Anticipatory Care Planning (ACP) in the Community with REDMAP

The 6-step RED-MAP framework is recommended to guide anticipatory care planning discussions in all care settings in Scotland. It gives some examples of what we can say at each step and highlights key phrases you can adapt to different people and situations.

Ask for help and support from colleagues, senior staff, or a specialist. Seek a second opinion if needed.

REDMAP framework for anticipatory care planning (ACP)	
Ready	Can we talk about your health and care? Who should be involved?
Expect	What do you know? Do you want to tell/ask me about anything? What has changed? Some people think about what might happen if…
Diagnosis	What we know is... We don't know... We are not sure … I hope that, but I am worried about… It is possible that you might…. Do you have questions or worries we can talk about?
Matters	What is important to you and your family? What would you like to be able to do? How would you like to be cared for? Is there anything you do not want? What would (name) say about this situation, if we could ask them?
Actions	What we can do is... Options that can help are…. This will not help because.... That does not work when…
Plan	Let's plan ahead for when/if.... Making some plans in advance helps people get better care.

Some communication approaches are known to be helpful when talking about deteriorating health, future care planning, or death and dying. The box below has some examples of these.

Talking about anticipatory care planning	
Generalisation	**Sometimes people** choose family members or close friends to help make decisions for them if they get less well in the future. Have you thought about that?
Hypothetical questions	**If** you were less well (like this) in the future, what do you think we should do?
Sharing decisions	Can we talk about what is **important** for you (and your family)? That will let us make good decisions together. Who **should be involved** in talking about your health and care? What would (*person's name*) **say** about this situation, **if** we could ask them? We **don't know** exactly what will happen or when, but **we can plan** for how to manage...
Hope linked with concern	We **hope** the (treatment) will help, but I am **worried** that at some stage, you will not get better…. We are doing our best to treat him, but **it is possible** he will die… I **wish** there was more treatment…Could we talk about **what we can** do if that will not help you?

Choosing language carefully when having anticipatory care planning conversations can help support clear, unambiguous communication that people and their families can understand.

The box below has some helpful tips.

Helpful language in anticipatory care planning towards the end of life		
Poor word choice	**Possible misinterpretation**	**DO SAY**
What do you want us to do?	*Patient (and/or family) is responsible for making the decisions.* *People can choose whatever they want.*	What is important for you and your family in this situation? What would (*person's name*) say if we could ask them?
There is nothing more we can do. S/he is being 'made palliative'. Treatment is 'futile'.	*Patient and family are being abandoned by the clinical team.* *This person is not valued.*	We will do everything we can to make sure you (*person's name*) are cared for well, and are as comfortable as possible.
We are going to 'withdraw' treatment.	*Professionals will give less care and attention to the person now.*	We are continuing to care for you (*person's name*) while stopping treatments that are not working and may cause distress or discomfort.
The 'ceiling' of treatment or care is…	*A person is not being given treatment that could help them.*	This is what we can do. Some treatments do not help when a person has these problems with their health/is seriously ill or dying.

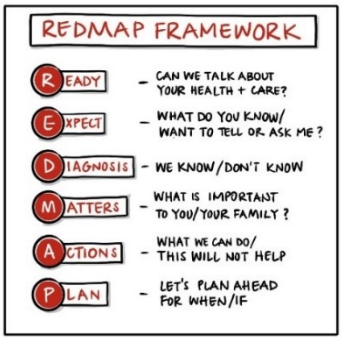
Adapted from ANZIC Guide 2014 (https://bit.ly/2XNEi6F)

Anticipatory care planning is relevant in all care settings and can help a wide range of patients and families. Different approaches to ACP and recording care plans are used in Scotland but the conversations are similar.

- Healthcare Improvement Scotland (HIS) Toolkit offers guidance on anticipatory care planning for professionals. https://ihub.scot/acp

- ACP prompt cards for professionals are downloadable to your device and/or for teaching. https://ihub.scot/media/8891/acp-prompt-cards-for-professionals.pdf

- NHS Inform has public information on anticipatory care planning including key questions about ACP, CPR decisions and how people can talk about care. www.nhsinform.scot/acp



The box below shows how REDMAP can be used to talk about anticipatory care planning in the community.

REDMAP Guide: Care planning in the Community

R eady	**Introduce ACP and outline why it helps people get better care.**

Plan these conversations in advance so everyone is prepared, and the right people are included.
**Can we talk about what is happening with your health in case you (*or people who support and help you at home*) get less well in future? *Would you like anyone close to you to be involved?*
** It helps to think ahead and talk about what **might happen** so we know **what is important** to you.*
Have you talked about **planning ahead for changes in your health, treatment or care with anyone before?*
**Do you have any kind of care plan already? Is there someone who has Power of Attorney for you?*
**We can talk about what might happen for (*person's name*), and what will be of most help to them.*

E xpect	**Find out what the person knows, thinks might happen, or is worried about.**

**Can I ask what you know about your health problems?*
**How have you been doing recently? Has anything changed?*
Have you talked or thought about what might happen **if you get less well or are seriously ill in the future?*
**Do you want to tell/ask me about anything important for you or your family?*

D iagnosis	**Share health information tailored to the person.**

Explain what we know in 'short chunks with pauses' to check for people's reactions and questions. Acknowledge and share uncertainty. Use clear language with no jargon and short sentences.
** What **we know** is that… *We are **not sure** about…*
We **don't know exactly what will happen or when, but **we can plan** for how to manage your care.*
We **hope you will stay well/ improve with.., but **I am worried** about… It's possible you will not get better.*
You are less well than before because… * **If that were to happen, having a plan would help with...*
**You may have thoughts, questions or worries we can talk about…*

M atters	**Talk about what is important to the person and their family.**

Can we talk about how you **would like to be cared for in the future?*
** What things would you **like to be able to do**?*
** Is there anything **you do not want** to happen or wish to avoid?*
What do you think (*person's name*) **would say about this situation, if we could ask them?*

A ctions	**Discuss realistic, available treatment and care options for this person/family.**

Options depend on a person's goals and preferences, best place of care, and clinical situation.
What we **can do is…. *Options that **can help** you are…" *That **may help**, but what could happen is…*
This **will not help because..." *That **does not work** for someone when…*
****I wish** we could do that/give you that treatment... Can we talk about what is possible?*
**Can we talk about what going to hospital might mean for you?*

Make a clinical assessment of CPR outcomes. Discuss CPR in line with the person's clinical situation.
**Can I ask if you know anything about cardiopulmonary resuscitation or CPR?*
CPR is treatment to restart the heart and breathing after they have stopped.
*- CPR **does not work** when a person is in very poor health or dying. It is better for us to plan good care.*
*- CPR **may work** but can leave a person in poorer health if they have certain underlying health conditions.*
- Some people choose not to have CPR.
*Any other treatments that **can help** you will be given/continued. Can we talk about your situation?*

P lan	**Agree a plan that is right for this person, record and share it. Plan regular reviews.**

**We make a personal treatment and care plan for you and share it securely with other professionals and teams so everyone knows what to do. *All care plans are reviewed regularly, or if your health, situation or wishes change.*