PALLIATIVE CARE STANDARDS FOR ZIMBABWE



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Hospice Association of Zimbabwe

TRÓCAIRE
Working for a Just World

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Foreword

Zimbabwe like any other country faces public health challenges that require the care and support of those with chronic illnesses. The high HIV/AIDS prevalence rates of 15.6% in 2007(MoH&CW HIV Estimates, 2007) mean that the burden of care for people infected and affected by HIV/AIDS will remain high for the foreseeable future as the disease takes its course. In addition the problems of non communicable diseases such as cancer have seen an upsurge over the last few years as it has also become a major health problem in Zimbabwe with a notable increase in the number of patients. Other non communicable and chronic illnesses such as hypertension and its complications, diabetes, epilepsy and mental illness continue to pose problems within the Zimbabwe health system. These challenges call for a concerted response to providing quality and comprehensive care in the health delivery system and communities.

Patients with chronic illness can be relieved of their pain and suffering by integrating palliative care into the health system and community strategies. The World Health Organisation (WHO) defines palliative care as an approach that: **improves the quality of life of patients and families facing the problem of 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, psycho-social and spiritual** (Sepulveda et al, 2002). Palliative care can be delivered in several settings that include home based care, outpatient care, outreach services such as roadside clinics, hospital based care, palliative care specialized unit, day care, hospice inpatient care and workplace programmes.

In Zimbabwe the increase in the burden of care due to HIV and AIDS and non communicable diseases as well as the challenges in the health system have resulted in a shift of care to the community level. Community and home based care has become one of the major settings for delivering care that promotes the health and well being of people living with HIV and AIDS and other chronic illnesses. However the quality of care is compromised by lack of knowledge, skills, coordination and resources to provide comprehensive palliative care.

These standards have been developed to promote the provision of holistic quality care to patients and families facing life threatening illnesses. They will provide benchmarks vital for achieving quality palliative care and will be a valuable tool for quality improvement and outcome measurement for the service providers, administrators, and other relevant stakeholders including palliative care donors. It is my hope that these standards will provide a unified understanding of minimum guidelines/standards of comprehensive and quality palliative care in Zimbabwe that will improve the lives of patients and families.

The government of Zimbabwe calls upon all stakeholders to support and implement these standards in order to create a supportive environment for patients, families and communities throughout the continuum of care.

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Secretary for Health
Ministry of Health and Child Welfare
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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral drugs
CHBC	Community Home Based Care
EDLIZ	Essential Drug List in Zimbabwe
HIV	Human Immunodeficiency Virus
MCAZ	Medicines Control Authority of Zimbabwe
NGO	Non-Governmental Organisation
WHO	World Health Organisation
NSSA	National Social Security Authority

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Definition of Terms

Term	Definition
Primary caregiver	The person who has the ultimate responsibility of caring for the sick person on a routine basis in the home. This is often a member of the family, household or someone close to the sick person.
Secondary Caregiver	A trained person who works with communities and families to share information about health practices, to provide simple treatments and to refer sick people to clinics and medical centres for other necessary treatment. This person is often a volunteer.
Preceptor	A person assigned to an individual by the organisation for a short period of time for the purposes of orientation and socialization.
Mentor	A person voluntarily selected by an individual, in any setting, for a long period of time to develop knowledge and skills.
Standards	• Statements that set out core functions that are optimal, achievable and measurable • Guides towards best practices in order to standardize care across all settings • Quality improvement tools that encourage continuous improvement • Indications of a pre-agreed level of quality service provision.
Palliative Care	Hospice and Palliative Care Association of Zimbabwe affirms that the concept of **palliative care** is a branch of medicine which enhances comfort and promotes the quality of life for the individual and their families. In view of this we accept and use the World Health Organisation (Sepulveda e al, 2002) definition of palliative care as our official definition of palliative care in all our operations. In this definition, Palliative care is defined as: ***An approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems***

	Palliative Care: • Provides relief from pain and other distressing symptoms • Affirms life and regards dying as a normal process • Intends neither to hasten nor postpone death • Integrates the emotional 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 patient's 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 antiretroviral therapy, chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications (WHO 2002).

Palliative Care for Children	The World Health Organisation (1998) definition of palliative care for children and their families applies the following principles which also apply to other paediatric chronic disorders. These include**:** • Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family. • It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease. • Health providers must evaluate and alleviate a child's physical, emotional, and social distress. • Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited. • It can be provided in tertiary care facilities, in community health centres and even in children's homes (WHO, 1998). The children's home refers to the child's own home, community home or institution.

Community and Home Based Care	Community and Home Based Care is the provision of holistic care for the patient in the home by the family, with the support of the community and the multidisciplinary and multi-sectoral team. It centres on both the client and the family to enable them to cope with illness.

Hospice	Hospices are a method of delivering end of life care in many countries and can be delivered at a hospice, home, hospital or clinic. Some hospices are included in the country's Palliative Care programme.

Models of Palliative Care	Palliative care is a philosophy of care which includes a wide range of interventions in the area of clinical, emotional, social and spiritual care. The following models can be adapted to suit the setting in which palliative care is to be implemented. These services can be delivered as: • Home based care • Outpatient care • Outreach services for example roadside clinic • Hospital based palliative care teams • Palliative care specialized unit • Day care • Hospice inpatient care • Workplace programmes

Introduction

This document has been developed by Hospice and Palliative Care Association of Zimbabwe (HOSPAZ) in collaboration with stakeholders and providers of palliative care in Zimbabwe. It equips palliative care providers with specific operational guidelines and benchmarks which are vital for achieving quality palliative care. It is hoped that the service providers, administrators and other relevant stakeholders, including palliative care donors, will find this a valuable tool for quality improvement and outcome measurement.

These standards target all those in palliative care service provision and training including other National Palliative Care Associations and Hospice services among others. They are applicable to all settings of palliative care delivery, namely home based care, inpatient services, outpatient programmes, day care programmes, hospital settings and any other models that are currently used in Africa.

Palliative Care Standards have been developed in Zimbabwe in order to promote the provision of holistic care to patients and families facing life threatening illnesses. The provision of palliative care has been in existence in Zimbabwe since 1979 with no national standards to guide implementers in the quality of service they ought to achieve, monitor and evaluate. The standards will aid the development of a unified understanding and definition of minimum standards of palliative care in Zimbabwe.

How to Use these Standards

The Palliative Care Standards comprise 24 different standards. Each standard is introduced by a preamble and then followed by measurable statements.

Standard 1: Access to Care

Preamble

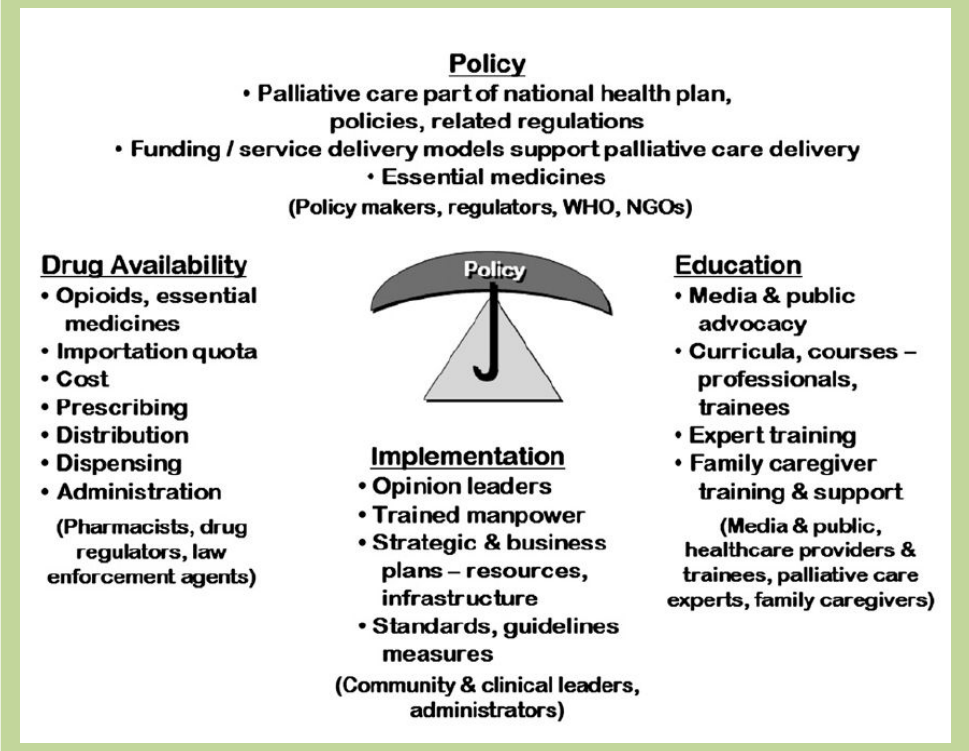
Community mobilisation is fundamental in the provision of palliative care. Information, education and communication on specific services should be made common place knowledge for all. Palliative care organisations should consider the care they provide as part of an integrated system which involves health care providers and different models of care to ensure that care is available across the continuum of care.

All patients and families needing palliative care should have access to palliative care based on their identified needs, regardless of age, race, gender, colour or creed. It is a human right for patients, families and children to access palliative care in order to improve the quality of life through alleviating pain and suffering. The purpose of this standard is to improve access to care so that the community is equipped with knowledge of palliative care well before the need arises.

Measurable Statements

- Assess the palliative care needs of the patient and family prior to admission into the palliative care programme. Develop and document a care plan involving the patient, family and children to provide appropriate and culturally sensitive care.
- Conduct initial and periodic community needs assessments and planning to contribute to the development and implementation of palliative care services.
- Provide palliative care education and information to all communities regarding the services offered, admission criteria of patients and referral systems.
- Provide information, education and communication material to communities to solicit support for palliative care.
- Mobilise communities to assist in sourcing for resources such as medicines.
- Provide information to patients and families regarding how to contact the multidisciplinary team when needed. This should include opening hours and the on call service to prevent patient and family distress.
- Provide fair and equal treatment to patients and their families so that they receive medicines and other supplies from palliative care services without discrimination, regardless of age, race, gender, colour or creed.
- Ensure that the Palliative Care multidisciplinary team is well trained and has access to on-going training in order for the team members to be highly skilled and equipped to meet the varying needs of patients and families.
- Ensure the availability and accessibility of services by providing medication, care providers and material resources to patients and families for the provision of culturally acceptable holistic care.

- Engage the interdisciplinary team and community representatives in regular evaluation of the service provided to enhance the continuum of care and align with the current trends of palliative care.
- Hold regular community forums to discuss gaps in palliative care provision and how they can be addressed.
- Provide community with regular feedback and information sharing on progress of service delivery.
- Ensure that there are local networks and referral systems in place
- Monitor and evaluate the services that are provided regularly and provide feedback to stakeholders
- Ensure palliative care is supported by government policies, adequate drug availability, education of health professionals, and that implementation of palliative care is integrated into all levels of the health care delivery system as recommended by WHO (2007)



With acknowledgement to WHO (2007)

Standard 2: Discharge Planning, Referral and Networking

Preamble

Discharge planning is the process of moving the patient from one level of care to another. The process starts on admission to service/care and continues through to the time of discharging the patient. It involves assessing the patient's needs and identifying support systems and resources available. It incorporates the multidisciplinary team approach involving the appropriate health professionals and community care providers in an effort to offer holistic patient care. It involves the patient or client in decision making.

Referral is the process of transferring a client/person needing care from one place or from one care provider to another in an effort to seek the necessary care.

Networking is the aspect of referral that involves one organisation seeking the input of another in palliative care. It also involves sharing of experiences, maximising on the available resources, establishing lines of communication and developing a clear sense of each other's roles and responsibilities in respect of the patients' needs. Through networking, palliative care is provided in an integrated and collaborative manner ensuring a continuum of care. Networking helps to build palliative care teams with community involvement.

A **continuum of care** is a comprehensive multi-level response from the hospital to the home and vice versa, covering a wide range of medical, emotional and social support needs of chronically ill patients and their families. Patients often move between various settings within the organisations. Without coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, services may be duplicated and the patient is exposed to avoidable risks. There is therefore critical need for discharge planning, referral and networking.

Measurable Statements

- Conduct a health assessment of the patient on admission to service/care and determine needs to enable timely and appropriate planning and implementation. Discharge planning starts on admission.

- Conduct a home assessment where applicable and identify resources and support required by the patient and family prior to discharge. Appropriate action is then taken to improve the quality of care.

