

Glasgow City's Riverside Care Home

A local story

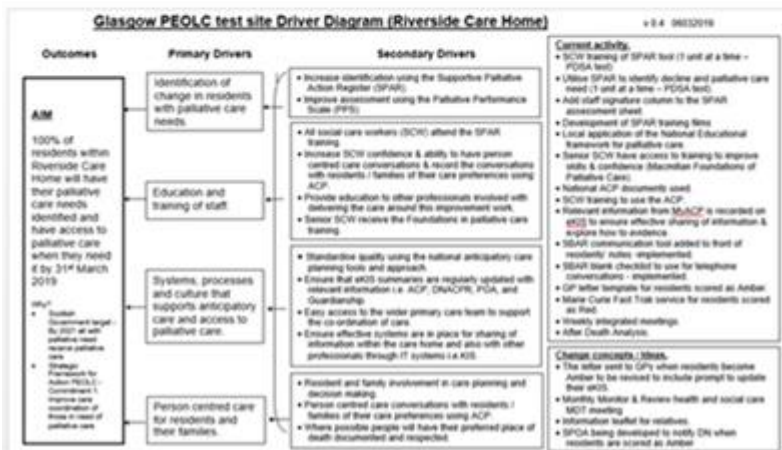
The vision of the Scottish Government's Strategic Framework for Action on Palliative and End of Life Care (PEOLC) is that by 2021, everyone in Scotland who needs palliative care will have access to it. To help achieve this, the framework identifies 10 Commitments, with Commitment 1 focusing on improving the identification and care coordination of those who would benefit from a palliative approach to their care. The work at Riverside Care Home responds both to Commitment 1 and to the aims of Healthcare Improvement Scotland's Living Well in Communities programmes.

The intention of this project has been to improve the palliative and end of life care experience of individuals living within residential care and their families. The priorities identified to achieve this included improving staff knowledge of PEOLC and consequently, their assessment of and response to residents' needs. This has been facilitated by the development of improved communication with residents and their families and among health and social care staff. A better care understanding of palliative care and more effective communication has also reduced admissions to hospital and has highlighted the importance of an individual's preferred place of care.



The Glasgow City Health and Social Care partnership (HSCP) project team used the Supportive Palliative Action Register (SPAR) and the Palliative Performance Scale v2 tool (PPSv2) to assist staff in identifying any change or decline in a resident living within Riverside Care Home and then to coordinate care based on the individual's wishes and level of need. Riverside Care Home is a 120-bedded care facility made up of eight 15-bedded units. The test of change began by training the care home staff on how to use the SPAR process (the traffic light system and the PPSv2 tool) to identify any changes or decline in a resident's condition and then take the appropriate action. The project team utilised the Model for Improvement, including Plan Do Study Act (PDSA) Cycles, throughout the project to guide their thinking, test changes and evidence any improvements.

In April 2018 the SPAR implementation process began in one 15-bed unit, with staff conducting weekly SPAR review assessments. Implementation in subsequent units has been rolled out one unit at a time, allowing new learning from PDSA cycles to be put into action. Continuous audit and review is ensuring that the SPAR process is embedded into the care home's practice. The project finished at the end of March 2019, with SPAR operational in all eight units at Riverside.



Glasgow City deliver their service by:



The SPAR process is used weekly to identify residents' changing needs and the results are recorded in each resident's assessment form.

- *'Green'* – Residents who do not appear to be declining or who are declining very slowly, and whose care needs are stable. The requirement for supportive and palliative care is fairly small for these residents.
- *'Amber'* – Residents whose condition has changed, possibly due to infection or a general decline. The requirement for supportive and palliative care may be increasing for these residents.
- *'Red'* – Residents whose condition has changed rapidly and whose care needs have significantly increased. In this situation, death might be anticipated in just a few days or weeks. This group have a high level of need for supportive and palliative care.

The Palliative Performance Scale v2 is a tool used to identify change in a person's functional status, originally used in cancer care within a hospice setting. In the care home population, the tool is used differently. Originally this tool works from left to right, scoring the individual's ambulation, activity and evidence of disease, self-care, intake and conscious level. However, in residential care the initial assessment starts with the 'Self Care' column reflecting the level of care required by the individual resident before considering the content of the other columns.



