DEDER GENERAL HOSPITAL

PAIN AND PALLIATIVE SERVICE PROTOCOL

PREPARED BY*: *HSQU

JULY 2016 E.C

DEDER, EASTERN ETHIOPIA

PROTOCOL APPROVEAL SHEET

NAME OF PROTOCOL: PAIN AND PALLIATIVE SERVICE PROTOCOL

PREPARRED BY			
S/N	**NAME**	**RESPONSIBILITY**	**SIGN**
1	Abdi Tofik (BSc, MPH)	Health Service Quality Director (HSQD)	
2	Abdella Aliyi (BSc MW)	HSQ Officer and Reform f/person	
3	Redwan Sharafuddin (BSc Pharm)	HSQ Officer	

APROVED BY			
S/N	**NAME**	**RESPONSIBILITY**	**SIGN**
1	Nureddin Yigezu (BSc, MPH)	Chief Executive Officer (CEO)	
2	Dr. Derese Gosa (MD)	Medical Director	
3	Dr. Isak Abdi (MD, G/Surgeon)	OR Director & SaLTS Team leader	

THIS PROTOCOL IS EFFECTIVE FROM JULY 2016 E.C TO JUNE 2018 E.C

Table of Contents

PROTOCOLAPPROVEAL SHEET **1**

1. Introduction **1**

2. Department of Pain and Palliative Care Services **2**

3 Palliative care multidisciplinary team **2**

i. Palliative care multi- disciplinary team members are **2**

4 Standard documents and tools for pain and Palliative care **3**

5 Medication, equipment and supplies **3**

6. WHO Analgesic Ladder **4**

7. Classification of Pain **7**

B. Pain Classification by Mechanism 8

8. Pain Scales **9**

B. Wong-Baker FACES scale **10**

9. Home based care palliative care **11**

10. Annexes **12**

11. References **26**

Abbreviation

WHO - World Health Organization

QI - Quality Improvement

MCH - Maternal and Child Health

SMT - Senior Management Team

NGO - Non Governmental Organizations

TOR - Term of Reference

GFR - estimated Glomerular Filtration Rate

NSAID - Non Steroidal antiinflamatory Drugs

1. Introduction

- Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.
- Pain is a subjective experience, varies from person to person and time to time. Pain is whatever the experiencing person says it.
- Palliative care is all about looking after people with illnesses that cannot be cured, relieving their suffering and supporting them through difficult times. (WHO 2004).

- Pain and palliative care extend beyond just pain and symptom control, also addressing the psychosocial and emotional suffering of patients and their families.
- Pain is now established as the 5th vital sign and the need for palliative care in Ethiopia is rapidly increasing.
- Hospice care is a form of palliative care that focuses on terminally ill patients.
- Eligible hospice care patients are those likely left less than 6 months to live.

The **holistic approach** looks at problems in four groups:

- **Physical** – symptoms (complaints), eg pain, cough, tiredness, fever
- **Psychological** – worries, fears, sadness, anger
- **Social** – needs of the family, issues of food, work, housing and relationships
- **Spiritual** – questions of the meaning of life and death, the need to be at peace.

2. Department of Pain and Palliative Care Services

- Department of Pain and Palliative Care Services
- All hospitals should have a Pain and Palliative Care unit/department
- The service is lead by full time pain and palliative care service director/coordinator; preferably senior physician, general practitioner or trained health officer.
- The pain and palliative care director shall report to the hospital's medical director and be a member of the SMT..

3 Palliative care multidisciplinary team

i. Palliative care multi- disciplinary team members are

1. Focal person Department head
2. physician
3. Nurses
4. Social workers
5. Clinical Psychologist/General Psychologist/Counselor
6. Clinical Pharmacies
7. Spiritual leaders
8. Secretary

4 Standard documents and tools for pain and Palliative care

- The hospital should avail pediatric and adult pain and palliative care protocols approved by the hospital management.
- All the hospital wards and clinical areas should receive a soft and hard copy of the protocols.
- The standard pain and palliative care guidelines should be available, understood and adhered to by all clinical staff in all service delivery points.
- The service should be audited regularly by reviewing patient medical records and QI activities should be done whenever gaps are identified.

5 Medication, equipment and supplies

- Availability of medical equipment's, Supplies and consumables are essential for the provision of pain and palliative care.

