Let's think ahead

Care Planning in Hospital - Key steps for clinicians

Introduction

Care planning supports effective person-centred care if a person's health is unstable or deteriorating. Care planning is a process that takes account of what matters to people and their health problems. RED-MAP model supports good care planning conversations with patients and families.

1. IDENTIFY: people with unstable or deteriorating health

►Progressive, life-limiting conditions: advanced cancer, organ failure, advanced neurological disease, or dementia.
►Progressive frailty in older people.
►New serious illness or infection, or disease complications.
►Multiple, long-term conditions or complex health problems.
►Increasing personal care and support needs due to declining physical and/or mental health.

Triggers for planning discussions

- Unplanned hospital admissions.
- Notable decline in function, abilities or overall health.
- Significant new diagnosis.
- Clinical indicators (e.g. SPICT).
- Frailty screening (eFI, Rockwood)
- Multiple NHS24 or A&E contacts.

2. ASSESS & PREPARE: Look at clinical and care situation before care planning discussions

►Usual health status: current illnesses and frailty; recent changes; decline since last clinical review.
►Treatment and care plan; review any ACP, ReSPECT form, advance statement, KIS or other plan.
► Do we know what treatment and care this person would like or does not want?
►Likely clinical outcomes of available tests and interventions? Are they of overall benefit or not?
►CPR status: Does this patient have a DNACPR form? Is CPR a treatment that would work for them? Has CPR been discussed before, and what happened then?
►Check next of kin, family/close friend/carer, POA (proxy) details. Consider family support needs.
►Who should be involved in decision-making and planning care? Patient's capacity for decisions?

3. TALK: with the patient and those close to them (use **RED-MAP Guide**)

It helps if we plan these conversations so people are better prepared.

We'd like to hear what's important to you, and make some plans for good care with you.
Can we make a time to talk about planning your treatment and care?
Should anyone close to you be involved? What is the best way for us to do that?

4. Plan: Plan current and future care (includes a Treatment Escalation Plan or Emergency Care Plan)

Tailor planning to each person. Actions taken must always be of overall benefit to them.

- How would this person like to be cared for, and is there any treatment or care they do not want?
- What would this person say about their treatment and care, if we could ask them?
- Make specific plans for: a) sudden/new illness or complication b) infection (including COVID-19) c) deteriorating health d) care if the person is dying e) carer support

CPR status; If CPR will not work, explain why and talk about what we can do to help.
If CPR has an uncertain outcome or may leave the person in poorer health, discuss personal goals.

- Review all medications and current clinical care. Plan for 'as needed' medicines, if appropriate.

►Offer to speak with family members/carers or legal proxy (POA holders), as appropriate.
►Involve a colleague, another team, or a specialist if additional support is needed.

5. COORDINATE CARE & REVIEW: Record and **share** care plan. Review and update plans as needed.

Kirsty.Boyd@ed.ac.uk – May 2021