Two Days Regional Workshop on Elderly & Palliative Care for State Nodal Officers (CPHC & NPHCE), Medical Officer, Staff Nurse, Community Health Officers and Auxiliary Nurse Midwives for NE States

27th - 28th August 2025

Organised by

Regional Resource Centre for NE States (RRC-NE)
Branch of National Health System Resource Centre (NHSRC)
Ministry of Health and Family Welfare (MoHFW)
Government of India (GoI)

1. Introduction:

In a significant step towards strengthening Elderly and Palliative care services in Ayushman Arogya Mandirs (AAMs) in North Eastern States, a two-day Regional Workshop on Elderly & Palliative Care for State Nodal Officers, CPHC (Comprehensive Primary Health Care) & NPHCE (National Programme for Health Care of the Elderly), Medical Officer, Staff Nurse, Community Health Officers and Auxiliary Nurse Midwives was organised by Regional Resource Centre for NE States (RRC-NE) from 27th - 28th August 2025 for the eight (08) Northeastern States. A total of 71 participants (including State Nodal Officers and other State level representatives) attended the Workshop.

2. Resource Persons:

The Workshop was facilitated by the following Resource Persons-

SL.	Name	Designation
1	Dr. Vineet Kumar Pathak	Master Trainer, NHSRC.
2	Dr Anuradha Deuri	Prof of Medicine & Nodal Officer, Regional Geriatric Centre Gauhati Medical College & Hospital (GMCH).
3	Dr. Mathews Numpeli	State level Executive Committee Member, Aardram Mission, NHM Kerala.
4	Dr Athul Joseph Manuel	Technical Consultant, Indian Association of Palliative Care, Kerala
5	Dr Mahesh N	Joint Coordinator, Aardram Mission, Kerala.
6	Dr. Anjana S P	Medical Officer, NHM Palliative Care Project, Kerala.
7	Mrs. Sheebamole M V	Staff Nurse, Training Consultant, CRHC, Kerala

3. Objectives:

The Workshop was organised with the following objectives:

3.1	To sensitize Primary Health Centre team across the NE region on the significance and need for Elderly and Palliative Care.
3.2	To equip Primary Healthcare Team with all essential skills as per CPHC guideline for delivering Elderly and Palliative care at AAM- SHC & AAM-PHC including referral & Continuum of Care.
3.3	To strengthen the existing pool of trainers by building their capacity to serve as key resource persons, enabling further training through a cascading model.
3.4	To develop model AAM, staffed with trained personnel, serving as learning hub for quality Elderly and Palliative Care.

4. Background & Methodology:

The Northeastern States of India display good coverage of Elderly and Palliative Care at AAM as of July 2025. The States of Manipur, Mizoram and Tripura are ahead of the remaining States with more than 95% coverage. Nevertheless, as far as Capacity Building in Elderly & Palliative Care is concerned, the range of achievement across cadres vary widely in the region. The State

of Arunachal Pradesh, despite achieving 94% rollout of the Service, completed 19% training of ANM and 55% for SNs. Although the level of coverage of Elderly & Palliative Care Services is high, the State of Manipur is lagging behind in MO training with achievement of 77%, which has high chances of affecting quality of Services, hampering Continuum of Care. Meghalaya has exceled in training of CHO, MO and ANM, but training of SN remains as low as 59%. While training of MO, CHO and ANM has already been completed, yet only 53% of the SN have been trained in Mizoram. Nagaland has much to achieve in overall training component. The State has completed only- 17% (SN), 25% (ANM) training despite achieving 85% of service roll-out. In Sikkim, only 34% of the MOs and 67% of ANMs have been trained, however, the training of the CHOs and SNs have been completed in the State. On the other hand, Assam has completed training of MO, SN and ANM which aligns with the percentage of rolling out of Elderly & Palliative Care i.e. 83%, and the State has completed 87% of training of CHO.

States	Elderly Care roll out	Palliative Care roll out	Training in Elderly & Palliative Care (%)			
			MO	SN	CHO	ANM
Arunachal Pradesh	94%	94%	100	55	100	19
Assam	83%	83%	100	100	87	100
Manipur	95%	95%	77	100	97	97
Meghalaya	97%	95%	98	59	100	92
Mizoram	95%	95%	100	53	100	100
Nagaland	85%	85%	84	17	100	25
Sikkim	95%	95%	34	100	100	67
Tripura	100%	100%	100	100	100	100

Source: AB-AAM Portal, as on 16-07-2025

Nevertheless, a significant gap exists in actual roll-out of Elderly & Palliative Care at the grassroot level across all the Northeastern States despite reporting high coverage as per AAM Portal. Although Facility-Based service is in place, Home-Based Palliative Care is yet to be implemented in most of the States except for few where the CHOs have been proactively rendering Care at the homes. Evidence from a rapid review conducted by RRC-NE in recent time and other supportive supervision visits to the States indicate substantial inconsistency in core components like- a streamlined system of line listing all the beneficiaries under Elderly & Palliative Care under the jurisdiction of the SHC-AAMs, screening, follow-up etc. A key challenge across the States remains to be incomplete capacity building of frontline staff for delivering the Services for Elderly & Palliative Care.

Amidst such grassroot level realities, an opportunity of improvement can be created by establishing a Model AAM in each State which may function as a hub. This Model AAM (PHC& SHC) would be manned by the staff who have completed the training, complete the roll out of Elderly and Palliative Care, complete line listing & screening of all the Elderly and Palliative Beneficiaries in their area as per the guidelines and provide, both facility based as well as home-based palliative care. Strong community participation with the help of community platform such as VHSNC & JAS, outreach activities on regular basis and effective communication activities (IEC-BCC) among the community should also be a vital part of the overall functioning of the Model AAM. With such enabled environment these Health Facilities/Model AAMs can provide learning opportunities for the remaining AAMs.

Selection of Participants:

The participants were selected by state as per the following norms:

a. Two (02) MOs, 02 Staff Nurses from selected two PHC-AAM (01 from each PHC for both cadres) from each State.
b. Two (02) CHOs & Two (02) ANMs from two SHC-AAMs (01 from each) which are linked to the selected PHC-AAMs from each State.
c. Sixteen State Nodal Officers (SNO) -- SNO, CPHC & SNO, NPHCE, from each State.

Agenda:

Agenda was finalized after discussing with the team of Resource Persons on virtual platform.

Method of impartation:

A mixed method was followed in the Workshop which included - PPT presentation, demonstration of skills, Group Work & Group Presentation etc.

5. Day 1:

Inaugural Session:

5.1. Welcome Address:

In her welcome address, Dr. Raj Prabha Moktan Director, RRC-NE greeted all the participants and the Resource Persons and expressed gratitude for being part of the Workshop. Highlighting the demographic transition with substantial increase of Elderly Population in India including the North Eastern region due to increasing Life Expectancy she emphasized the need of a compassionate, comprehensive and community-based care stressing that Elderly and Palliative Care should not be limited to clinical services but also encompass dignity, comfort, and the enhancement of quality of life for individual beneficiaries and their families.