- Hospitals shall identify and avail the national package of essential medications, standard equipment, and minimum supplies (**Annex 4**).

6. WHO Analgesic Ladder

The WHO analgesic ladder provides a general guide for pain management based on severity. However, it does not replace individualized management based on careful patient assessment.

Table 1: the WHO three-step analgesic ladder for Adult

SN	- Step 1 NON-OPIOID ± adjuvants	- Step 2 WEAK OPIOID ± non-opioid ± adjuvants	- Step 3 STRONG OPIOID ± non-opioid ± adjuvants
1	Paracetamol 500mg 2 tabs q/6 hrs.	**If pain is persistent or worsening:** Start codeine 30-60mg four times a day regularly	**Persistent or worsening pain** Commence strong opioid e.g. oral morphine Oral solution 10mg/5mL
2	NSAID e.g. ibuprofen, or	Tramadol 50 mg twice a day	
3	Naproxen250-500mg twice daily	± non-opioid ± adjuvants	±non-opioid ± adjuvants
4	celecoxib100mg twice daily, increased if necessary to 200mg twice daily ± adjuvants		
	Persistence and Worsening pain →		
	N.B Consider Prophylactic Laxative to avoid Constipation for Morphine		

WHO Analgesic Ladder Step 1 – Non-opioids

- For patients without risk factors for Paracetamol hepatotoxicity, the standard regimen is 1g four times a day.
- For patients with more than one hepatic risk factor (old age, weight less than 50kg, poor nutritional status, fasting/ anorexia, chronic alcohol use) – reduced dose of 500mg four times a day, increased if necessary to a maximum of 3g per day in divided doses, is advisable.
- For patients with severe renal impairment (eGFR<10ml/min) reduce dose (maximum 3g/24hrs)

WHO Analgesic Ladder Step 2 – Weak Opioids

- **Low Dose Morphine** generally provides quicker and better relief from cancer pain than weak opioids.
- If considering prescribing a weak opioid be aware that: **Codeine** has to be converted to morphine in the body to achieve an analgesic effect. Poor metabolizers of codeine may not experience analgesia.
- Ultra-rapid metabolizers may experience toxicity.
- Tramadol 50 mg twice a day

WHO Analgesic Ladder Step 3—Strong Opioids

- Strong Opioids Morphine is the strong opioid of choice for management of moderate to severe pain in palliative care patients, based on familiarity, availability and cost.
- The oral route is preferred as long as the patient has no problems with swallowing or absorption. Other strong opioids are used mostly when morphine is not readily available.
- There are generally no absolute contraindications to the use of strong opioids in palliative care patients with advanced progressive disease, provided the dose is titrated carefully against the patient's pain.

Non-opioids	ibuprofen or other NSAID, paracetamol (acetaminophen), or aspirin
Weak opioids	codeine, tramadol, or low-dose morphine
Strong opioids	morphine, fentanyl, oxycodone, hydromorphone, buprenorphine
Adjuvants or	antidepressant, anticonvulsant, antispasmodic, muscle relaxant, bisphosphonate, corticosteroid

Table 2: WHO Analgesic Pediatrics ladder

Step-1 Mild Pain		**Step-2 Moderate/Sever pain**
Non-Opioid		**Strong Opioid** **Morphine**
± adjuvants		± non-opioid ± adjuvants

NB: Consider Prophylactic Laxative to avoid Constipation for Morphine

- **.Step-1 For Mild Pain** Age>3 months Ibiprufin, Paracetamol, Age <3 months Paracetamol based on KG formula
- **Step-2 Strong Opioid :**Morphine is medicine of choice/may available or Phentaline, Oxicodine, Hydromorphine,
- **Adjuvants:** Antidepresants, Anticonvelsant, Antispasmodics, Muscle relaxants, bisphosphonate or Corticosteroid
    - *Combine an opoid and non-opoid is effective but, do not combine the same class*
    - *Time doses based on drug half-life (dose by the clock) do not wait pain to recur*

Pain as a 5th vital sign

Pain should refer to as the "fifth vital sign," (along with temperature, pulse rate, blood pressure and respiratory rate) and should be assessed regularly and frequently. Pain is individualized and subjective; therefore, the patient's self- report of pain is the most reliable gauge of the experience. All hospitals should have proper assessment of pain and this is essential for successful management.

