DEDER GENERAL HOSPITAL

CHRONIC PAIN AND PALLIATIVE CARE PROTOCOL

Adapted from National Palliative Care Guideline 2016

PREPARED BY: HSQU

July 2016E.C

Deder, Eastern Ethiopia

PROTOCOL APPROVAL SHEET

TITLE

Title:Chronic Pain and Palliative Care Protocol

AUTHOR

Name	Position	Role	Sign
Abdi Tofik (BSc, MPH)	Quality Director	Team leader	
Mahammad Aliyi (BSc N)	Quality Officer	Member	
Abdella Aliyi (BSc MW)	Quality Officer	Member	

STAFF APPROVAL

Draft Date: July 15, 2016E.C **Approved Date**: July 20, 2016E.C

Name	Position	Role	Sign
Nuredin Yigezu (BSc, MPH)	CEO	Chair person	
Dr. Derese Gosa (GP)	Medical director	Member	
Dr Isak Abdi (G/Surgeon)	Staff Representative	Member	
Dr. Dawit Seifu (GP)	IPD Director	Member	
Hamza Jamal (BSc N)	Metron	Member	
Abrahim Tahir (BSc N)	HR Head	Secretary	
Obsa Usma'il (BA)	Finance and procurement head	Member	
Bellisa Usma'il (BSc Pharm)	Pharmacy head	Member	
Alamudin Usma'il (BSc Lab)	Laboratory head	Member	
Dine Bakar (BA)	Internal Auditor	Member	
Redwan Sharafuddin (BSc Pharm)	Planning Head	Member	
Mahammad Aliyi (BSc N)	Reform Head	Member	
Nure Jamal (BA)	General service head	Member	
Mahammad Shamshaddin (BSc)	Qondaala Naamusaa	Member	

REVIEW

Reviewed and updated

Review date: July 2018E.C

TABLE OF CONTENTS

1. INTRODUCTION

Chronic pain and serious, life-limiting illnesses significantly impact the quality of life of patients and their families. Chronic pain—defined as pain persisting beyond the expected healing time—can cause substantial physical, emotional, and social suffering. Palliative care, meanwhile, is an approach aimed at improving the quality of life for patients facing life-threatening illnesses through the prevention and relief of suffering. It addresses not only pain but also a range of physical symptoms, psychological distress, social challenges, and spiritual needs.

At Deder General Hospital, providing effective chronic pain management and comprehensive palliative care is a key component of patient-centered healthcare. This protocol aligns with the Ethiopian Ministry of Health's National Palliative Care Guidelines and World Health Organization (WHO) recommendations to ensure that all patients with chronic pain and serious illnesses receive timely, compassionate, and holistic care.

This protocol is designed to guide healthcare providers across disciplines—doctors, nurses, pharmacists, physiotherapists, social workers, and spiritual care providers—in assessing and managing chronic pain and delivering palliative care that respects patient dignity, cultural values, and preferences.

1.1. OBJECTIVES

General Objective

To improve the quality of life of patients suffering from chronic pain and life-limiting illnesses by providing standardized, evidence-based, holistic assessment and management of pain and other distressing symptoms through an integrated palliative care approach.

Specific Objectives

1. To standardize the assessment and documentation of chronic pain as a vital sign in all patient encounters.
2. To promote the use of the WHO pain ladder and multimodal pain management strategies tailored to individual patient needs.
3. To ensure timely and appropriate use of opioid and non-opioid analgesics, adjuvants, and non-pharmacological therapies.
4. To integrate psychological, social, and spiritual support within the palliative care framework.
5. To involve patients and families actively in care planning and decision-making processes.
6. To build multidisciplinary team collaboration to optimize pain and symptom management outcomes.
7. To identify and manage special populations' needs, including pediatric patients, patients with HIV/AIDS, and those with renal or hepatic impairment.
8. To maintain thorough documentation of pain assessment, treatment, and patient response to guide ongoing care and quality improvement.
9. To monitor the availability and rational use of essential palliative care medicines within the hospital.
10. To ensure compassionate end-of-life care that respects patient dignity and cultural values.