She stated that the social fabric of the Northeastern region which is characterised by strong family ties, and community interdependence have been challenged in the recent times by modernization and rapid urbanization. More so, this transition in the social web shifted the family structure which impacted all age groups, especially the aged population. Such transition has called for a robust system to encompass need of each age group of the society with a holistic approach so that their needs can be fulfilled. She also pointed out that strengthening the Primary Health Care system of the country with a comprehensive and holistic approach for the elderly and palliative care beneficiaries is one of the key strategies in this regard.

Sharing her field experiences across the eight Northeastern States, she said that Elderly and Palliative Care Services have been rolled out at the AAMs, but lacunas have been observed in the field. She pointed out gaps in Capacity Building across various cadres, especially MPW (F) and Staff Nurses highlighting that Home-Based Palliative Care in the NE States is still very limited, and follow-up of beneficiaries is a major gap. Keeping in mind the status of program implementation, she said that the workshop has been designed, to impart knowledge, build

confidence, demonstrate models and create replicable learning-hubs across the Northeastern States.

The Director further encouraged all the participants to interact among themselves, share learnings from each other and from the esteemed team of Resource Persons some of whom have been associated with the Kerala Model of Palliative Care, widely recognized as one of the most successful Palliative Care approaches in India.

She concluded the welcome address by stating that the workshop will not only sensitize the team of Primary Health Centre- Ayushman Arogya Mandir (PHC-AAM) and Sub-Health Centre Ayushman Arogya Mandir (SHC-AAM) but will also help building Model AAM that can serve as learning-hubs for other AAMs in the NE states.

5.2. Keynote Address:

Dr. G. B. Singh, Advisor, CP-CPHC (Community Processes–Comprehensive Primary Health Care), NHSRC joined the inaugural session of the Regional Workshop on Elderly and Palliative Care through a virtual platform. In his keynote address, Dr. Singh emphasized the growing importance of Elderly and Palliative Care in the context of India's epidemiological transition and evolving disease patterns. He highlighted that the increasing burden of Non-Communicable Diseases (NCDs), including among the younger population, has compelled the health care system to shift from opportunistic care to universal, holistic services that address both prevention and long-term care needs.

Dr. Singh emphasized that strengthening the capacity of the Primary Health Care team is central to delivering Comprehensive Primary Health Care effectively, particularly for the elderly population. He described the Regional Workshop on Elderly and Palliative Care as a milestone initiative — paving the way for a renewed focus on building skills and systems to respond to emerging health needs.

Concluding his address, Dr. Singh expressed hope that the knowledge and skills gained during the workshop would be translated into meaningful action, especially in remote and underserved areas. He urged participants to approach their work with empathy and compassion, ensuring that the dignity and quality of life of the elderly population remain at the heart of service delivery at the grassroots level.

5.3. Address by Executive Director, NHSRC:

Maj Gen (Prof) Atul Kotwal SM, VSM, Executive Director, NHSRC, in his address delivered through the virtual platform, highlighted the importance of Elderly and Palliative Care, citing that nearly 20% of India's population comprises elderly individuals. He emphasized that the care needs of all elderly persons are not uniform and require tailored approaches. Speaking about Palliative Care, he clarified that it is not confined to cancer care, contrary to the common perception. He further underscored the importance of pain relief, noting that trauma is widespread and that agricultural and industrial accidents occur frequently.

Drawing the attention of all participants, he emphasized that the true outcome of any capacity-building programme lies in improving the quality of services delivered to the community and in building a strong rapport with them. He also mentioned the Revised Daily Routine of ANMs,

wherein ASHAs would play an extended role beyond their existing HBNC and HBYC activities and highlighted the supervisory responsibilities to be undertaken by the Medical Officers (MOs). Appreciating the dedication and hard work of the Primary Health Care teams, he acknowledged their significant contribution towards the effective implementation of the expanded range of services and the increased footfall at Ayushman Arogya Mandirs (AAMs).

He urged all participants to actively engage in the workshop, ask questions, share learnings, and offer inputs or suggestions for possible modifications to the existing guidelines. Concluding his address, he recognized the crucial role of RRC-NE in supporting the States for the smooth implementation of National Health Programmes and fostering a cohort of learning and collaboration.

The inaugural session concluded with vote of thanks by Mr. Amit Raj Roy, Consultant, CP-CPHC, RRC-NE.

6. Technical Sessions:

6.1. Background – the Indian Context:

The first technical session was led by Dr. Vineet Pathak, who presented the two-pronged strategy adopted by the Government of India to address public health challenges — a 'disease-based system' and a 'beneficiary-based system', with Elderly Care falling under the latter. Dr. Pathak emphasized that individuals in need of Elderly and Palliative Care are often in vulnerable situations. He explained that in Palliative Care, the ultimate endpoint is death, and therefore the primary aim should be to ease the journey toward the end of life. In contrast, Elderly Care often faces the challenge of an absent or unrecognized need — both from the beneficiaries themselves and, at times, their family members. He stressed the importance of recognising that each elderly person is unique, and not every health complaint should be regarded as a natural part of ageing. Instead, elderly individuals, along with their families, should be empowered with the capacity to make healthy and informed decisions. Such empowerment enables choices that uphold dignity and significantly improve quality of life.

The Resource Person then highlighted the data on Life Expectancy of India, which has gone through a big span of changes from 37 years before Independence to 70 years at present, resulting an increased elderly population in the country.

Projected population of Elderly in India							**Morbidity status among older people**			
Age Groups	**2001**	**2011**	**2021**	**2031**	**2041**	**2051**	**Morbidity status**	**No. in crore**	**Proportion**	**Care required**
60 + (crores)	7.7	9.6	13.3	17.9	23.6	30.1	No Disease	2.47	24.32	Preventive & Promotive
70 + (crores)	2.9	3.6	5.1	7.3	9.8	13.2	With 01 Disease	5.44	53.63	Promotive & Assistive
80 + (crores)	0.8	1.1	1.1	1.6	2.3	3.2	With 02 Diseases	2.12	20.83	Curative & Rehabilitative
							With 03 Diseases	0.310	3.01	Long-term care (home based care/critical care
Source: Registrar General of India							**Source: NSSO-MoSPI**			

As evident from the above table, number of elderly population has been increasing in India and by 2051, it is likely that elderly population aged 80+ will reach up to 3.2 crores. Those who are 60+, will reach a staggering number of 30.1 crore of the total population. Morbidity status among older people also significant, as 2.47 crore of elderlies without any disease needs preventive and promotive care and 0.31 crore older people with diseases, need long term care.