"**Pain is a more terrible lord of mankind than even death itself"**

Albert Schweitzer

7. Classification of Pain

Pain can be described and classified based on different ways:

A. ***Duration*** – acute or chronic

B. ***Mechanism*** – nociceptive or neuropathic

C. ***Origin*** – somatic or visceral

Situation – incidental pain, breakthrough pain, procedural pain.

A. Pain Classification by Duration

i. Acute Pain

- ☞ Characterized by help-seeking behavior such as crying and moving about.
- ☞ Definite onset with limited and predictable duration.
- ☞ Clinical signs of sympathetic over-activity: tachycardia, pallor, hypertension, sweating, grimacing, crying, anxious, pupillary dilation ***Example:*** trauma, surgery, or inflammation

ii. Chronic Pain

- ☞ Patients may not show signs of distress seen in acute pain
- ☞ ***Cause:*** chronic pathological process
    - Under-treatment of acute pain can lead to changes in the central nervous system that result in chronic pain

Signs/symptoms:

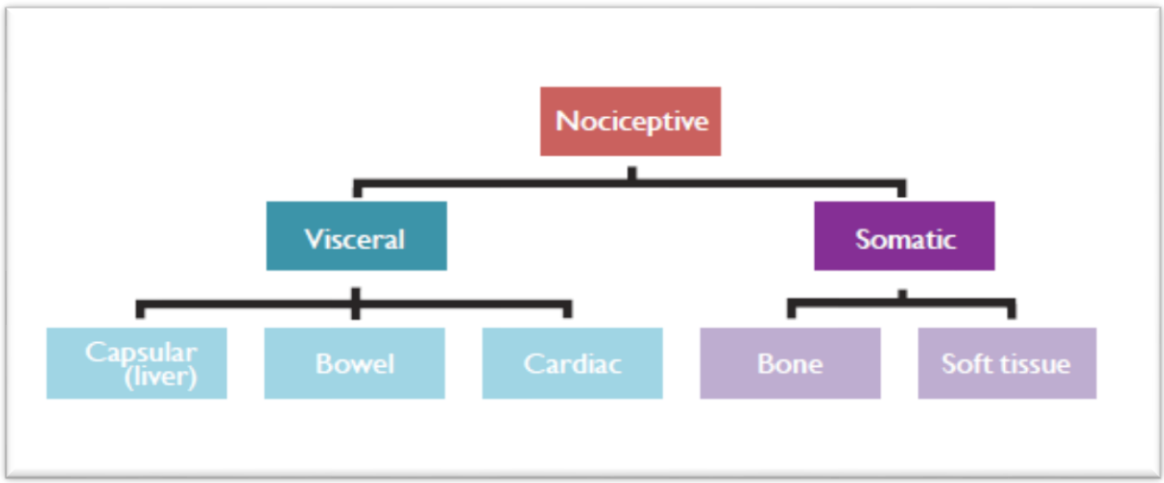
- ☞ Gradual or vague onset
- ☞ Continues and may become progressively more severe
- ☞ Patient may appear depressed and withdrawn
- ☞ Usually no signs of sympathetic over-activity.

B. Pain Classification by Mechanism

i. Nociceptive Pain

Caused when nerve receptors called nociceptors are irritated. Nociceptors exist both internally (visceral) and externally (somatic)

☞ Indicates that nerve pathways are intact



ii. Neuropathic Pain

☞ Caused by damage to nerve pathways.

☞ Described as burning, prickling, stinging, pins and needles, insects crawling under skin, numbness, hypersensitivity, shooting, or electric shock

☞ Causes: infiltration by cancer, HIV infection, or herpes zoster, drug-related peripheral neuropathy, central nervous system injury, or surgery.

C. Pain Classification by Origin

i. Somatic Pain

- ☞ Stimulation of nociceptors in the skin, soft tissues, muscle, or bone
    - Pain usually is in a particular location
    - Aching, throbbing, or persistent pain
    - Causes: bone or soft tissue infiltration

ii. Visceral pain

- ☞ Stimulation of nociceptors in internal organs and hollow viscera organs.
- ☞ Pain is often not in a single location
- ☞ Described as pressure, cramping, or squeezing pain
- ☞ Causes: blockage, swelling, stretching, or inflammation of the bowel, liver, cardiac…

D. Pain Classification by Situation

i. **Incident pain** – occurs only in certain circumstances (e.g. after a particular movement)

ii. **Breakthrough pain** – a sudden, temporary flare of severe pain that occurs on a background of otherwise controlled pain.

