Jamshedpur, Jharkhand, November, 2010, 2011, 2012

Site

Meherbai Tata Memorial Hospital (MTMH) and Tata Main Hospital (TMH)

- The hospital commenced palliative cares service operations in 2009.
- Meherbai Tata Memorial Hospital (MTMH) is a 72 bedded charitable cancer institute and was established by the Jamshedpur Branch of Indian Cancer Society. MTMH treats all types of cancer cases and it has a well equipped diagnostic centre. The hospital runs on a non-profit basis and 10% beds are reserved for those living below poverty line. It is generally agreed that 70 to 80% of inpatients have a 'palliative' diagnosis for which many are receiving treatment.
- The Outpatient Department (OPD) Palliative Care Clinic runs every morning, 6 days per week and is free of cost. Dr Urmila also provides consultancy to inpatients, while she also completes her routine oncology medical officer duties. Sunita works on the female ward.
- The neighbouring Tata Main Hospital (TMH) is a 900 bed hospital with all major specialties. Dr Koshy works in the very busy Critical Care Unit and Sister Jeseentha works on a male medical ward. She also coordinates the opening of 'overflow' wards on demand. Palliative Care is provided on a consultative basis, throughout the hospital, following phone referrals to Dr Koshy.
- Most people travelled from long distances and some appointments were attended by family members or carers only, as the patient was too ill to attend.

Year of Visit 2010 (first visit)	Year of Visit 2011 (second visit)	Year of Visit 2012 (third visit)
Australian Palliative Link International • Dr Anil Tandon, Palliative Care Physician, Perth • Wendy Scott, Clinical Nurse Consultant, Perth	**Australian Palliative Link International** • Dr Anil Tandon, Palliative Care Physician, Perth • Wendy Scott, Clinical Nurse Consultant, Perth	**Australian Palliative Link International** • Dr Anil Tandon, Palliative Care Physician, Perth • Wendy Scott, Clinical Nurse Consultant, Perth

Pallium India • Dr. M.R. Rajagopal, Chairman, • Mr Anosh Varghese, Project Officer, CanKids Kolkata	**Pallium India** • Dr. M.R. Rajagopal, Chairman, • Mr Anosh Varghese, Project Officer, CanKids Kolkata	**Pallium India** • Dr. M.R. Rajagopal, Chairman,
Participants from Meherbai Tata Memorial Hospital • Dr Master, Medical Director • Dr Urmila Patel, Senior Medical Officer ** • Ms Sunita Ekka, Staff Nurse, Meherbai Tata Memorial Hospital **Participants from Tata Main Hospital** • Dr Madhusudanan, General Manager, Tata Main Hospital • Dr Koshy Varghese , Anaesthetist, Critical Care Unit ** • Ms Jeseentha George, Staff Nurse, Tata Main Hospital ** (**Attended training in Trivandrum Institute of Palliative Sciences, Trivandrum, Kerala in 2009)	**Participants from Meherbai Tata Memorial Hospital** • Dr Master, Medical Director • Dr Urmila Patel, Senior Medical Officer ** • Ms Sunita Ekka, Staff Nurse, Meherbai Tata Memorial Hospital **Participants from Tata Main Hospital** • Dr Madhusudanan, General Manager, Tata Main Hospital • Dr Koshy Varghese , Anaesthetist, Critical Care Unit ** • Ms Jeseentha George, Staff Nurse, Tata Main Hospital ** (**Attended training in Trivandrum Institute of Palliative Sciences, Trivandrum, Kerala in 2009)	**Participants from Meherbai Tata Memorial Hospital** • Dr Bachoo Master, Medical Director (on leave) • Dr Urmila Patel, Senior Medical Officer ** **Participants from Tata Main Hospital** • Dr TP Madhusudanan General Manager Medical Services (absent, relieving another position) • Dr Koshy Varghese, Anaesthetist, Critical Care Unit ** • Ms Jeseentha George, Staff Nurse ** (** attended training at Trivandrum Insitiute of Palliative Sciences, Trivandrum, Kerala in 2009)
	Objectives of the visit: • Re-establish, foster and develop existing	**Objectives of the visit:** • Re-establish, foster and develop relationships

