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MINISTRY OF HEALTH MALAYSIA



Palliative Medicine Services Operational Policy

Second Edition

Medical Development Division
Ministry of Health Malaysia



Ministry of Health Malaysia

PALLIATIVE MEDICINE SERVICES: OPERATIONAL POLICY

This document was developed by the Medical Services Unit, Medical Development Division, Ministry of Health Malaysia and the Palliative Care Services Operational Policy Working Group.

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FOREWORD

DIRECTOR GENERAL OF HEALTH, MALAYSIA

I am profoundly honored to present the second edition of the "Palliative Care Services: Operational Policy," a crucial document that underscores Malaysia's unwavering commitment to providing compassionate and comprehensive care for patients facing life-limiting illnesses. This updated policy, developed by the Medical Services Unit of the Medical Development Division, Ministry of Health Malaysia, and the Palliative Care Services Operational Policy Working Group, represents a significant stride in enhancing our healthcare system.

Since palliative care was first recognized as a clinical service in the Ministry of Health in 1995 and subsequently as a medical subspecialty in 2005, its importance has grown exponentially. This document aligns seamlessly with the World Health Organization's (WHO) resolution on strengthening palliative care as a component of comprehensive care, and with our own National Palliative Care Policy and Strategic Plan 2019-2030. Our vision is to integrate palliative care services across all hospitals and community care teams, ensuring that quality, accessible, and integrated care is available to all who need it.

This policy meticulously outlines the operational framework for palliative care services, encompassing the scope of patients, components of service, organizational structure, staffing requirements, and essential medications. It emphasizes a holistic approach, addressing not only physical symptoms but also psychosocial and spiritual distress, thereby improving the overall quality of life for patients and their families.

I urge all healthcare providers, hospital managers, and policymakers within the Ministry of Health to embrace and implement the guidelines set forth in this policy. By doing so, we will collectively ensure that every patient with a life-limiting illness receives the dignified and compassionate care they deserve, reinforcing our commitment to universal health coverage.

Thank you.

DATUK DR MAHATHAR BIN ABD WAHAB
Director General of Health Malaysia



FOREWORD

DIRECTOR OF MEDICAL DEVELOPMENT DIVISION

It is with great pride and anticipation that I introduce the second edition of the "Palliative Care Services: Operational Policy," a document that significantly strengthens our framework for delivering essential palliative care within the Ministry of Health, Malaysia. This policy is a testament to the dedicated efforts of the Medical Services Unit of the Medical Development Division and the Palliative Care Services Operational Policy Working Group.

The evolution of palliative care from a recognized clinical service in 1995 to a medical subspecialty in 2005 underscores its growing importance in our healthcare ecosystem. This updated policy reflects our ongoing commitment to the World Health Organization's call for comprehensive palliative care and aligns perfectly with our National Palliative Care Policy and Strategic Plan 2019-2030. Our collective vision is to ensure that compassionate, accessible, and integrated palliative care services are available across all Ministry of Health facilities and community care teams.

This document meticulously outlines the operational aspects of palliative care, covering patient scope, service components, organizational structures, staffing, and essential medical resources. It reinforces the holistic approach of palliative care, emphasizing the crucial balance between managing physical symptoms and addressing the equally vital psychosocial and spiritual needs of patients and their families.

I urge all healthcare professionals, administrators, and stakeholders within the Ministry of Health to fully embrace and implement these guidelines. By working together, we can ensure that every patient facing a life-limiting illness receives the highest standard of care, preserving their dignity and enhancing their quality of life. This policy is a crucial step towards achieving our goal of universal health coverage, where no patient is left behind in their time of greatest need.

DATO' DR MOHD AZMAN BIN YACOB
Director of Medical Development Division



FOREWORD

HEAD OF PALLIATIVE MEDICINE SUBSPECIALTY

It is with immense pleasure and a deep sense of responsibility that I introduce the second edition of the "Palliative Care Services: Operational Policy." This revised document is a testament to the continuous dedication and collaborative efforts within the Ministry of Health Malaysia to advance palliative care as an integral part of our healthcare landscape.

Palliative care, by its very essence, is about affirming life and providing compassionate support to patients and their families facing the challenges of life-limiting illnesses. Since its recognition as a clinical service and subsequent development into a medical subspecialty, we have seen remarkable growth and an increasing awareness of its critical importance. This updated policy not only reflects these advancements but also reinforces our commitment to delivering holistic, patient-centered care.

This policy serves as a vital guide for all healthcare professionals, outlining the essential components, organizational structures, and operational frameworks necessary to deliver high-quality palliative care services across various tiers of our healthcare system. It underscores the multidisciplinary approach, emphasizing the crucial roles of doctors, nurses, allied health professionals, and community partners in ensuring comprehensive physical, psychosocial, and spiritual support.

I am confident that this second edition will further strengthen our palliative care services, foster greater integration within the healthcare system, and ultimately enhance the quality of life for countless patients and their families in Malaysia. Let us continue to work together to champion this essential service, ensuring that dignity, comfort, and compassion remain at the forefront of our care.



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LIST OF ABBREVIATIONS

WHO	World Health Organization
CME	Continuous Medical Education
UHC	Universal Health Coverage
SIG	Special Interest Group
AIDS	Acquired Immunodeficiency Syndrome
MDRTB	Multidrug-Resistant Tuberculosis
MOH	Ministry of Health
TC	Teleconsultation
ICU	Intensive Care Unit
SOP	Standard Operating Procedure
DD	Dangerous Drug
CPR	Cardiopulmonary Resuscitation
IPOS	Integrated Palliative Care Outcome Scale
ECOG	Eastern Cooperative Oncology Group
NGO	Non-Governmental Organization

BPKK	Bahagian Pembangunan Kesihatan Keluarga
e-GL	Electronic Guarantee Letter
HIS	Hospital Information System
ADPC	Advanced Diploma in Palliative Care
PIC	Person In Charge
RCA	Root Cause Analysis
KPI	Key Performance Indicator
CIOMS	Council for International Organizations of Medical Sciences
NMRR	National Medical Research Register

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EXECUTIVE SUMMARY

The ***"Palliative Care Services: Operational Policy"*** document, published in August 2025 by the Ministry of Health Malaysia, outlines the operational framework for providing palliative care services. It aims to guide healthcare providers, hospital managers, and policymakers on the requirements, operations, and development of these services in Ministry of Health hospitals.

KEY POINTS INCLUDE:

- Recognition and Integration: Palliative care has been recognized as a clinical service since 1995 and as a medical subspecialty since 2005. The document aligns with WHO resolutions and the National Palliative Care Policy and Strategic Plan 2019-2030, emphasizing integration into the healthcare system.

- **Scope of Services:**

Palliative care should be provided to all patients with progressive life-limiting illnesses, including both cancer and non-cancerous conditions. The scope includes managing physical, psychosocial, and spiritual needs with early identification and impeccable assessment.

- **Components of Service:**

Comprehensive palliative care includes inpatient, outpatient, consultative, community-based services, daycare, tele-consultation, counseling and bereavement services.

- **Organization and Staffing:**

The document details the organizational structure of palliative medicine services and units, staffing requirements based on service levels, and the need for healthcare professionals training.

- **General Policies:**

Key policies cover referrals, equipment management, medication, end-of-life care, and various service provisions. Essential medications and equipment lists are provided in the appendices.

- **Service Provision Tiers:**

The document defines five tiers of palliative care services based on the level of specialization and resources available, ranging from non-specialist hospitals to regional hospitals with specialized services.

- **Training and Education:**

Continuous training and education for all staff are emphasized, including formal programs, clinical attachments, and CME sessions.

- **Quality Assurance and Research:**

Quality assurance, audits, and research activities are integral to the service, with compliance to national and international guidelines.