1.2. DEFINITIONS

Chronic Pain: Pain that persists or recurs for more than three months beyond the usual course of an acute illness or injury. It may be continuous or intermittent and can result from a variety of causes including ongoing tissue damage, nerve injury, or unknown mechanisms. Chronic pain often leads to significant impairment in physical function and quality of life.

Palliative Care: An approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness. It involves the prevention and relief of suffering by early identification, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems. Palliative care is applicable early in the course of illness, in conjunction with other therapies intended to prolong life.

Pain Ladder: A stepwise approach recommended by the World Health Organization for the management of cancer and chronic pain, progressing from non-opioid analgesics to weak opioids, and finally to strong opioids, based on pain severity.

Adjuvant Analgesics: Medications not primarily designed to control pain but used for this purpose, such as antidepressants, anticonvulsants, corticosteroids, and muscle relaxants, often employed for neuropathic or inflammatory pain.

Breakthrough Pain: A transient exacerbation of pain that occurs on a background of otherwise controlled chronic pain, often requiring additional medication doses.

End-of-Life Care: Care provided in the final phase of life when curative treatments are no longer effective or desired. It focuses on symptom control, emotional support, and dignity preservation for the patient and family.

Multidisciplinary Team: A group of healthcare professionals from different specialties who work collaboratively to provide comprehensive care addressing the various needs of the patient.

2. GUIDING PRINCIPLES

- Effective chronic pain management and palliative care at Deder General Hospital are founded on the following principles:

2.1 Patient-Centered Care

- Respect the dignity, values, culture, and preferences of each patient and their family.
- Engage patients and families in shared decision-making about care plans and treatment options.
- Provide clear, compassionate communication about prognosis, treatment goals, and symptom management.

2.2 Holistic and Comprehensive Approach

- Address the **physical, psychological, social, and spiritual** dimensions of suffering.
- Recognize that uncontrolled pain and symptoms can cause anxiety, depression, social isolation, and spiritual distress.

2.3 WHO Pain Ladder and Individualized Treatment

- Follow the WHO three-step pain ladder for stepwise escalation of analgesics.
- Tailor therapy to the type and severity of pain and the patient's comorbidities, treatment response, and preferences.
- Regularly reassess pain and adjust therapy accordingly.

2.4 By the Mouth, By the Clock, By the Ladder

- Prefer oral administration of analgesics where possible for ease and comfort.
- Administer medication at regular intervals (by the clock) to maintain continuous pain relief, rather than waiting for pain to recur.
- Escalate analgesic strength stepwise as needed (by the ladder) for effective control.

2.5 Multidisciplinary Teamwork

- Involve a team comprising physicians, nurses, pharmacists, physiotherapists, social workers, nutritionists, and spiritual care providers.
- Collaborate to address complex symptom burdens, psychosocial issues, and care coordination.

2.6 Safe and Rational Use of Medicines

- Use opioids and other controlled medicines responsibly to maximize benefits and minimize risks of side effects or misuse.
- Co-prescribe preventive therapies such as laxatives and antiemetics.
- Monitor for adverse effects and drug interactions.

3.7 Equity and Accessibility

- Ensure all patients have access to pain relief and palliative care regardless of diagnosis, socioeconomic status, or geographic location.
- Provide culturally sensitive care respecting community beliefs and practices.

2.8 Continuous Quality Improvement

- Routinely monitor and evaluate pain management outcomes and service delivery.
- Use audit and feedback mechanisms to improve adherence to protocols.

3. PAIN ASSESSMENT

Effective pain management begins with accurate and thorough assessment. Pain is a subjective experience and must be regularly evaluated to guide appropriate treatment.

3.1 Routine Pain Screening

Pain should be assessed as the **5th vital sign** during every patient encounter, alongside temperature, pulse, respiratory rate, and blood pressure.

Document baseline pain on admission, and reassess pain at least daily for inpatients, or at each outpatient visit.

