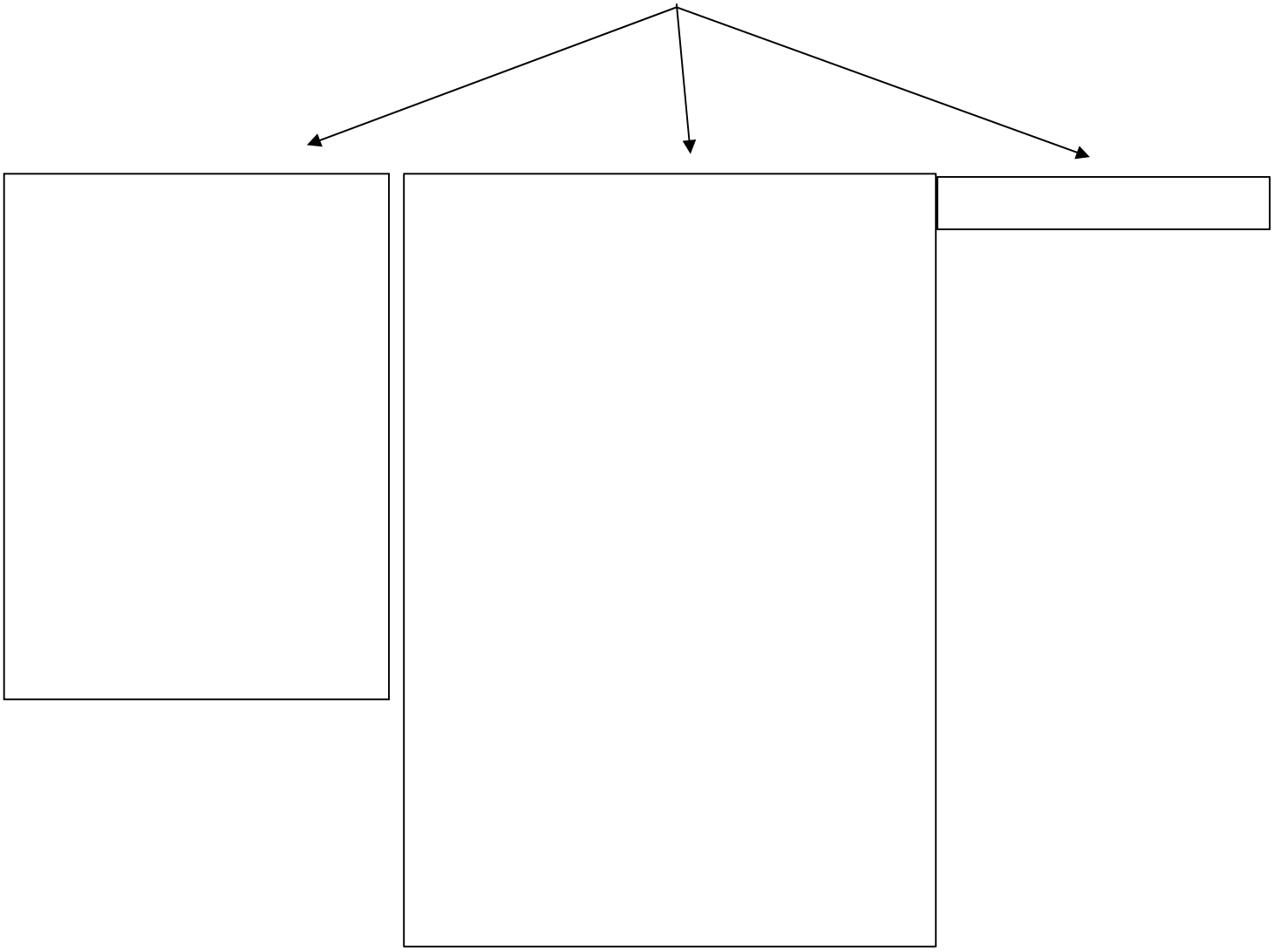
Drugs

E.g.: Cremaffin Plus (liquid paraffin + milk of magnesia + sodium picosulphate)