In essence, this policy provides a comprehensive framework for establishing and operating palliative care services within the Ministry of Health Malaysia, ensuring quality, accessible, and integrated care for patients with life-limiting illnesses.

OPERATIONAL POLICY PALLIATIVE MEDICINE SERVICES

1. INTRODUCTION	
1.1	Palliative care was first recognized as a clinical service in the Ministry of Health in 1995 and since then has further developed into the medical subspecialty of palliative medicine since 2005.
1.2	The World Health Organization (WHO) defines palliative care as an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illnesses. The complete definition is stated in Appendix 1.
1.3	In 2014, the Ministry of Health was a co-sponsor to a WHO resolution on palliative care at the 67th World Health Assembly in Geneva, where it called for a "Strengthening of palliative care as a component of comprehensive care throughout the life course" urging all member states to integrate equitable palliative care services throughout their countries.
1.4	In line with the WHA67.19 resolution and the United Nations definition of Universal Health Coverage (UHC), the Ministry of Health (MOH) affirmed its commitment to integrating palliative care into the healthcare system by endorsing the National Palliative Care Policy and Strategic Plan in 2019-2030.
1.5	In the National Palliative Care Policy and Strategic Plan, the vision “To provide compassionate care throughout the healthcare system” outlined plans to integrate palliative care services in all hospitals and community/ domiciliary care teams.
1.6	Despite the increasing numbers of specialists who have been trained in the medical subspecialty of palliative medicine, many hospitals still lack palliative care service provision.
1.7	In the absence of a palliative medicine specialist, the palliative care approach (i.e. pain and symptom management, counselling, good nursing care and discharge planning) should still be available to all patients who require it.

1.8	It is the responsibility of every healthcare professional dealing with patients with life-threatening conditions to ensure that comprehensive care is provided not only during the active management of a life-threatening condition but also during discharge and the dying phase.
1.9	This policy covers key areas of palliative care service provision such as organization, human resources, asset requirements, drug requirements, training, work processes, ethics and clinical governance.
1'10	It is intended to guide health care providers, hospital managers, and policymakers on the requirements, operations, and development of palliative care services in Ministry of Health hospitals.
1.11	The document outlines optimal achievable standards by best practices and guidelines. In hospitals where these standards are not fully met, necessary steps need to be taken to meet these standards.
1.12	The document shall be reviewed and updated every 5 years or when needed.

2. OBJECTIVES OF SERVICE	
2.1	Provide comfort and relief of distressing physical symptoms related to advanced and incurable progressive life-limiting conditions.
2.2	Provide support to patients and family members facing psychosocial and spiritual issues related to incurable progressive life-limiting conditions.
2.3	Prevent and minimise suffering by early identification, impeccable assessment and prompt intervention of physical, psychosocial and spiritual problems related to incurable progressive life-limiting conditions.
2.4	Ensure continuous access to essential palliative care medicines and minimise burdens to the patient and family.
2.5	Promote understanding and respect towards patients at the end of life through open communication and advance care planning to avoid unnecessary suffering and unwanted futile interventions.
2.6	Promote education in palliative care for both healthcare providers and the larger community.
2.7	Network with other palliative care providers in hospitals and the community to provide seamless care throughout the patient's illness.
2.8	Conduct palliative care research and ensure quality healthcare delivery.
2.9	Fulfil the vision of the National Palliative Care Policy and Strategic Plan by the Ministry of Health.

3. SCOPE OF SERVICES

3.1	Scope of Patients:	
	3.1.1	Palliative care should be provided to all patients of any age with progressive life-limiting illnesses experiencing serious health-related suffering. This includes both cancer and non-cancerous conditions.
	3.1.2	The scope of palliative care in non-cancerous conditions is continuously growing due to the evolving nature of treatment options and prognosis in many illnesses that now follow a chronic trajectory, resulting in serious health-related suffering. The following are common non-cancerous conditions requiring palliative care; however, this is not exhaustive: a)End-stage heart failure with refractory symptoms b)End-stage kidney disease with or without kidney replacement therapy c)End-stage liver disease with deteriorating liver function with or without options for liver transplant. d)Progressive neurodegenerative disorders, e.g. motor neuron disease, multiple sclerosis, dementia and Parkinson's disease e)Severe chronic lung diseases, e.g. chronic obstructive pulmonary disease, interstitial lung disease, cystic fibrosis with deteriorating respiratory function f)Life-limiting paediatric conditions, including severe congenital heart diseases and genetic disorders that may need a paediatrician's input for co-management. g)Chronic incurable infectious diseases such as AIDS and MDRTB with intractable symptoms where treatment is refractory or no longer feasible. h)Frailty in the elderly with multiple life-threatening co-morbidities.

		i)Patients with acute life-threatening conditions who are deteriorating and not responding to active treatments. j)Deteriorating with other illnesses and/ or complications that are not reversible (e.g. diabetes, haematological disease) despite best available treatment
	3.1.3	Due to less predictable nature of prognoses in non-cancerous conditions, some patients referred for palliative care with serious illness who were diagnosed to be approaching the end-of-life may later improve with appropriate medical therapy and good symptom management. In such cases, it is fair that the patient is then considered for further rehabilitative management as there may be prolonged survivorship. The role of palliative care however is still relevant as the main objective is still to improve quality of life which may also result in improved survivorship. This is described as the "Bowtie" model of palliative care. (Appendix 3).
3.2	Scope of management:	
	3.2.1	Palliative care is a holistic care that addresses multiple domains of suffering, essential to improving overall quality of life and well-being. This includes: a)Management of distressing physical symptoms, e.g. pain, dyspnoea, vomiting and delirium. b)Management of psychological distress, e.g. anxiety, depression. c)Addressing social issues, e.g. family issues, carer distress, financial support. d)Providing support for spiritual issues, e.g. fear, existential distress, anger, hopelessness.
	3.2.2	Provision of terminal care for patients at the end of life.
	3.2.3	Provision of respite care for patients and families.

	3.2.4	Providing a holistic management plan to optimise quality of life throughout the course of patients' illness and applying a multidisciplinary approach to care.
	3.2.5	Providing consultative advice and assistance to other medical colleagues regarding managing patients with life-threatening situations under their care.
3.3	Other scope of activities:	
	3.3.1	Collaborate with relevant services (e.g. oncology, pain medicine, nephrology, surgery and others) when required to optimise patient care.
	3.3.2	Coordinate and provide community palliative care support where possible.
	3.3.3	Organise and participate in teaching sessions and promoting palliative care.
	3.3.4	Lead the palliative care development in the institution, community, cluster and/or state (where relevant) .

4. COMPONENTS OF SERVICE

4.1	In general, the components of a comprehensive palliative care service include the following:	
	4.1.1	Inpatient palliative care service
	4.1.2	Outpatient palliative care service
	4.1.3	Consultative palliative care service in general wards
	4.1.4	Community palliative care service
	4.1.5	Day palliative care service
	4.1.6	Tele-consultation service
	4.1.7	Counselling and bereavement service
4.2	**Inpatient palliative care services** refer to a dedicated ward or designated beds where patients requiring palliative care can be admitted under the direct care of the palliative care team. Ideally, the staff caring for patients in the ward should have specialised knowledge and skills in palliative care.	
4.3	**Outpatient palliative care services** refer to care provided in clinic settings for patients who do not require hospital admission but need to be reviewed by the palliative care team. This is to reassess patients for new clinical problems or to continue with palliative care medications. Outpatient clinics may be scheduled for stable patients without distressing symptoms; however, for patients who are less stable or distressed, a walk-in clinic is preferred to allow ad-hoc visits to provide care promptly.	
4.4	A **consultative palliative care service** is where the palliative care team co-manages patients who are under the care of other specialities. The team will review and advise on the necessary palliative care management for the patient while still receiving care under the primary team.	

