Anticipatory Care Planning (ACP) with ReSPECT (REDMAP guide)

The 6-step REDMAP framework is recommended for anticipatory care planning discussions in all care settings. It gives examples of what we can say and key phrases you can adapt to different people and situations. REDMAP is used to guide conversations as part of the **ReSPECT process** (*Recommended Summary Plan for Emergency Care and Treatment*). (https://www.resus.org.uk/respect)

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.

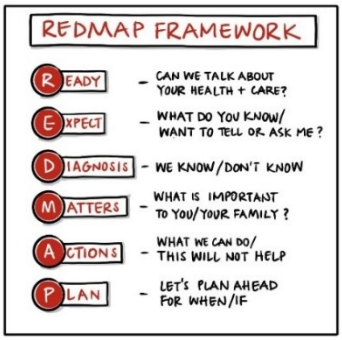
Adapted from ANZIC Guide 2014 (https://bit.ly/2XNEi6F)

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 a ReSPECT conversation.

REDMAP guide to talking about Care Planning using ReSPECT

R E D steps build 'Shared understanding of my health and current condition'.
M explores 'What matters to me in decisions about my treatment and care in an emergency'.
A is actions that can work or help: 'Recommendations for emergency care and treatment'.
P includes cardiopulmonary resuscitation (CPR) as part of wider care planning discussions.

REDMAP	
R eady	**Can we talk about why thinking and planning ahead helps people get better care?**
Plan these conversations in advance so everyone is prepared, and the right people are included. **Talking about your health is important in case you get less well and need urgent or emergency care.* **Would you like anyone close to you be involved? What is the best way for us to do that?* **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	**It would help to hear what you know about your health and think might happen.**
Can I ask what you know about your health problems and how you are now? How have you been doing recently? Has anything changed? Is there anything you want to tell/ask me about you/your family?* **Have you talked or thought about what might happen **if you get less well or are seriously ill?*	
D iagnosis	**There are things we know about your health, and things we are not sure about.**
Explain what we do know in "short chunks with pauses" to check for people's reactions or questions. Acknowledge and share uncertainty. Use clear language with no jargon and short sentences. **__If__ that were to happen, having a plan would help with...*What we know is that…*We are not sure about* **We __hope__ you will stay well/improve with... but __I am worried__ about… It's possible you will not get better.* **We __don't know__ exactly what will happen or when, but __we can plan__ for how to manage...* **You may have some thoughts, questions or worries we can talk about?*	
M atters	**What would be important for you if you get less well or are seriously ill?**
**Sometimes people need urgent care or emergency treatment. It helps to plan for what might happen.* **Can we talk about how you __would like__ to be cared for? Are there things you __do not want__ to happen?* **Can you tell me what you think (*person's name*) __would say__ in this situation, if we could ask them?* ** What matters more for you: having any available tests and treatments or quality of life and comfort?*	
A ctions	**Let's talk about what we can do to care for you, and things that may not help.**
Talk about realistic, available options for treatment, care and support for this person/family. **What we __can do__ is… *Options that __can help__ 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, 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 cardio-pulmonary 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	**We record and share your plan with other professionals so everyone knows what to do. All plans are reviewed regularly, and updated if your health, situation or wishes change.*