The Resource Person also outlined several programs initiated by the Ministry of Health and Family Welfare (MoHFW) for elderly care, summarizing the key features of these initiatives are as follows:

6.2. National Programme for Healthcare of the Elderly (NPHCE):

The Ministry of Health and Family Welfare (MoHFW) launched the National Programme for Healthcare of Elderly (NPHCE) during 2010-2011, in compliance with National Policy for Elderly Persons (NPOP) 1999. This initiative reflects the growing recognition of the need for a structured and comprehensive approach to elderly care in India.

The programme offers a well-defined package of services across different levels of the health system. At the **Sub-Health Centre (SHC)** level, it focuses on health education covering healthy aging, environmental modifications, nutritional needs, lifestyle changes, and behavioural adjustments, while paying special attention to home bound or bedridden elderly and training family healthcare providers to care for them. At the **Primary Health Centre (PHC)** level, weekly Geriatric Clinics are conducted by trained Medical Officers to carry out health assessments and basic investigations such as blood sugar testing. At the **Community Health Centre (CHC)** level, bi-weekly Geriatric Clinics and rehabilitation services are arranged by trained staff and rehabilitation workers, including domiciliary visits and counselling for family members. At the **District Hospital (DH)** level, dedicated Geriatric OPD services, a 10-bedded Geriatric ward, laboratory investigations, and rehabilitation services are provided. These services address the needs of elderly patients referred from PHCs and CHCs, while severe cases are referred to tertiary-level hospitals. Together, these measures represent a structured, multi-level strategy to ensure dignity, comfort, and quality of life for India's growing elderly population.

6.3. National Programme on Palliative Care (NPCC):

Providing the historical background of Palliative Care, Dr. Vineet explained that in earlier days, care for patients was rendered in their homes. Then came a period when old and dying people were cared for in 'hospices. The modern-day Palliative Care was started by Dame Cicely Saunders in the United Kingdom (UK). In India, at the initial stage, Palliative Care had been extended mostly by the Non-Governmental Organisations. The National Programme on Palliative Care (NPCC) was launched in the year 2012. In the subsequent period, Palliative Care has been recognised as an expanded package of service of Comprehensive Primary Health Care (CPHC) in the National Health Policy, 2017.

Dr. Vineet emphasised that it is important to identify the people who need Palliative Care, the kind of service required to be provided. He also stressed on knowing case burden of the respective jurisdiction before implementing the programme and providing the service.

Total Health: The focus should be on 'total health' which includes - physical, spiritual, social and emotional aspects. A person suffering and needing care can come under either of these elements. While managing pain, total health is to be kept under consideration. Comprehensive Primary Healthcare, as iterated before, is possible only with total health.

Service Provision under NPPC includes (source- Operational Guidelines NPPC)-

- ❖ Basic palliative care services through OPD and IPD services at District Hospital by qualified/trained palliative care professionals.
- ❖ Provision of out-reach services at CHC/PHC by Palliative Care team at fixed interval for providing palliative care to the patients admitted at CHC/PHC.

Components of Palliative Care	Basic Principles of Palliative Care
❖ Palliative care affirms life. ❖ Palliative care allays suffering. ❖ Palliative care promotes quality of life ❖ Palliative care supports the family	❖ Control Symptoms ❖ Companionship ❖ Respect ❖ Dignity ❖ Convey "*I care for you*"

The principles of palliative care need to be applied starting from the time of diagnosis in chronic ailments. This supportive care is required to be incorporated into disease specific treatment program. With time, as the disease progresses and the curative treatment decreases, the role of palliative care becomes even more crucial. (source- Operational Guidelines NPPC)

Further he added that in Palliative Care, soft skills have a very important role to play. The family environment is emotionally charged, and to communicate in such atmosphere is a skill. Palliative care is peculiar in a way that its end is death. It is a 24 *7 Care and can also be rendered by volunteers, if trained well, as it is not possible for CHO or Nurse to provide Care all the time.

6.4. Elderly & Palliative Care in Kerala and alignment with CPHC:

Followed by the brief introduction of Elderly & Palliative Care in India, Dr. Mathews Numpeli explained the Palliative Care Programme of Kerala which is more aligned with the CPHC Programme and NPHCE implemented by the Government of India. He also clarified the pillars of Comprehensive Primary Health Care (CPHC) and their integration with Elderly and Palliative Care, as illustrated in the table below:

Pillars of CPHC	Integration with Elderly and Palliative Care
Promotive Care	Change in lifestyle and diet and exercise patterns.
Preventive Measure	Vaccination, other preventive measures.
Early Diagnosis	NCD.
Curative Services	Starting medicines for HTN, DM etc.
Rehabilitative Support	To ensure physical, social and emotional support and rehabilitation.
Palliative Care	To ensure maximum quality of life by giving social and emotional support and controlling symptoms.

Discussing the pillars of Comprehensive Primary Health Care (CPHC) and their integration with Elderly and Palliative Care, Dr. Mathews emphasized that it is the responsibility of the Primary Health Care Team to ensure the provision of all these services. He further noted that the team must have a clear understanding of the current situation within the community, as well as the capacity to bring about positive change. While in many cases Palliative Care is provided by community members themselves, Dr. Mathews stressed the importance of the CPHC team being aware of how such care is delivered, which can be achieved through regular home visits. He highlighted that ensuring a continuum of care — by linking and integrating community-level care with programmes for Elderly and Geriatric Care, along with conducting comprehensive assessments and providing integrated support — is key to effective service delivery. He mentioned that in Kerala, Elderly Care has been divided into four groups for easy management and implementation which are as follows:

Elderly Care group	Definition
Bedridden/Bedbound	Needs support of another person/device to get up from bed due to any chronic condition.
Homebound	Needs support of another person to go out of house due to any chronic conditions. These patients may later become bed bound.
Elderly with chronic diseases	They are not bedbound, or home bound but have chronic diseases.
Active elderly	They are not bedbound, homebound or have any chronic diseases, but are active.

The type of care for elderly groups varies, with bedbound individuals requiring comprehensive promotive, preventive, curative, rehabilitative, and palliative support, while active elderly need selective care focused on ensuring healthy ageing, highlighting the necessity of an integrated approach, he added.

Keys for Effective Geriatric Care	Key for Home-based Care
❖ Home-based Care ❖ Patient and Family empowerment ❖ Community Engagement ❖ Facilitating Primary healthcare system with skills and knowledge ❖ Access to special services ❖ Ensuring continuum of care	❖ A doctor or a CHO cannot access Home-based Care without conducting Home Visits. ❖ Every hospital should promote Home-based Care, even if patient is admitted at hospital. ❖ Family can be taught about Home-based Care to provide support at home. ❖ Home-based Care does not indicate the need of visiting to patient at home all the time. It is also about developing a mechanism to provide support.