	relationships • Mentor and support Dr Urmila Patel: MTMH wards rounds, OPD. • Mentor and support the new project officer (PO) Mr Anosh Varghese as to the history and objectives of Project Hamrahi. • Assist PO in identifying future opportunities to support and develop the local teams. • Assess if recommendations from the previous report have been implemented, and if so, to what benefit. • Complete audit tool for National Standards for Palliative Care and identify if essential standards have been met. • Wendy Scott to work alongside the two nurses, at the two sites and assist them to develop their role. • Deliver the "Essential Pain Management" workshop (over 5 days) to interested medical officers and nursing staff. • Encourage the prescribing and administration of morphine.	from previous visits • Mentor and support Dr Urmila Patel at MTMH Oupatient Department (OPD) and wards rounds • Assess if recommendations from previous reports have been implemented, and if so, to what benefit • Complete the audit tool for National Standards for Palliative Care, and identify if essential standards have been met • Encourage prescribing and administration of morphine • Meet with hospital management to discuss the progress and the benefits of the project
	Potential threats to achieving objectives: • Limited numbers and irregular attendees at education sessions due to lack of staffing	**Potential threats to achieving aims:** • Limited numbers and irregular attendees at workshops due to lack of staffing resources

	resources and lack of promotion. • Palliative Care team members needing to perform other general duties. • No improvements in access to morphine.	and potential lack of promotion • Palliative Care team members needing to perform other general duties • No improvements in access to morphine • Access to MTMH and TMH executive staff
Summary: • The visit mainly consisted of promoting palliative care specialty and the project, meeting key stakeholders, and providing education on the requested topic of communication. • There was some, but limited opportunity, to mentor the four providers of palliative care providers from two neighbouring hospitals, the Meherbai Tata Memorial Hospital (MTMH) and Tata Main Hospital (TMH • The visit helped to establishing supportive relationships; identifying type of services provided and towards supporting the development of	**Summary:** • The team had a total of 60 consults during the week. • The majority of the clinical work occurred at the MTMH OPD and it was the expectation that the oncology and palliative care consults would require the same amount of time to complete and so Dr Urmila was under enormous pressure to finish a long and busy list, which always included some difficult cases. • There was no nurse in attendance nor was there a plan to replace the palliative care nurse. Thus nurse to nurse training was therefore not possible. Instead, Reena (a 'social worker' who had previously worked as a nursing assistant) a volunteer had been recently 'employed' for a short term period to attend the clinic, to assist in the management	**Summary:** • Five day visit and the main aim of the visit was to focus on working alongside Dr Patel, reducing the amount of formalised education and other commitments. • Dr Master was on extended leave and Dr Wagji, MTMH Superintendent, assisted in promoting the week. • We did not attend TMH due to the absence of Dr Varghese. • The total number of consults (including followups) completed during the week was 56. • The majority of the clinical work occurred in the MTMH outpatient clinic with time spent more evenly over both the male and female wards. There was greater opportunity to support medical officers and nursing staff and discuss cases in the staff offices. • The opportunity for the nurses to attend the