3.2 Pain Assessment Tools

- **Adults and adolescents:** Use the **Numerical Rating Scale (NRS)**, asking patients to rate pain from 0 (no pain) to 10 (worst pain imaginable).
- **Children (3 to 8 years):** Use the **Faces Pain Scale – Revised (FPS-R)**, which shows a series of faces ranging from happy (no pain) to crying (worst pain).
- **Infants and non-verbal children:** Use the **FLACC scale**, which evaluates five behavioral categories: Face, Legs, Activity, Cry, and Consolability.

3.3 PQRST Pain History

Assess the following aspects of pain systematically:

- **P (Precipitating/Palliating factors):** What triggers or relieves the pain?
- **Q (Quality):** What does the pain feel like? (e.g., sharp, dull, burning, throbbing)
- **R (Radiation):** Does the pain spread or remain localized?
- **S (Severity):** Rate pain intensity using the scales above.
- **T (Timing):** When did the pain start? Is it constant or intermittent? How long does it last?

3.4 Classification of Pain

A. Nociceptive Pain: Resulting from tissue injury, subdivided into:

- **Somatic:** Localized pain from skin, muscles, bones, joints. Usually described as sharp, aching, or throbbing.
- **Visceral:** Diffuse pain from internal organs, often described as deep, pressure-like, or cramping.

B. Neuropathic Pain: Caused by nerve damage, presenting as burning, shooting, electric shock-like, or tingling sensations.

C. Mixed Pain: Features of both nociceptive and neuropathic pain are present.

3.5 Impact on Function and Quality of Life

- **Assess how pain affects:**
  - **Physical function:** Mobility, ability to perform daily activities.
  - **Sleep:** Difficulty falling or staying asleep due to pain.
  - **Mood:** Presence of anxiety, depression, irritability related to pain.
  - **Social activities:** Withdrawal or difficulty fulfilling social roles.

3.6 Special Considerations

- Consider cultural factors influencing pain expression and communication.
- Use interpreters or family members when language barriers exist but prioritize direct patient communication when possible.
- For cognitively impaired patients, rely on behavioral indicators and caregiver reports.

4. CHRONIC PAIN MANAGEMENT STEPS

Effective management of chronic pain requires a **stepwise approach** tailored to the patient's pain severity, type, and response to treatment. The **WHO Pain Ladder** guides escalation from non-opioid analgesics to weak and then strong opioids, combined with adjuvant therapies and non-pharmacological measures.

Step 1 – Non-Opioid Analgesics

Medications:

- **Paracetamol (Acetaminophen):**
  - Dose: 500–1000 mg orally every 6 hours (maximum 4 grams/day).
  - Indications: Mild to moderate pain including musculoskeletal pain, headache, and some cancer-related pain.
  - Advantages: Generally safe, well-tolerated, minimal side effects.
- **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs):**
  - Examples: Diclofenac 50 mg three times daily, Ibuprofen 400 mg three times daily, Naproxen 250–500 mg twice daily.
  - Indications: Pain with inflammatory component such as arthritis, bone metastases, and soft tissue injury.
  - Cautions: Avoid in patients with peptic ulcers, renal impairment, bleeding disorders, or heart failure. Use lowest effective dose for shortest duration.
- **Adjuvants (as needed):**
  - Antidepressants or anticonvulsants may be added early for neuropathic pain components.

Monitoring and Side Effects:

- Watch for liver toxicity with paracetamol overdose.
- NSAIDs may cause gastrointestinal irritation, renal impairment, or increased cardiovascular risk.

Step 2 – Weak Opioids (Adults Only)

Medications:

- **Codeine:**
  - Dose: 30–60 mg orally every 4–6 hours (maximum 240 mg/day).
  - Use: Moderate pain not controlled by non-opioids alone.
- **Tramadol:**
  - Dose: 50–100 mg orally every 6–8 hours (maximum 400 mg/day).
  - Use: Alternative weak opioid for moderate pain.

Considerations:

- Use in combination with paracetamol or NSAIDs for synergistic effect.
- Avoid in children under 12 years due to risk of respiratory depression and poor metabolism.
- Monitor for side effects: sedation, nausea, constipation, dizziness.