Speaking on facilitating the Primary Healthcare System with skills and knowledge Dr. Matthews highlighted the followings:

- ❖ Capacity Building of Service providers for Geriatric and Palliative Care before rendering services and imparting knowledge to the community and the families.
- ❖ Most of the work in Palliative and Elderly Care is to be done by the community which is facilitated by the Primary Health Care team with good access to specialist services.

6.5. Healthy Ageing: Common diseases of the Elderly and Management and Palliative Care in North-Eastern States:

At the beginning of her session, Dr. Anuradha Deuri stated that ageing is not a disease; however, the elderly population is more susceptible to various illnesses due to a decreased immune response and reduced regenerative capacity. She emphasized that Healthy Ageing is the process of developing and maintaining the functional ability that enables well-being in older age. Dr. Deuri also highlighted that the country is experiencing a major demographic transition marked by a rapid increase in the elderly population. The elderly population in India is growing three times faster than the overall population. The proportion of people aged 60 years and above has risen significantly over time—from 5.4% in 1950 to 9% in 2016, and it is projected to reach 19% by 2050, reflecting a substantial demographic shift towards an ageing society. In her presentation she also mentioned about Geriatric Syndromes and Giants, which are as follows:

Geriatric Syndromes	Geriatric Giants
Dizziness, sleep problems, constipation, incontinence and signs like sarcopenia and delirium or events such as abuse and falls that occur more commonly in geriatric age groups are known as geriatric syndromes	Geriatric giants refer to the **04 (four) I's**: 1. Impairment of Intellect: Cognitive impairment, delirium and depression 2. Immobility 3. Instability 4. Incontinence Newer geriatric giants are frailty, sarcopenia, anorexia of ageing, elder abuse and nutrition issues in older adults.

Briefing on dementia (a clinical syndrome involving sustained loss of cognitive function & memory of sufficient severity to cause dysfunction of daily living) and its management, Dr. Deuri highlighted the symptoms which include- cognitive disturbances, impairment of occupational and social functioning and decline from previous level of functioning. She added that Detection and treatment of Behavioral and Psychological Symptoms of Dementia (BPSD) is important. Some BPSD are- agitation, wandering, depression, repeated stories and statements, psychosis, hoarding, screaming, aggression and hypersexuality.

Intrinsic Risk factors	Extrinsic Risk factors
❖ Advanced age ❖ Previous falls ❖ Muscle weakness ❖ Gait and balance problem ❖ Poor vision ❖ Postural hypertension ❖ Chronic conditions: arthritis, stroke, incontinence, diabetes, parkinsonism ❖ Fear of falling	❖ Lack of stair handles ❖ Poor stair design ❖ Lack of bathroom grab bars ❖ Dim lighting and glare ❖ Obstacles and tripping hazards ❖ Slippery/ uneven surfaces ❖ Psychoactive medications ❖ Improper use of assistive device

In conclusion, Dr. Anuradha said that ageing is associated with diverse disorders and the prevalence of diseases across various organ systems increases with ageing. Understanding

epidemiology, pathogenesis, presentation and course of multiple diseases in older adults is essential for identifying potentially reversible conditions and enhancing anti-ageing research.

6.6. Assessment tools for Geriatric Care in the Community:

Identification of Need for Care in the Community: Comprehensive Geriatric Assessment (CGA):

Dr. Vineet began his session by emphasizing the importance of assessing elderly individuals who visit health facilities. He pointed out that at the Sub-Health Centre–Ayushman Arogya Mandir (SHC-AAM) level, the primary aim of such assessments is not to make a complete diagnosis, but rather to identify potential health issues that may require further attention. He further mentioned that the benchmark age for categorizing an individual as elderly in India, as well as in several South Asian countries, is 60 years and above. Dr. Vineet then explained the concept of Comprehensive Geriatric Assessment (CGA), a multidimensional and often interdisciplinary process designed to evaluate an older person's medical, psychological, and functional status. The CGA helps in identifying the problems and capabilities of frail older adults, thereby facilitating the development of an overall treatment and long-term follow-up plan. He also mentioned the process of filling up CGA (overview of components of CPHC-CGA attached in Annexure III), which are as follows:

- ASHA identifies any elderly in need of further assessment, if answer to any of the (02) questions in Part B 3 of CBAC is 'Yes', she informs the MPW (M/F).
- MPW (M/F) conducts section 1 & 2, CGA and CHO conducts section 3 & 4, CGA.
- MO conducts section 5 of Comprehensive Geriatric Assessment of CPHC detailed assessment of the referred elderly individuals using CGA tool if the individual has greater than 3 red flags.
- If the individual visits the PHC directly, Staff Nurse conducts Facility-Based CGA and refers him/her to the MO.

6.7. Group Activity: On Elderly/ Geriatric Care:

The resource persons divided the participants into eight (08) groups for a group activity. Each group was given a case scenario and asked to identify the Scale of Assessment (as mentioned in Module on Elderly Care) applicable to the concerned case scenario. During the group work, Dr. Vineet emphasized on the followings:

- Even a negative score in the Assessment Tool provides significant learning to the Service Provider.
- Any Health Facility claiming to have implemented "Elderly Care" must administer CGA.
- CGA is not to be administered for every person, not every time. It is to be done annually.
- None of the Assessment Tools are 'Conformity Scale'. These are only 'screening' tools.

The group activity was presented by the eight (08) groups. The case scenarios used in the session are attached at Annexure IV.

6.8. Caring: Assessment & Care giving:

Dr. Atul deliberated his session by emphasizing that in Palliative Care, ensuring Continuum of Care is crucial and equally important is empowering patients and their families so that proper care is enabled in their homes beyond the walls of the health facility. He also mentioned that the only way to identify suffering is spending time with the person concerned, wherein communication and role of the family & the community becomes pertinent. The Resource Person emphasized that since patients may not always express their suffering to the health team, the family's role becomes crucial, and with empathy, skilled history-taking, and an understanding of home-based care, the AAM team should collaboratively develop a comprehensive Care Plan involving the patient, family, community, and the health team.

Following the discussions, the Kerala Team facilitated a practical session on 'Head to Foot Care,' emphasizing comprehensive care for bedbound patients through daily hygiene, skin, oral, perineal, hair and nail care, along with regular turning, passive range of motion exercises, and back care to maintain circulation, prevent pressure ulcers, and avoid musculoskeletal complications. The flow of practical skills discussed during the session is included at Annexure V.

Before concluding day one (01) of the Workshop, the participants were provided with eight (08) case scenarios (01 for each State) for Homework. Dr. Vineet explained the group activity and instructed to apply the CGA scale and give further solutions to the concerned cases.