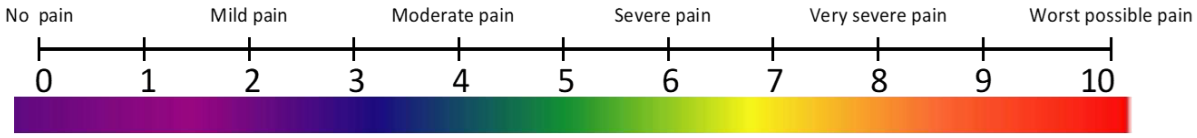
iii. **Procedural pain** – related to procedures or interventions.

8. Pain Scales

Scientifically validated pain scales:

1) Numeric Pain Rating Scale
2) Wong-Baker FACES Scale: for children who can talk
3) Observation-FLACC Scale: for children who can't talk

A. Numeric pain rating scale



- Pain levels from 0-10 can be explained verbally to the patient using a scale in which 0 is no pain and 10 is the worst possible pain imaginable
- Patients are asked to rate their pain from 0 to 10
- Record the pain level to make treatment decisions, follow-up, and compare between examinations

Ways to assess pain in children

- Ask the child: Wong-Baker Faces scale
- Ask the parent or caregiver
  - ☞ Ask about previous exposure to pain, verbal pain indicators, usual behavior or temperament
- Observe the child: FLACC scale
- The child is the best person to report his/her pain!

B. Wong-Baker FACES scale

- Use in children who can talk (usually 3 years and older)
- Explain to the child that each face is for a person who feels happy because he has no pain, or a little sad because he has a little pain, or very sad because he has a lot of pain
- Ask the child to pick one face that best describes his or her current pain intensity
- Record the number of the pain level that the child reports to make treatment decisions, follow-up, and compare between examinations

C. FLACC scale

☞ Use in children less than 3 years of age or older children who can't talk

☞ Use it like an APGAR (Appearance, Pulse, Grimace, Activity, Respiration) score, arriving at a score out of 10

☞ Face, Legs, Activity, Cry and Consolability

	SCORING		
CATEGORIES	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Each of the five categories: (**F**) Face; (**L**) Legs; (**A**) Activity; (**C**) Cry; (**C**) Consolability, is scored from 0–2 which results in a total score between 0 and 10 (*Merkel et al. 1997*)

- ☞ Score each of the five categories (0-2)
- ☞ Add the five scores together to get the total (out of 10)
- ☞ The total score can be related to pain intensity

Category	Score
Face	
Legs	
Activity	
Cry	
Consolability	
Total	

Pain intensity	FLACC score
Relaxed and comfortable	0
Mild discomfort	1-3
Moderate pain	4-6
Severe discomfort/pain	7-10

9. Home based care palliative care

- Home-based palliative care Guidelines, Protocol, Registration book, education materials etc.
- HBC Service plan (nursing care, Companion-ship etc.) and staff visiting schedule
- presence of MDT for HBC or trained team in facilities of the cluster/hub
- Look for reporting format, Activity Report or referral service linkage reports

10. **Annexes**

Annex 1: Reporting Format

Registration format for palliative care service (Inpatient, Outpatient and HBC Name of Hospital----------

S.N.	Name of patient	A	S	Religion	Case/Dx	management	Outcome Progress

Annex 3:

Palliative Care at outpatient department Patient satisfaction survey Exit interview questionnaire
Date of survey……

Facility Name…….. Survey code .....Department name……
Age…… Gender…….. Level of educations……
Instruction: Please circle or write in relevant boxes

Diagnosis

Cancer type……	HIV	NCDs	Others ……..

