Glasgow City's Riverside Care Home

A local story from Living Well in Communities

Shirley Byron, Mairi Armstrong, Vicki Cloney, Karen Neil, Janice Ritchie

Introduction

The vision of the Scottish Government's Strategic Framework for Action on Palliative and End of Life Care (PEOLC) is that by 2021, everyone in Scotland who needs palliative care will have access to it.

In response to this, the Glasgow City Health and Social Care Partnership project team has assisted staff at Riverside Care Home (a 120-bed local authority run facility) to improve identification and care coordination of residents who would benefit from a palliative approach to their care.

Aim

The intention of this project has been to improve the Palliative and End of Life Care (PEOLC) experience of individuals living within residential care and their families.

To achieve this the focus was put on improving staff knowledge of PEOLC and consequently, their assessment of and response to residents' needs. Also prioritised was the improvement of communication with residents, their families and among health and social care staff.

Method

In April 2018 the SPAR implementation process began in Riverside Care Home. Staff were trained on how to use the SPAR process to identify any change or decline in a resident's condition and then take the appropriate action. The project finished at the end of March 2019, with SPAR operational in all 8 units at Riverside. Continuous audit and review is ensuring that the SPAR process is embedded into the Care Home's practice.

What is SPAR?

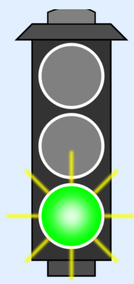
Residents are assessed weekly using the **Supportive Palliative Action Register (SPAR)** process to identify residents' changing needs and the results are recorded in each resident's assessment form. The SPAR process uses a traffic light system in conjunction with the PPSv2 Tool.

Palliative Performance Scale v2 Tool

The Palliative Performance Scale v2 Tool (PPSv2) uses a percentage system to assess a resident's functional status over five categories (see table below). In residential care homes, the assessment begins with the Self care category, as this immediately reflects their current level of need.

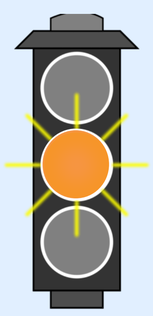
PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

SPAR traffic light system



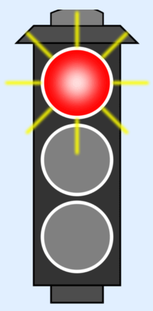
GREEN

Assessment: No major change in physical and/or mental status. Care needs are stable.
PPSv2 Score: No change
Actions: Continue to provide optimum management of long term conditions. Consider/update ACP documentation. Consider eKIS. Review weekly.



AMBER

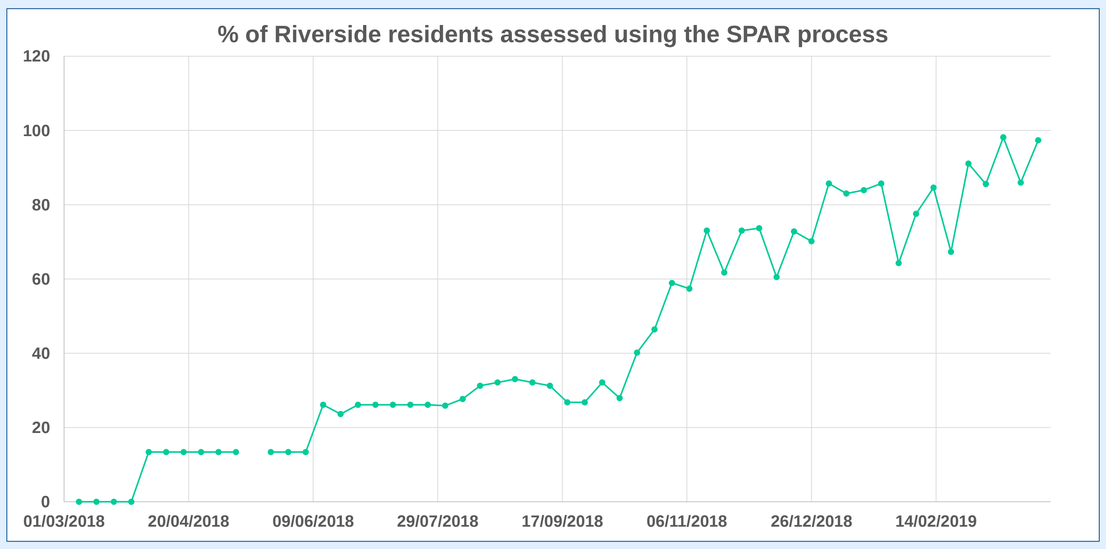
Assessment: Change/decline noted. Noticeable increase in care needs.
PPSv2 Score: Decline
Actions: Discuss change/decline with resident/family, share uncertainty. Consider preferred priorities of care, DNACPR, eKIS and ACP. Notify GP/DN. Review daily.