7. Day Two :

Day two (02) started with presentation of group activity for Geriatric Care by each State. Some key takeaways from the care plans included the use of Geriatric Scales in suspected adult abuse cases, Fall Assessments for frail patients, addressing financial concerns through appropriate counselling, monitoring urinary output and fluid intake in cases of incontinence, and providing emotional support to family caregivers. Additionally, Resource Person emphasized the following to conclude the group work:

- For suspected cases of adult abuse, create social groups of elderly in the concerned area. Such social networks reduce chances of abuse as accountability of near and dear ones increase in these cases.
- Try to avoid complaining to police in abuse cases immediately. The suitable route of complain should be:

CHO ⟶ loop in ⟶ MO ⟶ if needed, loop in ⟶ Police

- Significant weight loss might be caused by depression (if a person loses 10% weight in less than 3 months without any intention to lose weight through either dieting or exercises).

7.1. Care Plan Preparation (Group Activity): Palliative Care

Following the first session, the Resource Person divided the participants into six groups to prepare a holistic and patient-centred care plan for bedridden patients, assigning the following topics: (1) Symptom Management, (2) Medication Advice, (3) Non-Pharmacological Care, (4) Psycho-Social and Caregiver Support, (5) Communication with Patient and Family, and (6) Follow-Up Plan. During the presentations by groups, the resource person added few key pointers for caring for bedridden patients which includes preventing bedsores, maintaining personal hygiene, understanding and empathizing with patients' needs and requests, ensuring comfort with special attention to the back, keeping bed linen clean and fresh, providing skin care, and promoting exercise to prevent physical deformities.

7.2. Service Delivery Plan: Key highlights

After the conclusion of the group activity with the group presentation, the service delivery plan of Primary Health Care Team was explained by Dr Mathew. The Service Delivery Plan includes care at- Community level, SHC-AAM level, PHC-AAM level and Secondary/ Tertiary level. The key highlights were as follows:

- **ASHA (at community level):** Maintain updated line list of bed bound and homebound elderlies. Empower patient & family during home visits. Report any issues requiring medical and nursing care to AAM or PHC. Mobilise psychosocial support through linkage with other stakeholders. Ensure continuum of care at the home as per the need of the patient.
- **AAM Team (at SHC-AAM level):** Visit bedbound & home bound elderly and provide home-based care. Train the patient and care givers. Maintain homecare kit with medicines/equipment for providing homebased care. Conduct tele-consultation and awareness/training programme for the community.
- **PHC Team (at PHC-AAM level):** Ensure regular supply of medicines and consumables as per report of caregiver. Ensure the AAM team has necessary support system, to provide home-based care. Conduct regular meeting to review home-based care activities and address gaps.
- **Secondary/Tertiary Care Facility:** Ensuring continuum of care at the hospital, at higher level centre like District Hospital / Medical College as per the need of the patient.

7.3. Presentation on Special Digital initiative for Palliative Care in Kerala:

Digital Approach to Palliative Care: The State has converted CBAC into an App (a free App) called 'Shaili'. Through this App data on homebound and bedridden patient is captured, the SHC-AAM and PHC-AAM team conduct line listing of people requiring Palliative Care. The State has also collaborated with NGOs and Civil Society Organisations to facilitate Palliative Care and ensure Continuum of Care.

Palliative Care Grid & CARE Software: Recognised by the United Nations, this software shows real time data of those who all are registered in the platform called CARE. Registration is done by Nurses. Information is available on the total number of Human Resources involved in providing care. The CARE app can be logged in both by the Service Provider and Patient. Provision of AI audio filling of EMR (Electronic Medical Record) sheet is also available which is utilized by Service Providers like ASHA, ANM during screening of beneficiaries at the outreach. Only Medical Data captured by AI during voice command by Service Providers at the outreach. The platform is also utilised to fix appointment as patients can also access the Software and schedule for services either at Health Facility or at Home.

7.4. Present Scenario and Roadmap for Elderly and Palliative Care in the North-Eastern States:

Moderated by RRC-NE Team:

After all the technical sessions, the State Nodal Officers (SNO), Elderly & Palliative Care presented on the current scenario and future prospects for their respective States. A few key highlights are as follows:

7.4.1. **Arunachal Pradesh:** NPHCE was launched earlier in the State, however, it has been functional only since June 2024. Line listing of beneficiaries under Elderly and Palliative Care is not yet completed. Intersectoral coordination between Social Welfare department, Ayush Department, NGOs and Disability Services to integrate clinical care, rehabilitation and social assistance for the elderly and palliative patients exists in the State, an example of which is 'Ayang' in the East Siang district. However, challenges like irregular screenings, poor referral mechanism, limited physiotherapy and pain management services have hampered smooth implementation of the program in the State.

The State was requested to accelerate the process of line listing and screening of beneficiaries under Elderly and Palliative Care so that the beneficiaries receive the appropriate service.

7.4.2. **Manipur:** "Elderly Assistance Volunteer" training by IGNOU has been started in 2025 in the State. The State presented a well-designed flow chart of implementation of elderly and palliative care in both urban and rural areas. All CHOs have received a four-day foundation training on palliative care. The State has also implemented 'Geriatric Care Assistance Programme', a 6-Month Certification Course for interested volunteers. The State has been partnering with local CBOs, volunteers and women organisations.

7.4.3. **Meghalaya:** State has scheduled for joint field visits by SHSRC and CPHC team from September onwards to facilitate the districts in designing continuum of care pathway for elderly and palliative care. She also stated that many elderly

people in the urban areas lived alone as their children were abroad and that they would be needing service.

The State reported of a lack of integration which is required to ensure continuum of care. No dedicated space for elderly and palliative care available at the health facilities in the State. Palliative Care is being provided at District Hospital, Shillong. State has requested the MoHFW, GoI for approving three (03) new Centres to provide palliative care in Hub-and-Spoke Model. Morphine license for the State is awaited.

7.4.4. **Mizoram:** The State has completed Refresher Course in Elderly Care for HWOs (Health & Wellness Officer). With support from NPHCE Programme Division, the State could include of physiotherapy courses in the training. The State admitted that focus on the urban areas for screening of elderly and palliative care has not yet achieved as much as it should have been.

The state was informed that community demand for home visits is more in Mizoram as observed from field visits and needs urgent attention by the AAM team.

7.4.5. **Nagaland:** No specific training for Geriatric Care has been provided till now in the State. A brief session of 45 mins to 1 hour was included during the Induction Training. Elderly and Palliative Care is only being provided by the CHOs and the ASHAs at the SHC-AAM and Community level respectively without any involvement of PHCs and District Hospital. Dedicated NCD Clinics are to be strengthened in the health facilities and the PHCs have been instructed for initiating the same. The State emphasised on posting more Physiotherapists in future as only two CHCs in the entire State have Physiotherapists.

7.4.6. **Sikkim:** Home visits by the primary health care teams are being done in the State with the help of Anganwadi Workers and Panchayat members. Hilly terrain and hard-to-reach areas hinder in rendering the services. Poor network connectivity hampers teleconsultation and data maintenance. The State has only one (01) Geriatric Specialist. Focus has been made on making ABHA accounts and ABHA IDs for smoother referral. The State expressed their hope to strengthen the existing services in the future and include Geriatric Care in the Medical Courses.