4.5	**Community palliative care services** provide care in the community which is often in the form of home visits after a patient has been discharged from hospital or any other healthcare facility and identified to have palliative care needs that require continued support and follow up at home. This is to provide seamless transitions of care between hospital and home. It may be provided by the palliative care team based in a hospital, health clinic or in collaboration with an NGO community palliative care provider/ hospice team.
4.6	**Day palliative care service** refers to the provision of care for patients requiring procedures in the hospital of a short duration (less than 24 hours). These procedures may include therapeutic interventions such as pleural or peritoneal tapping, elective blood transfusions or diagnostic procedures.
4.7	**Teleconsultation service** refers to remote consultation or interaction with patients and their families using electronic means. This is most useful when patients have no community palliative care support.
4.8	**Counselling and bereavement services** are essential for patients and families who are identified to have psychological distress. Bereavement support should be provided to family members and caregivers after the patient has passed on to assess if there are issues of complicated grief and bereavement.

5. ORGANISATION		
5.1	The Palliative Medicine Unit should ideally be headed by a trained consultant palliative medicine physician recognised and credentialed by the Ministry of Health.	
5.2	If a consultant palliative medicine physician heads the unit, it should then come under the umbrella of the Department of Medicine as a medical subspecialty. In some circumstances, the palliative medicine unit can be a stand-alone department or under the umbrella of another department, such as oncology.	
5.3	An alternative organisation structure should be employed when a trained palliative medicine physician is not available. The palliative care unit shall then come under any department interested in supporting the service and has a specialist or medical officer willing to be in charge and responsible for running the unit.	
5.4	A general specialist or medical officer heading the unit should have basic palliative care training under the MOH Special Interest Group (SIG) training programme or equivalent.	
5.5	In non-specialist hospitals, the palliative care service will be under the responsibility of the hospital director.	
5.6	The head of the palliative care unit or palliative care service should be responsible for the following:	
	5.6.1	Administration and Service Development
	5.6.2	Clinical management
	5.6.3	Procurement of essential medications, equipment and consumables
	5.6.4	Development of local clinical policies and guidelines
	5.6.5	Continuous Medical Education Programme

	5.6.6	Research and Quality Assurance Activities
5.7	Nursing staff for palliative care services should be under the leadership of the respective hospital Matron or senior nursing sister. Nursing staff should be encouraged to receive specialised training in palliative care nursing either under the advanced diploma in palliative care programme by MOH or any other equivalent programme.	
5.8	Requirements for staffing of palliative care services are dependent on the level of palliative care service provided and the expected patient load. A guide for ideal staffing of palliative care services is outlined in Appendix 6.	

6. GENERAL STATEMENTS		
6.1	Referral to palliative care	
	6.6.1	Criteria for patients referred to the palliative care department include the following: a)Patients with advanced cancer who are suffering from physical, psychosocial or spiritual symptoms related to the cancer or its treatment. Patients who are actively receiving treatment may still be referred. (refer to the integrated model of palliative care in Appendix 3) b)Patients with any incurable progressive medical illnesses who may or may not be on active medical management and are suffering from physical, psychosocial and/or spiritual issues. c)Patients who have acute medical or surgical conditions which are not reversible and will inevitably deteriorate rapidly in an acute ward or ICU and require terminal care.
	6.1.2	All referrals must be made by the primary team with a proper referral procedure summarising patients' history and problems. This can be done using several methods: a)Referral letter b)Electronic referral system (e-Referral) c)Teleconsultation (TC) - can be adopted for referral purposes, following the relevant disciplines' standard operating procedure (SOP). d)Electronic social media consultation/referral - in accordance with the MOH Social Media Policy (Pekeliling KPK Bil. 10/ 2016: Garis Panduan Penggunaan Media Sosial dalam Perkhidmatan Penjagaan Pesakit di Fasiliti KKM)
	6.1.3	Existing guidelines such as "*Pekeliling KPK Bil. 2/ 2009: Garispanduan Rujukan dan Perpindahan Pesakit di Antara Hospital-Hospital KKM*" shall be compiled with when referring patients.

6.2	General Service Policies	
	6.2.1	The ideal components of a comprehensive palliative care service have been outlined in section 4. Ideally, each component should have adequate staffing to ensure effective service delivery. However, as human resource availability may be limited, teams should prioritise key components of service provision to fulfil local needs.
	6.2.2	All equipment and stocking of disposables is the responsibility of the ward or section manager (eg. nursing sister or Assistant Medical Officer) who will delegate further the duties of keeping track of palliative care equipment. A list of essential equipment for palliative care units is provided in Appendix 5.
	6.2.3	Equipment belonging to the palliative care service may be loaned to patients who are discharged home and require specialised equipment to ensure the continuity of care and comfort. In such circumstances, the palliative care service should have its local policy regarding how this should be done and to ensure the safe return of equipment. Patients and their families should be aware that the equipment is the property of the Ministry of Health, Malaysia. Failure to return equipment is equivalent to theft and will be reported.
	6.2.4	Regular unit or department meetings should be held with all members of staff and minutes should be recorded.
	6.2.5	CME sessions for doctors, nurses and allied health professionals should be conducted regularly, and ideally, an annual training operation plan should be made.
	6.2.6	All palliative care services should keep up-to-date records of their activities, patient statistics, and regularly audit services.
	6.2.7	Auditing of services shall be guided by the national key performance indicators, which will be revised from time to time according to the requirements of the MOH Clinical Performance Surveillance Unit (CPSU). This should also complement the national standards for palliative care services in Malaysia in the future.

6.3	Essential Palliative Care Medicines	
	6.3.1	The field of palliative care requires certain essential medications which are the tools needed to provide adequate symptom relief. A list of these medications can be obtained in the National Essential Medicines List by the pharmacy division of MOH under the section of palliative care.
	6.3.2	Certain palliative care drugs may be used for indications outside the standard indications as stated in the MOH drug formulary. This is acceptable in the palliative medicine field, provided the indication is supported by evidence in current palliative medicine literature and approved by the relevant authorities.
	6.2.3	A list of essential medications for palliative care and their indications is provided in Appendix 4.
	6.3.4	Record keeping of all dangerous drugs (DD) used by the department should be closely kept in accordance with the Dangerous Drug Act 1952. It will be the joint responsibility of nursing staff, medical doctors and pharmacists.
6.4	End-of-life care	
	6.4.1	Access to good palliative and end-of-life care should be seen as an essential human right, and its components are: a)Advance Care Planning: Each person is seen as an individual with personalised goals of care b)Fair Access to Care: Ensuring equitable access to end-of-life care. c)Maximising Comfort and Well-being: Recognising distress, skilled symptom management, and addressing all forms of distress. d)Coordinated Care: Shared records, clear roles, and continuity in partnership.

		e)Staff Preparedness: Professional ethos, support and knowledge-based judgement. f)Timely terminal discharge is in accordance with local guidelines for patients whose preferred place of care is at home.
	6.4.2	All hospital patients with incurable and progressive life-limiting illnesses should receive an advance care plan outlined by a practising clinician with or without the assistance of the palliative care team. The plan should outline decisions about cardiopulmonary resuscitation (CPR), intubation, Intensive Care Unit (ICU) admission, the use of aggressive antibiotic therapy or medical therapy in the event of rapid deterioration and/or cardio-respiratory collapse. This plan should be discussed and understood by the patient and family / caregivers.

