Let's think ahead →

Care Planning - Key steps for ambulance clinicians

Introduction

Some people already have an emergency care plan, or another care plan and/or a DNACPR form.
Others choose not to plan ahead or their plan may not be available to paramedics.
RED-MAP supports good care planning conversations with patients and families.

1. IDENTIFY: people with unstable, deteriorating health

- ► Progressive conditions: advanced cancer, organ failure, advanced neurological disease, dementia.
- ► Progressive frailty in older people.
- ► Multiple or complicated health problems.
- ► Increasing personal care/ support needs due to physical and/or mental health problems.

2. ASSESS: clinical and care situation

- ► Usual health status and any recent changes.
- ► Treatment and care plans for this person; review any available care plans (eg. KIS, ReSPECT form)

Any specific plans for: a) a sudden/new illness or complication b) an infection (including COVID-19)
c) changed or deteriorating health d) care if the person might be dying

- ►Do we know what treatment and care this person would like or does not want?
- ►Likely clinical outcomes of interventions: e.g. hospital assessment/admission, IV therapy, oxygen.
- ►CPR status; check for DNACPR form or discussion about CPR recorded in a clinical record or plan.

Use available clinical information to decide if CPR is a treatment that would work.

a) Person is dying – CPR is contraindicated and is not a treatment option.
b) Person is seriously ill or has health problems that mean CPR will not work/ help them.
c) CPR may work but there is a high risk the person would be left in much poorer health.

- ►Check next of kin, family, carer, legal proxy (POA) details. Consider family/carer support needs.
- ►Who should be involved in making decisions and planning care? Person's capacity for decisions?

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

'We need to talk about making good plans for your care.
We'd like to know what's important to you, and make a plan with you.
Is there anyone you'd like us to speak to?'

4. PLAN: Plan for current and future care

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

- ●**How** would this person like to be cared for now, and is there any treatment/care they do not want?
- ●**Where** can this person be cared for now that they are more unwell?

- Stay in their home - Further clinical assessment -Go to hospital

- ●**What** care plan meets their clinical, personal and overall care needs best?
- ● Review medications and current clinical care. Plan for 'as needed' medicines, if appropriate.
- ►Offer to speak with family members, a close friend or carer, as appropriate.
- ►Involve a colleague, another team, or a specialist if additional support is needed.

5. COORDINATE CARE: Record and **share** care plan. Agree plan ongoing care if staying at home.

(KIS or other electronic care summary is used to share care plans) Kirsty.Boyd@ed.ac.uk – May 2021