Step 3 – Strong Opioids

Medications:

- **Morphine (First Choice):**
  - Starting Dose: 2.5–5 mg orally every 4 hours for opioid-naïve patients.
  - Breakthrough Dose: Provide additional "rescue" dose equal to the 4-hourly dose for uncontrolled breakthrough pain.
  - Titrate dose based on pain control and tolerability.
- **Other Opioids:** Fentanyl (transdermal patches), hydromorphone may be used when morphine is contraindicated or not tolerated.

Management of Side Effects:

- **Constipation:** Prophylactic laxatives (e.g., senna, lactulose) should be prescribed routinely.
- **Nausea and Vomiting:** Prescribe antiemetics like metoclopramide as needed.
- **Sedation:** Usually transient; dose adjustment may be required.
- **Respiratory Depression:** Rare at therapeutic doses but monitor closely, especially during initiation or dose increases.

Prescribing Practices:

- Educate patients and families on the correct use of opioids, side effects, and safe storage.
- Follow local regulations and hospital policies regarding opioid prescribing and dispensing.

Adjunct Therapies (Adjuvants)

- To be used alongside analgesics to enhance pain control, especially for neuropathic or complex pain syndromes (details in Section 6).

Non-Pharmacological Therapies

- Should be integrated at every step to improve outcomes and reduce reliance on medications (details in Section 7).

Regular Reassessment

- Evaluate pain relief, functional improvement, side effects, and patient satisfaction every 24–72 hours after starting or changing treatment.
- Adjust doses or switch drugs as needed.

5. ADJUVANT ANALGESICS

Adjuvant analgesics are medications primarily used for other medical conditions but found to have significant pain-relieving properties in specific types of pain. They are often combined with primary analgesics to improve overall pain control, especially in complex or neuropathic pain syndromes.

5.1 NEUROPATHIC PAIN MANAGEMENT

Neuropathic pain arises from nerve damage or dysfunction and often responds poorly to opioids alone. Adjuvant drugs that modulate nerve activity can provide better relief:

- **Amitriptyline**
  - Dose: Start at 10–25 mg orally at bedtime; may increase gradually to 75 mg based on response and tolerance.
  - Mechanism: Tricyclic antidepressant that modulates pain pathways.
  - Side Effects: Drowsiness, dry mouth, constipation, dizziness. Use cautiously in cardiac patients.
- **Gabapentin**
  - Dose: Start at 100–300 mg at night, titrate upwards to 900–1800 mg/day in divided doses.
  - Mechanism: Anticonvulsant that reduces nerve excitability.
  - Side Effects: Dizziness, somnolence, peripheral edema.
- **Carbamazepine**
  - Dose: Start 100 mg twice daily; may increase as needed.
  - Use: Particularly useful in trigeminal neuralgia and certain neuropathic pain conditions.
  - Side Effects: Dizziness, nausea, hyponatremia, rash. Monitor blood counts and liver function.

5.2 Bone Pain

Bone pain, often caused by metastases or fractures, responds well to anti-inflammatory and steroid therapy:

- **NSAIDs** (see Step 1) help reduce inflammation.
- **Corticosteroids** (e.g., dexamethasone 4–8 mg daily) can reduce tumor-related edema and inflammation, relieving bone pain and associated symptoms.

5.3 Visceral Spasm

Pain from visceral spasms such as intestinal or biliary colic can be managed with antispasmodics:

- **Hyoscine butylbromide (Buscopan):** 20 mg orally three times daily.
- May be combined with analgesics for better effect.

5.4 Anxiety-Related Pain

Psychological distress can exacerbate the perception of pain. Use anxiolytics judiciously:

- **Diazepam:** 2–5 mg orally at bedtime or as needed to relieve muscle spasm and anxiety.
- Supportive counseling and relaxation techniques are recommended.