7. PALLIATIVE CARE SERVICE PROVISION

7.1	Inpatient Palliative Care Unit	
	7.1.1	Palliative Care Units provide comprehensive care for patients with advanced diseases, aiming to relieve symptoms, manage pain, and address psychological, social, and spiritual needs.
	7.1.2	Palliative Care Units may comprise of: a) Specialist Palliative Care Units (state level - Tier 1/2) b) Cluster Palliative Care Units (with visiting specialist - Tier 4)
	7.1.3	These units involve a multidisciplinary team of healthcare professionals, including doctors, nurses, pharmacists, social workers, spiritual care providers, counsellors, dieticians, physiotherapists and occupational therapists. They collaborate to create individualised care plans.
	7.1.4	Functional Considerations: a)It is recommended that 50% of beds in the palliative care unit be single rooms to meet the needs of patients and families. b) Bed requirements should follow the recommendations based on the Tier of Service. (Appendix 6)
	7.1.5	Design Characteristics of the ideal Palliative Care Unit a)Aims to create a warm and comforting environment for patients and their families. b)Domestic appearance - Resembling a home-like setting with soft colours, comfortable furnishings and decor contributing to a calming atmosphere. c)Colour and lighting - Natural light is prioritised, promoting a sense of well-being. Soft, soothing colours are used throughout the unit to enhance comfort and reduce stress.

		d)Family Rooms - Dedicated family rooms provide privacy and space for loved ones to gather, share moments, and find solace during difficult times. e)Meeting Areas - Designated meeting spaces where healthcare professionals, patients, and families can discuss care plans, address concerns, and collaborate effectively. f)Outdoor Spaces - Access to outdoor areas such as gardens or patios to allow patients to enjoy fresh air, connect with nature and find moments of peace
	7.1.6	Criteria for admission to the palliative care unit include: a)Patients with palliative care needs who are acutely deteriorating or have symptoms requiring stabilisation. b)Patients who are in the dying phase where they or their loved ones request terminal care in the hospital. c)Patients known to the palliative care service who require procedures such as pleural tapping or peritoneal tapping. d)Patients known to palliative care service who require respite care due to social issues. e)Patients with palliative care needs who are in acute psychosocial and/or spiritual crisis and require a safe place to work out issues. f)Patients seen by consultative teams who require transfer to the palliative care unit for further management upon approval by the person-in-charge. g)New referrals seen in the emergency department after referral to the palliative care team and deemed appropriate to be admitted under the palliative care unit after approval by the person-in-charge. h)Patients with palliative care needs in other healthcare facilities or community palliative care services requesting transfer to the palliative care unit for further management after approval by the person-in-charge.

	7.1.7	Patients requiring admission during office hours may be admitted directly to the palliative care unit after being reviewed as a “walk-in-review” (refer to 7.3.2), from the outpatient clinic, from the emergency department or as a scheduled admission from the community after review by the community palliative care service.
	7.1.8	After office hours, patients known to the palliative care department should be admitted to the unit through the emergency department unless stated otherwise in a local policy.
	7.1.9	Patients who are admitted after office hours should be seen upon admission by the medical officer on call and discussed with the specialist on call. On-call duties for medical officers and specialists may be passive on-call provided the on-call officer is able to come to the hospital within a reasonable time whenever required.
	7.1.10	Ideally, the specialist in charge should see all new admissions to specialist palliative care units within 48 hours of admission. If the service has limited human resources, the specialist should at least be consulted regarding the admission to ensure appropriate management is provided.
	7.1.11	Nursing staff should work on a shift basis, and the number of beds available in the ward depends on the number of nursing staff available.
	7.1.12	Nursing staff are required to be familiar with basic palliative care nursing skills, including the appropriate use of analgesic medication and simple devices like syringe drivers.
	7.1.13	Vital signs and observation of patients should be monitored regularly; however, the frequency of monitoring should be decided based on the patient's clinical condition. More importantly, observations for symptom distress should be prioritised, e.g., pain scores, sedation scores, and the Integrated Palliative Care Outcome Scale (IPOS). Good palliative care must always focus on attending to comfort and dignity.
	7.1.14	Clinical rounds should be conducted daily. A multidisciplinary team meeting should also be conducted regularly to allow all disciplines involved in patient care to network and discuss current patient management issues in the unit.

	7.1.15	The family and caregivers of admitted patients should be aware of the palliative care unit's role and the disease status and treatment intent. They should be aware of the goals of care and resuscitation status of the patient in the event of deterioration due to the primary disease.
	7.1.16	All patients should have appropriate discharge planning before discharge from the ward. Referral to appropriate community palliative care services should be made where available, and follow-up plans should be arranged.
	7.1.17	Patients in the terminal phase requesting to be discharged home may be managed according to a local terminal discharge guideline (refer to "Terminal Discharge Guidelines by Unit Perawatan Paliatif Jabatan Perubatan Am HKL, 1st Edition). This should address the procedure of providing rapid discharge home for a dying patient, ensuring adequate symptom control, comfort care and the provision of appropriate medications.
7.2	Consultative Palliative Care Service:	
	7.2.1	Referrals should be seen during office hours, and new cases should be seen within 1 working day of referral. Patients with severe distressing symptoms should be seen immediately.
	7.2.2	New referrals should be consulted (for Tier 4 Services) or reviewed by a specialist palliative medicine physician at least once within the week of referral (for Tier 1/2/3 Services).
	7.2.3	Patients under the care of the consultative team may require review by the medical officer on call over weekends and public holidays if deemed necessary.
	7.2.4	Large units may employ the services of a nurse coordinator (preferably with specialized nurse training) who will follow up on all new referrals and look into all palliative care nursing issues concerning the patient. The nurse coordinator also educates staff in other wards regarding pain management, monitoring of syringe drivers and relevant clinical issues.

	7.2.5	If no further active management is planned by the referring team and the patient's care is primarily palliative, the patient may be taken to the palliative care unit for further care if the family agrees.
	7.2.6	Good collaboration between the consultative and the primary teams should exist throughout the patient's care, and active discussions regarding the best management options for the patient should be facilitated to encourage holistic multidisciplinary care.
	7.2.7	Patients who are discharged from the primary team ward may either be followed up by community care teams or be given a follow-up appointment in the palliative care outpatient clinic. The primary team should organise the discharge of medication and planning.
	7.2.8	If patients previously seen by the palliative care consultative team come into the emergency department, the patient should not be automatically transferred under the care of the palliative care team. The emergency department team should assess all patients to determine which discipline should primarily manage the patient. If the patient is then admitted to another department as the primary team, the palliative care consultative team will still avail themselves of assistance in managing symptoms in such cases. If the needs of the patient are primarily palliative, then admission to the palliative care unit would be appropriate.
7.3	Outpatient clinic	
	7.3.1	The outpatient palliative care clinic is for follow-up of patients who are still relatively ambulatory and have a performance status of ECOG 1-2.
	7.3.2	The clinic should be at fixed times; however, walk-in reviews are acceptable if patients have urgent problems. The palliative care service should develop its local policy on "walk-in-reviews" to outline how and where this should be conducted and what patients should expect to be reviewed ad-hoc.
	7.3.3	The specialists and medical officers of the palliative care team should conduct clinic reviews.
	7.3.4	Medication should be provided in sufficient quantity until the following clinic review.

	7.3.5	Patients who are deteriorating and are too unwell to attend regular clinic appointments should continue follow-up by means of community palliative care services. Medications may be continued by the community team or obtained from the clinic by proxy.
7.4	Community Palliative Care Service	
	7.4.1	Community palliative care services are run by: a)Non-governmental organisations (NGO) or hospice organisations; hence where such NGOs are available, this component of care need not be duplicated. b)Domiciliary Palliative Care Program under Bahagian Pembangunan Kesihatan Keluarga (BPKK) c)Hospital-based Community Palliative Care Outreach team
	7.4.2	Good collaboration must exist between the palliative care services in hospitals and community palliative care services to provide seamless care. (Appendix 2)
	7.4.3	Upon discharge from the hospital, every effort to link patients to a community palliative care service provider should be made.
	7.4.4	If no community palliative care service is available, efforts should be made to collaborate with health clinics nearest the patient's residence for continuation of care. Community outreach services run by the hospital and palliative care services can be developed as an alternative.
	7.4.5	The Community Palliative Care team comprises nurses and/ or doctors from the hospital based palliative care team. Other allied health professionals may be part of this team as and when needed.
	7.4.6	The role of the Community Palliative Care Outreach team would be to review patients as and when necessary, in their homes to provide continuity of care after discharge from the hospital.