recommendations to assist improvements, particularly in the management of pain. • The team identified some challenges in service provision but there was obvious enthusiasm for training and for the development of local palliative care services. • It was extremely encouraging to see how much has been achieved with the existing small services but the visit also highlighted the need to continue the support to enhance sustainability and future growth. • The team decided to return in the 'soonest possible timeframe' to continue and enhance momentum in the most effective way and that the second visit needed to be specific and focused on individual mentorship of the palliative care team members	of the OPD patient files, to visit patients on the wards in the afternoons. There were discussions expand her role to include the administration of pain medications. • Basic pain medication such as tramadol, amitriptyline, combination diclofenac / paracetamol and lactulose with varying benefit was being prescribed. With mentoring, increasing doses of oral morphine were prescribed and the ordering of tramadol reduced. • The majority of the inpatient consults occurred at MTMH, with minimal time spent at TMH. This year, more time was spent on the male ward with Dr Urmila, and less time mentoring the general medical officers. The nurses were not available to attend consultations as they were very busy with chemotherapy treatments and other tasks. The patient: nurse allocation appeared to be 10:1, including day chemotherapy cases. • The Executive team were able to identify the need for improvements, particularly in pain management, and were very keen in incorporating pain assessment in their routine	bedside consultations was far greater than in previous visits and they were actively sought out and seemed to appreciate the opportunity to attend and participate during ward rounds. • This visit was very heartening as excellent changes and positive action at MTMH could be identified. • It felt as if the APLI team members had made a solid and mutually respectful relationship with all MTMH staff, and the return visits were maintaining awareness and interest in palliative care. • It remains unfortunate that despite great support by management at TMH, the nominated team members remain constrained in their roles, reducing the opportunites for service growth and development at that site. • At MTMH, Dr Patel has an increasingly recognisable role as the palliative care doctor with a consistency in the development of the service, particularly in the OPD. She continues to be overworked, managing dual roles with limited support. The demand for her expertise remains high. Staff were encouraged to consider utilising their knowledge to also make

• There was limited contact with the teams with no requests for intermittent support and guidance and it was identified that email access was unreliable and limited.	documentation as the 5th vital sign. • The lack of staff at TMH prevents further development of palliative care services in the short term and it would continue as the current 'pop up' consultancy model, dependent on the availability of the team. • Service development at MTMH has also been limited during the year. With no strategic direction and no expectation that home care services would be considered. • Maximising the time with Dr Urmila and joining her in all of her consultations appeared to be beneficial in developing her confidence in both pain management and effective communication. • Visiting Jamshedpur is difficult and challenging. There is a lot of room for growth, greater knowledge and improvement. A lot of the learning needs appear very basic. The task that the palliative care providers have appeared insurmountable at times and they need greater support. • **Education and Dissemination Activities** o The APLI team met with the medical and nursing executives at TMH twice.	palliative care decisions and orders thereby reducing dependency on while also assisting in generalisability, succession planning, timeliness to patient management, staff satisfaction and a greater team approach. • We do not expect there to be opportunity for service development in the short term future and do not predict that there will be opportunities for community services. • There is a continued need to assist in the development of skills to aid effective clinical assesments and decision making. • A fourth visit is recommended. **Education and Dissemination Activities** o No dissemination activities took place this visit. o In the absence of Dr Madhusudan at TMH, we met with the acting General Manager Medical Services to give a review of the week. o We had a meeting with Dr Master at her home along with Dr Wagii, Dr Patel and Reena. The meeting was very positive and the progress and future of Project Hamrahi

	○ 220 people attended a session ○ The team conducted an Essential Pain Management workshop which was attended by 10 Medical officers and 20 registered nurses. The instructor workshop was not delivered due to time constraints. ○ Dr Anil delivered a lecture on 'the Primary Management of Severe Pain' which was attended by 90 Medical officers (TMH+MTMH). ○ Wendy Scott delivered a session on 'Pain as the 5th Vital sign' to 100 nursing students. • **Quality Assurance** ○ There was a pre and post test of the EPM workshop. It was noted that prior to the workshop knowledge regarding opioid addiction, use of placebo, responsive treatment of pain and correct pain assessment was very limited. In the post test, there was substantial improvements regarding issues about opioid addiction (only 8% incorrect). Correct assessment and diagnosis of pain types improved moderately. Disappointingly, most	were discussed. There was a request for the APLI team to return as the mentorship of Dr Patel was identified as being very valuable. ○ Case study education sessions occurred daily between 1230 and 1400hrs at MTMH, and were attended by up to 25 MTMH medical and nursing staff and one staff member from the Radiotherapy Department daily. ○ Unlike previous visits, the sessions were more informal and staff were encouraged to present a current inpatient, with attendees then discussing the management plan. • **Quality Assurance** ○ The 'Standards Audit Tool for Palliative Care Programs' was done on the service provided at MTMH in 2010 and 2011 in the OPD with Dr Patel's participation. ○ 8 of the 28 standards are currently 'always met'. ○ 'Essential' documentation criteria are met in the OPD, but not utilized for the inpatients.