5.5 Monitoring and Safety

- Regularly review the effectiveness and side effects of adjuvants.
- Adjust doses slowly to minimize adverse reactions.
- Consider drug interactions, especially in patients on ART or multiple medications.
- Educate patients and caregivers about potential side effects.

6. NON-PHARMACOLOGICAL PAIN MANAGEMENT

Non-pharmacological interventions are essential components of a holistic approach to chronic pain and palliative care. These strategies complement drug therapies by addressing psychological, physical, social, and spiritual aspects of suffering, enhancing overall patient well-being.

6.1 Psychological Support and Counseling

- **Cognitive-behavioral therapy (CBT):** Helps patients develop coping strategies to manage pain and reduce distress.
- **Psychological counseling:** Provides emotional support, helps manage anxiety, depression, and grief related to chronic illness.
- **Family counseling:** Engages family members to support the patient and improve communication.

6.2 Physical Therapy and Rehabilitation

- **Physiotherapy:** Tailored exercises to maintain or improve mobility, muscle strength, and flexibility, which can reduce pain severity.
- **Positioning and ergonomics:** Use of pillows, supports, and adaptive equipment to minimize discomfort.
- **Occupational therapy:** Assists patients in performing daily activities with less pain and greater independence.

6.3 Relaxation Techniques

- **Breathing exercises:** Deep, slow breathing to reduce tension and anxiety.
- **Progressive muscle relaxation:** Systematic tensing and relaxing of muscle groups to ease muscle spasms and promote relaxation.
- **Meditation and mindfulness:** Focused attention practices that reduce the emotional impact of pain.

6.4 Complementary Therapies

- **Massage therapy:** Can alleviate muscle tension and improve circulation.
- **Heat and cold application:** Heat may relieve muscle stiffness; cold can reduce inflammation and numb localized pain.
- **Acupuncture:** May be considered where available, for certain types of chronic pain.

6.5. Spiritual and Pastoral Care

- Facilitate access to **chaplaincy services** or local spiritual leaders for patients requesting spiritual support.
- Respect and integrate patients' cultural and religious beliefs into care plans.
- Provide opportunities for rituals or practices that offer comfort.

6.6. Traditional Remedies

- Acknowledge and discuss any traditional medicine use by patients.
- Encourage only those remedies that are **safe, non-interfering with medical treatment, and evidence-supported**.
- Educate patients about potential risks and benefits.

6.7 Integration and Multidisciplinary Approach

- Non-pharmacological therapies should be integrated with pharmacological treatments for maximum benefit.
- Coordinate with physiotherapists, counselors, social workers, and spiritual care providers as part of the multidisciplinary team.

7. SYMPTOM MANAGEMENT IN PALLIATIVE CARE

Effective palliative care focuses not only on pain relief but also on the comprehensive management of other distressing symptoms commonly experienced by patients with life-limiting illnesses. Early recognition and treatment improve quality of life and comfort.

7.1 Dyspnea (Shortness of Breath)

- **Assessment:** Identify underlying cause (e.g., infection, anemia, heart failure, lung disease).
- **Management:**
  - Treat reversible causes when possible.
  - Administer supplemental oxygen for hypoxia.
  - Use opioids (morphine 2.5–5 mg orally every 4 hours) to reduce the sensation of breathlessness.
  - Position patient upright to facilitate breathing.
  - Provide anxiolytics if anxiety worsens dyspnea.

7.2 Nausea and Vomiting

- **Assessment:** Identify causes such as medication side effects, bowel obstruction, infection.
- **Management:**
  - Treat underlying causes.
  - Use antiemetics such as:
    - ✓ Metoclopramide 10 mg three times daily.
    - ✓ Haloperidol 0.5–1 mg at night or as needed.
    - ✓ Ondansetron 4 mg twice daily, especially if other agents fail.
  - Adjust diet and hydration as tolerated.

7.3 Constipation

- **Prevention:** Start prophylactic laxatives when opioids are initiated (e.g., senna 2 tablets at night, lactulose 10–20 ml daily).
- **Management:**
  - Encourage oral fluids and physical activity as tolerated.
  - Use stool softeners and stimulant laxatives as needed.
  - Monitor bowel movements daily.