	7.4.7	In some situations, the role of community outreach may also be to assist local domiciliary palliative care teams or NGO hospice teams to review challenging cases at home. Formal partnerships between hospital palliative care teams and NGO hospice services are encouraged.
	7.4.8	Minor procedures may also be performed at home if consent is given and deemed safe.
	7.4.9	The Community Palliative Care Outreach team should meet regularly with other multidisciplinary providers to discuss all cases on their list of patients for comprehensive management.
	7.4.10	An after-office-hours contact number should be available for patients who require assistance at home. The community nurses should have an on-call roster to answer this contact number. The medical officer on call should be available to assist the community nurse in handling after-office-hours problems.
7.5	Day Palliative Care Services	
	7.5.1	Day palliative care services provide access for patients who may require: a)Minor procedures for symptom control b)Diversional activities to enhance psychosocial and spiritual well-being, including social interaction
	7.5.2	The day palliative care service location may be in a commonly shared/utilised daycare unit of the hospital or in any designated space under the palliative care team.
	7.5.3	Respective hospitals shall have a dynamic list of procedures performed as day palliative care.
	7.5.4	Day palliative care services shall be provided during office hours.

	7.5.5	All patients scheduled for daycare services should bring along relevant documents to facilitate registration if required (e.g. identification documents, appointment card, guarantee letter (e-GL))
	7.5.6	All patients requiring day palliative care services need an appointment and advance order before the daycare encounter. Advance orders from previous admissions or clinic encounters in the Hospital Information System (HIS) can be made.
	7.5.7	Patients who present acutely to the outpatient clinic or walk-in clinic requiring minor procedures such as peritoneal or pleural tapping may also be slotted in even though they do not have advance orders.
	7.5.8	Consent shall be obtained by the attending doctor performing any procedure.
	7.5.9	A medical officer shall review patients before discharge; if they are deemed unfit, they may be admitted for further management.
	7.5.10	Administrative management, including billing for these patients, shall be in accordance with the Fee (Medical) (Cost of Service) Order 2014/ other relevant revised circulars.
	7.5.11	Refer to: *Surat Pekeliling KPK Bil.32/ 2010 Polisi Penyampaian Perkhidmatan Rawatan Harian di Hospital-hospital KKM dated 15 November 2010* and Day Care Anaesthesia Protocols, 2012.
	7.5.12	Day palliative care services for diversional and social activities may be jointly organised with the help of volunteer organisations that will provide the main human resource of this service.
	7.5.13	A nurse should be placed in charge of coordinating volunteers and patient daycare activities. While such daycare activities are not essential, they are recognised as a valuable, comprehensive palliative care service component.

7.6	Teleconsultation Services	
	7.6.1	Teleconsultation services in the form of tele-palliative care / virtual clinic services are essentially a form of follow up clinic service which is an add-on service to conventional outpatient clinic services.
	7.6.2	Such services are useful especially in the palliative care setting as it helps to provide additional support to patients who live in remote areas where physical follow up may be too difficult.
	7.6.3	It is also useful for rapid review of patients' conditions soon after discharge from hospital to ensure discharge plans have been implemented and there is sufficient support for the patient in the community.
	7.6.4	Teleconsultation follow up may be done using simple telephone communication when verbal assessment is sufficient. In situations where a more visual assessment may be required, the call may be converted into a video call in order to assess the situation better.
	7.6.5	Teleconsultation and virtual clinic follow ups are not equivalent to proper face-to-face clinical history and physical examination. All patients and family members must be aware that this service is merely adding on to existing conventional follow up clinics and is not meant to replace it.
	7.6.6	Proper documentation indicating that patients and family understand the nature of tele-palliative and virtual clinics should be recorded and consent should be taken if necessary.
	7.6.7	Teleconsultation and virtual clinics may be scheduled or conducted when necessary. This would depend on the overall service's human resource availability and resources.
	7.6.8	Teleconsultation equipment including mobile phones, tablet PCs and internet access should ideally be provided officially by the hospital / healthcare provider rather than to use personal mobile lines and equipment.

	7.6.9	A proper and conducive space should be allocated for running Teleconsultation and virtual clinics which have good wi-fi / mobile data access and have adequate privacy.
7.7	Bereavement Counselling Services	
	7.7.1	Bereavement counselling is considered the final component of a comprehensive palliative care service. It includes a support system for family and loved ones of the patient during the last stages of terminal illness and also in the immediate period after death of the patient.
	7.7.2	The purpose of bereavement counselling is mainly to provide ongoing support to family who may be having challenges during their grieving period and also serves to identify relatives who may be suffering from complicated grief that may require professional counseling or psychiatric referral.
	7.7.3	A bereavement service may include the process of reaching out to bereft family members by sending out a condolence card attached with more information on grief and bereavement as well as contact information if more needs arise.
	7.7.4	In services with more human resource, a trained personnel or volunteer may conduct bereavement phone calls to check on family members about 1-2 months following the death of a patient.
	7.7.5	Screening tools may be used to identify family members who may be at increased risk of complicated grief and consider early bereavement review.
	7.7.6	Family members identified to have complicated grief should be further followed up and referred to relevant services such as psychologists or psychiatrists if appropriate.
	7.7.7	Services should work together with local community palliative care providers to arrange bereavement follow up at home where needed and possible.

8. TRAINING AND EDUCATION

8.1	All palliative care services should ensure that a reasonable level of knowledge, skills, and competence exists within all its personnel. A continuous effort should be made to obtain as much formal or informal training for staff working in palliative care services, and although palliative care comprises a lot of good basic medical care, there are specific areas of care that require specialised training and knowledge just like any other medical sub-specialty.	
8.2	Training of Nurses and Allied Health Staffs	
	8.2.1	Nurses and allied health staff new to the concept of palliative care should undergo a period of in-house training and supervision to introduce them to the field.
	8.2.2	Formal training in the form of an Advanced Diploma in Palliative Care (ADPC) for nurses and allied health staff has been developed and is being conducted by the training division of the Ministry of Health. It is open to nurses, occupational therapists and physiotherapists. Upon completion of training, they are encouraged to do regular credentialing and privileging.
	8.2.3	Clinical attachments and short courses in palliative care are also helpful in providing informal training at centres where more expertise is available.
8.3	Training of Pharmacists	
	8.3.1	Pharmacists play an essential role in the provision of palliative care as they complement services in ensuring adequate access and dispensing of essential medications. They also play an essential role in counselling patients regarding palliative care medications and addressing fears and concerns that patients and families may have.

	8.3.2	Pharmacists play an important role in assisting procedures such as terminal discharge and using subcutaneous infusions of palliative care medications. They also assist in advising on precautions when using palliative medications in patients with multiple comorbidities and polypharmacy.
	8.3.3	Another role of the pharmacist is to help advise on deprescribing medications in patients who are deteriorating and approaching the terminal phase.
	8.3.4	The Pharmaceutical Division in the Ministry of Health has developed a handbook of palliative care pharmacotherapy while developing further education programmes in palliative care pharmacy.
	8.3.5	All palliative care services should engage a local pharmacist to undergo basic training in palliative care pharmacy and to join in clinical teaching to enhance knowledge and skills in this area.
8.4	Training of Medical Officers	
	8.4.1	All medical officers newly assigned to a palliative care unit or service should undergo basic training in palliative care skills and knowledge to enable them to understand the philosophy of care and management of patients in the palliative care setting.
	8.4.2	In units where there is a consultant palliative medicine physician, medical officers new to palliative medicine should undergo in-house training and a period of close supervision before they can independently be placed on call and the specialist in charge should determine the readiness of the medical officer to handle on-call duties.
	8.4.3	If no experienced consultant is available, training can be obtained through clinical attachments in centres with resident palliative physicians.
	8.4.4	Formal training in the form of a Special Interest Group (SIG) programme in palliative care is available for interested medical officers and specialists.