	attendees still felt placebos were useful and should be used in practice and there remained some limiting attitudes regarding pain treatment. ○ All respondents Agreed or Strongly Agreed that the program was useful, improved their understanding, enhanced their pain assessment skills and thought the training was effective. ○ The 'Standards Audit Tool for Palliative Care Programs' was used again in comparison to 2010 audit results, there was a decrease in the number of Essential Criteria effectively met due to the lack of a team approach, absence of regular meetings and the lack of a trained nurse. The APLI team does not expect the situation to improve without leadership, staffing, and a coordinated and collaborative approach. • Access to Morphine ○ There was an improvement in access to both oral and parental morphine although some limiting factors remained. ○ There were limitations to the supply of oral	○ The supply and access to morphine has improved and is now always available and essential criteria 1 to 5 are 'always met'. Poor patients have access to medication and treatment. Essential criteria numbers 6 to 8 remain unmet due to lack of team membership. Desirable standards 9, 11 and 14 are met. ○ As a sole provider of the Palliative Care at MTMH, and with limitations in executive and administrative guidance or support, it is not reasonable to expect Dr Patel to make substantial progess in meeting many more of the standards. ○ This audit is not necessarily reflective of the overall positive progress which has been made, particularly in the previous 12 months. • Access to Morphine ○ There were improvements in access to both oral and parenteral morphine and transdermal fentanyl at MTMH. ○ Storage and record keeping was satisfactory. ○ Progress at TMH was not reviewed.

	morphine and they were awaiting a signature from a Narcotics Officer. Currently TMH patients do not have access to oral morphine on discharge. TMH patients are administratively admitted to MTMH to access discharge medications. Staff did not expect an outpatient license to be given any time soon. o At MTMH there was no utilization of slow release morphine, and despite having access to oral morphine, oral or IV tramadol appeared to be the treatment of choice. o Administrative procedures prevented the use of morphine in ampoules.	Previously there was a restriction on the supply of oral morphine and they were awaiting a signature from the Narcotics Officer.
	Review of 2010 Recommendations • Improved access to oral immediate release, oral slow release and ampoules of morphine at both sites o Some improvements were obvious at TMH and Oral Morphine was still not available. o At MTMH, immediate release oral morphine was still available which patients kept in their locker and self administered. Ampoules of morphine were in stock but	**Review of 2010 Recommendations (MTMH only)** • Improved access to oral immediate release, oral slow release and ampoules of morphine at both sites o At MTMH, immediate release oral morphine was still available. Ampoules of morphine remained in stock in the recommended locked cupboard in the male ward. o Slow release morphine 30mg tablets was

	had not been utilised due to administrative delays, which was rectified during our visit. There was not an appropriate locked cupboard for storage.
	• Increased prescribing of morphine at appropriate doses to relieve pain and dyspnoea.
	  ○ At TMH, the team completed an IV Morphine trial, a process they had learnt at TIPS. Regular IV morphine was then prescribed as per dose effectiveness. On the day of discharge, this was then converted to immediate release oral morphine for dispensing by MTMH.
	  ○ At MTMH, IV and oral tramadol was prescribed in the majority of cases, which was usually not effective. Opiate rotation to morphine or commencement of morphine was appropriate in many circumstances and continual guidance to do this was required.
	• Improved prescribing of paracetamol at therapeutic doses.
	  ○ Not much of an improvement as paracetamol was prescribed, usually as
		available in Jamshedpur by mid-2012.
		  ○ Fentanyl patches (25mcg/hr) were now available and had been used sparingly as neither the medical nor nursing staff had been taught how to use them. We encouraged the use of fentanyl patches on stable patients and assisted in the education of the application and disposal of the patches and made suggestions on how to make a record in the medication book which would minimize medication errors.
		• Increased prescribing of morphine at appropriate doses to relieve pain and dyspnoea
		  ○ There still appeared to be a reliance on IV and oral tramadol for inpatients who ideally should have been prescribed morphine. Staff preferred Dr Patel to be the morphine prescriber, due to morphine phobia, specifically fear of respiratory depression / arrest. This practice resulted several patients having to wait to be referred to Dr Patel for essential pain management so that she could write the order.

