Ahmedabad, Gujarat, February, 2012

Site:

Gujarat Cancer Research Institute (GCRI)

- The Community Oncology Centre was established 28 years ago at Vasna in Ahmedabad with a significant donation from a wealthy individual.
- The Centre consists of a two level Administration Building which has a reception area, Director's Office, Board Room, Nurses' Office, Outpatients areas, doctors' rooms, mammography and xray facilities, and pathology. The upper level includes a comprehensive poster board type exhibition about cancer, the different types of cancers, and what causes it. There are also comprehensive explanations of palliative care.
- In the grounds of the centre are 5 small cottages, each with two rooms containing two beds each. Patients are expected to have a family member stay with them who will do the majority of physical care of the patient. Staffing is two to three nurses per shift.
- Most patients arrive with fungating head and neck tumours, the result of high use of chewing tobacco products.

Year of Visit 2012	Year of Visit 2020
Participants from Australian Palliative Link International • Sarah Begley – Palliative Care Clinical Nurse Specialist, Wagga Wagga, NSW • John Haberecht – Director of Learning & Development, Centre for Palliative Care Research and Education, Queensland Health Pallium India	Australian Palliative Link International • Sandy Hawkins - Palliative Care Registered Nurses, Wagga Wagga, NSW. • Toni Coleman – Palliative Care Registered Nurses, Wagga Wagga, NSW. Pallium India

• Dr. Saima Furqan, palliative care physician, who acted as translator for our visit	• Dr.SaimaFurqan
Participants from GCRI • Dr Geeta Joshi, Medical Director/CEO, Community Oncology Centre • Dr Dinesh, volunteer medical officer, Community Oncology Centre • Dipika, Nurse Unit manager of Community Oncology Centre, • Desai Queenjal, Community Nurse GCRI, • Suresh Maurya, who describes himself as 'the ward servant' but does IVs, catheters, subcutaneous insertions and more • Asif Mansuri the Centre driver • Bapu, the Administration Director, and holy man	**Participants from GCRI** • Dr Geeta Joshi, Medical Director/CEO, Community Oncology Centre • Dr Dinesh, volunteer medical officer, Community Oncology Centre • Rosie, nurse

Objectives of the visit:
• To support and mentor the nursing staff in the Community Oncology Centre (COC) by sharing knowledge and experiences of working within palliative care.
• Specific objectives:
  ○ Introduce ourselves
  ○ Understand how the nurses work in the COC
  ○ Build connections and relationships with the COC staff
  ○ Identify areas of practice where the nurses might benefit from input
	Objectives of the visit:

Potential threats to achieving objectives: • The short visit time frame • Communication – nursing staff had extremely limited command of English • Difficulty of preparation – attempts before our visit to identify areas of	**Potential threats to achieving aims:**

need for teaching to the nurses produced limited response along the lines of 'Anything you can provide will be valuable'. • New model of Hamrahi visit— First time two sets of nurses visited sequentially. The untested model had the potential not to be useful to Indian colleagues. • No medical colleague- Limited our ability to model good/equitable medical/nursing relationships in Australia and demonstrate that nurses in Australia take leadership roles.	
Summary: • The majority of wounds are maggot infested on arrival of the patient. • The nurses sought advice on dealing with malodorous wounds and were provided with a number of suggestions such as charcoal impregnated dressings, though recognising on our part that the cost of such dressings is prohibitive for the hospice. • The APLI team undertook clinical rounds each day with nurses and sometimes with Dr Joshi and Dr Dinesh, and one home visit with staff from GCRI. • Since a number of patients had bowel obstructions and were admitted for symptom management, we modelled conducting a thorough nursing assessment and taught the nurses to listen to bowel sounds, a skill they had not learnt before during the rounds. Each nurse took a turn and we repeated this skill each day. • The team also explored bowel assessment and constipation management • The APLI team also modelled daily thorough mouth assessment during each consultation and discovered that many patients had oral thrush.	**Summary:** • Two of the senior nurses whom the APLI team had spent a lot of time during our previous visit, had been transferred to work at the civil hospital. • There were 2 new graduate nurses with one in particular, Rosie, expressing a keen interest to learn as much as she could during the visit. The APLI team shared resource materials with her to plough through and prepare questions. • The team noticed that the hospice was almost full with only 4 beds vacant. • The team also attended rounds and contributed to the planning and clinical management of patients. • The APLI team decided to develop a case history for each patient in order to develop a management plan for our next patient round. • As there were a couple of patients with significant pain issues during rounds, the team was able to encourage the