	8.4.5	Areas of basic knowledge for medical officers managing palliative care services include the following: a) Introduction to palliative care b) Cancer pain management and using opioid analgesia c)Management of respiratory symptoms in advanced disease d) Management of GIT symptoms e) Managing delirium and confusion f)Palliative care emergencies g) End-of-life care h)Basic communication skills i)Ethics and clinical decision-making j)Communication at the end of life k)Advance care planning
8.5	Training of Specialists in Palliative Medicine	
	8.5.1	Palliative Medicine has been a recognised medical subspecialty since 2005, and training in palliative medicine is done through the Malaysian Palliative Medicine Subspecialty Curriculum as required by the Malaysian Medical Council.
	8.5.2	Credentialing of palliative medicine specialists is by the Ministry of Health Subspecialty programme under the training division of the Ministry of Health. Specialists trained in other centres or countries outside the Ministry of Health, Malaysia should have credentials equivalent to the training programme outlined by the local curriculum.

	8.5.3	All palliative medicine specialists should be registered under the National Specialist Registry having fulfilled its criteria for registration.
8.6	Continuous Medical Education (CME)	
	8.6.1	CME sessions / Journal clubs for doctors, nurses, pharmacists and allied health professionals should be conducted regularly.
	8.6.2	An annual training operation plan should be made and courses in palliative care education should be organized at a hospital level or cluster level at least once a year.
8.7	Advocacy and Public Awareness	
	8.7.1	Palliative care providers should engage in advocacy efforts at both the hospital level and the general public.
	8.7.2	All palliative care providers should be encouraged to participate in state and national public advocacy activities.

9. GENERAL HOSPITAL OPERATIONAL POLICY		
9.1	The Palliative Care Unit shall comply with the General Hospital Operational Policy in the following areas and updated as needed:	
	9.1.1	Hospital admission and discharge policy
	9.1.2	Policy on transportation service
	9.1.3	Infection control policy
	9.1.4	Sterilisation service
	9.1.5	Management of waste products
	9.1.6	Policy on supply of pharmaceuticals and consumables
	9.1.7	Policy on the acquisition of assets and equipment
	9.1.8	Catering service
	9.1.9	Laundry and linen supply
	9.1.10	Cleaning service
	9.1.11	Engineering service, including preventive and maintenance services
	9.1.12	Security service
	9.1.13	Fire precaution
	9.1.14	Medical record management
	9.1.15	Communication system
	9.1.16	Policy on quality assurance

	9.1.17	Occupational and Safety Health Assurance (OSHA)
	9.1.18	Policy regarding public relations, release of information and confidentiality.

10. **QUALITY ASSURANCE & AUDITS**	
10.1	The Head of The Palliative Care Unit / Person-in-charge (PIC) shall ensure the provision of quality care with staff involvement in the continuous safety and performance improvement activities of the palliative care service.
10.2	The PIC is responsible for planning, monitoring and managing safety and performance improvement activities.
10.3	A PIC or a committee needs to be appointed to undertake clinical reviews of all risk assessments, incident reports, audits, safety and performance improvement activities, mortality and morbidity reviews, etc. Each activity shall be completed for review and analysis within the services.
10.4	All staff should participate in quality improvement activities to improve the service quality. They should participate in clinical audits at the hospital and national levels.
10.5	Staff should be trained to conduct Root Cause Analysis (RCA) for major incidents and to investigate and report within the agreed time frame to prevent recurrence.
10.6	Indicators for accountability, including national Key Performance Indicators (KPI) and hospital accreditation standards, should be monitored.
10.7	All appropriate safety and performance improvement documentation shall be kept confidential and preserved within the service.

11. RESEARCH & PUBLICATION	
11.1	The palliative care team shall actively conduct research in all areas of interest in palliative medicine. Research projects can include investigator-initiated trials, industry-sponsored research, collaborative research or clinical database-based projects.
11.2	The hospital/department shall support research activities by facilitating the funding and facilities and protected time for the staff.
11.3	The palliative care team should work closely with clinical research centres where this is available.
11.4	All research conducted in MOH institutions and facilities must comply with the Declaration of Helsinki, International Ethical Guidelines for Biomedical Research Involving Human Subjects (CIOMS), ICH Guideline of Good Clinical Practice, Malaysian Good Clinical Practice and other local regulatory requirements and guidelines.
11.5	All research must be registered with the National Medical Research Register (NMRR).
11.6	All research activities must follow the conduct of research as stated in the National Institutes of Health (NIH) Guidelines for Conducting Research in the Ministry of Health (MOH) Institutions & Facilities. Refer to Surat Pekeliling Ketua Pengarah Kesihatan Bil. 9/ 2007: “National Institutes of Health (NIH) Guidelines for Conducting Research in the MOH Institutions and Facilities”.
11.7	All principal investigators and collaborators who wish to undertake interventional clinical trial research must acquire a Good Clinical Practice certificate (GCP) before being permitted to conduct trials.
11.8	All publications, whether in the form of research reports, journal articles or conference proceedings, arising from research undertaken by MOH personnel OR utilising data of MOH patient/sample/personnel as subject OR conducted in MOH facilities OR funded by MOH research grants, shall require prior review by the NIH, and subsequent approval by the Director General of Health prior to publication and presentation.

11.9	The hospital shall tag and maintain medical records of patients involved in clinical trials, including all relevant research documents. Management of records after expiry dates, e.g. disposal/archiving, shall be carried out in collaboration between the Medical Records Unit and Hospital CRC. Refer to:(a) *Surat Pekeliling KPK Bil.4/ 2011 Penyelidikan Klinikal dan Rangkaian Pusat Penyelidikan (CRC) di Hospital dan Penubuhan Jawatankuasa Penyelidikan Peringkat Negeri dated 4 March 2011, (b) Surat Pekeliling KPK Bil.9/ 2007 Garis Panduan Institut Kesihatan Negara Mengenai Penyelidikan yang Dijalankan di Institusi dan Fasiliti KKM dated 5 September 2007*.

12. **CLINICAL PRACTICE GUIDELINES**	
12.1	The practice of Palliative Medicine shall be guided by the Clinical Practice Guidelines and management protocols prepared by MOH. In the absence of any guidelines on any particular subject, the internationally recognised best practices shall be adopted.
12.2	Relevant local guidelines available in the field of Palliative Medicine include: a)Management of Cancer Pain Clinical Practice Guideline 2nd Edition b)Handbook of Palliative Medicine in Malaysia 2nd Edition c)Handbook of Children's Palliative Care Malaysia d)Terminal Discharge Guideline, HKL 2023 e)Advance Care Planning Guidance - MOH

