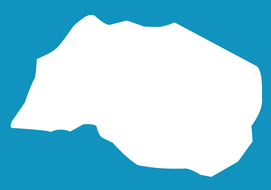
ALL ON THE SAME PAGE: A COLLABORATIVE APPROACH TO SUPPORTING PALLIATIVE CARE IN CARE HOMES

Ardgowan Hospice

INVERCLYDE HSCP Health and Social Care Partnership

Care Home Collaborative

Background



Inverclyde Health and Social Care Partnership (HSCP), in collaboration with Ardgowan Hospice, identified a need to strengthen palliative and end of life care within the 13 adult care homes in Inverclyde.

Before the project:

- hospital admissions near the end of life were common
- care home staff expressed variable confidence in managing deterioration and accessing specialist support.

Trends in place of death by 2040 show that two thirds of people in Scotland are likely to die in a community setting including their own homes, care homes and hospices, with hospital deaths accounting for 34% down from 50% in 2017.

It will not be possible to support these deaths well if community support is not creatively reimagined.

Education

- Six-week Palliative Care Champions Programme has been established across Inverclyde care homes.
- Champions act as local points of contact, promote best practice, and encourage early conversations about residents' changing needs.
- The programme has fostered peer support and improved engagement with the hospice advice line.
- RESTORE 2 training has been rolled out with support from the Care Home Collaborative (CHC)

> "Having met some of the palliative care team I would feel happy to call for advice. They are approachable."

The Collaborative Model

- Established as a joint initiative between Inverclyde HSCP and Ardgowan Hospice in December 2023.
- Includes:
  - Additional weekend district nursing capacity
  - Access to a senior decision maker
  - Direct hospice advice for care home staff
  - Education

A weekly MDT "Virtual Ward" Teams call gives everyone involved in care a chance to proactively discuss deteriorating residents. The link is available to all local care homes and they can join if needed to discuss a specific resident or residents.

Impact (Dec 2023 – Sept 2025)

> "89 Patients with 92 Episodes of Care"

> "Of the 82 patients who have died 81 have died in their usual place of residence"

> "1 patient died in Hospital"

Local ambulance conveyance rates have reduced, with professional consensus that many hospital admissions were prevented.

There is growing evidence of improved staff confidence, earlier identification of deterioration, and stronger relationships between care homes, community nursing, and hospice teams.

Learning & Reflections

- "Joined up" care reduces crises: weekly discussion promotes early, proactive planning and reduces unplanned hospital admissions.
- Relationships matter: collaborative working has improved mutual understanding across teams.
- Education empowers staff: champions are embedding a culture of confidence and compassion.
- Joint leadership is key: alignment between HSCP and hospice structures has ensured sustainability and shared ownership.