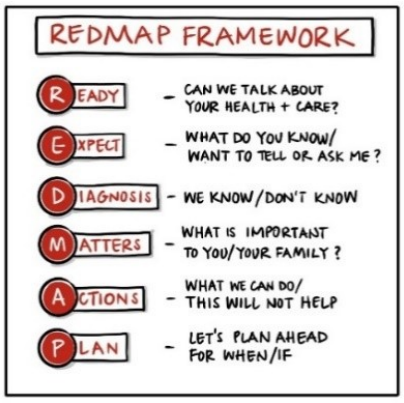
Anticipatory Care Planning using the ReSPECT process (REDMAP)



The 6-step RED-MAP framework is recommended to guide anticipatory care planning discussions in Scotland. It gives some examples of what we can say at each step and highlights key phrases you can adapt to different people and situations.

Some conversations about care planning are more difficult. Consider asking for support from colleagues or a specialist, if needed.

REDMAP is recommended as part of the ReSPECT process (Recommended Summary Plan for Emergency Care and Treatment) in all care settings (community, care homes and hospitals)

A crucial aspect of the ReSPECT process is the conversations that take place with the person and their family about what matters to them if their health changes, and options available to support them.

- Discussing and reaching a shared understanding of the person's current health and how that could change in the foreseeable future. (ReSPECT Section 2)
- Exploring what is important for this person and their overall goals of care. Is this towards life-prolonging treatments or a focus on quality of life and comfort? (ReSPECT Section 3)
- Making and recording shared decisions about available, realistic treatments and care in line with what the person would like or does not want. Explaining sensitively about the benefits of making decisions in advance about treatments that would not work for this person. (ReSPECT Section 4)
- Making and recording a shared decision and recommendation about CPR. (ReSPECT Section 4)

REDMAP framework for ACP with ReSPECT		
Ready	Can we talk about your health and care? Who should be involved?	*Build a shared understanding of my health and current condition.* (ReSPECT section 2)
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, if we could ask them?	*What matters to me in decisions about my treatment and care in an emergency.* (ResPECT section 3)
Actions	What we can do is... Options that can help are…. This will not help because.... That does not work when…	*Recommendations for my emergency care and treatment.* (ReSPECT section 4)
Plan	Let's plan ahead for when/if.... Making some plans in advance helps people get better care.	

REDMAP guide to care planning with ReSPECT

Ready	**Can we talk about why care planning helps people get better care?**

Plan conversations, even if the same day, so everyone is prepared, and the right people are involved.

- My name is…, I am (your title). My role in the team caring for you is...
- Can we make a time to talk about your treatment and care?
- Talking about your health is important in case you get less well and need urgent or emergency care. Is there anyone else we should speak to or include in our discussion?
- I'd like to talk about what we are doing to help you and hear about **what is important** for you.
- We are doing our best to care for you, but we **are worried** about your ... condition.
- Who should we talk to if you are less well and not able to make decisions with us? Do you have a Power of Attorney or any other kind of care plan already?
- We can talk about what might happen for (person's name), and what will be of most help to them.

Expect	**It would help to hear what you know about your health, and think might happen.**

- I'll explain what we think is happening, but do you want to tell/ask me anything important first?
- How have you been doing recently/today? What has changed with your health?
- Has anyone talked with you about what might happen **if** you get less well, or are very ill?

Diagnosis	**There are things we know about your health, and things we are not sure about.**

Share information tailored to people's understanding, and how they are feeling.
Explain what we know in 'short chunks with pauses' to check for people's reactions and questions.
Acknowledge and share uncertainty. Use clear language with no jargon and short sentences.

- What we know is that… We are not sure about… but we'll have a better idea in/when…
- You are less well because… It **is possible** you will not get better from …
- We **hope** you will stay well/improve with..., but **I am worried** about… I'm afraid you are seriously ill... I am sorry, but you could die with this illness...
- We **don't know** exactly what will happen or when, but we **can plan** for what to do if...
- You may have thoughts, questions, or worries we can talk about.

Matters	**We'd like to know what's important to you and your family.**

- Can we talk about how you **would like** to be cared for if you needed treatment in an emergency?
- Is there anything you **would like** to do if that happens?
- Is there anything you wish to avoid or do not want to happen? Is there any treatment you would not want?
- Can you tell me what you think (person's name) **would say** in this situation, if we could ask them? Have they ever talked about what they **would like** to happen if they were very ill or dying?
- What matters more for you: having any available tests and treatments, or focusing on quality of life and comfort?

Actions	**Let's talk about what we can do, and things that may not help or work for you.**

Talk about realistic, available options for treatment, care**,** and support for this person. Link these to what you have already found out about what the person is expecting and what matters to them. Be honest and clear about what can help or will not work. Options depend on the best place of care.

We talk about benefits and risks, alternatives, and the option of changing nothing just now.

- What we **can do** is...
- Options that **can help** you are…"
- This will **not help** because...
- That does **not work** for someone when…
- **I wish** there was more treatment we could give for this. Could we talk about what we can do?

- Can we talk about what going to hospital might mean for you?
- For people who are in poor health and need help from others at home or in a care home, it may be better to look after them in a familiar place when they are very ill or dying, if that's possible.
- Intensive care does not help everyone. For some people, it is better to care for them differently.

Make a clinical assessment of CPR outcomes. Discuss CPR in line with the clinical situation.

- Can I ask what you know about cardio-pulmonary resuscitation or CPR?
    - CPR is treatment to restart the heart and breathing after they have stopped.
    - CPR helps in some situations but does not work for everyone.
        - 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 even if it could work for them.
- Any other treatments that will help you are given, including life prolonging treatments you may wish to have.
- Can we talk about your situation?

Plan	**We record, share, and review all the plans we make for treatment and care.**

Use available forms and online systems to record and share care plans and CPR decisions.

- 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, or if your health, situation or wishes change. You can discuss your plan with us/your care team any time you wish.

Resources

- Healthcare Improvement Scotland (HIS) ACP Toolkit offers guidance on Anticipatory Care Planning for professionals: https://ihub.scot/acp
- ACP prompt cards for professionals are downloadable to your device and useful for teaching: https://ihub.scot/media/8891/acp-prompt-cards-for-professionals.pdf
- NHS Inform has public information on Anticipatory Care Planning including a short ACP video, CPR decisions, and how people can talk about care. www.nhsinform.scot/acp
- ReSPECT UK: www.resus.org.uk/respect

Effective Communication

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.

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 focusing on care and treatments that will help you.
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)