DYSPONEA

Reverse cause where possible eg. pleural tapping, correct severe anemia, treat infection and pain

Where any of the above not feasible



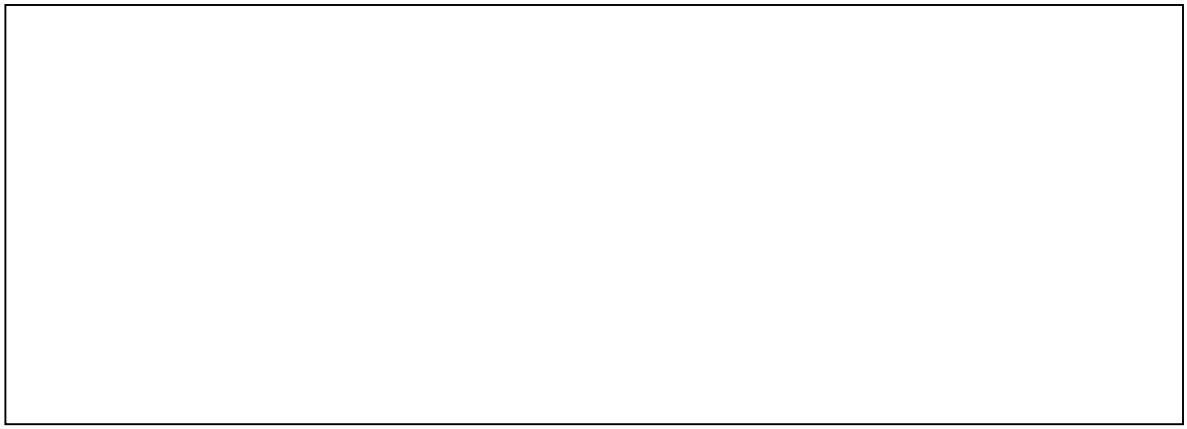
NURSING MEASURES

-Care of the mouth, back, bowel and eyes even in an unconscious patient
-Medical compliance
-Diet and regular exercise
-General hygiene
- Care of tracheostomy, colostomy or urinary drainage

- Care of vesico-vaginal or recto-vaginal fistula

MANAGEMENT OF FUNGATING WOUNDS

Caused by growth of anaerobic bacteria in a necrotic wound



MANAGEMENT OF MAGGOTS

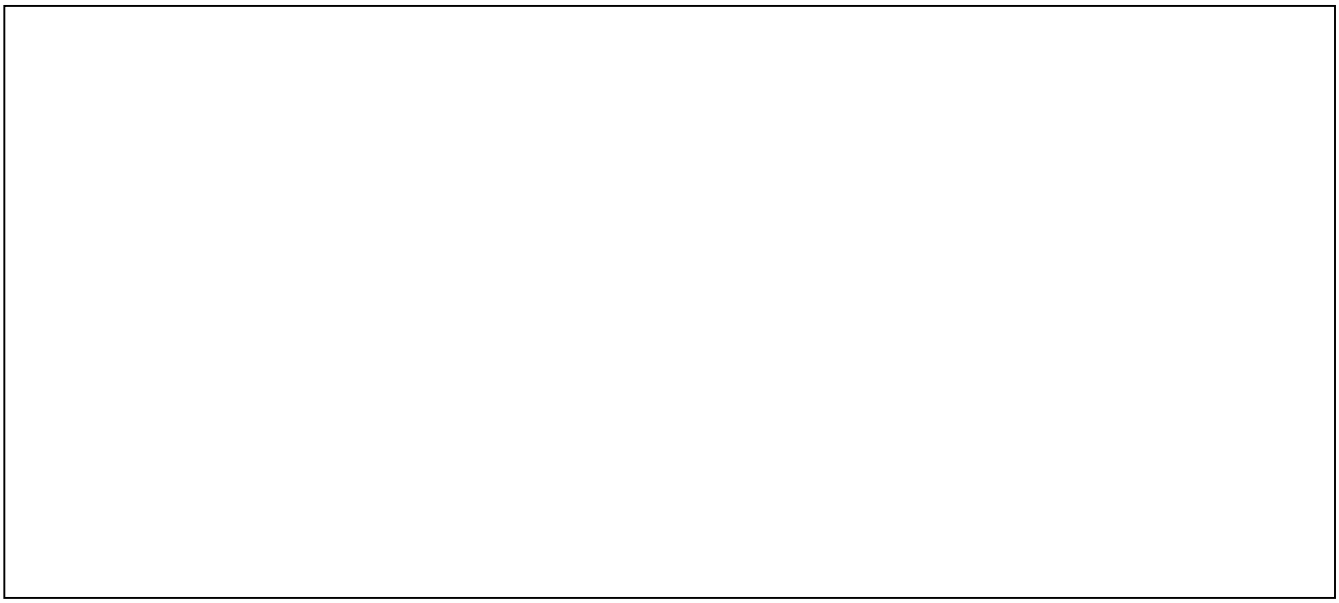
Associated with necrotic wounds due to anaerobic milieu