- Identify and create a database of service providers and networks in palliative care so as to facilitate the process of networking, referral and discharge planning to ensure holistic and continuous care.

- Develop a guideline for the support of the health care workers and other service providers in the discharge process so as to improve the quality of care.

- Develop clear roles, responsibilities and communication lines for health care and community providers at rural, district, provincial and tertiary levels of the referral system to ensure accountability and to minimise role conflict.

- Educate the patient, family and caregiver on the patient's management to involve them in effective and comprehensive palliative care.

- Adhere to the discharge planning procedures in order to facilitate the smooth transfer of patients as per Ministry of Health and Child Welfare guidelines.

- Ensure accurate and comprehensive documentation of information for record keeping purposes.

- Ensure clear and structured lines of referral of the patient and family among professionals, caregivers and institutions to minimise duplication of services, errors of omission and commission.

- Advise the patient and family on the follow up system and the need to observe review dates and re-supply of medicines to ensure continuity of palliative care.

- Inform the multidisciplinary team members about the patient's discharge plan and care at home.

- Ensure that the patient's records accompany the patient when transferred to ensure continuity of care.

- Refer patient timely to relevant service providers when necessary in order to ensure appropriate and effective care. Fill in the referral forms (see appendix 8) and collaborate with relevant disciplines.

- Ensure that when the patient is referred to another organisation the receiving organisation is given a written summary of the patient's clinical condition and interventions carried out for continuity of service.

- Ensure co-operation and coordination among the palliative care organisations by organising quarterly meetings to discuss issues pertaining to improved quality care.

- Compile reports on meetings and activities which will assist in the assessment of care delivered.

- Monitor and evaluate the referral and discharge process according to the Ministry of Health and Child Welfare Discharge Planning Policy (2000). Use a checklist (see appendix 6) to assess progress and make any necessary adjustments to improve the quality of care.

- Enable documentation and sharing of best practices including exchange visits.

Standard 3: Health and Safety

Preamble

Wherever palliative care is being provided, health and safety issues are of paramount importance. The health and safety measures are implemented according to the model of care such as home based care or institution based care. Measures are implemented to address the safety and security of health providers, patients, family members, caregivers, visitors and significant others, buildings and equipment including medicines. This is done as part of risk management for staff, patients, families, caregivers and visitors in accordance with the current regulations. Effective management of risk includes planning, education and monitoring of resources needed to support the services being provided. The purpose of the standard is to ensure that heath and safety issues are addressed in palliative care.

Measurable Statements

- Constitute a health and safety committee in the organisation with defined and documented roles and responsibilities for the committee members.
- Assess the organisation or workplace to identify hazards or risks to staff and clients.
- Provide staff members with written information and training on risks specific to carers (such as needle stick injuries and procedures to follow if exposed, in line with the National Social Security Authority (NSSA) regulations).
- Educate staff on personal safety, health and security during home visits.
- Provide security guards where possible to ensure safety and security of staff, volunteers, patients, visitors and buildings.
- Monitor the health of carers in compliance with policies and procedures.
- Educate all team members on health and safety procedures and a mechanism for summoning the assistance of police, security and fire brigade in case of emergencies.
- Where there is an established organisation ensure that:
    - Staff members are trained in the prevention of fires through safe handling and storage of flammable materials and in the use of fire extinguishers.
    - New members receive orientation training in fire prevention and evacuation and document procedures so that all members are conversant with fire safety procedures.
    - Fire fighting equipment is regularly inspected and serviced annually with a date of service recorded on the apparatus.
    - There are clearly marked notices against smoking and designated areas for smoking are assigned to ensure fire safety.

- Ensure that the organisation:
    - Develops, implements and evaluates a plan for reporting, monitoring and follow up on all incidents which include adverse drug reactions, theft, staff injury, property damage, motor vehicle accidents during organisational businesses and abuse of controlled medicines.
    - Develops and writes a plan to respond to disasters (such as floods, bomb threats, failure of water and electrical supplies) in order to deal effectively with unexpected emergencies.
    - Develops and implements a written plan for the management of hazardous wastes such as chemicals, chemotherapeutic agents, radioactive materials, household waste and regulated infectious waste. These are to be safely controlled and disposed of using a colour coding system of bags which identify different types of waste based on regulations.
    - Promotes adequate health and safety equipment for staff in response to the health hazards at hand.
- Inspect buildings regularly and document findings.
- Conduct repairs when necessary to avoid buildings collapsing due to cracks, roof leaks and plumbing problems.
- Ensure safe and effective use of medical equipment, including during delivery, set up and maintenance; ensure that defects are appropriately reported and dealt with.
- Conduct health and safety meetings as determined by legislation, and when requested by staff or management.

Standard 4: Governance and Leadership

Preamble

Corporate governance is the system by which organisations are directed, controlled and held accountable. Governance focuses on policies, systems, organisational structures and processes, direction as well as compliance with relevant laws and regulations, conformance to ethics, standards and codes of best practice. Good governance ensures greater accountability and transparency. This in turn ensures a better relationship between stakeholders and their different interests as well as the rights and powers of the organisation. Good corporate governance is highly associated with good leadership behaviour.

Effective leaders engage in both professional and personal leadership behaviours to achieve organisational objectives. Professional leadership provides direction of the organisation, creates processes for achieving organisational goals, aligns processes and procedures and provides coordination of members of the organisation. Personal leadership is personal behaviour and entails demonstrating expertise, building trust, caring for people and acting in a moral way.

Certain organisational policies, guidelines and procedures should be in place for the effective functioning of the organisation. These include a Human Resources Policy, Code of Conduct, Board Policy, HIV and AIDS Policy, Fundraising Policy, Asset Management Policy, Financial Policy, Risk Management Policy, Office Systems and Procedures Policy, Transfer Criteria or guidelines, Infection Prevention and Control, Health and Safety and Emergency Preparedness.

Measurable Statements

The Governing Body and Management should ensure:

Effectiveness of the Governing Body

- Board members are competent, effective and work well together as a team.
- Roles and responsibilities between the governing body, management and staff are clearly defined and documented.
- Composition of the governing body is all inclusive and broad enough to ensure fair representation of all stakeholders.
- There are effective systems for recruitment, induction and support for new board members.
- There is a clear board constitution and definition of a quorum for when meetings are held.
- Lines of communication and authority are presented in an organogram or other document to ensure good communication and cooperation between those who govern and those who manage the organisation.
- The Board meets regularly and is regularly informed of the organisation's activities and issues affecting the organisation.

- The board approves plans, policies, procedures, budgets and allocation of resources of the organisation.

- Annual general and review meetings are held to share information and discuss activities, financial and non-financial aspects of the organisation. This is to ensure transparency, open channels of communications, provide opportunities for public decision making and provide direction to the functioning of the governing body, management and staff.

- Meaningful participation of all stakeholders regardless of gender, age, race, creed, health status and religion is displayed in the organisation's decision making processes, whether directly or indirectly.

- The Board has a performance evaluation and continuous development system for the governing body, management and employees.

Definition of Vision and Mission of the Organisation

- The organisation has an established participatory process which includes both the internal and external stakeholders for defining, developing, reviewing and implementing a strategic plan designed to assist the organisation realize its mission and vision.

- The organisation has mechanisms to regularly communicate the strategic plan and vision to its internal and external stakeholders.

Management and Control of Human Resources

- The organisation has a coordinated, efficient and uniform process of recruitment, evaluation and appointment of staff, to ensure the availability of adequate numbers of qualified staff at all times to match the organisation's mission, resources, patient and client needs.

- In-service education, a clear staff development policy and other learning opportunities are provided to maintain or advance skills and knowledge, based on identified needs.

- Staff is supported through counselling and de-briefing mechanisms to cope with work related and personal loss, grief and change.

- Fair labour practices, grievance and disciplinary procedures are practiced consistently to prevent labour unrest which can impact negatively on patient and client care.

- A clear HIV/AIDS workplace policy is in place for staff members or for the organisation.

Management of Information

- Security and confidentiality of financial, staff, patient and client records is maintained to prevent unauthorized access, theft, loss and destruction.
- Information is obtained and used to improve patient outcomes, individual and organisational performance, risk management programmes and to support in-service training.
- Timely and accurate documentation of clinical records is maintained.

Management and Control of Financial Resources

- The organisation practices effective financial management and resource mobilization guided by recognized and acceptable accounting principles and other relevant standards.
- Financial expenditure is guided by clearly defined and approved budgets; clear lines of authorization and approval are in place between the governing body and management.
- Financial reports are prepared quarterly or as required for accountability and transparency.
- Financial statements of the organisation are audited at least once a year by independent external professional auditors.
- Financial statements and the organisation's budget are regularly monitored and reviewed.

Management of Equipment, Supplies and Buildings

- Equipment and supplies are ordered and maintained to ensure availability at all times, and supported by clear storage and distribution policies.
- Policies that safeguard the security and safety of organisational equipment, supplies and staff, both on and off the organisational premises, are in place.
- Written policies and procedures are provided that direct the reporting and follow up on all incidences or accidents to staff, patients, family, property, and equipment when on hospice and palliative care business.

Implementation of Quality Management and Improvement

- A quality management strategy supported by appropriate institutional provisions is in place as an integral performance management strategy of the organisation.
- Clearly defined indicators for performance evaluation are available and used to assess quality of service.

Promoting Ethical Behaviour

- Members of the governing body and leadership of the organisation uphold high personal leadership qualities that promote good ethical standards for the organisation.
- The organisation clearly displays non-tolerance of unethical behaviour and mechanisms of dealing with unethical behaviour are clearly defined.
- The organisation provides patient care within business, financial, ethical and legal norms to reduce conflict of interest, provide clear guidelines for services offered and protect staff, patients and clients.

Standard 5: Ethical Practice In Palliative Care

Preamble

Patients and their families including children should be informed of their rights to privacy and deserve to be treated with dignity by competent staff. They should be assured that all information shared will be treated as confidential. Staff should understand and respect patients' beliefs and values **without discrimination, regardless of age, race, colour, creed, gender or health status** and provide considerate, respectful care that protects patients' dignity. This helps to build open, respectful and trusting relationships between patients, families and palliative care organisations. Patients and families should be protected from participating in research and clinical trials without informed consent. Euthanasia is illegal in Zimbabwe. There are four basic ethical principles that must be observed in the provision of palliative care services:

The respect for autonomy recognises the right and ability of an individual to decide for him or herself, based on his or her own values, beliefs and cultural norms. The patient's decision should be informed and well-considered, reflecting his/her values. It is acceptable, for example, that a patient refuses certain therapy according to his own religious beliefs. Respect for autonomy implies truth telling and exchange of accurate information about status, goals of care, options and expectations.

Beneficence requires prevention or removal of harm, while doing or promoting good. It implies that the healthcare team should do positive acts in maximising the benefits of treatment, such as delivering effective and beneficial treatments for pain and symptoms and providing support for patients and families.

Non-maleficence means that care providers ought not to inflict harm deliberately. Violation of this concept may include offering information in an insensitive way, providing inappropriate treatment of pain or other symptoms

Justice relates to fairness in the application of palliative care. It implies that patients receive equal care and treatment according to need.

Measurable Statements

- Train staff about their role in the protection of patient and family rights in order to promote ethical decision making.
- Develop policies, protocols, guidelines and procedures to assist health care workers in ethical decision making to ensure legal and ethical support for health care workers.
- Establish multidisciplinary committees which consist of health care workers, a priest, social workers, family representatives and people of good standing in the community for discussion around ethical problems in palliative care. This ensures support to carers in situations where difficult ethical choices are necessary.
- Respect the patient's and family's culture and spirituality in all aspects of care.

- Prevent and remove of harm, while providing care and promote good for patients and families including children

- Maintain privacy and confidentiality by only sharing with multidisciplinary team members information that is necessary for patient care and with the patient's consent.

- Explain procedures fully to patients before carrying them out to obtain permission and minimize anxiety.

- Educate patients on their rights to make informed decisions on treatments, where to be treated, care processes, tests and procedures that they receive.

- Inform the patient and family on their rights to refuse or stop any treatments such as artificial hydration, artificial nutrition, life support, resuscitation etc. without risk of punishment or loss of benefits to ensure patients' dignity.

- Provide the patient and family with information regarding legal support in cases where rights have been violated.

- Provide fair and equal treatment to patients and their families so that they receive medicines and other supplies from palliative care services.