7.4.7. **Tripura:** The State has made provision of fixed day for Elderly and Palliative Care from SHC up to DH level. However, capacity building is not yet completed. State has issue of shortage of Physiotherapy services and limited fund.

The state was advised to complete the training of Primary Health Care Team as per the guidelines on priority basis.

In response to the issue of translation of Module in local language, the Bengali Module from the State of West Bengal would be shared to them.

The state was also asked to ensure better integration of NPHCE with CPHC, which is lacking as observed during field visits.

8. Concluding Remarks from Director, RRC-NE:

In the beginning of her concluding remarks, Director, RRC-NE expressed gratitude to the Resource Persons, as well as the SNOs and participants for attending the Workshop. She emphasized on applying the learnings of the Workshop in the grassroots to the best possible extent with the goal of delivering quality Elderly and Palliative Care. Acknowledging the challenges of providing optimal care in the difficult geographical terrains of the North-Eastern region, she urged the participants to pay special attention to rural and hard to reach areas. She highlighted the need to adapt care and work-plan to the local conditions and domestic architectural realities. Noting that many elderly individuals live alone while their children work abroad, she recommended identifying such individuals and preparing a line list for targeted support. The Director also emphasised on the need for States to develop Action Plan that include Comprehensive Primary Health Care for the Elderly and Palliative Care in the urban areas.

She emphasised on the community participation as one of the strengths of the social system in the northeastern States and that it could be optimally utilized for leveraging health services. Emphasizing on strengthening Elderly and Palliative Care at the primary care level, she advocated for integrating various National Programmes and promoting teamwork through convergence. Additionally, she also called for a focus on screening for Hypertension and Diabetes Mellitus. She concluded her address by wishing everyone success in their future efforts.

The Workshop concluded with vote of thanks offered by Mr. Amit Raj Roy, Consultant, CP-CPHC, RRC-NE.

****

Photo Gallery

Practice session

Technical Session

Group Presentation

Address by ED, NHSRC on virtual platform

Group Work

Technical Session

Annexure I

Sl.	Name of the Participants	Designation	Contact No	Email id
Arunachal Pradesh				
8	Dr. Appir Apang	SNO, CPHC	9436050945	appirapang@gmail.com
9	Dr. Bomto Riram	Epidemiologist NP-NCD cum ASNO - NPHCE	9599929423	lowangd@ymail.com/ dr.bomtoriram@gmail.com
11	Dr. Kago Bharat Ambing	MO	9163161200	kagoambing2@gmail.com
12	Tui Patuk	Health & Wellness Officer	9402271736	tuipatuk25@gmail.com
13	Kamem Pertin	Health & Wellness Officer	9402633621	pertinkamem13@gmail.com
14	Yamoti Tabi	Nursing Officer	7629828460	
15	Anshy Hage	Nursing Officer	9862506652	anshyhage26@gmail.com
16	Chajut Bosai	ANM	9612509017	chajut07@gmail.com
17	Sujana Mannow	ANM	8731835411	sujanamannow@gmail.com
Assam				
18	Dr Amiya Kumar	SNO Teleconsultation & NPHCE, Sarathi 104	8638213792	sampark.teleconsultation.assam @gmail .com
19	Dr Siddhartha Nath	M & HO -I	9854682425	iamsid42@gmail.com
	Dr. Naren Burung	Medical Officer	8486286051	narenburung77@gmail.com
20	Pinki Das	CHO	8753994219	
21	Rosena Begum	ANM	8472976881	rosena1286@gmail.com
22	Jharna Newar	Staff Nurse	9366005062	jharna.newar@gmail.com
23	Rimpy Dutta	Staff Nurse	7896508164	
24	Madan Kumar Biswas	CHO	9864882137	madankumarbiswas8@gmail.com
25	Nazma Begum	ANM	9854649120	nazmabegum96454@gmail.com
Manipur				
26	Dr. Rajkumari Rosie	SNO CPHC	8837406717	rkrosie.msccs@gmail.com
27	Dr. L.Tilakeswari Devi	SNO, NPPC & NPHCE	8014774741	tilakeswari2021@gmail.com
28	Dr. T. Jayananda Singh	Sr. MO	8414873235	jayanandasingh6@gmail.com
29	Dr. Heisnam Lily Devi	MO	7627974395	lily.heisnam@gmail.com
30	Thoidingjam Sumatibala Devi	Staff Nurse	9774945108	sumatibalamutum@gmail.com
31	Senjam Ranjana Devi	Staff Nurse	9089822891	senjanranjana22@gmail.com
32	Oinam Memmi Devi	CHO	9402697853	omemni10@gmail.com
33	Takhellambam Helena Devi	CHO	7005429166	helenatakhellambam@gmail.com
34	Ngangom Ranitombi Chanu	ANM	9856128848	sranitombi@gmail.com
35	Laishram Binapani Devi	ANM	873081182	oinamsuresh@gmail.com
Mizoram				
36	Dr Catherine Lalmuanawmi	SNO NPHCE	9436352497/8923 25258	drcatherine9@gmail.com
37	Dr Cindy Lalngaihawmi	Medical Officer	8798561245	clhauhnar@gmail.com
38	Dr. Michelle Lalrinsiami	Medical Officer	8974287935	michellelalrinsiani2021@gmail.com
39	Dr Nunsangzela Khupchawng	State Consultant,CPHC	8444857971	nunsangk@gmail.com
40	Dr Vanlalhmangaihzuali	DPO,NP-NCD cum NPHCE	9612512776	zbkhenglawt123@gmail.com
41	R. Lalremthangi	Nursing Officer	8366106067	lalremthangiralte23@gmail.com
42	Lalchamliani Sailo	Nursing Officer	8787479723	chamisailo55@gmail.com
43	Sairengpuii Sailo	Health Worker	8575905840	sairengisailo9@gmail.com
44	Noel Lalruatpuii	HWO	8259070265	noelruatpuii@gmail.com