The SPAR Process enhances an Anticipatory Care Planning (ACP) approach by:

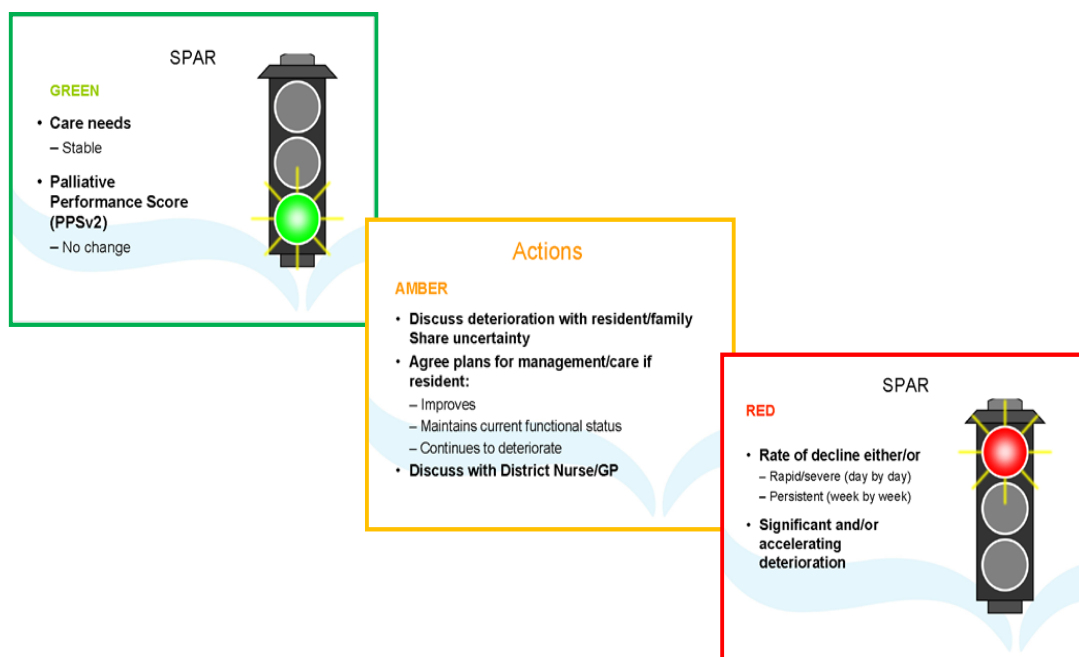
- Enabling staff to identify change and respond to it using improved assessment, communication skills and a clear documentation system
- Ensuring residents PEOLC needs are assessed at maximum timescale of weekly, enabling staff to quickly identify a decline in residents due to an increasing or more complex level of need.
- Encouraging the use of a robust Anticipatory Care Planning (ACP) document to record significant discussions and decisions such as Preferred Place of Care (PPC) and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR).
- Encouraging an improved multi-disciplinary approach to care through effective communication skills and structures.
- Ultimately being aware of the resident's wishes and hopefully then achieving their preferred outcomes of care.



The actions in the SPAR process support individuals to continue to live in a homely setting.

- Green - Continue to provide optimum management of long term conditions, update ACP documentation, review weekly or sooner if significant/sudden change.
- Amber - Discuss change in condition with resident & their family. Notify GP via template letter and phone if required. Consider preferred priorities of care, DNACPR, prompt an update of electronic Key Information Summary (eKIS) and ACP. Review daily unless improvement noted.
- Red - Discuss change in condition with resident, their family, district nurses and GP. Consider preferred priorities of care informed by resident/family wishes. Discuss Just in Case medications, DNACPR and Registered Nurse Verification of Expected Adult Death (RNVoeAD). Also, update ACP and prompt an update to eKIS. Review daily or more frequently according to changing need.

These interventions promote a proactive approach to palliative care and encourage residents and their families to become active participants in that care. Working together with care home staff, community nursing and GPs, residents are supported to stay in their preferred place of care.