- Provide families with information when making informed decisions regarding treatment and care for vulnerable groups such as children, the unconscious, the mentally disturbed, the blind, the deaf and prisoners, considering cultural and traditional customs to ensure their protection.

- Instruct patients and families to keep medical records safe and carers to maintain confidentiality.

- Provide a written document which describes the rights of patients in a language they can understand so that they can remember and refer to these.

- Advocate for access to the most convenient and effective form of medication and treatment that does not negatively impact on the individual, in order to uphold the individuals' right to die with minimal pain, in peace and with respect.

- Create awareness for families and communities to avoid stigma and discrimination so that patients are treated with the dignity they deserve.

- Refer palliative care emergencies such as spinal cord compression, haemorrhage, convulsions and airway obstruction for further management to improve quality of life.

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Standard 6: Symptom Management

Preamble

A **symptom** is what the patient complains of, for example, cough, tiredness or shortness of breath. Symptoms are caused by the disease itself such as cancer, HIV related diseases, opportunistic infections (OIs), or the treatment of the disease such as radiotherapy. The symptoms cause tremendous discomfort which, if not addressed, compromise physical performance and a sense of well-being in many patients.

The aim of treating and preventing symptoms is to provide comfort and quality of life for the patient, not only to prolong life. Symptoms should be managed according to the set protocols in Zimbabwe, taking ethical and cultural issues into consideration. Symptom control and management should be planned and agreed upon with the patient, family and members of the interdisciplinary team to prevent duplication of care.

Measurable statements

- Equip health professionals and caregivers as well as the multidisciplinary team with the necessary skills to assess and manage symptoms effectively.
- Explain to the patient and family the possible causes of the symptoms and how they are going to be managed to enable patients and families to make informed decisions about their care.
- Educate patients including children on the importance of reporting all symptoms so that they can be managed.
- Assess physical, emotional, spiritual and social symptoms such as fever, loss of appetite, nausea and vomiting, diarrhoea, oral thrush, constipation, cough and shortness of breath, anger, fear, anxiety and loneliness in order to provide appropriate intervention.
- Teach patients and families the relevant skills to reduce and control symptoms such as diarrhoea and vomiting by use of oral rehydration solution or salt and sugar.
- Identify the cause and severity of symptoms including opportunistic infections, through a thorough assessment.
- Manage common symptoms in a timely manner to ensure that the patient is comfortable. Use set protocols as recommended by Ministry of Health and Child Welfare.
- Manage opportunistic infections using appropriate medication to ensure the patient is comfortable.
- Promote health practices such as clean, safe water, nutrition and universal precautions to ensure that the identified needs of patients are met by the multi-sectoral and multidisciplinary team.
- Manage symptoms using non-pharmacological interventions where applicable, to make the patient comfortable and to reduce the use of medicines. Examples include emotional support,

relaxation techniques, massage, acupuncture and traditional and herbal remedies from registered practitioners. Inform health personnel.

- Manage other symptoms emanating from psychological, social and spiritual concerns through social support and counselling.
- Review the initial patient assessment and management on an ongoing basis so that patient needs are addressed.
- Document assessment findings, symptom control, management and evaluation in care plans for communicating with other team members to prevent repetition and address legal requirements.
- Refer when necessary to the interdisciplinary team members for the continuum of care and provide information on where to get help.

Standard 7: Pain Management in Adults

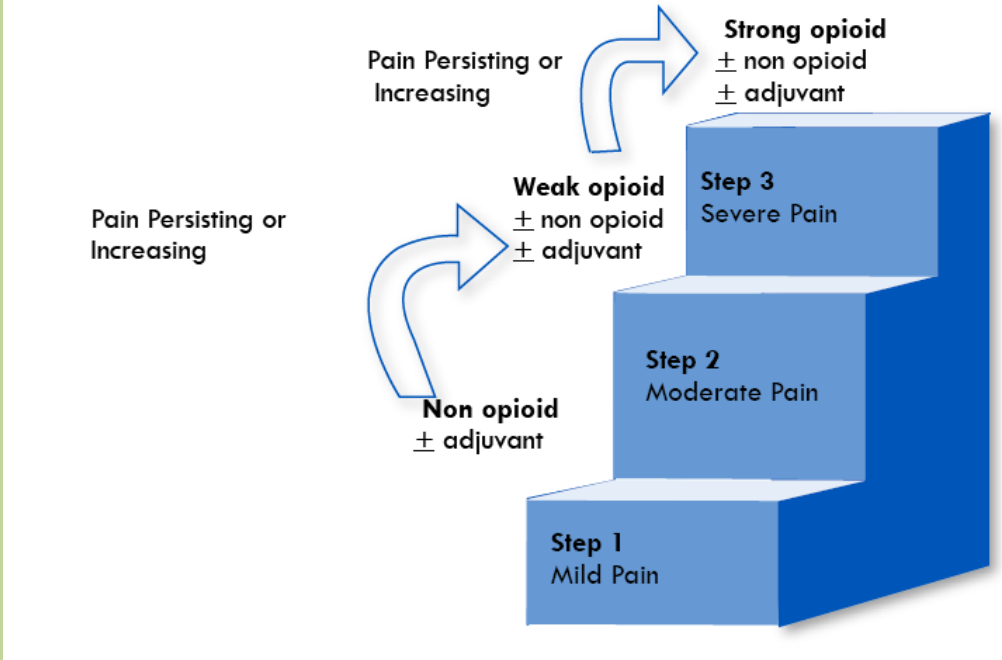
Preamble

Pain is defined as an unpleasant sensory and emotional experience associated with potential or actual tissue damage or described in terms of such damage (International Association for the Study of Pain, 1994). It is complex because it stems from several different factors which include physical, emotional, social, spiritual and cultural problems. This is referred to as "Total Pain". It is subjective and therefore pain is "what the patient says hurts".

Pain is one of the most common symptoms in palliative care and should be considered the fifth vital sign after blood pressure, pulse, temperature and respiration. It is usually under treated, resulting in unnecessary suffering. Fear of addiction to morphine is a major contributing factor to under treatment.

The WHO (1998) analgesic ladder outlines the proven stepwise approach which should be used in managing physical pain. The analgesics should be available and accessible at all times. Non-pharmacological interventions such as emotional support, relaxation techniques, massage, acupuncture, traditional and herbal remedies can help to reduce all the components of pain.

Pain management involves a multidisciplinary team that is aware of the concept of total pain and is able to assess, diagnose and manage pain holistically. The aim of pain management is to allow patients to be pain free so that they are able to carry out their usual daily activities.



With acknowledgement to HPCA, APCA (2005)

Measurable statements

- Equip health professionals and caregivers as well as the multidisciplinary team with the necessary skills to assess and manage pain effectively.

- Assess pain at every visit or contact to identify the site and cause of each pain; take a history of each pain using pain assessment tools; determine the location, severity, quality, onset and duration, timing, any alleviating and aggravating factors, interference with daily living and associated symptoms.

- Acknowledge the patient's pain and provide assurance on management of the pain to alleviate anxiety.

- Use the most commonly used pain rating scales which are culturally acceptable such as the Visual analogue and the Numerical rating scales where applicable depending on literacy levels, visual and auditory impairment. Use the same scale every time with the same patient.

- Provide analgesics to alleviate physical pain:

  - By the **mouth**: The best and non-invasive way for managing chronic pain.
  - By the **clock**: Medicine for persistent pain should be administered on an around-the- clock basis.
  - By the **ladder**: This refers to the titration of mild analgesics to strong analgesics.
  - By the **individual**: Pain is a multifaceted experience that is influenced by emotional and contextual factors which require that pain management be individualized for each patient.

- Manage physical pain using other interventions such as radiotherapy, chemotherapy, nerve blocks, surgical procedures, hormone therapy in certain tumours and antiretroviral drugs where indicated, to improve the quality of life. Refer if necessary.

- Provide pain relief using non-pharmacological interventions such as relaxation techniques, massage, and acupuncture, traditional and herbal remedies, to reduce the need for analgesics.

- Provide emotional support and counselling for the patient and family to alleviate pain that emanates from emotional, psychosocial and spiritual issues such as fears and anxiety, including suicidal tendencies.

- Assess the response to pain control measures by using the same tools as for the initial assessment and adjust the medication as necessary. Regular follow up is required when a patient is started on opioids.

- Educate health professionals, team members, carers and patients that addiction to opioids used in palliative care is very rare. This is important in order to dispel myths which contribute to under treatment of pain.

- Explain to the patient and family the possible causes of pain and how pain is going to be managed. Set realistic aims, such as pain free at rest, at night and pain free on movement. Communicate these with the patient and carers.

- Ensure that medicines on EDLIZ are always available for use in the management of pain to alleviate suffering of patients. Refer if necessary.

- Document all medicines given to patients, ensuring clear communication of what has been given, reflecting accurate legal practice.

- Report medication adverse reactions through completion of an adverse drug reaction reporting form (see appendix 9) and send to Medicines Control Authority of Zimbabwe (MCAZ), 106 Baines Avenue or P.O. Box 10559, Harare.

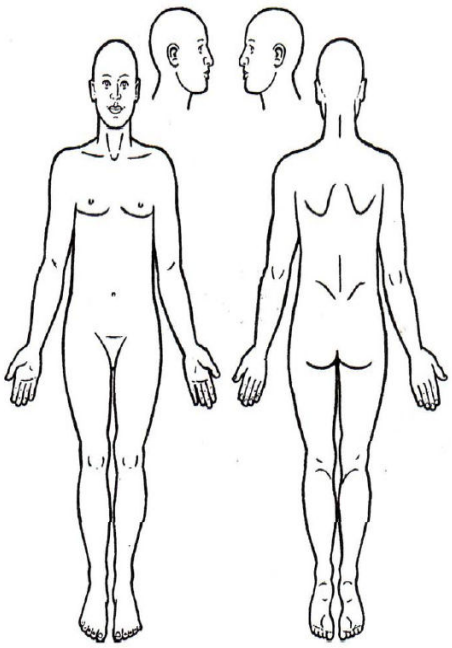
- Prevent side effects of opioid analgesics (such as constipation) by prescribing laxatives and giving information on diet to assist patients to remain comfortable.

ASSESSING PAIN

Examination is an essential part of the assessment. To treat pain effectively it is important to identify the cause of the pain, as pain from different causes requires different treatments. A comprehensive clinical assessment is key to successful pain management. Many patients have more than one pain, therefore it is important to identify the site and cause of each pain separately. Assess all patients for pain at every visit or contact

Use body charts

General body charts to indicate the site and number of pains. The patient gives this information with history taking. Also indicate on the chart the main finding on clinical and physical examination.



With acknowledgement to Hospice Africa Uganda (2007)

Standard 8: Management of Medicines

Preamble

Medicines are a crucial component of effective provision of palliative care. WHO (2008) highlighted drug availability as one of the four foundational measures for palliative care, that includes education, policy and implementation. All palliative care organisations must ensure that appropriate medicines such as antibiotics, analgesics, laxatives, antiretrovirals (ARVs), chemotherapy drugs, ointments and antiseptics are available at all times and that they can be dispensed to patients when required.

The organisation develops and maintains a list of medicines with reference to the ABC classification system according to EDLIZ. The organisation shall follow the applicable laws and regulations as set by the Minister of Health and Child Welfare in accordance with the Medicines and Allied Substances Control Act. The approval to store medicines at any palliative care organisation is applied for and obtained from Medicines Control Authority of Zimbabwe.

Measureable Statements

Ensure that:

- Health professionals and team members are trained on medicines and relevant doses so that they are competent and well informed in the use of medicines. Where possible a pharmacist or pharmacy technician is part of the team.
- Health care providers undergo in-service education on an ongoing basis to equip them with knowledge of new medicines.
- Palliative care medicines are available at all times to meet patients' needs and to improve adherence.
- Ordering and dispensing is done by those with the prerequisite knowledge, experience and permission by law, registration or regulations. These are persons such as doctors, nurses, registered pharmacists or those permitted to order and dispense medications.
- Prescribing is done by those with the prerequisite knowledge, experience and permission by law, registration or regulations. These are persons such as doctors or nurses who are permitted to prescribe palliative care medicines.
- Medicines with a valid expiry date are stored in a secure and clean environment, out of reach of children and in accordance with the manufacturer's instructions.
- Patients and caregivers have received adequate instructions on the use of prescribed medicines.