RED

Assessment: Rapid change/decline noted. Significant/very increase in care needs.
PPSv2 Score: Further change or significant decline
Actions: Discuss change/decline with resident, family, GP/DN/ANP. Consider preferred priorities of care informed by resident/family wishes. Consider anticipatory prescribing (Just in Case), DNACPR and RNVoED. Update ACP and prompt update to eKIS. Review daily or more frequently.

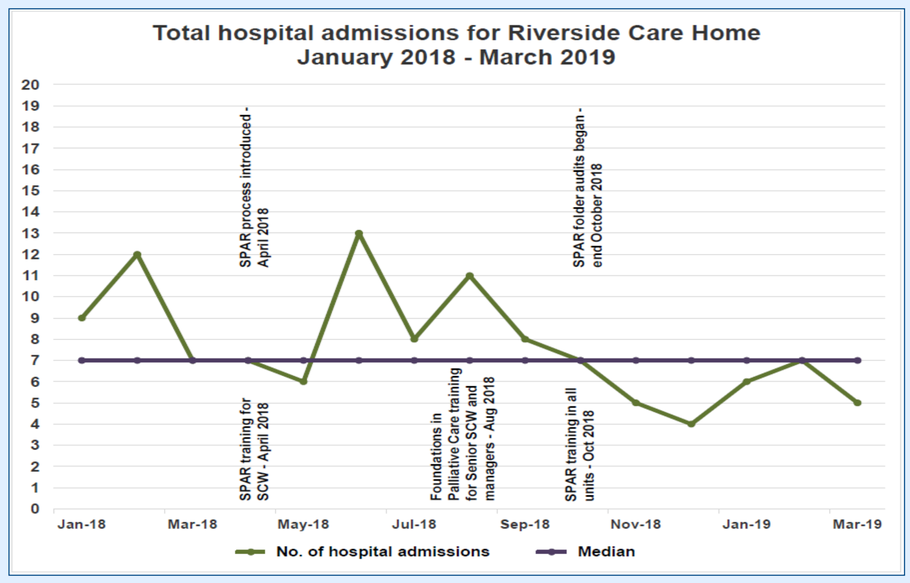
Results



By the end of March 2019 the total percentage of residents assessed was 97.4%

The SPAR work at Riverside Care Home has offered benefits to both residents and staff. These benefits include:

- **Improved staff knowledge and skills** in relation to palliative care and has helped them to better support their residents, both now and in the future
- The SPAR process has contributed to a **significant increase in confidence of staff** to assess the residents' need for palliative care and to communicate with their healthcare colleagues
- **Reduced admissions to hospital**, resulting in a resident dying in their preferred place of care (see graph below)



- The number of residents with a completed *My Summary* section of the **national ACP document** saw an increase
- The percentage of residents who had information forwarded to their GP to update their **Key Information Summary** also increased

More Information

Primary Care Palliative Care Team – palliative.care@ggc.scot.nhs.uk
Website: www.palliativecareggc.org.uk/primarycarepcteam/

Janice Ritchie – Service Manager, Riverside Care Home Janice.Ritchie@glasgow.gov.uk

Healthcare Improvement Scotland - Living Well in Communities programmes:
https://ihub.scot/improvement-programmes/living-well-in-communities/