7.4 Anorexia and Weight Loss

- **Assessment:** Identify factors contributing to poor appetite (e.g., nausea, depression, infection).
- **Management:**
  - Provide nutritional counseling.
  - Encourage small, frequent, nutrient-dense meals.
  - Consider short courses of corticosteroids (dexamethasone 4 mg daily) to stimulate appetite.
  - Use appetite stimulants when appropriate.

7.5 Depression and Anxiety

- **Assessment:** Screen for mood disorders routinely.
- **Management:**
  - Provide psychological counseling and support.
  - Use antidepressants such as SSRIs (e.g., fluoxetine 20 mg daily) when indicated.
  - Prescribe anxiolytics (e.g., diazepam) for short-term relief of anxiety symptoms.
  - Engage family and community support networks.

7.6 Other Common Symptoms

- **Fatigue:** Encourage rest balanced with activity; address treatable causes such as anemia or depression.
- **Insomnia:** Use sleep hygiene measures and pharmacotherapy if needed.
- **Pruritus:** Use moisturizers and antihistamines if appropriate.

8. SPECIAL CONSIDERATIONS

Certain patient populations require tailored approaches to pain and palliative care due to their unique clinical conditions and risks. This section outlines key considerations for vulnerable groups.

8.1 HIV/AIDS Patients

- Pain in HIV/AIDS may arise from multiple causes including opportunistic infections, neuropathy related to antiretroviral therapy (ART), malignancies, or other co-morbidities.
- Careful pain assessment is essential due to the complexity and overlapping causes.
- Monitor for potential **drug interactions** between analgesics (especially opioids and adjuvants) and ART medications.
- Adjust dosages as needed to minimize toxicity while ensuring adequate pain control.
- Incorporate psychosocial support addressing stigma, mental health, and social challenges.

8.2 Renal Impairment

- Renal dysfunction alters the metabolism and excretion of many analgesics, increasing the risk of accumulation and toxicity.
- **Dose Adjustments:**
  - Reduce opioid doses and extend dosing intervals. Morphine metabolites accumulate in renal failure, so use cautiously.
  - Prefer opioids with less renal clearance such as fentanyl or hydromorphone when available.
  - Avoid NSAIDs due to nephrotoxicity.
- Monitor renal function regularly.

8.3 Hepatic Impairment

- Liver disease affects drug metabolism, requiring cautious use of analgesics.
- **Dose Adjustments:**
  - Reduce doses of opioids and avoid high-dose paracetamol (>2 grams/day).
  - Monitor for sedation and respiratory depression.
  - Avoid hepatotoxic drugs when possible.
- Collaborate with hepatology specialists for complex cases.

8.4 Pediatric Patients

- Children require special consideration due to differences in pharmacokinetics, pain expression, and risk of side effects.
- Use the **WHO Two-Step Ladder** approach for children:
  - Mild pain: Paracetamol and/or NSAIDs.

- Moderate to severe pain: Low-dose morphine preferred; **avoid codeine and tramadol** due to risk of variable metabolism and respiratory depression.

- Use age-appropriate pain scales (Faces, FLACC).
- Monitor carefully for side effects and sedation.
- Engage parents/caregivers in pain assessment and medication administration.

8.5 Elderly Patients

- Increased sensitivity to opioids and risk of side effects such as sedation, confusion, and falls.
- Start with lower doses and titrate slowly.
- Monitor for polypharmacy and drug interactions.

8.6 Patients with Substance Use Disorders

- Balance effective pain relief with risk of misuse or diversion.
- Use multidisciplinary management including addiction specialists when possible.
- Employ careful monitoring and clear communication.

9. END-OF-LIFE CARE

End-of-life care focuses on providing comfort, dignity, and support to patients in the final phase of life when curative treatments are no longer effective or desired. It involves comprehensive symptom control, psychosocial support, and respect for patient and family wishes.

9.1 Continuity of Pain and Symptom Management

- Continue all effective pain relief and symptom control measures.
- Anticipate and proactively manage new or worsening symptoms.
- Avoid abrupt discontinuation of analgesics; adjust doses based on patient comfort.