Measurement Plan

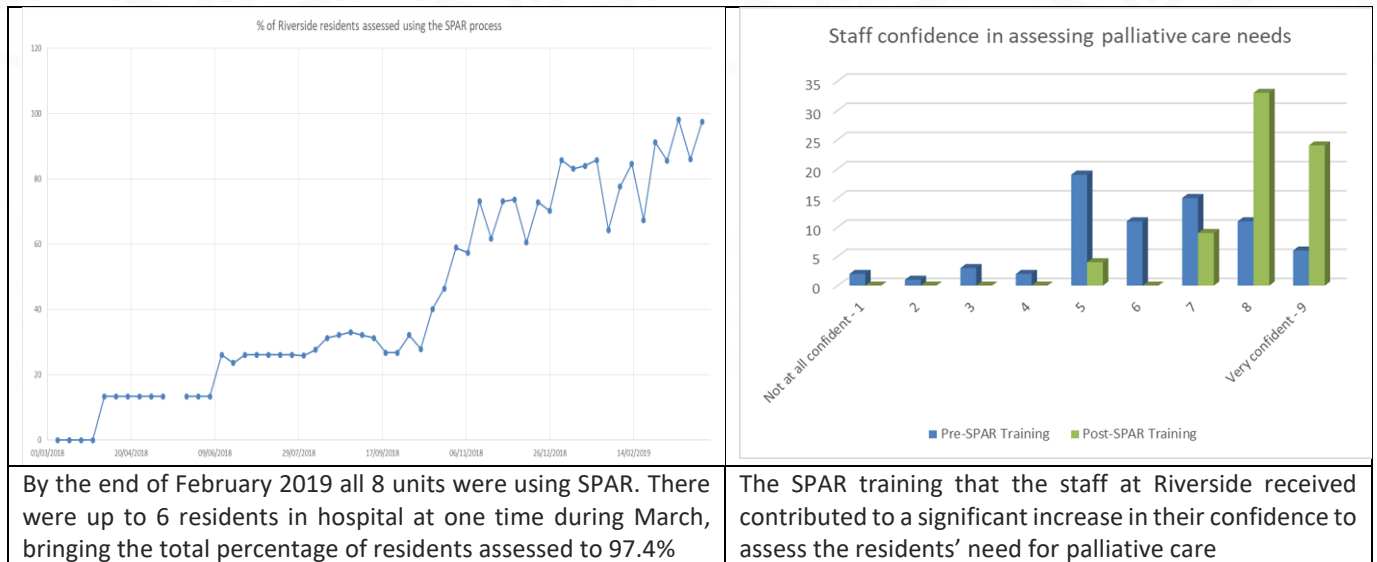
Measures linked to each Primary Driver of the Driver Diagram.

Primary Driver		Measures	Type
Identification of change in residents with palliative care needs	1	% of residents in the care home assessed using the SPAR process.	Outcome
Education and training of staff.	2	% of care staff in the care home who have attended SPAR training.	Process
	3	Increase in skills and confidence levels of care staff in the SPAR process	Process
	4	% of the management team in the care home who have attended the Foundations in palliative care training.	Process
Systems, processes and culture that supports anticipatory care and access to palliative care.	5	% of residents where the information for eKIS has been forwarded to the Associate Clinical Director, to then forward to GP.	Process
	6	% of residents identified as amber or red where actions have been followed through.	Process
	7	% of residents with a completed DNACPR form.	Process
Person centred care for residents and their families.	8	% residents who have the 'My Summary' pages of their ACP completed.	Process
Extra		Qualitative evidence <ul style="list-style-type: none"> • Case examples • Staff experience of SPAR etc. 	Process

Data Collection...what we've learned

Training

The SPAR process is underpinned by training. Prior to introducing the new process to each unit, the care home staff participated in SPAR training. Additionally, senior social care workers and care home managers were given the opportunity to attend a four-day Macmillan Foundations in Palliative Care (FIPC) course led by Macmillan Nurse Facilitators from the Primary Care Palliative Care team. Both training courses 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.

