# Supportive and Palliative Action Register (SPAR)

Resident's Name: Peter Piper CHI: 0105418765 Care Home: Ben Starav

| Date | PPSv2 % | Failing Rate *(please tick)*: Minimal Green *Monthly review* | Moderate Amber *Weekly review* | Rapid / Major Red *Daily review* | Comments |
|---|---|---|---|---|---|
| 15/06/17 | 60 | ✓ | | | No change<br>MTA&MPs given to Peter/family |
| 11/07/17 | 60 | ✓ | | | No change<br>No actions needed |
| 06/08/17 | 50 | | ✓ | | Lost interest / needs more help<br>DN contacted – will visit |
| 13/08/17 | 50 | ✓ | | | No change from last week<br>DN visited / nil to add |
| 15/08/17 | 30 | | | ✓ | Sudden change / Chest infection?<br>GP visit requested / Family contacted |
| 16/08/17 | 30 | ✓ | | | Seems a wee bit better<br>Family contacted |
| 24/08/17 | 40 | ✓ | | | Peter stable again<br>Nothing extra needed |
| 20/09/17 | 40 | ✓ | | | Stable |
| 19/10/17 | 40 | ✓ | | | Stable |
| 18/11/17 | 40 | ✓ | | | Stable |
| 04/12/17 | 40 | ✓ | | | Son (London) unhappy<br>Big discussion / SPAR evidence<br>Updated ACP & PPC |
| 03/01/18 | 30 | | ✓ | | Peter becoming frailer<br>DN contacted |
| 07/01/18 | 20 | | | ✓ | Peter seems very ill / chest infection?<br>All staff aware / GP visit requested<br>Family contacted |
| 08/01/18 | 10 | | | ✓ | Peter dying?<br>DN visiting & GP reviewing later<br>Family aware |
| 09/01/18 | 10 | | | ✓ | Peter unresponsive<br>Seems comfortable<br>All family present |
| 10/01/18 | | | | | Peter died peacefully at 03:17 |

| Assessment of Severity and Speed of Change – Failing Rate | Action |
|---|---|
| **GREEN**<br><br>**Rate of decline**<br>– No major change in physical and/or mental status over last month<br>**Care needs**<br>– Stable<br>**Palliative Performance Score (PPSv2)**<br>– No change | **GREEN**<br><br>**Continue to provide optimum management of long term conditions**<br>**Consider commencing/updating Anticipatory Care Plan**<br>**Consider use of 'My Thinking Ahead & Making Plans'**<br>**Consider KIS (GP)**<br><br>**Review every month or sooner if significant or sudden change** |
| **AMBER**<br><br>**Rate of decline**<br>- Slow to moderate (month by month)<br><br>**Sign of irreversible impairment e.g.**<br>– History of recent fall(s)<br>– Recent infection<br>– Slight weight loss despite nutritional supplements<br>– Lack of interest in usual activities e.g. socialising<br><br>**Care needs**<br>– Noticeable increase<br><br>**Palliative Performance Score (PPSv2)**<br>– Decline | **AMBER**<br><br>**Discuss deterioration with patient/family. Share uncertainty**<br>**Agree plans for management/care if patient:**<br>– Improves<br>– Maintains current functional status<br>– Continues to deteriorate<br><br>**Discuss with resident's Community Nurse and/or GP**<br>**Possible joint Care Worker & Community Nurse assessment**<br>**Consider preferred priorities of care informed by patient/family wishes**<br>**Commence/update Anticipatory Care Plan**<br>**Consider use of 'My Thinking Ahead & Making Plans'**<br>**Discuss with GP completion of DNACPR**<br>**Commence/update KIS (GP)**<br>**Revise Supportive and Palliative Action Register (SPAR)**<br><br>**Review weekly or sooner if sudden deterioration** |
| **RED**<br><br>**Rate of decline either/or**<br>– Rapid/severe (day by day)<br>– Persistent (week by week)<br>**Significant and/or accelerating deterioration**<br>**Extent of reversible deterioration is uncertain or unlikely e.**g.<br>– History of recent fall(s)<br>– Repeated infections<br>– Reduced food/fluid intake<br>– Significant weight loss despite nutritional supplements<br>– Lack of interest in life e.g. staying in bed<br>**Care needs**<br>– Significant/very significant increase<br><br>**Palliative Performance Score (PPSv2)**<br>– Further or significant decline<br><br>And<br>**Admission to hospital is felt not to be appropriate or is declined** | **RED**<br><br>**Discuss deterioration with patient/family. Share uncertainty**<br>**Prepare for possibility of imminent death/recovery**<br>**Agree plans for management/care if patient:**<br>– Improves<br>– Maintains current functional status<br>– Continues to deteriorate<br>– Dies<br><br>**Discuss with GP/Resident's Community Nurse**<br>**GP review**<br>**Consider preferred priorities of care informed by patient/family wishes**<br>**Consider Anticipatory Prescribing (JiC)**<br>**Update Anticipatory Care Plan**<br>**Discuss with GP completion of DNACPR & RNVoED**<br>**Update KIS (GP)**<br>**Revise Supportive and Palliative Action Register (SPAR)**<br><br>**Review daily or more frequently according to clinical need** |
| **If clinical judgement indicates patient is dying** | **Consider NHSGGC Guidance at End of Life (GaEL)** |