- Medicines are administered by properly trained health care providers and trained family caregivers so as to protect the patient from receiving wrong medicines and over-and-under dosing.

- Medicines for specialist use require administration by specialised health professionals. This person should check medicines against the original prescription and ensure accurate documentation of all medicines used.

- Medication adverse reactions are reported to MCAZ through a formal reporting system as soon as they occur (see appendix 9).

- Provide education and explanation to patients and the family on the use of medicines to enable them to make informed decisions and to improve adherence (by keeping a record).

- The patient has access to the most convenient form of medication that does not negatively impact on the individual.

- An organisation that has incorporated palliative care into their programme (such as a home based care group) should have the support of health professionals at the nearest clinic or health centre. The organisation should then get assistance in the management of medicines which the patients are using.

- Controlled medicines are kept locked. Keys are kept by a qualified person and accurately accounted for to prevent abuse, misuse and theft.

- Policies and procedures should be adhered to by a team consisting of medical, nursing, pharmacy and administration staff.

- Mixing of traditional herbs and prescribed western medicines is discouraged. Patients and families are encouraged to seek guidance from a health professional before use to prevent medicines from working against each other, causing toxic drug interaction.

Standard 9: Care Planning

Preamble

A written **care plan** specifically outlines observations to be made, care to be delivered and instructions required by the patient and family members. Developing a care plan involves all the key stakeholders such as patients and their families, including children so that the care plan is developed in such a way that it suits the stated goals for the individual patient. The care plan should reflect the needs of the patient and informed decisions made by patients together with family members.

Care plans should be reviewed regularly to address changing needs. Care should be provided by a multidisciplinary team to ensure that patients and relatives receive the best possible care that is holistic and culturally sensitive. The referring institution identifies and allocates the team that will be responsible for patient care for accountability.

Measurable statements

- Identify the needs of the client and family, including children, by using a standard assessment form when planning for care.
- Develop a care plan together with patients and their families, based on initial and subsequent assessments, to provide appropriate and individualized care.
- Mobilize adequate resources together with the family for use during care to ensure patient comfort.
- Provide holistic care using the multidisciplinary approach to address physical, emotional, social and spiritual needs based on the national standardized treatment guidelines.
- Provide the family with information on the management of minor ailments at home, nutritional and dietary needs of the patient and chronically ill children, considering cultural taboos.
- Encourage honest and open communication between the patient, family and the multidisciplinary team.
- Reassess the care plan periodically together with the family to determine if it still meets the patient's needs.
- Establish referral guidelines and tools when providing care.
- Document the care plan clearly and briefly to reflect responses to care, treatment and symptom control and informed decisions made by patients and their families. This is essential for communicating with the multidisciplinary team and to meet legal requirements.
- Continue care plans across all settings such as the hospital, clinic and home.

Standard 10: Palliative Care in Children

Preamble

The aim of palliative care in children is to improve the quality of life for children facing life threatening illnesses through pain and symptom management. The WHO (1998) definition of palliative care in children and families applies the principles of other long term conditions in children. It includes a holistic approach that addresses the total care of the child's body, mind and spirit, and involves giving support to the family.

Children's palliative care must be delivered according to the stages of child development. It requires assessment and communication skills for each age, and a flexible approach which addresses the needs of the individual child. Communication with children is more challenging than with adults as there are many levels of communication, such as with the parents and the child him/herself.

Cultural influences need to be taken into consideration such as talking through the parent/guardian or caregiver, that the children should be seen and not heard and the need to consult the extended family in decision making.

The way children understand death and dying differs from that of adults. Therefore there is need to equip health care professionals and caregivers with adequate skills in palliative care in children.

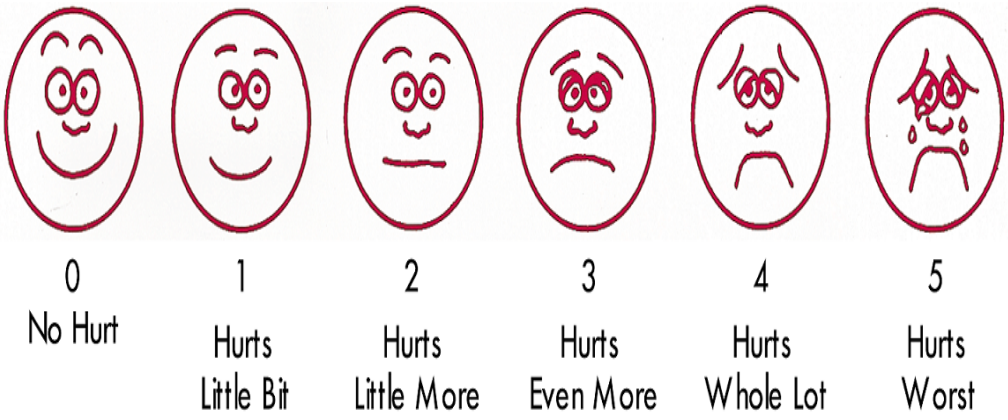
Measurable statements

- Ensure that health professionals and care providers are trained in palliative care for children. The training should include child assessment, pain and symptom management, communication skills, child counselling, child and family counselling, use of play, drawing, understanding of child development, child bereavement issues and HIV in children.
- Allow children to take part in their care by including them in decision making and care planning in a way that is comfortable for them.
- Provide children with relevant and consistent information, given their developmental abilities and needs.
- Encourage truth telling with children, among families, caregivers, teachers and health professionals in a culturally sensitive manner.
- Obtain informed consent from the parent/guardian before carrying out any procedure.
- Obtain informed consent from a child above 16 years for HIV screening according to the HIV and AIDS National Guidelines (MoHCW, 2007).
- Encourage children to report the pain and other distressing symptoms they have, while working with the child's family and caregivers.
- Create awareness on the rights of children and youths to receive individualized, culturally and age appropriate palliative care.
- Ensure all care providers know and understand the rights of the child and their family, along with their organisation's responsibilities to provide palliative care for children.

- Create awareness in children of their responsibilities, such as their responsibility towards the family, society, state and other legally recognized communities, according to the age of the child.
- Involve siblings in caring for the sick child to enhance care and support for the children.
- Use assessment instruments that are appropriate for the child's age and development in order to build rapport and get information from the child for better management of symptoms.

FACES SCALE

The child chooses the face that best describes his/her pain or hurt



The Wong rating scale is recommended for persons age 3 years and older.

Original instructions:

Point to each face , in turn and explain in the child's language what it means in terms of pain.

Face 0 is very happy because he/she feels no pain.

Face 1 hurts just a little bit. **Face 2** hurts a little more. **Face 3** hurts even more. **Face 4** hurts a whole lot. **Face 5** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the person to choose the face that best describes how he is feeling.

Brief word instructions: Point to each face using the words to describe the pain

With acknowledgement to Hospice Africa Uganda, (2007)

- Manage pain in children following the four essential concepts or rules in the WHO approach to chronic pain management:

  - **By the mouth**: The best and non-invasive way for managing chronic pain
  - **By the clock**: Medicine for persistent pain should be administered on an 'around the clock' basis
  - **By the ladder**: This refers to the titration of mild analgesics to strong analgesics
  - **By the individual**: Pain is a multifaceted experience that is influenced by emotional and contextual factors which requires that pain management be individualized for each patient

- Reassess to check how the child is responding to the treatment.
- Communicate with the child and family by building rapport, listening and sharing his/her fears and worries to promote quality of life for the child and family.
- Provide emotional support relating to illness, loss and bereavement through telling a story, drawing and playing together, as children communicate in different ways according to their age and developmental stage.
- Provide spiritual support through singing, rituals and prayer where applicable in order to create hope and to achieve peace and harmony.
- Address the social and educational needs of children in palliative care to improve their well being and to minimise isolation.
- Provide pain relief using non-pharmacological interventions such as massage, play and keeping the child company.
- Provide a good referral system for children among the multidisciplinary team; encourage communication among staff, parents/guardians, spiritual leaders, hospitals and others involved in palliative care for children in order to facilitate continuity of care across care settings.
- Provide food, school fees, medication, shelter, transport, monitoring of defaults and counselling for special groups such as orphans and vulnerable children.
- Equip families with basic nursing skills, information on universal precautions, treatments, who and how to contact for assistance to reduce powerlessness and facilitate effective care.
- Educate families and provide information on issues of disclosure of HIV status to create awareness on their health status.
- Assist families in making treatment and care decisions for children, to cope with illness, loss and bereavement.

Standard 11: Nutrition

Preamble

Nutrition plays an important role in reducing morbidity and mortality and is important for a good quality of life for everyone, especially people living with HIV and AIDS. In HIV infection, good nutrition improves the immune system and delays progression to AIDS. A healthy balanced diet consisting of combinations of proteins, carbohydrates, fats, vitamins and mineral salts provides the right foods, in the right amounts. Patients and families should be educated on the balanced diet and on food/drug interactions.

Contamination of food in the home should be prevented through good hygiene, safe food preparation and handling, proper storage and management of food waste. Patients and their families including children should participate in planning and selecting foods consistent with their nutritional and developmental requirements and culture.

Measurable Statements

- Ensure that a trained nutritionist/dietician/nurse or knowledgeable person assesses and monitors, when possible, the nutritional status of patients. This is done by reviewing the patient's medical history and risk factors, monitoring weight and height and evaluating dietary intake, medicines being taken, social and economic conditions and records changes.

- Ensure that nutrition therapy is planned, selected and monitored. This should be done together with the patient and family using foods that are in season, locally available, unrefined and not processed for a healthy and inexpensive diet.

- Ensure availability of food and other nutrients at all times, addressing the likes and dislikes of patients, meeting nutritional requirements in the right amounts and that are consistent with the patient's clinical condition, culture and care that the family can afford.

- Educate the patient and family about healthy eating habits based on a balanced diet and fluids per day.

- Demonstrate how to prepare a meal, observing hygienic conditions.

- Educate the patient and family:

    - To avoid alcohol, foods which may interfere with absorption of drugs or interact with drugs such as ARVs, antibiotics, antimalarials and anthelmintics (medicines for worms) and avoid too much salt

    - About safe food handling and avoiding contamination by washing hands with soap or ashes after using the toilet, before food preparation and eating, keeping food covered and ensuring safe disposal of faeces, food waste and refuse.

    - To use water from a safe source

- About safe food storage by using food before expiry dates, storing high risk foods (meat, poultry, fish) separately to avoid contaminating or being contaminated by other foods and storing raw foods separately from cooked food to prevent cross contamination.
- Ensure food handlers wear protective clothing and report any infections and undergo annual medical examination to avoid contamination in institutions.

- Identify organisations that provide nutritional support systems in the community and make appropriate referrals.



With acknowledgement to MoHCW, Nutrition Unit (2005)

Standard 12: Patient Records

Preamble

A patient's record is information about the patient. It is written either on patient notes, in a care plan, on a hospital card, referral letter or in a computer. Patient records are a means of collecting and storing up to date information about the patient's diagnosis, investigations, results, treatment regimen and care being rendered to the patient. It aids in the continuum of care. The patient's records should be accurate and user friendly, written clearly and completely and kept in confidence to comply with ethical and legal requirements.

Measurable statements

- Use a standard assessment form to ensure that patient information is collected in a consistent manner using the same tool.
- Maintain a central recording mechanism which captures information on all patients receiving care and allow access by care providers.
- Train palliative care providers on proper record keeping and usage in order to collect and maintain accurate records.
- Ensure that signatures on patients' records are identifiable and recorded in ink for permanency.
- Ensure that only authorized persons have access to the patient's records to maintain confidentiality and safety.
- Provide safeguards to prevent unauthorized access to computerized records by limiting passwords to key people.
- Ensure that the patient's records are updated and kept current.
- Provide patients and their families with a record of the medication and any other relevant information for continuum of care and when referrals are made.
- Keep records of a patient who has died according to the time stated by the hospital or organisation to meet legal requirements.
- Instruct patient and family to keep records safe.

Standard 13: Spiritual Care

Preamble

Spirituality is involved with the search for meaning and purpose in life, suffering and loss. It is a person's relationship with a higher being, or a person's understanding of how and why they fit into the world. Religions provide a way of incorporating spiritual beliefs and rituals into everyday life by offering a structured means of communicating with a higher being.

Palliative care recognizes that spiritual healing can occur even when a physical cure or recovery is not feasible. Spiritual care addresses innermost feelings, values and fears in an attempt to create hope, enhance peace, harmony within oneself even for those who hold no belief. Palliative care providers should not impose their own values and belief systems on patients and the family. Spiritual care should be non-judgemental and accepting, recognizing the uniqueness of each individual's belief.