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APPENDIX 1

WHO DEFINITION OF PALLIATIVE CARE

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

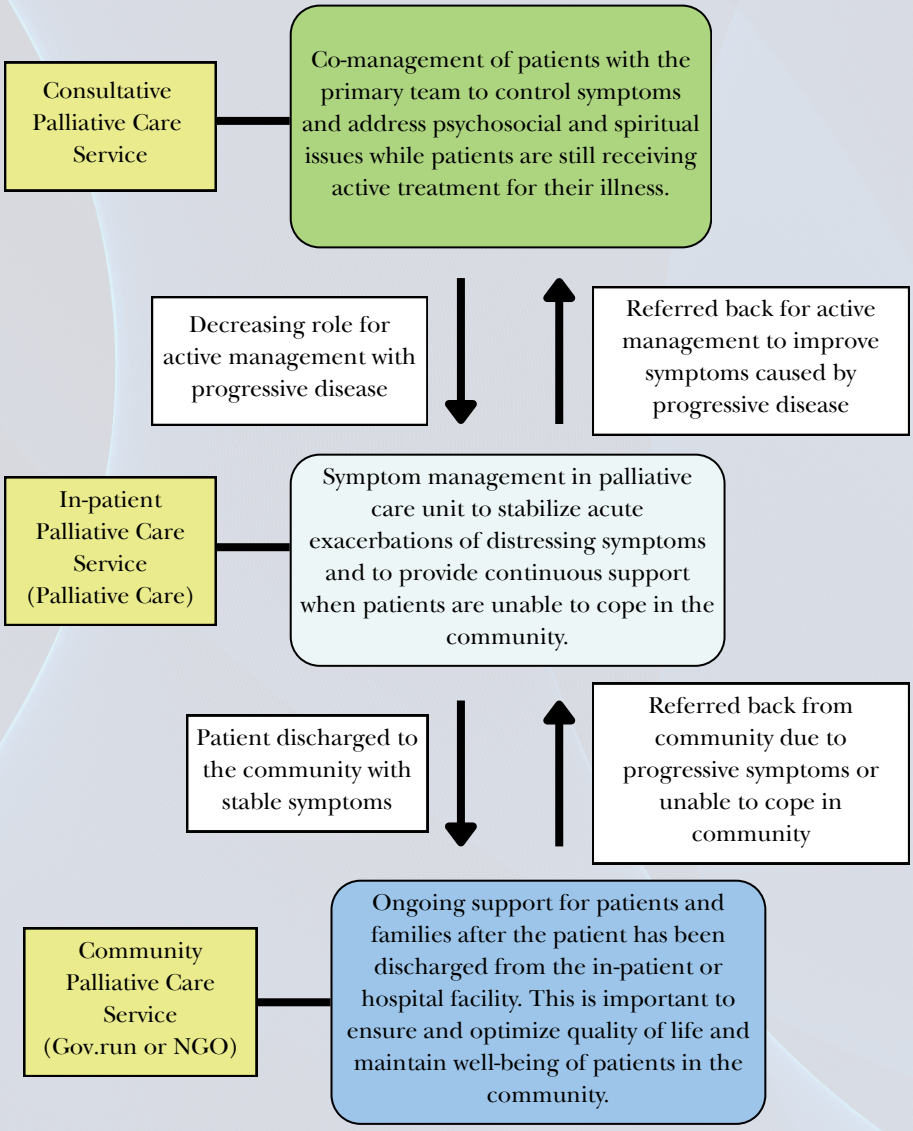
- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

WHO DEFINITION OF PALLIATIVE CARE FOR CHILDREN

Palliative care for children represents a special, albeit closely related field to adult palliative care. WHO's definition of palliative care appropriate for children and their families is as follows; the principles apply to other paediatric chronic disorders (WHO; 1998a):

- Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family.
- It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease.
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centres and even in children's homes.

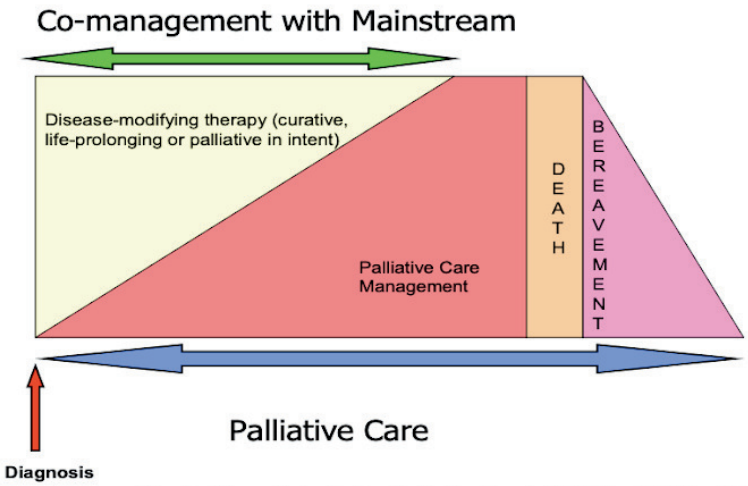
APPENDIX 2



Components of Palliative Care Services and their relationships

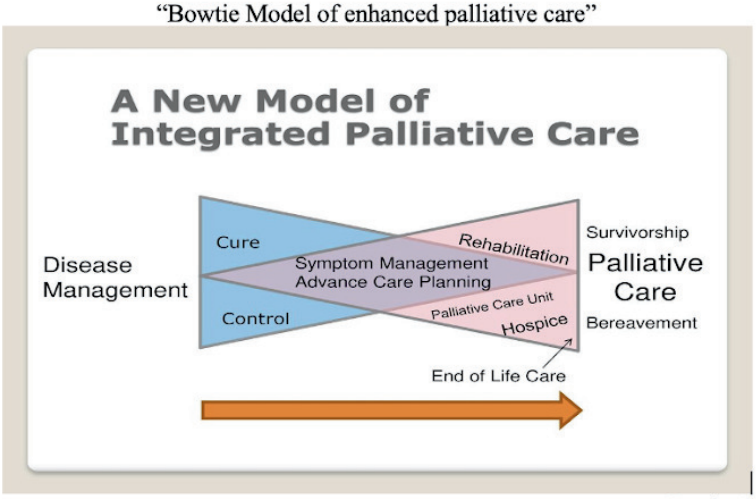
APPENDIX 3

Integrated Model of Palliative Care



Adapted from "Introducing Palliative Care" 4th Edition 2002 by Robert Twycross

"Bowtie Model of enhanced palliative care"



Hawley PH, 2014

APPENDIX 4

Recommended Essential Drugs for Palliative Care Services in MOH Malaysia

A. PAIN MEDICATIONS

No	Drug Name	Dosage Form	Indication
1	Diclofenac	Oral Injection	Step 1 analgesic for mild to moderate somatic pain
2	Ibuprofen	Oral	Step 1 analgesic for mild to moderate somatic pain
3	Paracetamol	Oral	Step 1 analgesic for mild pain or used in combination with stronger opioids for additional effect.
4	Dihydrocodeine tartrate	Oral	Step 2 weak opioid analgesia for moderate pain.
5	Tramadol	Oral Injection	Step 2 weak opioid analgesia for moderate pain. Useful in patients with renal impairment requiring opioid analgesia.
6	Morphine	Oral Injection	Step 3 analgesia of choice for moderately severe to severe cancer pain. Useful for relieving dyspnoea
7	Oxycodone	Oral Injection	Step 3 opioid analgesia for moderately severe to severe cancer pain. Useful as a second line or alternative opioid during opioid rotation.

8	Fentanyl	Transdermal Patch Injection	Step 3 opioid analgesia for moderately severe to severe cancer pain. Useful as a second line or alternative opioid during opioid rotation. Useful for patients with renal failure requiring opioid analgesia. Useful for patients who are unable to swallow medication orally.