	Strongly disagree 1	Disagree 2	Agree 3	Strongly agree 4
1- During this visit, the health care worker treated me with courtesy and respect	1	2	3	4
2- During this visit, the health care worker listened carefully to me	1	2	3	4
3- During this visit, the health care worker explained things in a way I understand	1	2	3	4

4- I had enough time to discuss my problems with the health care worker	Yes		No	
5- Were you given health information and education on the disease you are told to have?	Yes		no	
6- How do you rate this health facility? - On scale of 1 to 10 (0 being the worst and 10 being the the best facility)				10
	Worst ……to……..best			
7- Would you recommend this outpatient department /clinic to your family and friends	1	2	3	4
	no ,never	not sure	yes ,probably	Yes Very sure

Annex 4:

Essential Palliative Care Medicines List

Drug Name	Properties	Clinical Uses	Alternative Drugs
Paracetamol	Non opioid Analgesic	Fever Pain	
Aspirin	Non opioid Analgesic Antipyretic	Pain Fever	
Ibuprofen	NSAID	Pain (esp. bone pain) Fever	Diclofenac Indomethacin
Tramadol Codeine	Weak opioid Analgesic	Pain	Low dose morphine
Morphine liquid	Strong opioid Analgesic	Pain Introduction Breakthrough pain Difficulty swallowing children	Morphine slow release tablets
Morphine (slow release tablets)	Strong opioid	Pain Severe diarrhea	Morphine Liquid
Dexamethasone	Corticosteroid Anti- inflammatory	Painful swelling inflammation	Prednisolone
Amitriptyline	Tricyclic Antidepressant	Neuropathic pain (nerve pain)	Carbamazepine Phenytoin
Amitriptyline	Tricyclic Antidepressant	Depression	Imipramine
Hyoscine Butyl bromide	Antimuscarinic Antispasmodic	Abdominal pain (Colic)	Propantheline
Diazepam	Benzodiazepine Anticonvulsant	Muscle spasm Seizure	Lorazepam
Phenobarbitone	Anticonvulsant	Seizure	Diazepam

Metoclopramide	Antiemetic	Vomiting	Haloperidol Domperidone
Metoclopramide	Pro-kinetic	Abdominal Fullness	
Chlorpromazine	Antipsychotic	Hiccups	Metoclopromide
Magnesium Trislicate	Antacid	Indigestion Gastro-esophageal	
Loperamide	Antidiarrheal	Chronic diarrhea	
Bisacodyl ORS	Stimulant laxative Rehydration Salt	Constipation Diarrhea Rehydration	
Chlorpheniramine	Antihistamine	Drug reactions	
Flucloxacillin	Antibiotic	Chest infection Skin infection	
Cotrimoxazole	Broad Spectrum Antibiotic	PCP treatment & prophylaxis Infective diarrhea in HIV/AIDS	
Metronidazole	Antibacterial for anaerobic infections	Foul smelling wounds gingivitis dysentery	
Lumefantrine artemether (LA)	Anti- malarial	Malarial treatment	
Acyclovir	Antiviral	Herpes zoster	
Chloramphenicol e	Antibacterial	Eye infections	
Fluconazole	Antifungal	Oral & esophageal candidiasis	
Clotrimazole 1% Cream	Topical	Fungal Skin	
Nystatin Suspension and pessaries	Antifungal	Oral & vaginal candidiasis Prophylaxis	

Annex 6:

Palliative care Equipment and supplies list

Examination room
Patient Couch
Pillows
Sheets
Blankets
Slippers
Desk for Health Care Professional
Chairs for HCPs, patient and family members
Filing Cabinet
Nursing/Dressing Trolley
Material for Dressings- Gauze, cotton wool, bandages.
Stitch material
Surgical blades
Normal Saline for cleaning wounds
Chlorhexidine
Hydrogen Peroxide
Antiseptic Cream
Sphygmomanometer
Stethoscopes
Thermometers
Lock box for medicines
Syringes and Needles
Pain Measurement Scales
Coffee table and comfortable chairs for counselling and breaking bad news
Oxygen, tubing and mask.
Wheelchair
Commode and bed pan
Sanitary towels and pads for incontinence

Incontinence Pants
Mackintosh sheeting –plastic-for incontinent patients
Gloves- surgical and clean-all-sizes
Kidney dishes
Vomit bowls
Dressing sets
Aprons
Face Masks
Hand Sanitiser-soap
Cleaning Materials
Air Fresheners
Charcoal Dressings
Jugs for vaginal douches
Toilet Paper
Paper Towels and Material towels
Uretheral Catheters and catheter bags
IV catheters
IV fluids
Blood Transfusion sets
Bandages for IVS
Adhesive Tape
Small Gauze
Rubbish bin
Bin to dispose of dressings and soiled matter
Patient gowns
Stationary including paper, pens, markers, envelopes, stapler, tape.
Log book for patients
Suction Catheter
Bedside commodes.
Geriatric recliners (geri chairs)