Measurable Statements

Palliative care providers should:

- Respect the spiritual uniqueness of the patient and family including children so as to enable each person to practise his/her belief without being judged.
- Assess spiritual needs in the palliative care assessment by exploring the meaning and purpose of life for the patient and family so as to provide appropriate care and support in order to provide holistic care.
- Establish a trusting relationship with the patient and family to enable them to discuss any spiritual issues freely without fear of being judged.
- Initiate and discuss regularly spiritual concerns with the patient and family, to provide opportunities to find peace and harmony within themselves.
- Palliative care providers should, where appropriate and with the patient's permission involve the patient's spiritual leaders such as a priest, pastor, minister of religion, traditional or faith healer.
- Encourage those rituals which the patient finds helpful such as prayers, meditation, rites.
- Provide information to patients and families on how to contact a spiritual leader of their choice.
- Provide relevant information regarding spiritual care to assist the patient and family to make informed decisions.

Standard 14: Emotional Support

Preamble

Emotions are feelings and experiences that arise with the diagnosis of a life-threatening illness or bereavement. Emotional support is provided through counselling. This counselling is an ongoing process through the continuum of illness and bereavement. People living with life-threatening illness may experience many reactions. These include anxiety, fear, guilt, anger, sorrow, depression, isolation, abandonment and low self-esteem.

Palliative care providers should provide a safe counselling environment by ensuring confidentiality and a non-judgemental and accepting approach. Effective communication skills and adherence to the core principles of counselling are essential in the provision of emotional support.

Principles of Counselling

Confidentiality

Acceptance

Self determination

Non judgmental Approach

Individualisation

Controlled Emotional Involvement / Empathy

Measurable Statements

- Providers have appropriate training and communication skills to provide safe and effective counselling services.
- Providers have access to appropriate counselling services to refer to when necessary.
- In the initial assessment, providers should complete an emotional care assessment of the patient, family and children that details any previous mental health problems, coping styles, earlier difficult experiences, depression or substance abuse.
- Explore reactions to illness, previous coping strategies and family relationships through counselling.
- Ensure that confidentiality and privacy are maintained at all times.
- Initiate conversation about how the illness impacts on the family.
- Providers use counselling to enable the patient, family and children to actively participate in their care plan and to make their own decisions and solutions which are relevant to their situation.
- Prepare the family and children for bereavement and provide information on grief to enable them to cope following the death of the patient.
- Provide information on loss and grief and the availability of bereavement support services to family members after the death of the patient.
- Encourage the patient, family and children to join support groups which assist in promoting their emotional well being.
- Conduct ongoing assessment of the patient, family and children's emotional welfare in order to re-plan care interventions which result in the improvement of quality of care.

Standard 15: Social Support

Preamble

Social refers to the society and community in which the individual lives. Patients do not exist in isolation. Social support includes assessing and meeting needs for housing, transport, education and school fees, food and hospital fees among others. The aim of palliative care providers is to mobilize social resources so as to meet the needs of the patient, family and children. A comprehensive social support assessment should be undertaken to identify the social needs of the patient and family.

Palliative care providers should be aware of the social challenges such as stigma, discrimination and abandonment and resource needs often encountered by the patient and family. It is important to raise and maintain community awareness for social support in palliative care. In order to provide comprehensive palliative care, it is important for caregivers to acknowledge the support systems used by the patients and families including vulnerable groups such as women, girls, and children at large, both at family and community levels.

Measurable Statements

- Palliative care providers have training in the social needs of patients, families and children in order to enable them to provide quality care.
- Providers have access to a database of social support resources.
- Assess the losses and social needs of the patient and family. These may include materials, food, finance, living arrangements, carer availability, sexuality and access to services. This assessment then helps in seeking practical support from social services and other relevant organisations.
- Provide support where possible such as school fees, food packs for the family, children and community caregivers in delivering palliative services to patients.
- Assess the patient's age, marital status, stage of illness, current treatment, number and ages of own children and dependants to plan for interventions.
- Establish the family member's experiences in caring for patients, how they view illness and how they make decisions about patient care to provide appropriate care and support.
- Develop a care plan in consultation with the patient and family to address the social needs and improve the quality of life.
- Integrate and respect cultural values, beliefs and customs so as to provide culturally sensitive palliative care. Be aware of issues relating to vulnerable groups such as women, children both boys and girls that require support.
- Review the care plan regularly to address changing social needs.
- Refer the patient and family to relevant social and counselling services when necessary in order to meet specific social needs as identified by the patient and family.

- Mobilize the community and educate them on their role in social support.
- Raise awareness of palliative care by educating the community through the media, staff and volunteers so as to gain their support.
- Encourage the patient and family who are facing life threatening illness to join support groups to promote their social and emotional wellbeing.
- Provide respite for relatives caring for the patient so that they have time to rest without guilt or fear.
- Use respite care for the patient in a hospital or nursing home or other family member for a short time for change of environment.
- Register children with a committee of child welfare or refer to nearest district welfare office.

Standard 16: Bereavement Support

Preamble

Bereavement is any loss of something that someone values. In this context it refers to loss of good health and death. It starts at diagnosis when the family is informed of the terminal illness. Then when a person dies the family and children are bereaved because they have lost someone precious to them.

Bereavement involves grief and mourning. Grief is a term used to describe the feelings of pain and loss after a loved one dies. Mourning is an outward expression of the loss such as wailing, weeping and performing rituals for the dead. Many families have rituals that they perform when someone dies which are helpful to them. Therefore cultural considerations must be acknowledged when helping and supporting the bereaved in dealing with the loss.

People have individual ways of expressing their grief and there is no prescribed time frame for grief and mourning. The person offering the support should have training and experience in bereavement care as well as recognizing complicated grief and mourning. This is essential for effective management of the client and family. The aim of bereavement support is to help the individual and family to adjust and cope with the loss.

Measurable statements

- Palliative care providers should conduct an initial assessment that includes previous losses, grief reactions and coping mechanisms for all family members including children.
- Providers should have basic training in bereavement that equips them to recognise healthy grief reactions and complicated mourning, both in adults and children.
- Palliative care providers develop a referral system between the health system, community groups and secondary caregivers to identify those who require bereavement.
- Providers have access to specialist bereavement support for referral of complicated grief reactions.
- Encourage the family and patient to address practical aspects such as indicating burial preferences, writing a will, planning custody of children and for inheritance to facilitate distribution of the deceased estate in an orderly and fair manner.
- Support family members, children and significant others during the death of the patient through information giving, reassurance and by involving spiritual leaders if requested.
- Encourage families to perform culturally acceptable bereavement rituals.
- Palliative care providers give bereavement support by listening, asking about the deceased and the death, exploring activities that help the bereaved and facilitating the grief process.
- Encourage families including children to join bereavement support groups for support and sharing of experiences.

- Palliative care providers facilitate the bereaved to express their grief and mourning in individual ways, recognising that people experience loss differently and find unique ways to manage their bereavement.

- Sensitize the community (such as churches, local leaders and other care workers) on helpful support to be given to families during bereavement.

- Identify support systems in the community to help families through the grieving process.

- Encourage the family and the patient to gather momentoes which are culturally acceptable such as video tapes, memory books and storytelling to help in the grieving process.

Standard 17: Care of Carers

Preamble

Carers who look after patients with life- threatening illnesses can easily be overwhelmed with the burden of care giving. Carers include family members (primary caregivers) and volunteers (care facilitators or secondary caregivers). All carers need to be supported physically, emotionally, spiritually and socially to improve their quality of life and that of the patients. This prevents burnout and volunteer turnover which can result in poor care or unnecessary institutionalization of the patient, which is expensive and emotionally distressing for all involved. Carers need to be provided with adequate resources and training to enable them to deliver quality care and minimize burnout.

Measurable Statements

- Educate carers to:
  - Recognize stress which can manifest as lack of concentration, mood swings, sleeplessness, unexplained tiredness and being short tempered in themselves and with others to prevent abuse and neglect of the patient.
  - Attend to their own physical and emotional needs while caring for others by taking a balanced diet, having adequate rest, sleep and exercise and setting realistic expectations.
  - Manage stress, using effective coping mechanisms such as discussing problems with others, using support groups, relaxation, massage, debriefing etc. to reduce physical, mental and emotional tension.
  - Acknowledge need for support, recognize own limits and seek help where needed
  - Use respite care of the patient in a hospital or nursing home for a short time and encourage the extended family to visit and help with care giving to reduce caregiver role strain.
  - Use social and community support services such as hospitals, clinics, nursing homes, spiritual advisors and disease specific associations to reduce social isolation.
  - Use counselling services, individual and group, to reduce patient and family anxieties.
  - Have self awareness of own strengths and weaknesses in caring for patients and refer patient to other team members
- Ensure that interventions are congruent with cultural values to reduce conflicts and with religious beliefs and practices to afford hope and support coping.
- Train carers in basic nursing and communication skills, emergency procedures and addressing social needs of terminally ill patients to build the carers' confidence in performing necessary patient care skills.

- Provide information to patients and families on how to contact the multidisciplinary team, when needed, hours worked and the on call service to prevent patient and family distress and access the services when required.
- Ensure that carers have adequate resources when caring for the patient to facilitate effective care.
- Ensure that carers training equips them to be accommodating of cultural and religious differences that might be in conflict with own values and refer to the multidisciplinary team.
- Encourage and support carers to refer needs that are beyond them to team members.
- Refer needs of carers that are beyond the team member's scope to other organisations.
- Assist secondary caregivers in conflict resolution to reduce conflicts.
- Supervise caregivers monthly to provide support, improve their knowledge and skills and prevent burnout and high turnover.
- Provide team building sessions annually so that caregivers feel appreciated.

Standard 18: Family Care

Preamble

The family systems theory (von Bertalanffy, 1974) states that illness in any one member of the family affects the rest of the family members. The effects of living with a family member with a life-threatening illness include the burden of daily physical care, financial concerns, lack of support and resources. There is reduced socialization for the entire family, difficulty with coping with role and responsibility changes, disruption in daily routines and fear of death. Role changes require adjustment and new skills to successfully manage new changes. These stressors threaten the family's integrity and can alter their ability to cope with the situation. Team members therefore need to prepare and support the family in adapting to changes that arise from illness, dying and bereavement. Special attention should be paid to vulnerable groups such as women, children and grand-parents who often carry the burden of caring for the sick and orphans at home.

Measurable Statements

- Use patient records, observations and feedback from patients and family members on an ongoing basis and within established time frames so that needs are prioritized and addressed accordingly to assess:
    - Family relationships and adjustment to role and responsibility changes to reduce conflicts.
    - Whether financial issues are affecting the care of other family members and refer to social worker where indicated.
    - Use of appropriate recreational activities to reduce tension, stress and fatigue in the family.
    - Living arrangements which can affect the quality of care rendered and provide support where necessary.
    - The family's source of support within the community to strengthen support systems.
    - Decision making regarding care of the patient to empower the families to be in control of their lives.
    - Physical and emotional needs such as nutrition, rest and sleep and being there for one another to reduce stress related health problems.
- Provide adequate facilities and equipment for patient comfort and privacy during assessment.
- Document assessment findings in patients' records for clear communication to other team members and as a defense against legal action.
- Develop a comprehensive care plan collaboratively with patients and their families that:
    - Reflects the informed decisions they make.

- Addresses the patients' physical, emotional, social and spiritual needs
- Describes nutritional needs
- The mode of referral to other service providers

- Review care plans regularly to reflect changes in patient and family needs.
- Identify and train the main carer in the family to prevent confusion and ensure continuity of care and communication.
- Encourage patient and family who are facing life threatening illness to join support groups to promote their social and emotional wellbeing
- Ensure that interventions are congruent with cultural values to reduce conflicts and with religious beliefs and practices to afford hope and support coping.
- Respect at all times the autonomy of the family in end of life issues without fear of ridicule or withdrawal of treatment
- Ensure availability of the multidisciplinary team or ethics committees when patients and families experience ethical dilemmas.
- Train family members in basic nursing skills, palliative care emergencies, universal precautions, treatments, adjusting to disruptions in activity patterns and who and how to contact for assistance to reduce powerlessness and facilitate effective care.
- Provide written instructions to the family on patients' medication.
- Provide a supportive non-threatening, calm and private environment when counselling and responding to family concerns to reduce anxiety.
- Provide counselling services for family to address their emotional needs.
- Conduct family conferences to assist with decision making about placing the patient for long term care in nursing homes, which may not be culturally acceptable in Zimbabwe, to reduce conflicts between family members.
- Inform and refer families to community groups which can provide medicines, equipment, materials to ensure that they have adequate supplies at all times for provision of safe and effective care

Standard 19: Staff Support

Preamble

The palliative care organisation should recognize that palliative care staff members are prone to **burnout.** This manifests as physical and emotional exhaustion and arises from stressors associated with caring for dying patients and their families. Staff members therefore need physical, spiritual and emotional support to assist them to cope with work-related and personal loss, grief and change.