- The community nursing visits highlighted that visits followed a similar model found in Australia- with the main difference being that nurses insert IV cannulas instead of SC Intimas.
- **Education and Dissemination Activities**
  - All education sessions required the presence of Dr Saima to translate.
  - There were several teaching sessions at the COC covering a range of subjects from wound care, basics of palliative care, nausea, constipation, breathlessness, introduction to syringe drivers, communication and pain management.
  - An education session was also delivered to approximately 30 nurses at GCRI. A brief session was also provided on use of the Edmonton Symptom Assessment Scale.
  - 5 syringe drivers, 1 NIKKI and 4 Graseby pumps were donated to the COC by John.
  - The nurses practised loading and handling syringe drivers.
  - Sarah and John handed over the donated items to Sandy and Toni would come prepared to teach the nurses to use and reload the drivers on an appropriate patient.
  - Since Dr Geeta highlighted that communication with carers was an area that could be further improved upon, we intentionallu included carers during consultations on ward rounds. A role playing communication workshop was also delivered.
  - The APLI team touched upon all the medications prescribed and the rationale, the indications for the different analgesics and anti-emetics as nurses were keen to learn of the same even though were reluctant use of the pain scale and then revisit patients in half an hour to assess effectiveness of treatment. The objective was to empower the nurses to raise these issues with the doctors and seek permission to give further pain relief within a shorter time frame and not wait for 2-4 hours if the pain was unresolved.
- Dr.Saima was also given permission to conduct rounds as part of our education and mentoring plan.
- Carers were encouraged to ask questions and some families felt more empowered to make the decision to continue care at home.
- The APLI team spent time with families to have discussions about death and dying
- The APLI team also met Dr.Preeti Sangho at her clinic at Cancer Unit within the Civil Hospital.
  - The team was amazed and overwhelmed to see that Dr Preeti handling approx 200 patients per day
  - It was wonderful to see some resident Doctors taking a particular interest in palliative care
  - The team also accompanied one of the clinic nurses on a home visit.
- The APLI team met Dr Jay Panchal who is trained in palliative medicine by Cardiff University.
  - Dr Panchal invited the team to observe a trigeminal nerve block procedure, at a private hospital, on a

at first.
• **Access to Morphine**
  ○ Oral and parental morphine is available in Gujarat.
  ○ Patients are routinely prescribed oral opioids and slow release formulations are available.
  ○ Nurses were confident in administering oral opioids and using oral morphine for breakthrough pain.
  ○ Parental morphine is only administered by doctors.
  ○ The nurses had limited access to parental morphine in the absence of Dr Geeta, as she had the supply of parental morphine in a locked box in her office.
  ○ A Ryles (nasogastric) tube would be inserted to allow opioids to be administered via NGT for patients who were terminal or unable to swallow.
	patient with a head and neck cancer.
	  ○ It was interesting to hear the reasoning for choosing a block as a treatment option before offering opioids, since it translates to financial gains for the private sector.
	• The team wishes to connect with Rosie, to provide mentorship from a distance.
	• The team noted a particular shift in staff dynamics this visit. Whilst polite and grateful for our visit, there was a change in the level of connection between nursing staff, patients and families. We can only hope that leading by example may have some impact.
	• The importance of empowering the nursing staff to work collaboratively with Dr Geeta to gain the best outcomes for the patients in the Hospice was achieved by demonstrating the benefits of assessment tools and value of good communication between patients, their families and health Care Professionals.

Positive observations • Safe hospice grounds with a logical layout amongst nature • Tranquil setting- a haven amongst the chaos of a dusty city • Easily accessible and free service, available to all patients	

• Hospice well connected to main hospital. Nurses have trained and worked in both an oncology hospital setting and a hospice setting. • High levels of support between nursing colleagues • High levels of support for patients and families in hospice- they are provided with food and some medications. • Very good use of face pain scale for non-verbal patients • Regular and consistent documentation of some symptoms and nursing cares • Nurses make notes on medical rounds to document plan of patient • Regular use of oral morphine • Very good understanding of symptom management basics by nursing staff • Rapid response to management of maggot infested fungating wounds. • Highly organised nursing resources, medications and supplies • Allied health (social work) involvement in community nursing visits	
Recommendations 2012 • Use the next nursing visit to start a syringe driver under the guidance of Australian mentors. • Consider the introduction of a sub-cutaneous route for appropriate patient. This may reduce need to insert NGT and IV cannulas at end of life. • Further education and support on the role of palliative care nurses in supporting carers/ family. • Further education and support in the area of breakthrough and incident	

pain and development of protocol around analgesia prior to wound care and ADL's • Work together to formulate a constipation/bowel management protocol • Continue to explore dressings and wound care options to further improve maggot therapy and treatment. • Further encourage medical and nursing staff to build relationships and work together, perhaps through weekly team meetings • Arrange / organize a computer with internet access for nurses salon to allow them to access online palliative care resources, such as Therapeutic Guidelines • Educate and empower nurses to use parenteral opioids	