

NATIONAL HEALTH MISSION- TAMIL NADU

From
The Mission Director,
National Health Mission- TamilNadu,
359, Anna Salai,DMS Complex,
Chennai 600 006.

To
All DDHS

Ref.No.1918/P9/SHS /2016, dated.07.08.2018

Sir / Madam,

Sub: NHM – SHS – TN – National Program for Palliative Care (NPPC) –
– Instructions to BMOs for Establishing Home Based Palliative
Care Services In Block Area Under Control Of Directorate Of
Public Health - Reg.

Ref: 1. RoP 2017-18
2. Minutes of DDHS Review Meeting, MD, NHM,
dt.:10.05.2018

Palliative care primarily aims to relieve suffering and improve quality of life of adults and children affected by life-threatening and life-limiting illness. Community based Palliative Care Services are being planned to be made available in all 385 blocks of the state.

In this regard, Staff Nurses @ 1 Staff Nurse per block are being trained in Home Based Palliative Care. After undergoing training, the staff nurse designated as 'Community Palliative Care Nurse' will provide Palliative care nursing services to those who are bed-ridden and approaching last days of their life in home setting. This service would reduce the physical difficulties of the severely debilitated patients in accessing a health care facility.

The Community Palliative Care Nurse will visit at least 5 households per day. He/she will carry a 'Home Care Kit' containing necessary consumables and drugs for the patient. The nurse will be given Rs 250/- per day as flat rate for mobility support as an addition to their existing salary.

The detailed guidelines for the implementation of Community based Palliative Care is enclosed in Annexure.

Encl.: Establishment of Long-Term Care System in Tamil Nadu


For Mission Director

Copy to

1. The Director of Public Health and Preventive Medicine, Chennai-6.
 2. All DPOs of NCD
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ESTABLISHMENT OF LONG-TERM CARE SYSTEM IN TAMIL NADU

Guidelines for Operationalization of Home-based Community Palliative Care Services

Introduction:

Long-Term Care (LTC) is an approach that caters to the needs of people with functional dependence and their primary caregivers regardless of the etiology of the disability, age, sex or socio-economic status. The ultimate purpose is to improve the 'Quality of Life' (QoL) of those patients with chronic incurable illnesses and terminally ill where the scope of curative treatment is limited.

Palliative care is an integral part of LTC. It primarily aims to relieve suffering and improve quality of life of adults and children affected by life-threatening and life-limiting illness. This involves inclusion of their family members as a part of care giving services. It is a holistic approach that aims to meet the needs of the whole person, not just to treat their clinical condition alone. Potential beneficiaries of palliative care include patients suffering from cancer, Cardiac Failure, COPD, Chronic Kidney Disease, mental retardation, hemiplegia, paraplegia, congenital mental and physical disabilities, Alzheimer's, Parkinson's, chronic debility in the elderly etc. For children, the major disease categories which require palliative care include cancer, HIV, progressive non-malignant conditions, congenital anomalies etc.

It is estimated that 7 % of the population of Tamil Nadu require palliative care. Moreover 10.6 % of Tamil Nadu belongs to elderly age group (third highest in India) and about 70% of them require palliative care. Increasing proportion of dependent population takes a huge toll on working age group physically, emotionally and financially.

In India, primary responsibility for taking care of the sick and elderly lies with family members. Establishment of LTC System by integrating NCD programs aims to supplement the efforts of family members by providing institutional care and community care by providing basic nursing services at the door-step of the patient.

Objective:

1. To establish Community Based Long Term Care (LTC) system in the state with thrust on Primary Health Care Approach.
2. To create 'Architecture for improving Quality-of-Life' of those functionally dependent on others regardless of age, sex, socio-economic status or etiology of dependency.
3. Capacity building of informal care givers with particular focus on women caregivers.