Support systems that involve sharing of experiences, establishing clear lines of communication and developing a clear sense of each other's roles and responsibilities need to be in place to minimize role conflict. Staff members should be provided with adequate resources, supervision, support and training to enable them to deliver quality care and minimize burnout. Staff members should also be provided with a platform where they can express their feelings.

This standard aims to reduce absenteeism, anger, frustration, anxiety and loss of commitment which may in turn lead to poor quality of care and high staff turnover.

Measurable Statements:

- Support staff members to deal with own unresolved issues pertaining to death for them to deal effectively with death and dying issues.
- Avail a counselling service for staff members where they can express their feelings.
- Staff should be educated to:
    - Identify early warning signs of stress (such as anger, frustration, anxiety and loss of commitment in one's self and other team members) to facilitate interventions that enhance individual coping.
    - Develop effective coping strategies to reduce physical, mental and emotional tension (such as regular exercise, balanced diet, adequate rest and sleep, massage therapy, relaxation, caring for one self and setting realistic personal expectations).
    - Use available resources to express feelings generated by death experiences (such as debriefing by trained counsellors, social workers, chaplains; peer support; preceptors or mentors and to seek these where necessary to alleviate stress.
    - Involve staff members in planning strategies, including staff retreats, to prevent or reduce burnout.
- Provide adequate resources and remuneration to promote satisfaction with work and reduce burnout.
- Identify educational needs through job performance reviews and for new clinical procedures and equipment to generate enthusiasm, commitment and build confidence.

- Establish processes that support staff development and continuous education to update knowledge and skills to ensure consistency with patient needs.
- Orient new staff members to the organisation and/or new work areas to ensure smooth adjustment, improve practice and reduce costs.
- Provide supportive supervision through quarterly identification and discussion of strengths and weaknesses to improve knowledge and skills.
- Address emotional well-being through counselling to prevent burnout.
- Ensure adequate staffing levels at all times for even distribution of workload per staff member; permit time for support and appropriate time off, including leave.
- Provide staff and volunteers with support and education to enable them to develop coping strategies to prevent stress and burnout, while working in the palliative care services.
- Provide a written plan specifying the number and types of staff members required and the skills and knowledge required in each department and service.
- Provide a written guide of roles and responsibilities of caregivers.
- Provide a written job description for all staff members which defines duties and responsibilities to reduce ambiguity and role conflict.
- Consider cultural values and religious beliefs when assigning staff duties to avoid ethical dilemmas.
- Equip caregivers with non-judgmental attitudes when exploring cross cultural and spiritual differences.
- Provide a well maintained vehicle and ensure that the driver is suitably licensed to drive for safety during palliative care visits if possible.
- Ensure grievance and conflict resolution procedures are in place for just and fair treatment of staff members and avoid lengthy litigation processes for the organisation.
- Ensure confidentiality of personnel records to address human rights considerations and minimize fraudulent activities.

Standard 20: Home Based Palliative Care

Preamble

Home based palliative care seeks to address the issue of caring for the terminally ill at home. It focuses on death and dying and pain and symptom management. Its aim is to address the physical, emotional, social and spiritual needs of the patient, family, children as well as the caregivers. The multidisciplinary team should deliver home based palliative care to enable the patient, family and children to cope with illness and bereavement in a culturally sensitive manner. It also enables patients to live as actively as possible until death. Where there is adequate home based palliative care back up, referral to health facilities are minimised.

Measurable statements

- Ensure that there are support systems in place such as counselling, respite care, support groups and the extended family to enable the primary and secondary caregivers to work efficiently and effectively in the home setting. This is essential for the prevention of burnout.
- Ensure that care providers have appropriate training and skills in order to provide quality care to patients.
- Assess the patient's pain and other distressing symptoms and manage appropriately to improve quality of life.
- Assess the physical, social, spiritual and emotional needs of the patient, family and children in order to provide appropriate care.
- Develop and implement an appropriate care plan in collaboration with the multidisciplinary team to address the changing needs of the patient which include medication, nutrition, emotional, social, physical and spiritual care.
- Respect the religious and cultural beliefs of the patient and family to minimise conflict.
- Explain treatment options, choices and possible side effects to enable the patient and family to make informed decisions.
- Mobilize adequate and appropriate resources including medicines in collaboration with the family and other stakeholders for effective patient care.
- Assess and acknowledge the patient's pain and other distressing symptoms and treat in an effective manner to ensure that the patient is comfortable.
- Discuss and document the patient and family's wishes about the terminal stage of illness.
- Recognise the importance of the environment in which care is provided to ensure safety, space and privacy where possible.
- Ensure that the patient, family, children and the multidisciplinary team members understand their roles and responsibilities to reduce conflict.

Standard 21: Infection Prevention and Control

Preamble

Infection control involves guarding against the spread of new or different types of infection from an external source or infecting other members of the household or caregiver. Observing infection control measures minimizes cross infection of patients, family members, caregivers and health personnel. Infections can enter any place of patient care through patients themselves, families, staff members, volunteers, visitors, as well as animals, insects and rodents, hence the need to regularly conduct surveillance on infection. For an infection control to be effective, it must be comprehensive, encompassing patient care, caregivers, health care providers, the environment and resources. In palliative care there is therefore need to promote practice of universal precautions when caring for patients.

Measurable Statements

Institutional care

- Designate an individual member of staff who is trained in infection prevention and control to be responsible for the programme as well as post exposure prophylaxis.
- Monitor, review, evaluate and update the programme biannually and more frequently as the need arises.
- Conduct and document in-service training of staff on infection prevention and control bi-annually and more frequently as the need arises.
- Orient new staff members on the programme in universal precautions to prevent and control infection in the health institutions.
- Implement principles of universal precautions in institutions and home care setting which includes the following:
    - Avoid touching body fluids such as blood, vomitus, urine and stool without protective clothing.
    - Wash hands with soap and water (preferably running water) before and after handling a patient, before handling food and after visiting the toilet.
    - Use protective clothing in the form of gloves and plastic aprons or improvise with a plastic bag to handle body fluids, diarrhoea, soiled linen and dirty bandages. Dispel the myth that wearing gloves indicates lack of love for the patient.
    - Keep nails short and cover abrasions or lacerations before handling a patient.
    - Keep wounds covered with a clean bandage or cloth.
    - Minimise contact with the patient if having an infection such as flu, sore throat, diarrhoea, boils and skin rashes.

- Provide:
    - On going education to patients, family members and caregivers in the prevention and control of infections.

    - Protective clothing such as rubber gloves, gowns, aprons, boots and goggles for handling blood spills, body fluids and other human waste.

    - Equipment such as sharps containers and special colour coded bins for safe disposal of hazardous and infective waste.

- Dispose of hazardous and infective wastes using national standards and appropriate codes in incinerators to ensure safety.

- Sub contract other health institutions for safe disposal where there is no incinerator.

Home Care

- Provide on-going education to patients, family members and caregivers in the prevention and control of infections.

- Document the information given to patients, family and caregivers in the prevention and control of infection.

- Inform family members and caregivers to collect protective clothing from hospitals, clinics and home based care organisations.

- Educate patients, family members and caregivers on:

    - Good hygiene, safe food handling and preparation, proper storage and management of food waste to prevent contamination of food in the home.

    - Safe disposal of refuse and human waste to prevent the spread of infection.

    - Safe drinking water sources.

    - Avoiding sharing of personal sharps like razor blades, shaving machines, and needles.

Standard 22: Training in Palliative Care

Preamble

Education is an integral part of palliative care and should be provided at appropriate levels to all healthcare professionals, the interdisciplinary team, families and the community in order to acquire knowledge, skills and attitudes that improve the quality of care of patients in need of palliative care. Duration, content and depth of the training will be guided by the background of the population and prevailing stipulated guidelines.

Ongoing training and support should be provided for health professionals, team members, family members, primary and secondary caregivers and the community to keep up with current trends in palliative care. The content covered should include cancer and HIV and AIDS prevention and education, principles and concept of palliative care, palliative care for children, pain and symptom management, psychosocial aspects, communication skills, the concept of suffering in the terminal phase, ethics, death and dying, spirituality, cultural issues, team work, working with families and bereavement.

Measurable Statements

- Ensure that trainers have a minimum of two years experience working in palliative care and a Trainer of Trainers Certificate in palliative care so that they can use their expertise to meet different needs of participants.
- Ensure that qualifications for trainers in palliative care are at Certificate, Diploma, Degree, Masters or PhD levels in palliative care.
- Conduct needs assessment through questionnaires, self-assessment and performance reviews to ensure that ongoing training addresses staff and organisational needs.
- Provide on going palliative care training and education for the interdisciplinary team through weekly clinical meetings, monthly updates with other team members, weekly case presentations, quarterly supervision sessions by team leaders, monthly debriefing sessions and journal clubs to keep professionals up to date with current trends in palliative care.
- Train family members in basic nursing skills, palliative care emergencies, universal precautions, treatments, adjusting to disruptions in activity patterns and who and how to contact for assistance to reduce powerlessness and facilitate effective care.
- Provide accreditation for updating information on palliative care in the form of attendance certificates and documentation on the supervisory sessions. Other Certificates or Diplomas should only be issued for examinable courses.
- Ensure that palliative care training is based on the National Training guidelines which specify the duration and timing for different levels of care providers at that particular time in order to standardise theory and practice.
- Ensure availability of training equipment at all times to enhance learning.

- Use various training methods to link theoretical information to practice and facilitate acquisition of knowledge, skills and attitude change in favour of palliative care.

- Ensure that the trainer observes the trainee health professionals conducting assessments on 5 patients and families using a standard assessment tool to make them familiar with palliative care issues.

- Document assessments of health professionals as proof of clinical experience.

- Ensure that secondary caregivers conduct a minimum of 5 visits under the supervision of a palliative care practitioner within, the first year of training, followed by bi-annual supervision and mentorship, on a one- to-one basis using a standard tool.

- Document visits to existing services to identify gaps in knowledge that require training intervention to the already existing home based care programmes.

- Undertake placement or exchange visits for trained personnel to local, regional and international programmes to facilitate sharing information and learning different models of palliative care provision.

- Provide annual refresher courses for all grades of trained personnel to increase knowledge base and keep a record of attendance.

- Ensure palliative care organisations liaise with schools of nursing and universities to develop training curricula for medical, nursing and paramedical students and include compulsory and examinable topics in palliative care. The curricula should be reviewed at least every 3 years to keep up with current information.

- Ensure availability of evaluation tools such as audits, self-reports, suggestion boxes to demonstrate change in behaviour, identify gaps, improve the quality of training and assess whether training objectives have been achieved.

- Ensure palliative care training is evaluated and linked to competencies and standards.

- Assess, monitor and evaluate the outcome of palliative care education and training

- Identify staff development needs through performance appraisal and form a part of ongoing professional assessment.

- Provide adequate resources to support professional educational development within organisations and institutions.

Standard 23: Multidisciplinary Team Approach

Preamble

The provision of high quality palliative care requires a multidisciplinary team approach which includes nurses, doctors, physiotherapists, pharmacists, dieticians, social workers, counsellors, spiritual leaders, psychologists, family members including children and community caregivers.

The team members can be recruited by establishing linkages with different NGOs, institutions and individuals. This helps to ensure coordinated holistic care that addresses the physical, emotional, social, cultural, spiritual and developmental needs of the patient. The team members must have shared knowledge of the referral systems, lines of communication and accountability, team building and functioning, group dynamics, the art of negotiation and the change process. Effective communication is important among the multidisciplinary team.