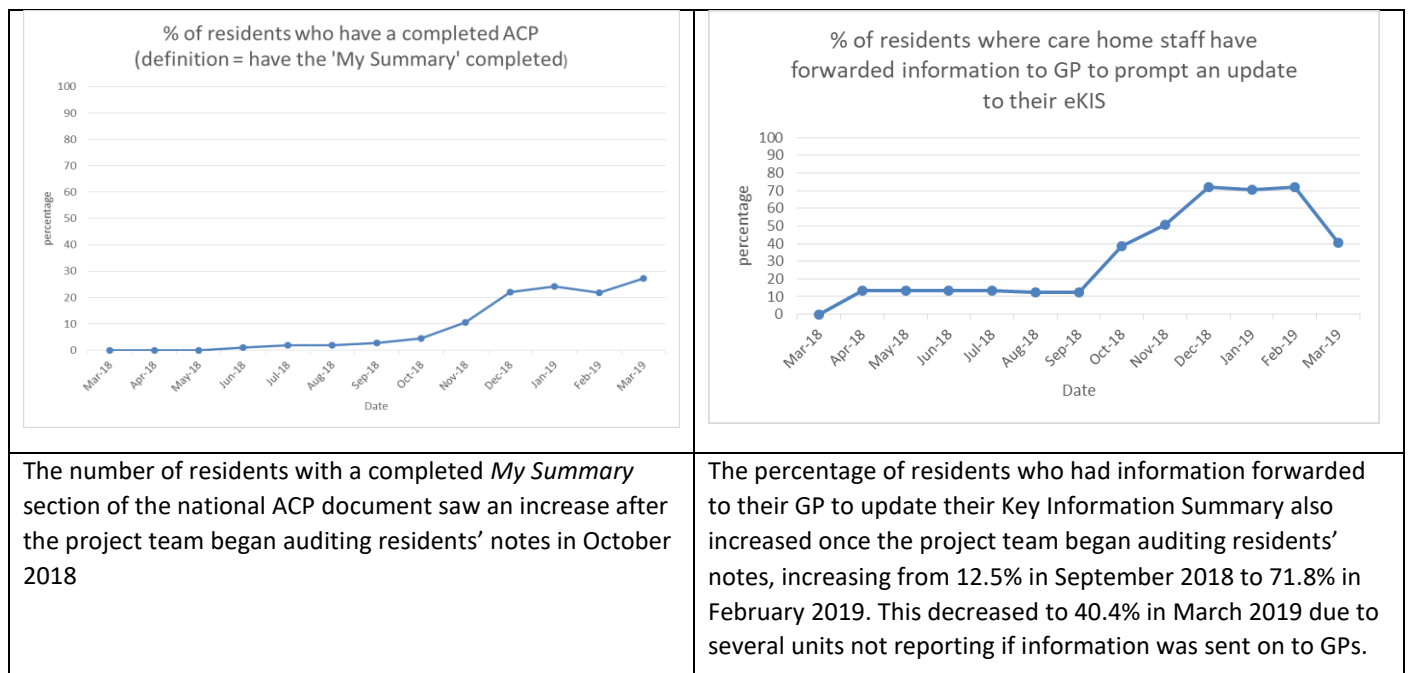


By the end of February 2019 all 8 units were using SPAR. There were up to 6 residents in hospital at one time during March, bringing the total percentage of residents assessed to 97.4%

The SPAR training that the staff at Riverside received contributed to a significant increase in their confidence to assess the residents' need for palliative care

Communication to facilitate and plan care

The FIPC training gave staff at Riverside the confidence to have Anticipatory Care Planning (ACP) conversations with residents and their families, giving the residents the opportunity to share their thoughts on their care and wishes for the future. The care home uses the national ACP tool, My Anticipatory Care Plan, to facilitate and document these conversations. However, the project team discovered that an individual's most important wishes can be captured by completing just the *My Summary* section of the document.



The number of residents with a completed *My Summary* section of the national ACP document saw an increase after the project team began auditing residents' notes in October 2018

The percentage of residents who had information forwarded to their GP to update their Key Information Summary also increased once the project team began auditing residents' notes, increasing from 12.5% in September 2018 to 71.8% in February 2019. This decreased to 40.4% in March 2019 due to several units not reporting if information was sent on to GPs.

Similarly, participating in the SPAR test of change helped improve the care home staff's confidence to communicate with their healthcare colleagues. By implementing an SBAR (Situation, Background, Assessment, Recommendation) tool, social care workers at Riverside were able to pass relevant information to the district nurses and GP practices when a change in a resident's condition was identified. The test of change also developed a process to enable care home staff to provide information to GPs to update the residents' Key Information Summaries (KIS). With the care home staff's increased confidence in communicating with district nurses and GP practices, relationships with these healthcare colleagues have developed and an integrated care team has emerged.

The future for SPAR in Glasgow

The SPAR work at Riverside Care Home has achieved benefits for both the residents and staff. Recognising this success, Glasgow City Health and Social Care Partnership (HSCP) are rolling out the SPAR process to two further local authority-run care homes within Glasgow City. This new phase of the SPAR project started in April 2019 and is led by the Macmillan Nurse facilitators and an integrated team of health and social care professionals.

More information about the SPAR process is available on the [Primary Care Palliative Care Team page](#) of the NHS Greater Glasgow and Clyde Palliative Care website.

Alternatively, please contact:

- Shirley Byron – Macmillan Nurse Facilitator Shirley.Byron@ggc.scot.nhs.uk
- Mairi Armstrong – Macmillan Nurse Facilitator Mairi.Armstrong@ggc.scot.nhs.uk
- Vicki Cloney – Associate Improvement Advisor Victoria.cloney@ggc.scot.nhs.uk
- Janice Ritchie – Service Manager, Riverside Care Home Janice.Ritchie@glasgow.gov.uk

There is more information on Living Well in Communities, including resources on palliative and end of life care, on the ihub [website](#).