45	Vanlalhmingchhuangi	Health & Wellness Officer	7627907569	hmingijuly30@gmail.com
46	C. Lalrinkimi	Health Worker	9612738479	kinteicc85@gmail.com
Meghalaya				
47	Dr. Carolinda. Iangrai	Jt. DHS, SNO CPHC/NCD	9436103037	caroliangrai@gmail.com/ npcdcsmeghalaya@gmail.com
48	Mainderson Sutnga	Medical & Health Officer	9562982507	mainderson11@gmail.com
49	Dr. Yasmin K Sangma	Medical & Health Officer	8731095100	yasminkongkar@gmail.com
50	Nosimchi D Arengh	CHO/MLHP	8787893898	nosimchidarengh@gmail.com
51	Smt. Dona Lewish A. Sangma	ANM	9863574302	agitkdonalewish@gmail.com
52	Munry M. Sangma	Staff Nurse	986263517/ 8787785873	munrysangma8@gmail.com
53	Smt. Prestilin Nongbri	Staff Nurse	8731981747	presstynongbri@gmail.com
54	Smt. Marwanka Myrchiang	ANM	9615167898	marwankamyrehiang415@gmail.com
55	Larihunaka Majaw	MLHP	8794251469	larihunakamajaw@gmail.com
Nagaland				
56	Alemwabang Aier	Jt. Director-SPO, NP-NCD/ NPHCE	8794736163	npcdcsnagaland@gmail.com
57	Kukehieto Tase	Consultant HWC	9612331293	nagalandhwc@gmail.com
58	Dr. Thangmang Thomsong	Medical Officer	9366089501	bpmuathibung@gmail.com
59	Dr. Atoli Sumi	Medical Officer	8787515819	ato7kiho@gmail.com
60	Anei Singsong	ANM	8729924590	bpmuathibung@gmail.com
61	Kimhoichong	CHO	9863446796	bpmuathibung@gmail.com/ kimhoichong1@gmail.com
62	Nengpi Khongsai	ANM	8794869080	bpmuathibung@gmail.com/ nengpikhongsai09@gmail.com
63	Kikali Sharon Awomi	CHO	6009014959	sharonawomi123@gmail.com
64	Akha Dane Poa	ANM	9366769396	dpmudimapur.nhm@gmail.com/ jacidane720@123Gmail.com
Sikkim				
65	Dr. Maya Silal	Director , Health Service	9832321067	mayasilal2015@gmail.com
66	Dr. Namita H. Subba	ADHS cum SNO CP-CPHC	8900084134	cpsikkim@gmail.com
67	Dr. Tshering Dikee Lepcha	Medical Officer	7384568384	tsheringrhyes@gmail.com
68	Dr. Eden Bhutia	Medical Officer, PHC Pakyong	8919492023	bhutiaeden20@gmail.com
69	Dawmit Lepcha	CHO	7679430399	lucksomdawmit@gmail.com
70	Dipika Subba	CHO	9593986808	dipikasubba759@gmail.com
71	Sonamit Lepcha	Staff Nurse	8250160680	sonamitlepcha011@gmail.com
72	Lingzimit Lepcha	ANM	7407182391	lingzimitlepcha@gmail.com
73	Ms. Megha Gurung	Staff Nurse	7866801220	gurungmeghna70@gmail.com
74	Sushma Bhandari	ANM	7908310091	sushmabhandari14@gmail.com
Tripura				
75	Dr.Bhaskar Roy Biswas	Medical Officer	9862033130	dr.bhaskarroybiswas@gmail.com
76	Dr.Nilanjan Debbarma	Medical Officer	9612075546	nilanjandebberma@gmail.com
78	Kaberi Singha	CHO	9612084228	kaberisc1991@gmail.com
79	Dalia Sharma	CHO	6909319654	daliasharma8@gmail.com

Annexure II

Agenda			
Time		**Session**	**Speaker / Moderator**
Day 1			
8:30 - 9:00	30 minutes	Registration	RRC-NE
9:00 – 9:45	45 minutes	Inauguration: Welcome Address by Director, RRC NE	Dr. Raj Prabha Moktan
		Keynote Address by Advisor, CP CPHC, NHSRC	Dr. Gurinder Bir Singh
		Special address by Executive Director, NHSRC	Maj Gen (Prof) Dr. Atul Kotwal, SM, VSM
		Vote of Thanks	Mr. Amit Raj Roy
9:45-10:15	30 minutes	**Tea break and group photograph** Knowing the participants	
10:15-10:25	10 minutes	Overview of 2-day training program	RRC NE
10:25-11:25	60 minutes	Introduction to Elderly and Palliative Care with respect to National Programs for Palliative and Elderly care including Community Based Care.	Dr. Mathew and Dr Vineet
11:25-12:25	60 minutes	Healthy Aging, Common illness/ailments and management in elderly and palliative care in NE States.	Dr Anuradha Deuri, Prof of Medicine, Nodal officer, Regional Geriatric Centre.
12:25-1:25	60 minutes	Identification of need for care in the community. Comprehensive Geriatric Assessment using formats- Group Work.	NHM, Kerala and Dr Vineet
1:25 – 2:10	45 minutes	**Lunch break**	
2:10 - 3:10	60 minutes	Assessment and Management of Pain.	NHM Kerala & Dr Vineet
3:10 - 5:10	120 minutes	Nursing Skills- Elderly and Palliative Care Skill Stations	NHM Kerala.
		Tea break	
5:10- 5:30	20 minutes	Group Work- Present Scenario and Roadmap for Strengthening Elderly & Palliative Care including Convergence & linkages with Tertiary Care	To be assigned by RRC-NE
Day 2			
9:00-9:30	30 minutes	Recap	
9:30-11:00	90 minutes	• Care of Bedridden Patient (Case Study Presentations) • Pharmacology for Nurses • Palliative Care in HIV/AIDS • End of Life Care-Care of Dying	NHM Kerala and Dr Vineet
11. 00-11.15	15 minutes	**Tea break**	
11:15-12.45	90 minutes	• Communication & Counselling with beneficiary and family • Home Care / Role of care givers • Psychosocial and Spiritual Support • Community Participation and awareness.	NHM Kerala
12.45-1.15	30 minutes	Role of Stakeholders in Palliative, Elderly care.	NHM Kerala
1.15– 2.00	45 minutes	**Lunch break**	
2:00 -3:00	60 minutes	Service delivery framework and Roles/ responsibilities of primary health care team	Group Work (MO, SN, CHO & ANM)
3.00 - 4.20	80 minutes	**Presentation by State Nodal Officer (EPC):** Present Scenario and Roadmap for Strengthening EPS including Convergence & linkages with Tertiary Care (10 minutes each)	Panelists: Director RRC NE and Resource Persons
4:20 – 4:40	20 minutes	**Post-Test – link will be shared.**	
4:40- 5:30	50 minutes	Way forward-Model AAM for Elderly & Palliative Care	RRC NE & Resource Persons

Annexure III

Overview of Components of CPHC-CGA		
Section	**Contents under each section**	**Person responsible for each section**
Section 1: Basic Details	A. Registration details B. Identification data of elderly person	MPW (M/F)
Section 2: History Taking	A. Chief Complaints B. Details of Complaints C. Past medical history D. Drug history E. Consumption of addictive substance F. Nutritional History G. Family History H. Social and spiritual history I. Personal history J. Home safety environment	MPW (M/F)
Section 3: 10 minute comprehensive screening	A. Screening for geriatric syndromes B. Screening for other age-related problems C. Functional assessment	CHO or SN at PHC
Section 4: Physical examination	A. General examination B. Systemic examination	CHO or SN at PHC
Section 5: Syndromic specific toolkit for assessment of the problem identified in section 3.	A. Memory loss B. Screening for cognitive impairment C. Screening for depression D. Fall risk evaluation E. Incontinence assessment and management guide	MO at PHC
Section 6: Comprehensive Geriatric Assessment Report.		CHO or SN/MO at PHC

Annexure IV

Case Scenarios

Case 1

In a small village of Varanasi, lives **Ram Prasad**, a 73-year-old retired farmer. He spends most of his day sitting in the courtyard. His wife often complains that he forgets where he keeps his betel box and sometimes even fails to recognize distant relatives who visit. When the **CHO visits for a routine elderly screening**, Ram is given three words — *apple, chair, river* — to remember. After three minutes, he recalls only *apple*. When asked to draw a clock showing "10 past 11," he draws a circle but places numbers incorrectly and shows the wrong time

Identify the scale that can be applied?
Management that can be possible at Primary level.