Measurable statements

The multidisciplinary team should:

- Maintain privacy and confidentiality by sharing with multidisciplinary team members only information that is necessary for patient care and with the patient's consent.
- Identify the patient's and family's needs using a team approach that includes family members and children in order to come up with a comprehensive care plan for the delivery of quality care.
- Identify community support systems that can be used by the patient, family and children.
- Implement the care plan whilst collaborating among team members in order to provide holistic patient care to avoid duplication of services.
- Document clearly and sign for any care provided, for the purpose of communicating effectively with members and for legal purposes.
- Identify and source care resources required by the patient and the family in order to enhance care provision and cost effective use of resources.
- Monitor and evaluate care given to the patient and re-plan in order to address the changing needs of patient and family in the physical, emotional, social, spiritual and cultural aspects.
- Refer the patient to other service providers, depending on need, for effective management.
- Hold meetings on a regular basis in order to ensure co-ordination of palliative care activities, exchange information and provide feedback on patient care.
- Ensure that team members are aware of professional boundaries and understand the roles and responsibilities of each team member.
- Ensure that clear lines of communication are in place within the caring team and with all others involved in the patient and family care.
- Provide a mechanism for supervision of team members and keep records.

Standard 24: Monitoring and Evaluation

Preamble

This standard ensures that the quality of palliative care programmes continually improves through the development and use of a monitoring and evaluation (M&E) system. Monitoring is a routine process of tracking or measuring what is happening. It involves collecting information on how the inputs are being used, how activities are proceeding, whether deadlines are met and generally whether or not things are working out as intended. The 5 domains of palliative care for quality measurement are used to measure the quality of care being provided to patients and families. The domains relate to physical, emotional, spiritual, and social care and information received by the patient and family to improve family support.

An M&E system also produces information about a programme's efficiency and effectiveness. Palliative care managers can then take this into consideration as they write programme reports and consider the programme's future direction. Managers also use M&E information to identify possible problems in a programme. For example, if monitoring shows that there was a dramatic decrease in the number of patients served in the previous month; this informs management that there may be a problem which needs to be addressed.

Evaluation is the process that tries to determine in a systematic and objective way the worth or significance of an intervention or policy (impact). It helps us to learn more about long-term programme impact, such as whether or not a programme has increased the capacity of communities to provide home-based care. Most importantly, M&E shows us whether the organisation's programme is on track to meet its overall goals. Palliative care providers submit quarterly reports to the National Palliative Care Association and these reports feed into the national health system, to guide the implementation of palliative care in the country.

Measurable Statements

M&E has many benefits. Palliative care programme managers should therefore:

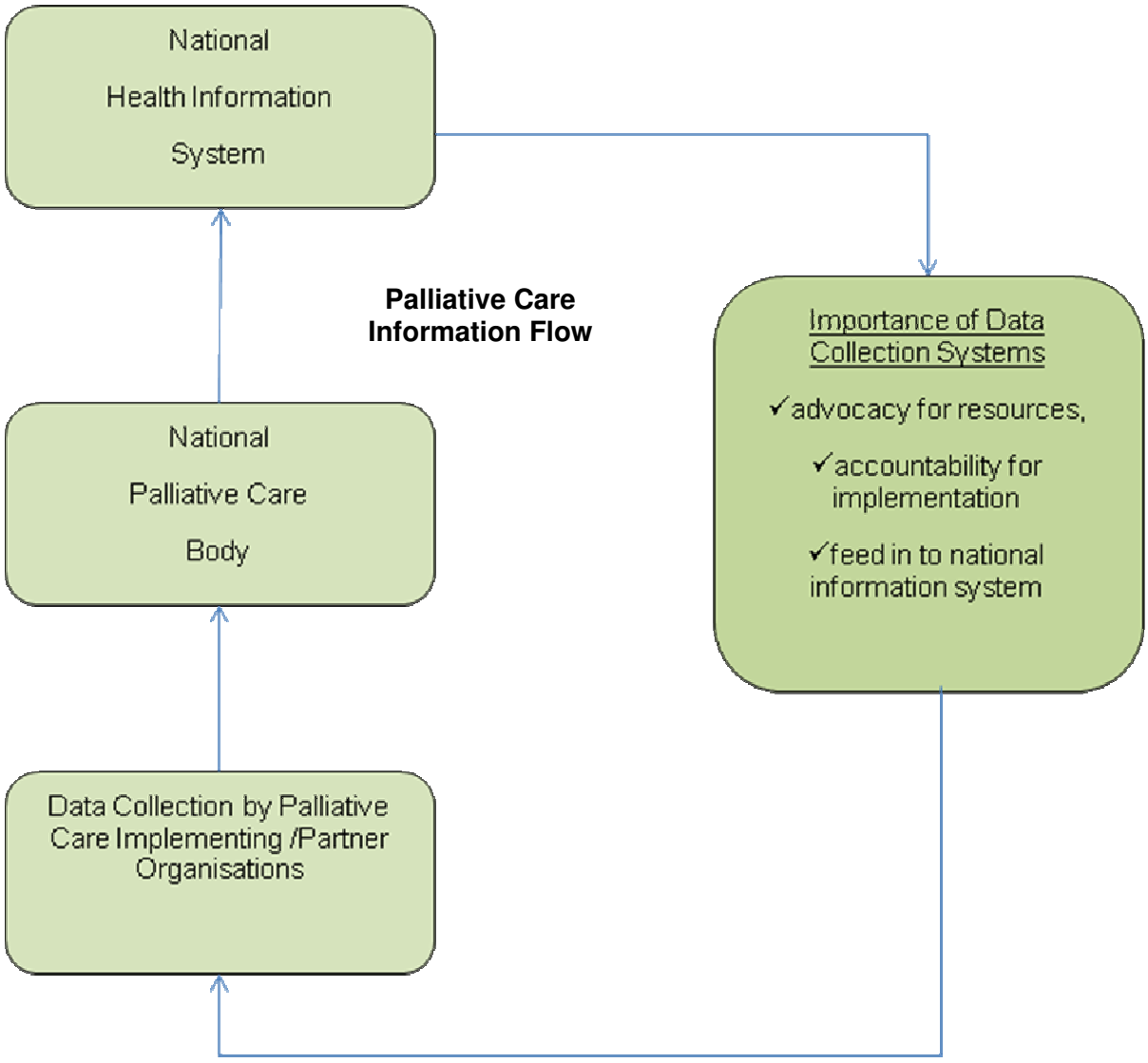
- Begin every project by carrying out a "baseline survey". This survey informs the organisation about existing home-based care activities within the community. By repeating this same survey at a later date, management can assess the impact of the new palliative care programme.
- Ensure data collection needs are clearly defined, and care and service providers know what is expected of them.
- Ensure lessons are documented and used to improve care provision
- Conduct monitoring and evaluation exercises regularly, ensuring that the appropriate tools and systems are in place to support this work.
- Apply the M&E findings to inform how the palliative care programme operates.
- Train caregiver teams in the use of M&E tools and systems. In particular, caregivers and volunteers need to know about "data collection", or the gathering and reporting of information that helps monitor how well a programme is doing.

- Ensure that the programme has a monitoring and evaluation system, and that tools and training activities support this system.
- Review and learn from M&E findings to improve programmes implementation
- Ensure that there is a work plan which specifies organisational or programme goals, objectives, activities, what is to be measured and how to measure it.
- Ensure M&E is incorporated into all programme activities and conducted throughout a programme's lifespan

Care providers ensure that the following palliative care quality indicators relating to palliative care outcome scale (POS) are achieved in accordance with the set standards:

- Patient's pain and symptoms are relieved
  - % of patients who report relief of pain through the programme services (target %)
  - % of patients who report relief of symptoms through the programme services (target %)
- Patients have access to essential palliative care medicines and ART, including both medicines per prescription as well as those purchased over the counter (OTC)
  - % of patients in the programme who receive prescribed drugs including ART (target %)
  - **Note:** prescribed drugs include both drugs per prescription as well as those purchased over the counter (OTC)
- Emotional and spiritual support as well as grief counselling is provided to patients and families
  - % of families who report anxiety/sadness who receive emotional and spiritual support through the programme (target %)
  - % of patients who report anxiety/sadness who receive emotional and spiritual support through the programme (target %)
  - % of families who received bereavement support during illness and after death of the patient
- Support for family caregivers caring for the patient at home
  - % of "family" or primary caregivers who report that the programme has helped them feel more confident in caring for the patient (target %)
- Increased proportion of families and patient receiving support for planning for the future**,**
  - % of families within the programme who report that they have received support in planning for the future (target %)
  - % of patients within the programme who report that they have received support and are included in planning for the future (target %)
  - % of patients referred from the programme to other programmes for further support (target %)

- Ensure reporting and designed formats are provided to ensure that stakeholders report in a standardised way.
- Ensure reporting is carried out according to reporting plans in the organisation, national or donors
- Provide regular accurate reports on programmes being implemented.
- Provided reports written in a language that is understandable to stakeholders using appropriate reporting mechanisms and technology.



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Appendix 1: Sample Patient Assessment Form

CONFIDENTIAL

Patient background information **Ref No…….**

Surname……..……..First Name ……...……

ID No……..Address…….....

Tel……..DOB……..Age…….Sex…….....

Marital status (e.g. Married, Divorced, Single, Widowed, Child)…….....

Occupational Status (e.g. Formal, informal, Unemployed, School going)…….....

Head of Household (e.g. Patient, wife, husband, aunt, children, grandparent)…… .....

Religion……Household Family size…….....

Number of Children in household……Number of orphans…….....

Name of primary caregiver……Age of primary caregiver…….....

Next of kin……Address……Tel…….....

Patient brief Medical History

Referring Doctor……Tel…….....

GP……Tel…….....

Specialist……..Tel…….....

Medical Aid……..Number…….....

Member's Name……Employer…….....

Diagnosis…….....

Reason for referral…….....

HIV Test (Yes No)……If Yes when tested…….....

Is patient on ART?.....Yes…….No…….N/A…….....

Is patient on prophylaxis treatment?.....Yes…….No……N/A…….....

Patient attending OI Clinic?……..Yes……No……N/A…….....

Patient's functional status:

Fully active, Restricted, Ambulatory, Limited self care, Bedridden…….....

If bedridden, for how long…….....

Allergies…….....

Date of referral……Date first seen…….....

Name of secondary caregiver …….....

Social worker (if any)…….....

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PATIENT INFORMATION SHEET

Family and Social History

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Past Medical History

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Present History

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EXAMINATION

General Condition…….....
Appetite…….....
Passing urine…….....
Bowels…….....
Anaemia (pale)…….....
Jaundice (yellowish colour)…….....
Skin, rashes etc…….....
Wounds…….....
Mouth sores, thrush…….....
Hearing, ear discharge…….....
Sight…….....
Etc

Knowledge of illness

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Physical Examination

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Emotional state

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CONFIDENTIAL

SUMMARY

Main Problems

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Care Plan

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PATIENT DRUG SHEET

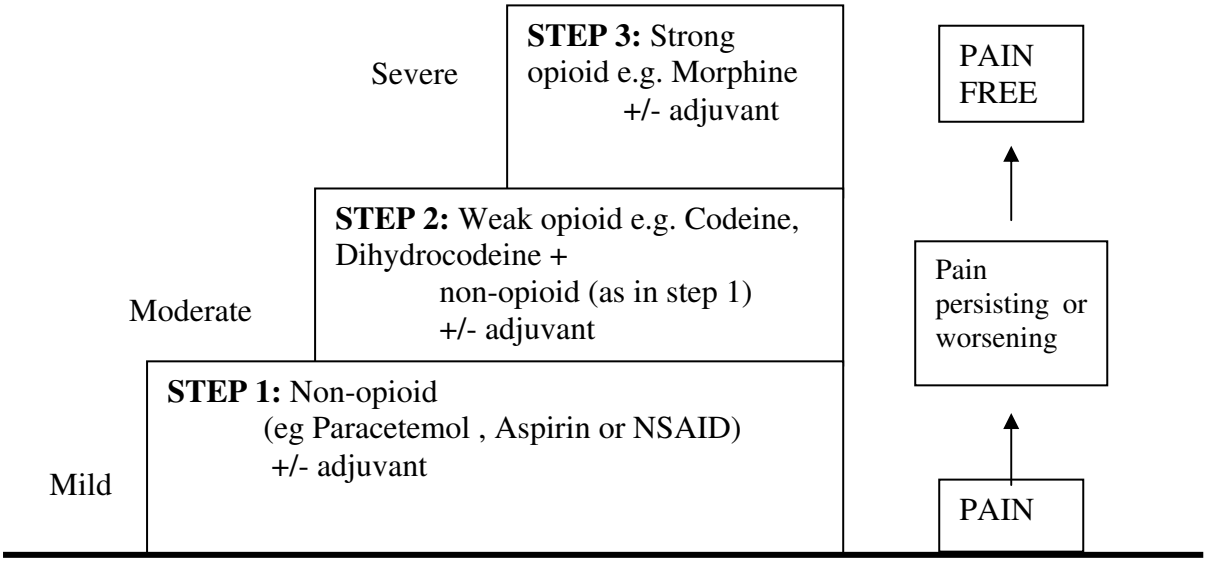
Name of medicine	Reason for prescribing	Dosage	Date commenced	Date completed

Appendix 2: Care Plan

Name of Patient……..