B. ANTI-EMETICS

No	Drug Name	Formulation	Indication
1	Metoclopramide	Oral Injection	1st line anti-emetic for any cause of vomiting except complete bowel obstruction.
2	Haloperidol	Oral Injection	2nd line anti-emetic particularly for central nausea Also useful for delirium and terminal restlessness.
3	Ondansetron Therapeutic alternatives -Granisetron	Oral Injection	Prevention and treatment of nausea and vomiting induced by cytotoxic chemotherapy and radiotherapy

C. LAXATIVES

No	Drug Name	Formulation	Indication
1	Bisacodyl	Oral Suppository	Constipation
2	Macrogol	Oral	Constipation
3	Glycerin enema		Constipation with impacted stools in lower rectum
4	Lactulose	Oral	Constipation

D. SEDATIVES

No	Drug Name	Formulation	Indication
1	Lorazepam	Oral	Insomnia Anxiety / Panic attacks
2	Midazolam	Oral Injection	Anxiety Terminal restlessness
3	Diazepam	Rectal Solution	Anxiety Also as a muscle relaxant and anticonvulsant.
4	Zolpidem	Oral	2nd line drug for cancer related insomnia

E. ADJUVANT ANALGESICS

No	Drug Name	Formulation	Indication
1	Amitriptyline	Oral	Depression 1st line for Neuropathic pain
2	Carbamazepine	Oral	Epilepsy Neuropathic pain
3	Sodium Valproate	Oral Injection	Epilepsy Neuropathic pain
4	Gabapentin	Oral	2nd line in neuropathic pain

F. CORTICOSTEROIDS

No	Drug Name	Formulation	Indication
1	Dexamethasone	Oral Injection	Main role in reducing peri-tumour oedema which may relieve symptoms due to mass effect of tumour. Neuropathic pain Anorexia Nausea and vomiting
2	Prednisolone	Oral	Anorexia

G. ANTICHOLINERGIC AGENTS

No	Drug Name	Formulation	Indication
1	Hyoscine butylbromide	Oral Injection	Relieving colicky visceral pain Reducing terminal secretions Nausea & vomiting from bowel dysfunction
2	Loperamide	Oral	Diarrhoea

H. MEDICINE FOR OTHER SYMPTOM AND SUPPORTIVE MEDICINE

No	Drug Name	Formulation	Indication
1	Fluoxetine	Oral	Depressive disorder
2	Zoledronic acid	Injection	Hypercalcaemia

REFERENCES

1. National Essential Medicines List Publication:7th Edition (2025)
2. International Association for Hospice and Palliative Care (IAHPC) List of Essential Medicines for Palliative Care

APPENDIX 5

Essential Palliative Care Equipment (Medical):

No	Item
1	Hospital Beds (Adjustable height +- Electric) + Mattress
2	Syringe drivers (lightweight and portable)
3	Syringe Pump (+- PCA function)
4	Oxygen concentrator
5	Ripple Mattress
6	Walking frames
7	Suction machine
8	Commode chair
9	Patient transfer mat
10	Recliner wheelchair
11	Nebulizer machine
12	Examination couch (Adjustable height)
13	Pulse Oximeter

Non- medical Equipment:

No	Item
1	Single chair sofa bed
2	Television set
3	Dining Table and chair set
4	Microwave Oven
5	Electric Kettle
6	Refrigerator
7	Teacups and plates sets
8	Stand fans
9	Personal computer

APPENDIX 6

TIERS OF PALLIATIVE CARE SERVICES

Tier 1: Hospital with additional specialised services, such as interventional pain management, research centre, and integrated multidisciplinary care.

- Inpatient service with >15 bedded dedicated ward
- Human resource: Ideally 5 resident physicians, 6 medical officers, 24 nurses (50% with specialized nurse training), 6 Health assistants
- A wide range of allied health professionals including pharmacist, occupational therapists, physiotherapists, social workers, dieticians, clinical psychologists and spiritual care provider or a chaplain
- Providing training for basic palliative care, advanced palliative care training and subspecialty training
- Provide community palliative care outreach service
- Involved in training, collaboration with international organisations (other than KKM) and advocacy programmes

Tier 2: Hospitals with resident palliative care physician(s) with dedicated ward and staff.

- Inpatient service with 8 bedded dedicated ward
- Human resource: at least 3 medical officers, at least 16 nurses (30% with specialized nurse training), 6 health assistants
- A wide range of allied health like pharmacist, occupational therapists, physiotherapists, social workers, dieticians, clinical psychologists and spiritual care provider or a chaplain
- Providing training for basic palliative care, advanced palliative care training and subspecialty training
- Provide integrated outreach service
- Involved in training, collaboration with external organisations (other than KKM) and advocacy programmes

Tier 3: Hospitals with resident palliative care physician(s) providing in-patient, consultative and outpatient services.

Tier 4: Non-specialist* hospitals with visiting palliative care physicians.

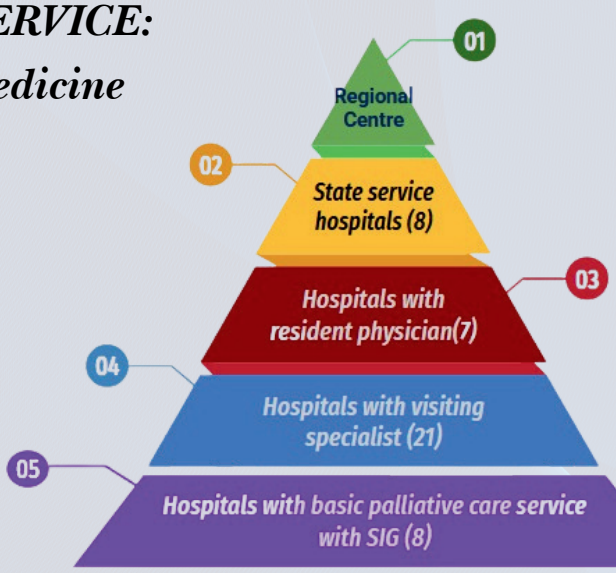
- Consultative and outpatient services provided by a visiting palliative care physician.
- Assisted by 1-2 liaison medical officers and one nurse.

Tier 5: Non-specialist* hospitals providing palliative care services.

- Only provide consultative service with outpatient service.
- Service is provided by either trained dedicated specialist / medical officer with special interest in palliative care.
- Inpatient service with designated beds in a medical or a surgical-based ward.
- Provides dedicated palliative care clinic and day palliative care activity.
- Human resource: at least 2 Medical Officers and 2 nurses to assist in consultation and clinic services.
- Allied healthcare services are available on a need basis

*Non-specialist hospital refers to a hospital without a resident palliative care physician.

TIERS OF SERVICE: Palliative Medicine



FACILITIES	TIER 1 (Regional Hospital)	TIER 2 (State service Hospital)	TIER 3 (With resident physician)	TIER 4 (Visiting service)	TIER 5
Inpatient service	1 ward (15 beds)	1 ward (8 beds)	With or without designated bed	No	No
Consultative service	Yes	Yes	Yes	Yes	Yes
Day Palliative Care service	Yes (procedures) Yes (diversional therapy)	Yes (procedures) Yes (diversional therapy)	No	No	No
Outpatient service	Yes (resident physician)	Yes (resident physician)	Yes (resident physician)	Yes (visiting physician)	Yes (non-specialist)
Human Resource	At least 5 resident physicians 6 MO 1 pharmacist 1 nursing sister 24 nurses (including specialist nurse role with 50% ADPC trained) 6 PPK 1 dedicated PT / OT 1 clinical psychologist 1 spiritual care provider	At least 3 resident physicians 3 MO 1 pharmacist 1 nursing sister 16 nurses (at least 30% ADPC trained) 6 PPK 1 dedicated PT / OT 1 clinical psychologist 1 spiritual care provider	1 or more resident physician 2 MO 1 pharmacist 2 nurses 1 PT / OT	1-2 specialist / MO 1 nurse (special interest)	1-2 specialists / MO (special interest)

FACILITIES	TIER 1 (Regional Hospital)	TIER 2 (State service Hospital)	TIER 3 (With resident physician)	TIER 4 (Visiting service)	TIER 5
Medical Equipment	Electric adjustable bed POCUS machine Refer to APPENDIX 7	Electric adjustable bed POCUS machine Refer to APPENDIX 7	Electric adjustable bed Refer to APPENDIX 7		
Space Areas / Facilities	Ward (include private room) Dedicated clinic Family conference room Day palliative care space Research/ Education Space	Ward (include private room) Dedicated clinic Family conference room Day palliative care space	Clinic Day palliative care space	Clinic space	Clinic space
Specific Budget	Essential medications	Essential medications	Essential medications	Essential medications	Essential medications

APPENDIX 7

BASIC REQUIREMENT FOR PALLIATIVE MEDICINE MINISTRY OF HEALTH MALAYSIA

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