- Daily dressing , wound should be covered all the time to prevent flies
- Apply turpentine oil diluted 1:10 concentration (can even be dropped into discharging sinuses)
- Remove stunned maggots with the help of forceps, repeat daily for 3-4 days

PSYCHOLOGICAL CARE

Psychological care and emotional support are extremely essential part of palliative care. It offers a support system to help patients live as actively as possible until death and help the family cope during the patient's illness and in their own environment.

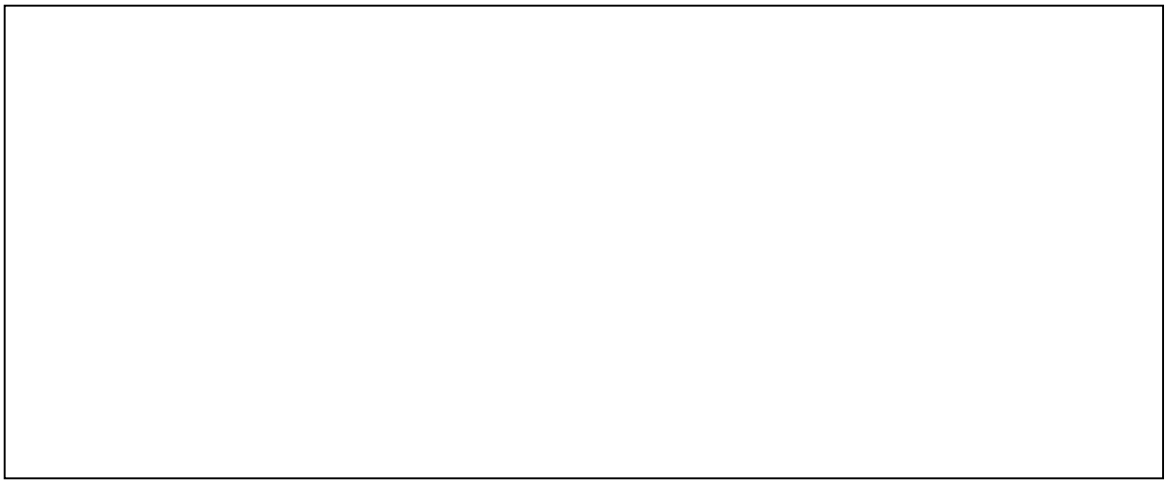
Principle guidelines for psychological care in palliative care



SOCIAL CARE

Ongoing Psycho Social Assessment is fundamental need in palliation to assess emotional, social, economical status of patients and families to help them sustain in advance phase of the disease.

