Supportive and Palliative Action Register (SPAR)

Resident's Name: .... CHI: .... Care Home: ....

Date	PPSv2 %	Failing Rate *(please tick)*:			Comments
		Minimal Green *Monthly review*	Moderate Amber *Weekly review*	Rapid / Major Red *Daily review*	

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 Anticipatory Care Plan documentation (Health Section in Care Plan)** **Consider use of 'My Thinking Ahead & Making Plans'** **Review every month 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 Anticipatory 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 weekly or sooner if sudden deterioration**
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 Anticipatory Care Plan documentation (Health Section in Care Plan)** **Discuss with GP completion of DNACPR & RNVoED** **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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