Anticipatory Care Planning in Hospital (ACP/TEP) with REDMAP

The 6-step RED-MAP framework is recommended to guide anticipatory care planning discussions 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.

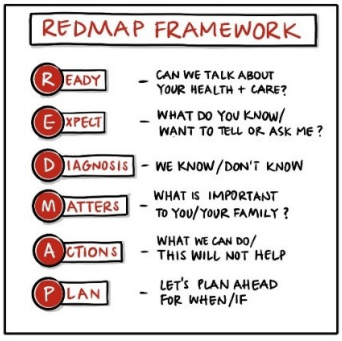
Adapted from ANZIC Guide 2014 (https://bit.ly/2XNEi6F)

Anticipatory care planning is relevant in all care settings and can help a wide range of patients and families. Different approaches to ACP are used in hospitals across Scotland – e.g. Treatment Escalation Planning (TEP) and the ReSPECT process - 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 hospital.

REDMAP guide to care planning for hospital professionals

Ready	**Can we talk about why care planning helps people get better care?**

Plan conversations, even if the same day, so everyone is prepared, and the right people are involved.

- My name is…, I am (your title). My role in the team here is...
- Can we make a time to talk about your treatment and care?
  Is there anyone else we should speak to?
- I'd like to talk about what we are doing to help you and hear about **what is important** for you.
- We are doing our best to care for you, but we **are worried** about your ... condition.
- Who should we talk to if you are less well and not able to make decisions with us?
- We can talk about what might happen for (person's name), and what will be of most help to them.

Expect	**It would help to hear what you know about your health, and think might happen.**

- I'll explain what we think is happening, but do you want to tell/ask me anything important first?
- How have you been doing recently/today? What has changed with your health?
- Has anyone talked with you about what might happen **if** you get less well, or are very ill?

Diagnosis	**There are things we know about your health, and things we are not sure about.**

Share information tailored to people's understanding, and how they are feeling. 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.

- You are less well because… It **is possible** you will not get better **if**… I'm afraid you are seriously ill...
- We **hope** you will improve with..., but **I am worried** about…
  I am sorry, but you could die with this illness...
- We **don't know** exactly what will happen or when, but we **can plan** for what to do if...

You may have thoughts, questions, or worries we can discuss.

Matters	**We'd like to know what's important to you and your family.**

- Can we talk about how you **would like** to be cared for?
- Is there anything you **would like** to do?
- Is there anything you wish to avoid/do not want to happen?
  Is there any treatment you would not want?
- Can you tell us what you think (person's name) **would say** in this situation, if we could ask them?
  Have they ever talked about what they **would like** to happen if they were very ill or dying?

Actions	**Let's talk about what we can do, and things that may not help or work for you.**

Talk about realistic, available options for treatment, care**,** and support for this person. Be honest and clear about what can help or will not work. Options depend on the best place of care.

- What we **can do** is...
- Options that **can help** you are…"
- This will **not help** because...
- That does **not work** for someone when…
- For people who are already in poor health and need help from others at home or in a care home, it may be better to look after them in a familiar place when they are very ill and dying, if that's possible.
- Intensive care does not help everyone. For some people, it is better for us to care for them differently.
- **I wish** there was more treatment we could give for this. Could we talk about what we can do?

Make a clinical assessment of CPR outcomes. Discuss CPR in line with the clinical situation.

- Can I ask what you know about cardio-pulmonary resuscitation or CPR?
    - CPR is treatment to restart the heart and breathing after they have stopped.
    - CPR helps in some situations but does not work for everyone.
        - 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 are given.
- Can we talk about your situation?

Plan	**We record, share, and review all the plans we make for treatment and care.**

Use available forms and online systems to record and share care plans and DNACPR decisions.