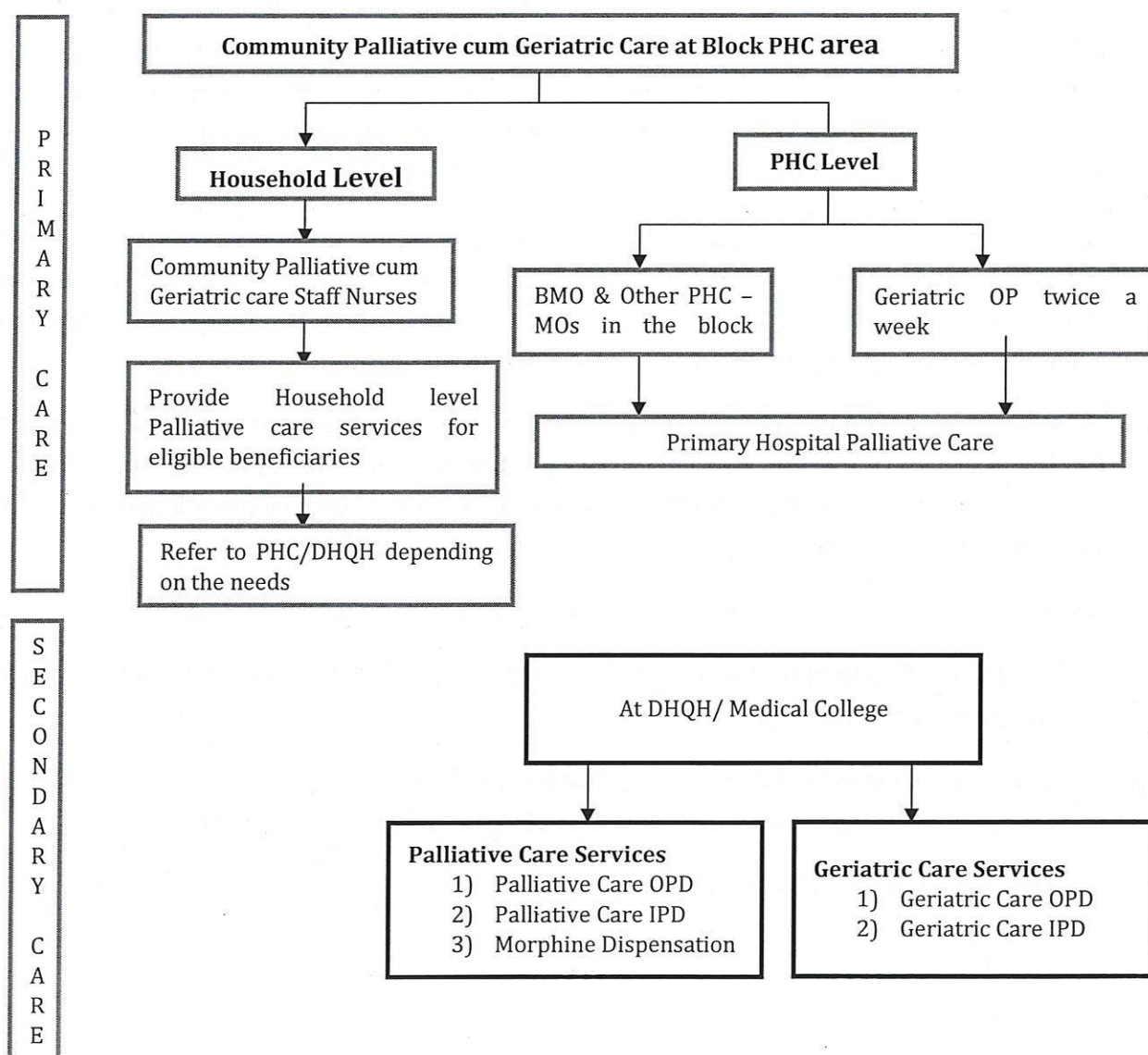
Strategy:

In Tamil Nadu NPCDCS, NPHCE and NPPC are three national programs where LTC concepts are embedded. These three programs are already 'integrated' at District Hospitals called as 'Comprehensive Rehabilitation Unit for NCDs' so that services are seamlessly connected and resources are optimally utilized. [G.O No 3]. The term 'integration' is meant as *bringing together of otherwise independent administrative structures, functions in such a way as to combine these into a whole with proper coordination.*

Now, 'Community Based Long Term care System' is an extension of this concept below the District level hospital to Block PHCs and to community. At Block PHCs too NPCDCS, NPHCE and NPPC are integrated. At Block level, the aim is to provide primary level of care in Geriatric and Palliative with emphasis on 'Home-care'.

Hence the Staff Nurse providing home based services is called Community Palliative & Geriatric care Staff nurse.

