Supportive and Palliative Action Register (SPAR) 

**Resident’s Name: CHI:**

Care Home/Unit: Room Number:

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| **Date** | **PPSv2 %** | **Failing Rate** *(please tick)*: | | | **Comments/Actions** | **Staff Name Print and Sign** |
| GREEN  **Weekly review** | AMBER  **Daily review initially** (returning to weekly review when improvement identified) | RED  **Daily review** (or more frequently according to clinical need) |
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| **Assessment of Severity and Speed of Change – Failing Rate** | **Action** |
| **GREEN**  **Rate of decline**  – No major change in physical and/or  mental status over last month  **Care needs**  – Stable  **Palliative Performance Score (PPSv2)**  – No change | **GREEN**  **Continue to provide optimum management of long term conditions**  **Update Future Care Plan documentation (Health Section in Care Plan)**  **Consider use of ‘My Thinking Ahead & Making Plans’**  **Review every week or sooner if significant or sudden change** |
| **AMBER**  **Rate of decline**  - Slow to moderate (month by month)  **Sign of irreversible impairment e.g.**  – History of recent fall(s)  – Recent infection  – Slight weight loss despite nutritional  supplements  – Lack of interest in usual activities e.g.  socialising  **Care needs**  – Noticeable increase  **Palliative Performance Score (PPSv2)**  – Decline | **AMBER**  **Discuss deterioration with resident/family. Share uncertainty**  **Agree plans for management/care if resident:**  – Improves  – Maintains current functional status  – Continues to deteriorate  **Discuss with resident’s DN/GP**  **Consider preferred priorities of care informed by resident/family wishes**  **Update Future Care Plan documentation (Health Section in Care Plan)**  **Consider use of ‘My Thinking Ahead & Making Plans’**  **Discuss with DN/GP completion of DNACPR**  **Prompt update of KIS (GP)**  **Revise Supportive and Palliative Action Register (SPAR)**  **Review daily initially then return to weekly if improvement identified** |
| **RED**  **Rate of decline either/or**  – Rapid/severe (day by day)  – Persistent (week by week)  **Significant and/or accelerating**  **deterioration**  **Extent of reversible deterioration is**  **uncertain or unlikely e.g**.  – History of recent fall(s)  – Repeated infections  – Reduced food/fluid intake  – Significant weight loss despite nutritional  supplements  – Lack of interest in life e.g. staying in bed  **Care needs**  – Significant/very significant increase  **Palliative Performance Score (PPSv2)**  – Further or significant decline  And  **Admission to hospital is felt not to be**  **appropriate or is declined** | **RED**  **Discuss deterioration with resident/family. Share uncertainty**  **Prepare for possibility of imminent death/recovery**  **Agree plans for management/care if resident:**  – Improves  – Maintains current functional status  – Continues to deteriorate  – Dies  **Discuss with DN/GP. GP review**  **Consider preferred priorities of care informed by**  **resident/family wishes**  **Consider Anticipatory Prescribing (Just in Case)**  **Update Future Care Plan documentation (Health Section in Care Plan)**  **Discuss with GP completion of DNACPR & RN Confirmation of Death**  **Prompt update of KIS (GP)**  **Revise Supportive and Palliative Action Register (SPAR)**  **Review daily or more frequently according to clinical need** |
| **If clinical judgement indicates resident**  **is dying** | **Consider NHSGGC Guidance at End of Life (GaEL)** |

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