Interventions:



Annexure 7

ASHA Worker Home/ Community Assessment

Palliative Case No: PC/DIST/INST/0-00/14 Patient Name: Age: Sex: Address: Contact No:	Name of ASHA Worker Name of PHC Village:

PATIENT ASSESSMENT CHECKLIST		
Nervous System 1. Difficulty in Movement of Limbs 2. Convulsions 3. Uncontrolled Pain 4. Bowel Habit – Constipation/ Loss of Control 5. Bladder Habit – Retention/ Loss of Control	Bedridden Patient 1. Bedsores 2. Feeding Difficulties 3. Nutrition	Cardio Respiratory System 1. Breathlessness at rest/ exertion 2. Cough 3. Hemoptysis – Coughs out Blood 4. Repeated admission for Breathlessness 5. Weight Loss 6. Pedal Oedema
Renal System: 1. Repeated Urinary System/ Decreased Urine Output 2. Pedal Oedema 3. Facial Puffiness	Hepato Billiary System 1. Repeated Jaundice; 2. Weight Loss 3. Fatigue	Cancer a. Non – Healing Ulcer b. Change in size/ number of lump c. Change in colour and number in the mole d. Weight Loss e. Unexplained Fever f. Bleeding from any Orifice
HIV/AIDS 1. Unexplained Fever 2. Unexplained Weight Loss 3. Chronic Diarrhoea	OTHERS 1. T.B with poor GC 2. Mental Retardation 3. Epilepsy 4. Sickle Cell Anaemia 5. Thalassemia 6. Malnourishment	1. Oral hygiene 2. Personal Hygiene 3. Wound care 4. Tracheostomy Care 5. Ryles Tube Care 6. Catheter Care

HOME/ COMMUNITY ASSESSMENT	SOCIAL ISSUES 1. Social Isolation 2. Family Issues 3. Grief 4. Disease affecting activities of Daily Living	FOLLOW UP 1. Availability of medicines 2. Medical Compliance 3. Relief/Worsening of Symptoms 4. Any new symptoms 5. Mention 6. No of strips of Morphine Given/ Left

ASHA WORKER
Follow Up Sheet
Symptoms/ History/Examination/Social/Home

Date of Visit	Intervention						
	Patient Complaints	Medicines given	Medication compliance	Wound Management	Counseling	PHC /RH/DH Referral	F/U

ASHA Form (Marathi)

आशा वर्कर फॉर्म

घरच्या आणि सामाजिक परिस्थितीचे निरीक्षण

रुग्ण परीक्षा		
मज्जासंस्था परीक्षा: • हातपाय हलवायास त्रास • आकडी • सहन न होणारे दुखणे • जुलाब • बद्दकोष्टता • जाणीव आहे का नाही • मर्त्यु विसजन (न होणे,कंट्रोल नसणे) कधीपासून/ केव्हापासून:	वसनसंस्था परीक्षा: • दमलागणे • खोकला • खोकल्यातून रक्त • दम्यासाठी नेहमी भरती होणे • पायावर सूज • वजन कमी होणे कधीपासून/ केव्हापासून:	अर्धांगवायू झालेला रुग्ण: • बरे व्हा न होणारे व्रण जखमा • खाण्यास त्रास • आहार कमी कधीपासून/ केव्हापासून :
मूत्रपिंडाची परीक्षा: • लघवीला त्रास • पायावर सूज • चेहऱ्यावर सूज कधीपासून/ केव्हापासून :	यकृत(लिवर) परीक्षा: • कावीळ • वजन कमी • वाढत जाणारा गाठ / संख्या वाढणे थकवा कधीपासून/ केव्हापासून :	कॅन्सर: • बरा न होणारा जखम • वाढत जाणारा गाठ / संख्या वाढणे • तीळ-रंग • कारण नसताना ताप येणे • रक्त स्राव होणे कधीपासून/ केव्हापासून :
एच आइ वी / एड्स: • बरा न होणारा ताप • वजन कमी होणे • सतत आजारी असणे • पातळ संडास होणे	इतर लक्षणे: • टी बी/ सतत आजारी असणे • मतीमंद • आकडी	इतर निरीक्षण: • तडाची स्वच्छता • शारीरिक स्वच्छता • जखमची काळजी • घशातील नल ची काळजी