	part of a diclofenic / paracetamol combination and in sub therapeutic doses (50mg/500mg TDS).
	• Improved prescribing of laxatives.
	  ○ Remains to be an area where improvements can be made.
	• Increased awareness of the benefits of truth-telling and the risks of fostering false hope
	  ○ There appeared to be some improvement by some individuals, although the reasons for staff not being clear and precise are complex and likely to be difficult to resolve. Family expectations were high and their knowledge and understanding poor, causing unrealistic expectations.
	  ○ There also appeared some limitation in the ability to recognise and assess patients with acute and expected deteriorations in their condition, which in turn delayed the opportunity to provide appropriate treatment and discussion.
	• Improved opportunities for patient and family privacy to assist in effective communication and preservation of privacy and dignity.
	  ○ The busy and crowded MTMH OPD had its
		○ We mentored medical staff to have confidence in their ability to make appropriate care decisions. The urgency of good pain management was discussed. It was also suggested that it was unnecessary for Dr Patel to make all the decisions, and their change in practice would reduce the burden of her workload as well as provide better patient outcomes.
		• Improved prescribing of paracetamol at therapeutic doses
		• Improved prescribing of laxatives
		  ○ Not formally reassessed during this visit but our impressions were that improvements had been made.
		• Increased awareness of the benefits of truth-telling and the risks of fostering false hope
		  ○ Though MTMH medical officers stated that there had been some improvements in the communication between staff, patients and their families, there remained a lack of confidence.
		  ○ Dr Patel gained experience during the visit and was observed to be ‘breaking bad news’ with greater confidence. Her time

	own Palliative Care consult room with an examination bed with a curtain and several chairs. The clinic was previously conducted in a shared room with an oncologist. ○ Privacy remained an issue due to people spontaneously opening the door, entering and staying in the clinic room which was clearly disruptive to Dr Urmila. The team suggested Reena to instruct non-essential people to remain in the waiting room until called for. ○ There was a shortage of mobile screens on the ward, which were not utilised during the terminal phase, but instead were used to screen the body after death. • Improved medical and nursing teamwork at MTMH. ○ Dr Urmila was isolated in her role as nurse Sunita was on paternity leave and had some help from Reena. • Improved collaboration between the palliative care teams at MTMH and TMH. ○ Collaboration was limited as the non-palliative care workload for TMH staff had	management of these discussions also improved. • Improved opportunities for patient and family privacy to assist in effective communication and preservation of privacy and dignity ○ Improvements noted per 2011 recommendations review. • Improved medical and nursing teamwork at MTMH ○ Nurse Sunita had returned from maternity leave but had not been reinstated in the role and had instead been allocated to general ward nursing duties. She had been replaced by Reena. • Improved collaboration between the palliative care teams at MTMH and TMH ○ Collaboration remains limited. • More nursing and medical staff to access palliative care training ○ Dr Patel had been awarded a scholarship for a palliative care diploma course by Cardiff University • Collaboration with 'The Mahadeo Education & Welfare Society', to enhance psychosocial and supportive care.

	increased, due to which they didn't have time to develop palliative care activities. • More nursing and medical staff to access palliative care training o Dr Urmila has enrolled in the palliative care course run by Cardiff University. o Staffing resources at both hospitals had declined with no opportunities for leave cover or additional placements. • Collaboration with the 'Mahadeo Education & Welfare Society' to enhance psychosocial and supportive care. o This did not occur, due to the lack of coordination and leadership. Though there were a lot of volunteers providing multiple roles in the outpatient clinics, it was still unclear as to who was coordinating or supporting their roles. • Return visit by Australian team members in 2011	o This has not occurred and Reena and other volunteers continue to provide some services.
	<u>Recommendations 2011</u> • Amendments to '(4hourly) Clinical Charts' at TMH (document number TMH/FRM/CLIN/ALL/16.00) and MTMH to include pain as the '5th vital sign' with a 0 to 10	<u>Review of Previous Recommendations (2011)</u> Many of the 2011 recommendations had been implemented with positive benefits. We also noted there had been many physical quality improvements at MTMH. These included a

