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? Has anything changed? How do you see things going for you now?*
Have you thought about what might happen **if you are less well or get 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.. It's possible you will not get better.*
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 outcomes 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 after they have stopped.
*- CPR **does not work** when a person is in very poor health or dying. It is better to plan good care.*
*- CPR **may work** but can leave a person in much poorer health. Underlying conditions affect the outcome.*
*Any other treatments that **can help** you will be given/continued**.** 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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