Case 2:

Shanti Devi, aged 69, is well respected in her community. She has always managed household finances but recently her daughter noticed she struggles with simple calculations while buying vegetables. During a village health camp, the CHO administers a scale. Shanti correctly answers most orientation questions and recalls 3 out of 5 items. However, her daughter reports that she often forgets conversations and needs repeated reminders to take her blood pressure medicines

Identify the scale that can be applied?
Management that can be possible at Primary level.

Case 3:

Hari Ram, a 77-year-old widower, lives with his son and daughter-in-law. During a home visit, the ASHA notices that he looks frail, with dry lips and torn clothes. When asked privately, he whispers that sometimes he is not given enough food and is scolded for being a "burden."

Identify the scale that can be applied?
Management that can be possible at Primary level.

Case 4:

In a village, **Parvati Amma**, aged 82, lives with her granddaughter. She is affectionate and chatty, but increasingly dependent. She can eat and use the toilet by herself but struggles to bathe and dress without help. Her granddaughter reports she cannot walk to the nearby temple without assistance.

Identify the scale that can be applied?
Management that can be possible at Primary level.

Case 5:

Joseph, 71, a retired schoolteacher, lost his wife recently. Since then, his appetite has declined, and neighbors notice he looks thinner. At the health camp, he weighs 48 kg with a BMI of 18.3. On the applying a scale, he reports reduced food intake, 3 kg weight loss in 3 months, occasional stress, and mild depression. His calf circumference is only 30 cm

Identify the scale that can be applied?
Management that can be possible at Primary level.

Case 6:

Kamla Bai, 74, lives in a joint family but often stays alone during the day. She fell twice last year while going to the bathroom at night. She now avoids walking outside. During the **Timed Up & Go test**, she takes 18 seconds to rise from a chair, walk 3 meters, turn, and sit again (normal <12 sec). The CHO also notes weak quadriceps, poor vision due to cataract, and slippery bathroom tiles

Identify the scale that can be applied?
Management that can be possible at Primary level.

Case 7

Prakash Yadav, 76, is brought by his son to the HWC. He looks thin and tired.

- **Head/Neck:** missing teeth, poor oral hygiene, reduced hearing.
- **Chest:** wheeze and crepitations suggestive of COPD.
- **CVS:** BP 160/95, irregular pulse.
- **Abdomen:** slightly enlarged liver.
- **Musculoskeletal:** knee pain, difficulty squatting.
- **Skin:** early pressure sore over sacrum

Identify the scale that can be applied?
Management that can be possible at Primary level.

Case 8

Leela Amma, 69, lives alone after her husband's death. She avoids community gatherings and cries often.

When the CHO visits, she answers the **appropriate applied scale** questions:

- Life feels empty → Yes
- Feel helpless → Yes
- Prefer to stay at home → Yes
- Loss of interest in activities → Yes
- Feels worthless → Yes

Identify the scale that can be applied?
Management that can be possible at Primary level.

Annexure V

Flow of Practical Skills: Palliavtive Care

1. **Haircare:** First put the macintosh cloth under the head. Then fold the macintosh into a funnel shape. The end of the macintosh should fall into a bucket or a tub. Then wash the hair with water, take care to protect the eyes with a cotton piece or a gauze piece. Make sure water falls to end of the bucket. After the wash, dry the hair using a towel. For further haircare, cut the hair short if the patient is willing. Wash the hair weekly or twice a week with soap or shampoo.

2. **Eye Care:** Clean the eyes with a clean cotton and water. Wash from inner canthus to outer canthus. For unconscious patients clean three times daily. Apply medications, if any.

3. **Nose care:** Make a small piece of clean cloth like wick and dip it in clean water and wring it out the inside of nostrils. Then gently wipe the outside of the nose. If feeding tube is inserted through the nose, it requires special care.

4. **Ear Care:** Clean the inner surface of the pinnae with moistened cotton cloth. Gently pull back the inner side of the ear, then with a cloth like wick, clean. Do not put earbuds, safety pin and other substances inside the ear. Make sure to use separate clothes for each ear.
5. **Oral Care:** In oral care, assessment is important. Assess symptoms and signs of problems such as altered taste, oral pain, dry mouth, halitosis, ulcers, oral and pharyngeal candidiasis or dental problems. Regular examination of lips, tongue, teeth and oral mucosa. If necessary, a local dental team can also be involved.

6. **Skin Care:** Keep skin moisturized. Take care to prevent bedsores. Skin care improves circulation and also regulates body temperature.

7. **Back care:** Place a bath towel **close to the patient** so that the bed is not wet and spread it lengthwise on the mattress. Use a soapy towel or using both hands, wipe the patient from the back of the neck to the lower edge. Pay more attention to bony prominence area, rub in a circular motion for a while to remove dirt and increase blood flow. Check for bedsores. Clean with water and dry it. To increase blood flow, massage with any emollient.

8. **Perineal Care:** Clean with soap and water from top to bottom using separate towel one stroke at a time. If urinary catheter is present, lift the tube and clean from top to bottom. Cut hair short by using trimmer or scissors. Avoid abrasions. Clean with soap and water twice or thrice daily according to amount of discharge.

9. **Nail Care:** Keep feet and hands clean and dry. Trim nails and keep them short to prevent injury. Prevent accumulation of dirt and micro-organisms underneath the nails.

10. **Bed Bathing Technique:** A bed bath involves cleaning a patient's skin using a washcloth, soap, and warm water while they remain in bed, maintaining dignity by covering them with a bath blanket and exposing only the area being washed. The process starts with washing the cleanest areas (face, neck, arms) and progresses to less clean areas (trunk, legs, and finally the perineal area), with a skin check for redness, especially in skin folds, and thorough drying after washing and before applying lotion. It is crucial to maintain the patient's comfort, privacy, and to involve them in the process as much as possible.