• काळजी कधीपासून/ केहापासून :	• ंसिकल सेल अनेंमिया , थलेसेंमिया • कुपोषण , डा बेट क फू ट गॅ ीन कधीपासून/ के हापासून :	• तोडातील नल ची काळजी • लघ वसाठा घातलेल्या नल ची काळजी

सामाजिक परिस्थितीचे निरीक्षण : • एकटेपणा • कौटुंबिक वाद • दुःख • नेहमीच्या कामात अडचण	फॉलोअप निरीक्षण: • औषधाची उपलब्धता • औषधे वेळेवर घेणे, न चकवणे • लक्षणे कमी होणे • नवीन लक्षणे • मॉर्फिन गोळ्याची मोजणी (दिल्या-/शिल्लक)	इतर लक्षणे :

आशा वर्कर फॉलोअप

लक्षणे / इतिहास / परीक्षा / सामाजिक परिस्थिती / घरची परिस्थिती

भेटीची तारीख	मदतीसाठी केलेला हस्तक्षेप						
	पेशंटला होणारा त्रास	औषधे दिली	औषधे वेळेवर घेणे, न चकवणे	जखमेची काळजी	समुपदेशन	पुढचीला पाठविणे	फॉलोअप

Annexure 8: Palliative Care Register

PALLIATIVE CARE REGISTER

P.H.C……..

District ……..

PALLIATIVE CARE CASE RECORD

Palliative Care Reg No. -_____Date of Reg. -_____
Name of the Patient -_____
Address - _____
_____
Contact No. -_____
(Patient's Identification No) - _____
Age -_____ sex - _____
Religion -_____Marital Status – _____
Name of Concerned ASHA -_____Phone No. of ASHA _____
Diagnosis - _____
Name of the Hospital / doctor where diagnosis confirmed - _____

SOCIAL ASSESSMENT

Head of Family - _____
Family / NGO Care Giver - _____
Occupation -_____Addiction - _____

PSYCHOLOGICAL ASSESSMENT

1) Patient awareness of Disease – Diagnosis / Prognosis - _____
2) Care giver awareness of Disease – Diagnosis / Prognosis - _____
3) Family Concerns - _____
4) Family Collusion - _____
5) Stage of Grief - Bargaining / Anger / Denial / Depression / Acceptance
6) Spiritual Concerns - _____

CLINICAL ASSESSMENT

1) Presenting Complaints - _____
2) Symptoms Assessment - _____

Sr. No	Symptoms	Mild	Moderate	Severe	Sr. No	Symptoms	Mild	Moderate	Severe
1	Pain				11	Anxiety			
2	Fatigue				12	Drowsiness			
3	Fever				13	Cough			
4	Nausea				14	Breathlessness			
5	Loss of Appetite				15	Tremors			
6	Vomiting				16	Inability to walk			
7	Loose Motions				17	Inability to hold objects			
8	Constipation				18	Loss of Sleep			
9	Oral Thrush				19	Feeling of Wellbeing			
10	Depression				20				

3) Physical Findings (O/E) –
General Examination - _____
_____
_____
Local Examination - _____
_____
_____
Systemic Examination - _____
_____
_____

Investigations -

Treatment - Taken / Given

Follow up Advice –

Medical :-

Nutritional Advice: -

Counseling: -

FOLLOW UP NOTES

Sr.No	Date	Name of Medical Officer	Patient Asses at OPD / Home / Call	Symptoms Assessment	Clinical Assessment(Physical Examination)	Treatment / Advice Provided	Intervention / Counseling Referral etc.