Organization of Service Delivery:



Secondary level Palliative Care:

- Secondary level Palliative Care provides the specialty care for patients requiring institution based Palliative Care. Each District has got one Secondary level Palliative care center attached to respective District Head Quarters Hospital/ Medical College Hospitals.
- The Secondary Level Palliative Center at District Head Quarters Hospital/Medical College Hospital will have the following facilities
 1. Exclusive Out Patient Department (for Palliative Care)
 2. Exclusive In Patient Palliative Care by ear marking beds
 3. Exclusive Human Resources (for Palliative Care) which includes
 - 1 Medical Officer
 - 4 Staff Nurses
 - 2 Multipurpose Hospital Workers
 4. Home-care services for bed-ridden patients needing palliative care in the surrounding urban area.
 5. Dispensation of Oral Morphine tablets
- An MBBS Doctor or with any higher specialty after undergoing 10 days Foundation course training or 6 weeks Certificate Course training in Palliative Medicine can provide secondary level of Palliative Care.
- District Head Quarters Hospital/Medical College Hospitals also has an exclusive Secondary Geriatric Care Center with separate infrastructure and Human Resources for patients above 60 yrs above since Geriatric care often needs providing palliative care services and vice versa.
- Both Geriatric Care and Palliative Care units established at District level are referral centers for patients requiring specialty care/ Institutional care.

Primary Level Palliative Care:

- Primary Level Palliative Care is provided by Community Palliative cum Geriatric care Staff Nurses and PHC Medical Officers which includes
 - 1)Home-based palliative care service by Community Palliative cum Geriatric Care Nurse @1 Community Palliative Care Nurse per Block area.
 - 2)Primary institutional care services provided by Medical Officers in Additional and Block PHCs when required.
 - 3)Geriatric Care OPD services (twice a week) at Block PHC.

- The Community Palliative cum Geriatric Care Staff Nurse after undergoing 10 days training in Palliative Nursing would be eligible to provide Home-based community palliative care services.

Operationalization of Home- Based Community Palliative Care Services under LTC System:

Services provided:

The following are few of the services provided in Home-based Community Palliative care services:

1. End-of life care
2. Nutrition advice
3. Evaluation of physical and mental symptoms
4. Psychosocial support to the patient and family.
5. Naso-gastric tube insertion
6. Catheterisation
7. Wound care
8. Mouth care
9. Bowel care with suppositories, enema and manual evacuation
10. Ascites tap
11. Lymphoedema care
12. Colostomy care
13. Eye care
14. Pressure sore cleaning
15. Administration of IV fluids
16. Teaching Exercises
17. Bed bath
18. BP measurement
19. Temperature assessment
20. Dispense drugs if prescribed by Doctor
21. Teaching primary care giver basic patient care techniques.

Identification of beneficiaries:

- The VHN/ SHN/ any volunteer from community has to be sensitized by the trained Community Palliativecum Geriatric care Staff Nurse on the types of Beneficiaries who can be benefited by community home visits. (Annexure 1)

- The VHN/ SHN/ volunteer from community has to submit the list of beneficiaries to the Medical Officer of PHC who in turn has to verify and submit the final list of potential palliative care patients needing home-care to BMO in the format mentioned (Annexure2)
- Home-Based Palliative cum Geriatric Care Services will be provided only to the registered patients .A separate register may be maintained for this purpose (Annexure3)
- The BMO/MO need not make a separate assessment if the patient is being referred from Geriatric or Palliative Unit from District Level Hospitals (DHQH)/ MCH for home-care.
- The primary care-giver is always encouraged to bring the patient to Block PHC at the time of registration.
- The Community Palliative cum Geriatric Care Nurse may visit the house of the patient along with VHN/SHN/ Community Volunteer and make a preliminary assessment of the patient at his/her first visit.

Conducting a Home Visit:

Pre-visit stage:

1. The trained Community based Palliative care Staff Nurse has to be engaged only in Home based palliative cum Geriatric care services.
2. The palliative cum Geriatric care Staff Nurse has to carry out Home based visits in the area under their respective block from 9 am to 5pm on all days in a week except Sundays.
3. The Staff Nurse has to submit ATP for the following week on every Saturday to the BMO along with the requirement of consumables to be used in the field depending upon the services planned to offer to the patients on Home visit.

During Home-visit:

- The Community Palliative cum GeriatricCare Staff Nurse should be in his/her uniform with ID card. The female staff nurse can wear white churidar as uniform and should wear ID card.
- The nurse should carry a 'Home-care Kit' containing necessary dressing materials, consumables and drugs as per the needs of the patient. The components of the Home-care kit are mentioned in (Annexure 7)