	scale and to be utilised at the bed side. • Development and support of 'Pain Champion' role on each ward to support quality improvement, mentorship and education of colleagues. This could be a senior nurse who attended the recent EPM workshop. Champions could educate colleagues about 'RAT' using the EPM program. • Reena's role to be developed to only include palliative care patients seen by Dr Urmilla, to provide psychosocial support to the patient and their families. • To enhance dignity and privacy in the OPD clinic room, only the current patient and their family members should be present during the consult. • The Project Officer to explore the opportunities in regards to the provision of psychosocial care. This may include contacting 'The Mahadeo Education & Welfare Society' who had indicated great interest in developing services and the coordinated approach to volunteers. • Third visit by mentors in 2012. • Investigation of opportunities for creation of	separate room for the preparation of chemotherapy, new mattresses, locked boxes on each floor for the storage of injectable opioids and other equipment. In addition, the general building was well maintained, had been recently painted and was regularly cleaned. • Amendments to '(4hourly) Clinical Charts' at TMH (document number TMH/FRM/CLIN/ALL/16.00) and MTMH to include Pain as the '5th vital sign' with a 0 to 10 scale, and to be utilised at the bed side. o The APLI team did not visit TMH and was therefore unable to comment on action. o The clinical chart at the end of the MTMH patient's beds remained unchanged, and Dr Patel still utilises a numerical pain score chart for patients to complete themselves. Compliance with this was poor. • Reena's role to be developed to only include Palliative Care patients seen by Dr Patel, to provide psychosocial support to the patient and their families. o Reena's became a salaried staff and her role was developed. She maintains the

	business case for submission to Australian Volunteers International, Indian office, to support an Australian palliative care health care provider to assist Jamshedpur to develop and sustain community palliative care services.	administrative requirements of the OPD in the mornings and then completes wound dressing and supportive counselling in the afteroons. • To enhance the dignity and privacy of patients in the OPD clinic room, only the current patient and their family members should be present during the consult. Reena to ensure the door remains closed and uninvited people removed promptly. A sign on the door may also help. o The new signage on the door and on an internal wall has proved to be valuable in raising the profile of the specialty service. o The examination table has privacy screening and the positioning of the desk, computer and chairs support a reduction of physical barriers, enhancing a therapeutic relationship. o Reena was ensuring the door is closed and a consultation is complete before people have access to the room. • The Project Officer to explore the opportunities in regards to the provision of psychosocial care. This may include contacting 'The

		Mahadeo Education & Welfare Society' who had indicated great interest in developing services and the coordinated approach to volunteers. ○ It is unknown if there had been opportunity for this to occur. • Final return visit in 2012. ○ The visit was completed within 12 months to continue the momentum of the project and to support the objectives of Project Hamrahi.
		<u>Recommendations 2012</u> As per 2011 recommendations: • Make amendments to '(4hourly) Clinical Charts' to include Pain as the '5th vital sign' with a 0 to 10 scale, and to be utilised at the bed side. Staff to complete the assessment each shift. • The Project Officer or other to explore the opportunities in regards to the provision of psychosocial care. This may include contacting 'The Mahadeo Education & Welfare Society' who had indicated great interest in developing services and the coordinated approach to volunteers.

		Additionally: • All MTMH medical staff to prescribe morphine for pain and other essential medications as appropriate, following their palliative care assessment to assist in the timely management of patient distress. Subsequent referral to Dr Patel for her to review and advise on ongoing palliative management should not prevent early treatment of distressing symptoms. • The development of planned 'debriefing' and 'clinical discussion' opportunities for team members. • OPD palliative care patient assessment information to also be available to ward staff if the patient is admitted as an inpatient. • The nomination of a palliative care nurse 'champion' on each ward to assist in the development and utilization of pain management assessment tools and to work informally with Dr Patel. • Return visit by APLI team members in 2014.