Date	Problem	Expected Outcome	Interventions/ Actions	Outcome Evaluation
10 March 2007	e.g. Pain	Able to walk without pain	• Assess for pain using a scale • Check BP and pulse • Give prescribed analgesics	Pain less as shown on scale, changed from 7 to 3

Appendix 3: WHO Analgesic Ladder



Note

- **Weak opioids should not be combined with strong opioids.**
- Non-opioids may be combined with weak or strong opioids.
- Adjuvant analgesics can be added to any step of the WHO ladder at any stage for pain that is less sensitive to opioids.

Example of Adjuvant Analgesics

Adjuvant Analgesics	Example	Use
Corticosterioids	Dexamethasone Prednisolone	Bone pain Neuropathic pain Headache due to raised intra-cranial pressure Pain associated with oedema and inflammation
Antidepressants	Amitriptyline	Neuropathic pain
Anticonvulsants	Carbamazepine	Neuropathic pain
Antispasmodics	Hyoscine Butylbromide	Smooth muscle spasm, e.g. colicky abdominal pain, renal colic
Muscle relaxants	Benzodiazepine, e.g. Diazepam	Skeletal muscle spasm Tension headache
Anxiolytics	Benzodiazepine, e.g. Diazepam	Anxiety-related pain
Bisphosphonates	Disodium Pamidronate Zoledronic acid	Bone pain

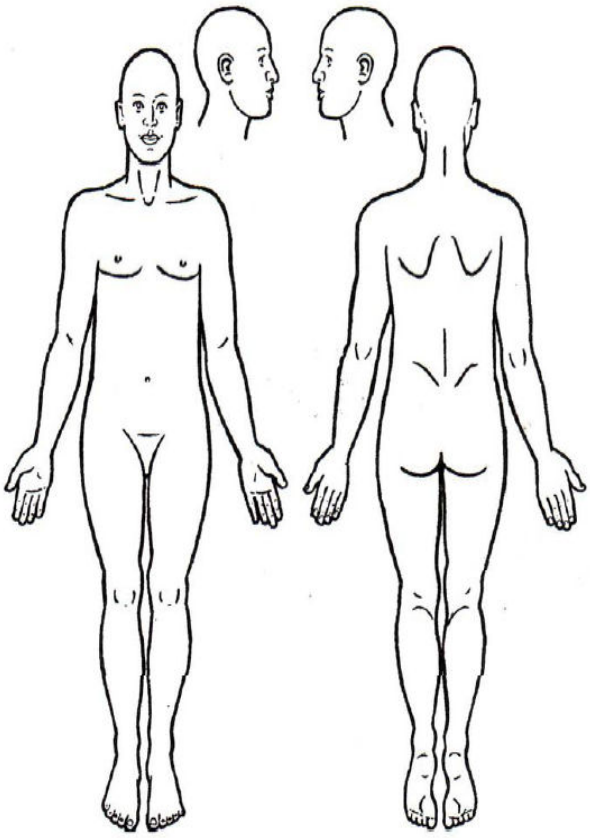
Appendix 4: Pain Assessment Tool

Assessing pain

Examination is an essential part of the assessment. To treat pain effectively it is important to identify the cause of the pain, as pain from different causes requires different treatments. A comprehensive clinical assessment is key to successful pain management. Many patients have more than one pain, therefore it is important to identify the site and cause of each pain separately. Assess all patients for pain at every visit or contact

Use body charts

General body charts to indicate the site and number of pains. The patient gives this information with history taking. Also indicate on the chart the main finding on clinical and physical examination



Numerical Rating Scale

The Numerical Rating Scale is from 0 to 5
0 being the lowest score = **No** Pain
5 is the highest score = **Worst** pain possible



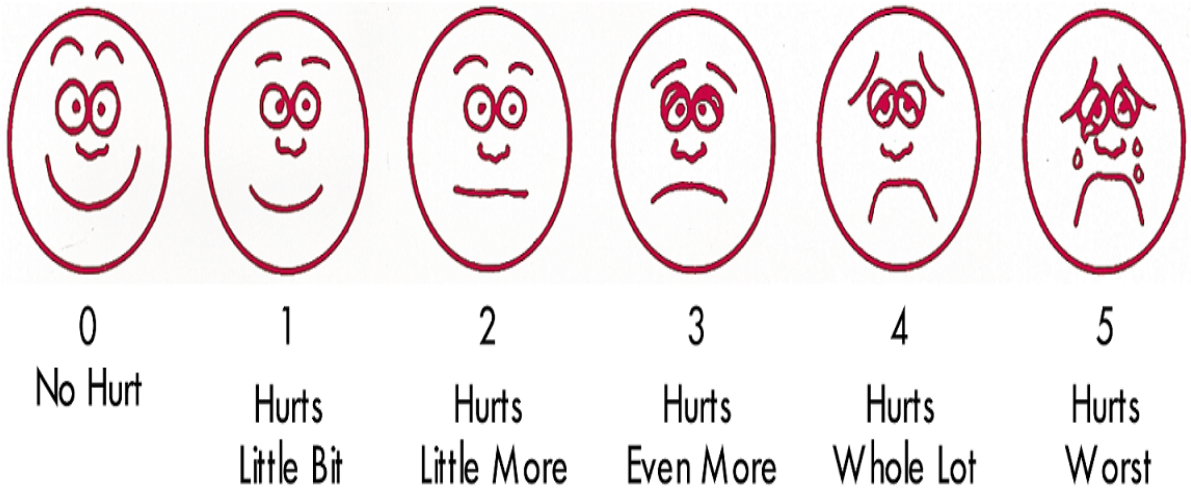
Use of the five fingers of the hand to grade severity of patient's pain, starting with the little finger upwards:

- Little finger – Mild Pain
- **Ring finger – Moderate pain**
- Middle finger – Moderately severe pain
- Index finger – Severe pain
- Thumb – **Overwhelming pain.**

Appendix 5: Pain Scale for Children

FACES SCALE

The child chooses the face that best describes his/her pain or hurt



The Wong rating scale is recommended for persons age 3 years and older.

Original instructions:
Point to each face , in turn and explain in the child's language what it means in terms of pain.

Face 0 is very happy because he/she feels no pain.

Face 1 hurts just a little bit. **Face 2** hurts a little more. **Face 3** hurts even more. **Face 4** hurts a whole lot. **Face 5** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the person to choose the face that best describes how he is feeling.

Brief word instructions: Point to each face using the words to describe the pain

Appendix 6: Follow Up Checklist for Discharge

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Name of Patient…….....

Name of District…….....

Date Admitted…….....

Date of Discharge…….....

Form Completed by…….....

Criteria	Yes	No	Comments
1. Has contact been made with the primary caregiver?			
2. Has the patient been referred to another institution?			
3. If Yes to Q2: Was the institution informed?			
4. Was a Referral Form completed?			
5. If the patient is using an ambulance, has the ambulance been booked?			
6. Did the patient get education on his/her management?			
7. Did the primary caregiver receive education on the management of the patient?			
8. Did the primary caregiver receive training in basic nursing care to be provided at home?			
9. Was advice given on the review date?			
10. Does the patient have medicines to take home?			
If Yes to Question 10: Are the medicines ordered?			
11. Did the patient receive information on how to take the medicines?			

12. Did the patient and family receive information on other available resources in the community?			
13. A discharge summary is written for each patient and made available in the patient's records			
14. The discharge summary includes all information considered pertinent to the patient's continued care			
15. The discharge summary includes instructions given to the patient and family prior to discharge			
16. Management ensures that all relevant parties (physician, family and receiving organisations) are notified of the patient's discharge			
17. When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation			

Appendix 7: Palliative Care Essential Drug List

Anti-emetics	**Other for different symptoms**
	Amitryptylline
Valoid (cyclizine)	Dexamethazone (Dexone)
Maxolon (metoclopromide)	Trifluperazine
Motilium (domperidom)	Predinisolone
Stemetil (prochloperazine)	Carbamazepine
Haloperidol (serenaze)	Lorazepam
	Diazepam
Analgesics	Chlorpromazine
Codeine phosphate	Quinine (for leg cramps)
Paracetamol	
Aspirin	
Panadeine	
Stopayne	
Stronger analgesics: Morphine mixture and tablets Morphine injections	**Antiacids**
Dextropropoxyphene	
Anti-inflammatory medicines	**Anti-diarrhoea**
Methocid	Loperamide
Ibuprofen (brufen)	Codeine
Diclofenac	Oral morphine – use when accompanied with pain
Laxatives	**Vitamins**
Liquid paraffin	Multivites
Vegelax	Vitamin B6, B12, B Complex
Bisacodyl (oralax)	
Glycerine suppositories	**Dressings**
Agarol	Crepe bandages
Milpar	Betadine solution
Senokot	Betadine scrub
Dulcolax suppositories	Liquid paraffin
Castor oil	Gauze dressings
Antibiotics	Gloves Micropore /tape
Chloramphenicol	Granuflex – if available
Amoxil	
Cotrimoxazole	**Miscellaneous**
Metronidazole	Methylated spirit
Cloxacillin	Cotrimazole oral paint
Miconazole	Creams and lotions
Ketokonazole	Catheters
Mycostatin	Soda bicarbonate
Acyclovir (tablets and cream)	Urine bags

Appendix 8: Referral Form

----------***DISTRICT***

REFERRAL FORM

REFFERRED FROM: ----------

REFERRED TO…….

REASON FOR REFERRAL ……...

……

……

NAME OF PATIENT: ---------- AGE: ----------SEX----------

PHYSICAL ADDRESS: ----------

DATE OF DISCHARGE: ----------

DISTRICT: ---------- WARD: ----------

VILLAGE: ---------- CHIEF: ----------

NEAREST CLINIC: ----------HOSPITAL NUMBER: ----------

DIAGNOSIS: ----------DOCTOR: ----------

RELATIVE COUNSELLED: ----------

CLIENT COUNSELLED: ----------

NAME OF NEXT OF KIN: ----------

NAME OF CAREGIVER: ----------

RELATION TO CLIENT: ----------

INFORMED CONSENT BY CLIENT: ----------

INFORMATION ON CONDITION OF CLIENT

GENERAL CONDITION: ----------

CURRENT MEDICINES

NAME OF PERSON REFFERING: ----------

DESIGNATION: ----------

REVIEW DATE (if any): ----------

Appendix 9: MCAZ Report Form

MCAZ

MEDICINES CONTROL AUTHORITY OF ZIMBABWE

Report of a Suspected Adverse Drug Reaction			
Identities of Reporter, Patient and Institute will remain confidential			
Patient Details (to allow linkage with other reports)			
Family Name:	**OR Patient Clinic/hospital Number:**		
Forenames:			
Date of Birth:		Weight	Sex:
Age:		Kg	M/F
Adverse Reaction			
Date of Onset:			
Duration:	Less than one hour	Hours	Weeks
		Days	Months
Description			
Outcome	Recovered	Fatal	Unknown
	Not yet recovered		
Suspected Drug(s)			
Drug:	Generic Name:		
	Brand Name:		
Indication drug given for:			
Daily dose/route:			
Date begun:		Date stopped:	
Concomitant (Other) drugs taken & Dates/period taken:	Name of drug:	Dated started:	Date stopped:
Laboratory tests results:	Baseline CD4+ Count:	Last ; CD4+ count:	
Reported by			
Family Name:			
Forename(s):			
Status:	Doctor	Pharmacist /Pharmacy Technician	Nurse
Address:			
Signature:		Date:	

Send to: The Director-General, Medicines Control Authority of Zimbabwe
106 Baines Avenue, P O Box 10559,Harare
Fax: +263-4-736980, e-mail: mcaz@africaonline.co.zw, website: www.mcaz.co.zw