- He/ She have to visit 5 households in a habitation and should provide required Palliative Care nursing care to the patients and also train the primary care given. The mode of transport is the choice of the nurse.
- The Nurse should take adequate Infection control and hygiene measures while performing clinical procedures.
- The Nurse should maintain a 'Day Book' mentioning the condition of patients and procedures done.
- In case of any emergency while performing a Home-care procedure, the Staff Nurse has to inform the BMO and the respective PHC Medical Officer. The Medical Officer of the respective PHC or the nearest PHC should attend to the patient at house hold level.
- The BMO/Medical Officer is bound to provide necessary clinical and administrative guidance to the Nurse.
- A Telegram/ Whatsapp group should be created for the district with the following members: the DDHS, DPO(NCD), BMOs and/or Trained MO at Block PHC, PHC MOs, Palliative Care Medical Officer and Nurse at Medical College/ DHQH and the Community Palliative Care Nurses
- After completion of a house visit the details of the patient along with the diagnosis and details of procedure done has to be posted in the social group created. The Staff Nurse should also post the information of the area of next house to be visited. This has to be done for ensuring the Safety of Staff Nurses.
- In areas of poor Internet connectivity, the BMO has to be informed about the above said details through text message.

Termination of a Home-visit to a patient:

1. Death of the patient
2. Primary care giver denies home care services
3. Patients with sound mind denies home care services
4. Primary care givers became capable of providing further nursing care
5. Home-care not required if the patient can easily access the PHC for services.

Mobility support:

1. Rs 250 will be given at a flat rate per day for conducting at least 5 home-care visits (5 households).

2. No incentive will be given for that particular day if the number of home-care of the day is less than 5.
3. Each Staff Nurse has to get attendance certificate from BMO for every month to claim the mobility support. Mobility support will be given only for the days the respective Staff Nurse has carried on at least 5 home care visits
4. The incentive amount will be released from State NCD Cell to District Health Society. Respective DDHS can release the fund to BMO who in turn will release the mobility support to Community Palliativecum Geriatric Care Staff Nurses on monthly basis.

Referral:

- During house visit if the patient requires institutional Palliative Care Services(in case of uncontrolled symptoms) or further pain management, the Palliative care Staff Nurse can refer the patient to nearby PHC for basic In-Patient care or to Palliative care OPD established at District Head Quarters Hospital/MCH for specialty care services and pain management.

Monitoring and Evaluation

- Services of palliative cum Geriatric care Staff Nurse has to be regularly monitored by the BMO.
- BMO has to check the ATP and Beneficiaries list. Home based visit has to be done by the Palliative care Staff Nurse only after getting the approval of BMO on every Saturday.
- Random field inspection and home visits has to be carried out by the District level officials DPO-NCD, APM and BMO to evaluate during Home based Palliative care services.
- Monthly report in the prescribed format (Annexure 5) has to be compiled by BMO and sent to District NCD Cell, who in turn will compile the monthly report for the entire District (Annexure 6) and sent to State NCD Cell within 5th of every month with a copy marked to DDHS and DPH office through District NCD Cell.
- The Community Based Staff Nurses has to take part in the monthly block reviews to present the status of the beneficiaries, take help of VHN for further case monitoring, follow up of patients required, The BMO to review, guide and support for the program needs.

Roles and Responsibilities:

1. Community Palliative Care Nurse

- a. Conduct Home-care services
- b. Submit weekly Home-care visit plan to BMO
- c. To participate in the monthly review conducted in Block PHC.
- d. Fill monthly report and submit to BMO as per Annexure 5

2. Block Medical Officer

- a. To provide necessary instructions to Community Palliative Care Nurse before every home visit.
- b. To monitor the field activities of the nurse.
- c. To attend to any patient at the patient's home at the time of emergency.
- d. To ensure the availability of necessary dressing materials and consumables for home-care from the PHC.
- e. Maintain attendance register for the nurse and submit Attendance Certificate to DDHS in the format mentioned in(Annexure 4)
- f. Sent monthly reports to District NCD Cell in the format as per Annexure 5
- g. To monitor the daily Home-care duty of the Community Palliative Care Nurse.
- h. To carry out instructions from higher authorities whenever required.

3. Palliative/ Geriatric Care Physician at DHQH/MCH

- a. To provide necessary clinical guidance to the Medical officer and Community Palliative Care Nurse over mobile phone.
- b. To refer palliative care patients for home care services
- c. To train BMO or any other Medical Officer of the Block PHC in Palliative Care
- d. To sensitize the PHC MOs, field functionaries and other concerned officials in basic principles of geriatric and palliative care.

4. Palliative Care Nurse at DHQH

- a. To provide necessary guidance to the Community Palliative Care Nurse whenever necessary over mobile phone.