Annexure 9
Nursing Assessment

Name of the Patient -

Sex -_____ Age _____

Patient PHC Reg. No. - _____

Address of Patient - _____

_____

Contact No - _____

PAIN ASSESSMENT	PHYSICAL EXAMINATION
Pain Present: Yes / No Location: Duration of Pain: Effect of Pain: Does the Patient's pain affect his/her daily routine? Yes/ No • Performs ADL with Discomfort • Interferes with ADL & Sleep • Others	Height Weight Temperature Pulse Respiration Intake Output Pressure Sores
ELIMINATION Urinary Bowel	OTHER SYMPTOMS

INTERVENTION

Nutritional Advice	Medical Compliance	Rehabilitation Services
Follow Up Advice	Referral	Counselling
Personal Hygiene	Health Education	Wound Management Ryle's tube care Catheter Care Tracheostomy Care

Name of Assessing Nurse: Date & Time: Sign:

FOLLOW UP NOTES

Sr. No	Date	Name of Nurse	Patient Asses at OPD / Home Visit	Symptoms Assessment	Clinical Assessment (Physical Examination)	Treatment / Advice Provided	Intervention / Counseling Referral etc.

Annexure 10

PALLIATIVE CARE CASE RECORD REGISTER

Name of the Patient Address:

Diagnosis:

Age: Sex: P.R. No.

Date of Visit to PHCs / Home	Name of Medical Officer	Family Care Giver accompanying Patients	PATIENTS PSYCHOLOGICAL ASSESSMENT	Presenting Complaints	Physical Examination of Patients	Investigations	Nutritional Advice	Next Follow up date

Annexure 11

Essential Drug List

Sr. No	*Name of Medicine / Consumable*	*Dose*
1	Tab. Paracetamol	500mg
2	Tab. Combiflam	400 mg Ibuprofen+325mg Paracetamol
3	Inj. Diclofenac Sodium	50mg-100mg
4	Tab. Narcogin Forte	Codeine Phosphate 60mg+Paracetamol 625mg
5	Cap. Tramadol HCL 50 mg	50 mg-100mg
6	Inj. Tramadol HCL	50-100mg
7	Tab Buscopan	10 and 20 mg
8	Tab. Morphine 10mg	10 mg
10	Tab.Morphine SR	10/20/30mg
9	Inj. Morphine	10mg/1ml
10	Tab. Gabapentin	100mg/300mg
11	Cap. Omeperazole	20 mg
12	Tab. Ranitidine HCL	150mg
13	Susp. Gelusil	
14	Tab. Ondensteron	8mg-16mg
15	Tab. Metoclopramide	10mg
16	IV Metoclopramide	10mg/2ml
17	Tab. Domperidone	10mg
18	Sys. Domperidone	10mg
19	Tab Haloperidol	0.5-5mg
20	Tab. Dexamethasone	0.5/4/8mg
21	Tab. Ethamsylate	500mg

22	Inj. Ethamsylate	500mg/1ml
23	Tab. Traxenamic Acid	500mg
24	Inj. Traxenamic Acid	500mg/1ml
25	Syp. Cremaffin Plus	liquid paraffin 1.25 mL, magnesium hydroxide 3.75 mL, sodium picosulfate 3.33 mg/5 mL.
26	Syp. Lactulose	
27	Dulcolax Suppository	
28	Glycerin Suppository	
29	Softovac Enema	
30	Proctoclysis Rectal Enema	
31	Tab. Metronidazole	400mg
32	Metrogyl gel	
33	IV Metronidazole	100 ml

Annexure 12

ASHA Worker Tool Kit

1.	T. Narcogen Forte
2.	T. Combiflam
3.	T. Ethasymlate 500mg
4.	T. Imodium
5.	T. Metoclopramide
6.	Metrogyl Ointment
7.	Betadine Ointment
8.	Rolled Bandage
9.	T. Imodium
10.	Sticking tape (White)
11.	Petroleum Jelly
12.	Betadine Solution
13.	Disposable Gloves
14.	1 Marker/ Sketch Pen

ANNEXURE-13

(Monthly Report)

National Palliative Care Programme

Format - A

Name of District: Name of Block:

Name of the Institute:

Month: Year:

1) Patients Identified & Treated in District/Sub-dist. Hospital/ Rural Hospital

Sr. No	Name of the Institute	Monthly Report		Progressive Total Patients
		New Patients	Old patient	
1				
2				
	Total			

2) Patients Identified & Treated:

Sr. No	Activity	Monthly Report			Progressive Total Patients
		New Patients	Old patient (Follow up at DH/RH)	Total Patients	
1	Palliative Care provided in OPD				
2	Palliative Care provided in IPD				
	Total				

3) Patients Identified by ASHA:

Sr. No	Activity	Monthly Report			Progressive Total Patients
		New Patients	Old patient (Follow up at PHC)	Total Patients	
1	Patients suspected / referred by ASHA				
2	No. of Patient confirmed referred by ASHA				

4) Details of Psycho-social intervention provided by Medical Social Worker

Sr. No	Name of the Institute	No. new patients counseled	No of follow-up Patients counseled in OPD	No of follow-up Patients counseled during home visits	Patient given morphine	
					Inj.	Tab
1	SDH/RH					
2	PHC					
	Total					
	Progressive					

5) Home Visits :

Sr. No	Designation	No. Of home visits	No of Patients provided palliative care (During month)	Progressive
1	Medical Officer			
2	Multi-task Worker			
	Total			

(Monthly Report)

National Palliative Care Programme

Format - B

Name of District: Name of Block:

Name of the Institute:

Month: Year:

A) Disease wise patients registered at DH/SDH/RH:

Sr. No.	Disease name	No. of New Patients in this month			Progressive
		DH	SDH	RH	

B) Disease wise patients registered at PHC

Sr. No.	Disease name	No. of New Patients in this month			Progressive
		DH	SDH	RH	

Signature of District Civil Surgeon.

(Monthly Report)

National Palliative Care Programme

Format - C

Name of District: Name of Block:

Name of the Institute:

Month: Year:

A.) Patients Identified & Treated at PHC:

Sr. No	Activity	Monthly Report			Progressive
		New Patients	Old patient (Follow up at PHC)	Total Patients	Total Patients
1	Patients provided Palliative Care in OPD				
2	Patients provided as Home based Palliative Care				
3	Patients suspected / referred by ASHA				
4	Registered Patients of PC referred to SDH or Higher facility for Pc/ Treatment				

B.) GNM/Multi-task worker/ Physiotherapist(NCD):

Sr. No	Name	Designation	Date of Home visit	No of Patients provided palliative care
1				
2				
	Total			

C.) ASHA Activity Report :

Sr. No	Name of ASHA	No. Of new patients suspected for PC	No. Of ASHA's patients confirmed for PC	No. Of home visits to registered patients by ASHA
	Total			

Signature of District Civil Surgeon.

National Palliative Care Programme

Format - D

Name of District: Name of Block:

Name of the Institute:

Month: Year:

Sr No	Name of the Patient	Age	Sex	Code No (PC/Dist/Inst/00-0/14)	Institute	Diagnosis	Palliative Care given		Patient contact details	Name of the Asha (Contact NO)
							IPD	Home visit		

National Palliative Care Programme

Format - E

Name of District: Name of Block:

Name of the Institute:

Month: Year:

Inventory Report :

Sr. No	Name of Medicine / Consumable	Stock available at the end of the month	Expenditure during the month	Stock available at the end of the month	Requirement

6) Financial Report

A) Grant received and expenditure:

Sr. No	Particulars	Amount in Rs	Remarks
1	Budget received during the month		
2	Progressive Budget received since 1st April including current month		
3	Expenditure during the month		
4	Expenditure progressive since 1st April 2012		
5	Balance at the end of month		

B) Details of the expenditure:

Sr. No	Activity	Amount in Rs	Remarks
1	Training (Please mention participant in the training)		
2	T.A/D.A paid to Staff		
3	Medicine & Consumables		
4	Incentives to ASHA		
5	Referral of Patient		
6	IEC		
7	Salary of staff		
8	Office Expenses / Stationary, etc.		
	Total		

Signature of District Civil Surgeon.