Healthcare Improvement Scotland | ihub

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RED-MAP: Care planning in the Community

R eady	Introduce ACP[1] 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 and care in case things change for you (*or people who care for you*) in future?* **Should anyone close to you be involved in the conversation?*
** It is helpful to think ahead and talk about what **might happen** so we know **what is important** to you.*
Have you talked about **planning ahead for your health and 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 think about what might happen for (*person's name*), and what will be of 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, and has anything changed?*
Have you 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/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 that supports shared decision-making.
** 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...*
We **hope you will stay well/ improve with.., but **I am worried** about…*
You are less well than before because…* ** **If that were to happen, having a plan would help with...*
**Do you have any thoughts, questions or worries I can help with?*

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 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 treatment and care options for this person.

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

Talk about CPR, if appropriate. Make a clinical assessment of medical outcome of CPR for this person.
**Can I ask if you know anything about cardiopulmonary resuscitation or CPR?*
CPR is treatment to restart the heart and breathing.
*- CPR **does not work** when a person is in very poor health or dying. It is better to plan good care.*
*- With these health problems, CPR **may work** but can leave the person in much poorer health.*
*Any other treatments that **can help** will be given. 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 and changed, if needed.

[1] ACP= Anticipatory (Advance) Care Planning

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