5. District Program Officer (NCD)

- a. To implement Home- Based Community Palliative Care Services in the District.
- b. To ensure that line listing by VHNS/SHNs/Community Volunteers is complete.
- c. To orient the BMO and MO about program aspects of National Program for Palliative Care and National Program of Health Care of Elderly.
- d. To provide necessary instructions to the concerned officials regarding the implementation aspects of the program.
- e. Evaluate the performance of the Staff Nurse as per the objectives of the program.
- f. Ensure that the incentive amount is released to the nurse.
- g. Send monthly reports to State NCD Cell in the format mentioned in (Annexure 6)
- h. Conduct Monthly review meetings.

6. Deputy Director Health Services

- a. Identification of Staff Nurses and redeployment to Block PHC.
- b. Provide necessary orders to concerned institutions for smooth implementation of the program.
- c. Release Mobility support to Community Palliative Nurse on monthly basis.
- d. Monitoring and Evaluation of the program.

Annexure 1

Indicator tool for VHNs/SHNs/Community Volunteers

- Bedridden patients more than 6 months due to any reason
- Old Age patients who are dependent on others for their basic needs like, food, bowel, bladder and movement.
- Paralysis below waist
- Paralysis of one side of body
- Chest pain on least exertion
- Breathlessness on least exertion due to COPD
- Patients on catheter
- Patients on naso-gastric tube for feeding Cancer patients who are bed-ridden
- Lymphoedema
- Diabetic foot ulcers
- Varicose ulcers
- Foul smelling wounds

Annexure 2

Line-list format (For listing Beneficiaries)

Sl. No	Name of the patient	Age	Sex	Address of the patient	Name & relation of primary caregiver	HSC Area

Annexure 3

Register format

Sl. No	Name of the patient	Age	Sex	Diagnosis	Address of the patient	Name & relation of primary caregiver	HSC Area

Annexure 4

Attendance Certificate for Mobility Support

This is to certify that Mr/Mrs/Ms.....of.....Block has conducted.....days of Home-Based Palliative Care Service in the month of.....

s/d

Block Medical Officer

Annexure 5
Monthly Reporting Format to DHS

Name of PHC:

Name of Block:

Name of MO:

Name of Community Palliative Care Nurse:

Sl. No		April	May	June
1	No of days gone for Home visit			
2	No of patients visited under home-care			
3	No of cancer patients			
4	No of spinalcord injury patients			
5	No of CVD patients			
6	No of patients with psychiatric disorders			
7	No of patients above 60 years			
8	No of catheterizations done			
8	No of wound dressings done			
9	No of enema given			
10	No of Tracheostomy care			
11	No of colostomy care			
12	No of lymphoedema care			
13	Other procedures (specify)			

Annexure 6

Monthly reporting format to State NCD Cell, NHM

Name of the District:

Name of DPO:

Sl. No		April	May	June.....
1	No of patients visited under home-care			
2	No of cancer patients			
3	No of spinalcord injury patients			
4	No of CVD patients			
5	No of patients with psychiatric disorders			
6	No of patients above 60 years			
7	No of catheterizations done			
8	No of wound dressings done			
9	No of enema given			
10	No of Tracheostomy care			
11	No of colostomy care			
12	No of lymphoedema care			
13	Other procedures (specify)			

Annexure 7
Home-Care Kit

1. Adhesive Plaster 2.5 x 5 cm
2. Artery Forceps 6" (Curved)
3. B.P.Apparatus (Mercuric Type Elko meter)
4. Cotton Wool 400gm
5. Cutting Scissors
6. Disposable Syringe with needle 20 ml
7. Disposable Syringe with needle 10 ml
8. Disposable Syringe with needle 5 ml
9. Disposable Syringe with needle 2 ml
10. Foley's Catheter 14FG (RUSCH)
11. Foley's Catheter 16FG (RUSCH)
12. Foley's Catheter 18FG (RUSCH)
13. Gause Absorbent 10x100cm
14. IV Set
15. Lignocaine jelly 2%
16. Micro Plaster (paper Plaster) 2.5 x 5cm
17. Nail Cutter
18. Normal Saline
19. Providone Iodine Lotion 400ml
20. Providone Iodine ointment 15gmx
21. Ryles Tube
22. Shaving set with Blade
23. Small Bowl
24. SV Set 23
25. Sponge Holder 10"
26. Sterile Surgical Gloves 7"
27. Sterile Surgical Gloves 6.5"
28. Stethoscope (Pulse Wave)
29. Surgical Tray 80
30. Surgical Tray 8x6
31. Surgical Scissors-Straight
32. Thermometer
33. Torch
34. Tourniquate
35. Turpentine Oil 100 ml
36. Unsterile Rubber Gloves 6.5"
37. Unsterile Rubber Gloves 7"
38. Urobag