9.2 Emotional and Spiritual Support

- Provide compassionate emotional support to patients and families.
- Facilitate access to spiritual care providers or community religious leaders as requested.
- Respect cultural rituals, traditions, and preferences regarding death and dying.

9.3 Communication

- Maintain honest, sensitive, and open communication about prognosis, care goals, and treatment options.
- Involve the patient and family in decision-making to the extent they desire.
- Discuss advance care planning and do-not-resuscitate (DNR) orders when appropriate.

9.4 Maintaining Patient Dignity and Comfort

- Ensure privacy, personal hygiene, and a comfortable environment.
- Address psychosocial needs including fear, loneliness, and anxiety.
- Support family members and caregivers through the dying process.

9.5 Care Coordination and Support Services

- Coordinate care among hospital teams, community health workers, and home-based care providers.
- Provide information on hospice services or palliative home care options if available.
- Arrange for bereavement support after the patient's death.

10. DOCUMENTATION

Accurate and consistent documentation is vital to ensure effective pain management and palliative care, facilitate communication among healthcare providers, and support ongoing quality improvement.

10.1 Pain and Symptom Assessment Records

- Record pain scores using validated tools (NRS, Faces, FLACC) at every patient encounter.
- Document detailed pain characteristics (PQRST), type, and impact on function.
- Note all associated symptoms such as nausea, dyspnea, anxiety, and sleep disturbances.

10.2 Treatment Plans and Interventions

- Clearly document all analgesics and adjuvant medications prescribed, including dose, route, frequency, and start date.
- Record non-pharmacological interventions provided.

- Specify breakthrough medication doses and frequency.

10.3 Response to Treatment

- Note patient's reported pain relief, functional improvement, and any side effects or adverse reactions.
- Document changes made to the pain management plan based on reassessment.

10.4 Communication and Consent

- Record discussions with patients and families about pain management goals, treatment options, and advance care planning.
- Document informed consent for opioid prescriptions when required by hospital policy or regulation.

10.5 Continuity of Care

- Ensure that pain and symptom management information is transferred accurately during shift changes, referrals, and discharge summaries.
- Include recommendations for follow-up pain management.

11. REFERENCES

1. **World Health Organization (WHO).** *Cancer Pain Relief: With a Guide to Opioid Availability*, 2nd edition. WHO, 1996. https://apps.who.int/iris/handle/10665/37896
2. **World Health Organization (WHO).** *WHO Definition of Palliative Care*. 2020. https://www.who.int/cancer/palliative/definition/en/
3. **Ethiopian Federal Ministry of Health.** *National Palliative Care Guideline*, 2019. Addis Ababa, Ethiopia.
4. **National Comprehensive Cancer Network (NCCN).** *NCCN Clinical Practice Guidelines in Oncology: Adult Cancer Pain*. Version 2.2024. https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf
5. **Canadian Pain Society.** *Guidelines for the Management of Chronic Pain*, 2017. https://www.canadianpainsociety.ca/guidelines
6. **World Health Organization (WHO).** *WHO Guidelines for the Pharmacological and Radiotherapeutic Management of Cancer Pain in Adults and Adolescents*, 2018. https://www.who.int/publications/i/item/9789241550390
7. **National Institute for Health and Care Excellence (NICE).** *Chronic Pain (Primary and Secondary) in Over 16s: Assessment of All Chronic Pain and Management of Chronic Primary Pain*, NG193. 2021. https://www.nice.org.uk/guidance/ng193
8. **Ethiopian Ministry of Health.** *Essential Medicines List Including Palliative Care Medicines*, 2021.
9. **World Health Organization (WHO).** *Ensuring Balance in National Policies on Controlled Substances: Guidance for Availability and Accessibility of Controlled Medicines*, 2011. https://www.who.int/publications/i/item/9789241564371
10. **Fainsinger RL, et al.** *Palliative Care: Principles and Practice*. Oxford University Press, 2010.