Nebulizers.
Overbed tables.
Shower chairs.
Wheelchairs
Pain assessment tools

Annex 8:

Palliative Care Audit Tool

	Does the hospital clinic have a functioning palliative care team?	Yes	NO	Remark
	Do they have the minimum number of palliative care staff in the team? (according to WHO guidelines)			
	Have the palliative care team attended a one-week training course?			
	Do they have a room or office to meet and see patients?			
	Do they have a hospital palliative care policy with referral criteria?			
	Do they have palliative care notes which are stored appropriately for their patients? Check 6 Patient Records)			
	Do they have access to palliative care medicines including morphine -including liquid form?			
	Is there evidence of a palliative assessment including pain as the 5th vital sign Check 6 Patient Records)			
	Is there evidence of pain and symptom control assessment and appropriate treatment (Check 6 Patient Records)			
	Do they have palliative care equipment (according to list)			
	Do they have a linked home-care service?			

	Do they offer a bereavement service?			
	Have any of the team any post-graduate education in palliative care?			
	Does the palliative care hub have volunteers to support patients and family?			
	Does the hub have a clear referral pathway for patients from all appropriate departments?			
	Do the palliative care hub team provide basic updates/experience sharing with other health care professionals in the hospital			
	Do Pain and palliative care team have schedule for HBC and working based on standard			

Annex 9

Job Description of Pain and Palliative Care Work Force

Job Description of palliative care Unit/ Department Head

Lead the team

Timely report palliative care activity ,opoid consumption report monthly to the stakeholders (IPD,MD,RHB,MOH)

Facilitate the working environment

Perform monthly meeting with the hospital management about palliative care

To procast training need and propose training for the team members

To procast opoid medication timely

Ensure medicine and other necessary medical supplies are purchased and available in the hospital

To prepare documentation in collaboration with other stake holders (protocols ,TOR,SOP,patient history form and others)

To prepare annual plan of the unity which is in favor of fulfilling national strategy plan

To organize and deliver appropriate training for the team time

Job description of palliative care physician

Assess patient's need for total pain and symptom control and offer quality care and support based on the palliative care national guideline.

Take history, physical examination and necessary investigation to reach on diagnosis.

Treat the patient by using holistic approach and treat pain using standard WHO pain ladder approach

To have regular schedule for the patient OPD and inpatient visit

Refer patient with the proper form to different discipline if needed.

Job description of palliative care nurse

Care out physician order and also assess patient's need for total pain and symptom control and offer quality care and support based on the palliative care national guideline.

Perform standard nursing care for kept palliative care patient

Keeping the patient information and records well

Recording and controlling medicines useful for palliative care
Make sure bereavement support is provided for patient family as necessary
Ensure medicine and other necessary medical supplies are available in the unit
Ensure there is good patient referral system and linkage with necessary stakeholders
Facilitate and participate during case discussion among the clinical staff
Supervise and lead the work of care givers who are directly involved in patient care
Help students who may be assigned at hospital from medical school in PC attachment
Ensure psychosocial and spiritual supports are provided by experts when needed
Provide holistic Home care service as per the schedule in addition to the outpatient and inpatient care
Develop work plan every month or quarter and communicate with palliative focal person
Have a great team approach
Perform any other duty assigned by immediate supervisory
Accept tasks assigned by the palliative care team leaders which is related to palliative care service

Job description of palliative care Social workers

assess patient's need for social pain and its management
asses patients family need for social pain and its management
to have regular visit with the team to palliative care patient
Have regular meeting with palliative care team and handling social problem happen in the team (involving in care for care giver service)
To prepare gate together ceremony for the team and if it can with other stakeholders and patients
Accept tasks assigned by the palliative care team leaders which is related to palliative care service

Job description of Psychologist

Asses the patient psychological problems of the patient and families
Document the patient psychological problems clearly
Manage the psychological problems of the patient and families

Have regular meeting with palliative care team and handling psychological problem happen in the team (involving in care for care giver service)
To give onsite training on psychological problem identification and managing for the team
Refer the patient if needed
Accept tasks assigned by the palliative care team leaders which is related to palliative care service

Job description of Clinical Pharmacist

To assess the standard who pain management implemented to the palliative care patient
To report opoiod consumption report to the focal person timely
To involve in DTC meeting regularly
To give health education on opoid medication use and there side effect
To promote appropriate use of opoid
To prepare and distribute leaflet about pain medication and how to use
Record and manage side-effect and negative outcome regarding to pain medication
Update pain medication medicine timely
Give information the availability, stock out stats of pain medication to palliative care unit timely.
Accept tasks assigned by the palliative care team leaders which is related to palliative care service

Job description of Spiritual leaders

To assess the patient spiritual issues
To manage the patient spiritual issues
To assess the patient family spiritual issues
To document the patient spiritual problems appropriately
To train others how to handle spiritual problems
Have regular meeting with palliative care team and handling spiritual problem happen in the team (involving in care for care giver service)

Accept tasks assigned by the palliative care team leaders which is related to palliative care service

Job description of Volunteers

To help the patient in need
To transport and direct the patient to appropriate place
To involve in community visit
To involve in patient tracing system for delivering palliative care service
Accept tasks assigned by the palliative care team leaders which is related to palliative care service (The team can refer from strategic plan)

Pain and Palliative Care work force

Pain and palliative care require teamwork and a multi-disciplinary approach.
Regular planning clinics are required to discuss patient cases as well as regular ward rounds with the team. Furthermore, patients can be seen in outpatient clinics run by pain and palliative care staff.
The hospital human resources development plan is expected to incorporate pain and palliative care training need.
All clinical staffs working in all service delivery points should get training on pain management and palliative care service. Since pain is assessed and managed in all service areas, the hospital should assign facilitators in all departments. Availability of pain and palliative care trained personnel is important to support other hospital in the hubs and make need based capacity building.
The hospital should establish a pain and palliative care workforce that identifies priority areas of patient need and establishes procedures for collaboration with other pain and palliative care health care professionals and cross- referral in the unit. Take the skill mix of professionals into consideration. Establishes procedures to refer patients to specialized services.
Each palliative care professional is responsible for the following:
Collaborate with patient and their family and cares
Work with palliative care team, to form overall goals and plan for patient
Make referrals to specialized rehabilitation/palliative care professionals and other clinical staff and community services.
Collaborate with other health care professionals in teaching, consulting, and management and research activities

11. References

1. National Palliative Care guidelines (2016) MOH, Ethiopia
2. Hospice Fundamentals, LLC PALLIATIVE CARE HANDBOOK (2019) Jean Acevedo, LHRM, CPC, CHC, CENTC, AAPC Fellow,
3. World Health Organization (1990) Cancer Pain Relief and Palliative Care. Available at: http://whqlibdoc.who.int/publications/9241544821.pdf (Accessed: 8 September 2011).
4. World Health Organization (2002) WHO Definition of Palliative Care. Available at: http://www.who.int/cancer/palliative/definition/en/ (Accessed: 10 November 2010).
5. World Health Organization (2014a) WHO African Region: Ethiopia. Available at: http://www.who.int/countries/eth/en/ (Accessed: 4 August 2014).
6. World Health Organization (2014b) 'Strengthening of Palliative Care as a Component of Integrated Treatment throughout the Life Course', Executive Board 134th Session, Provisional Agenda Item 9.4. EB134/28, World Health Organization.
7. World Palliative Care Association (2005) an Advocacy Tool Kit for Hospice and Palliative Care Organizations. Available at: http://www.wpca.org.uk/advocacy_toolkit_05April (1).pdf (Accessed: 10 August 2014).
8. Wright, M., Clark, D., Hunt, J. and Lynch, T. (2006) Hospice and Palliative Care in Africa. A review of developments and challenges. 1st edition. New York: Oxford University Press.
9. Wube, M., Horne, C. J. and Stuer, F. (2010) 'Building a Palliative Care Program for Ethiopia: the impact on HIV and AIDS patients and their families', Journal of Pain and Symptom Management. 40, (1) pp.6-8.
10. Palliative Home Care and Services provided in a Rural Area – Kerala, India', Indian Journal of Palliative Care, 18 (3), pp.213-218