Let’s think ahead

7 steps to ACP:
Creating Covid-19 relevant ACPs in Care Homes

Implementation Guidance & Resources

May 2020
These resources have been provided through collaboration between Effective Communication for Health (EC4H) and Edinburgh Health and Social Care Partnership (EHSCP) to support care homes and GP practices during the Covid-19 pandemic.

You can find further resources for Covid-19 effective communication for professionals on the EC4H website:

https://www.ec4h.org.uk/covid-19-effective-communication-for-professionals/

There is additional ACP implementation support available through the ACP implementation and training package: 7 Steps to ACP for Care Home Staff, which provides a more comprehensive ACP improvement approach. This includes resources for team reflection, training and quality assurance. For more information please visit the EHSCP ACP resource webpage:


Or contact the EHSCP Long Term Conditions Programme ACP team: AnticipatoryCarePlanning@nhslothian.scot.nhs.uk
Anticipatory Care Planning (ACP)

Supporting residents and their family to have open and honest discussions about their health and wellbeing and wishes for the future helps put the resident at the centre of decisions about their health.

You can watch a video clip to hear Dr Andrew Mackay explaining ACP in Care Homes. The video gives an overview of what ACP is, the process of creating an ACP with your GP practice, and why it is beneficial for all residents to have an ACP in place. Click here, or copy and paste the link into your web browser https://vimeo.com/340150410
ACP Care Home Pathway

Follow this process to create and review ACPs. **Purple text** shows Care Home activity, **black text** shows GP activity.

It can be helpful to discuss the ACP pathway with your GP practice using this flowchart to agree your roles and responsibilities (also included in Appendix 5, Document 5). It helps to discuss with your GP practice ways in which the process of creating and reviewing ACPs will work best. It’s important to agree how you will review and update ACP-Key Information Summaries (ACP-KIS).

You can find examples on the [EHSCP ACP Resources](#) webpage of how 7 steps to ACP for Care Homes has worked well with care homes and GP practices in Edinburgh.
New patient registration form

The new patient registration form is how you share information for registering new residents with the GP practice. This information also populates the ACP-KIS at the GP practice. You may have your own version of this form.

The version provided has been designed to be used with the ACP questions to ensure all relevant ACP information is shared to create a comprehensive and quality ACP-KIS. Included in Appendix 3: Document 2.

Care Home Acute Clinical Incident Flow Chart

This flowchart illustrates how to use the ACP-KIS when there is an acute clinical incident. It can be helpful to share this with all of the care home team including agency staff. Included in Appendix 7: Document 6.
There are two versions of this guidance: one for your discussions with residents and families or friends, and one for your discussions with families and friends of residents who do not have capacity. Use the most appropriate version to guide your discussion. Please see Appendix 4: Document 3, and Appendix 5: Document 4.

The RED-MAP 6 step approach on the first page will guide you, residents and their families through ACP conversations.


The ACP questions on the 2nd page enable you to make a plan with residents, their families and friends.

Use the ACP resident and family information leaflet to help explain ACP and why it’s important.

Included in Appendix 1: Let’s Think Ahead Leaflet
Notes on RED-MAP steps 2 & 5

Step 2: Expect

When talking about what to expect (step 2) there is a prompt for the resident to continue with making the plan, or leave the discussion for another time. It’s important that the resident, family/close friend is ready to have the conversation with you.

Getting family or close friends together can be difficult. They can have different or unrealistic expectations regarding care home residents’ deteriorating health. It is helpful to have a shared understanding of a resident’s health before starting to make plans for the future.

Knowing that the care and treatment preferences can be changed and reviewed gives residents and family reassurance that ACPs are not set in stone and can be reviewed.

Step 5: Action

In the Action section (step 5) there is some information about CPR. CPR is a medical treatment which is only appropriate when it is going to help. The clinical team should therefore decide if there is any prospect of CPR being successful before CPR is discussed with residents, families/close friends.

Many care home residents have medical conditions which mean CPR would not be effective for them. Any conversation about CPR should take this into account.

You can find out more about RED-MAP together with more resources on the EC4H website: www.ec4h.org.uk

Notes on the ACP questions

The ACP questions on the 2nd page enables residents, their family/close friends, to talk with you about their care and treatment preferences should they become very unwell. The questions help you to explore together the three most common deterioration scenarios for which residents are most often unnecessarily admitted to hospital.

Care home teams who use the ACP questions say that having these conversations early leads to a shared understanding with residents, families and the health teams involved in their care. They have found this reduces stress in times of crisis and gives them the confidence to clearly communicate and act on residents’ wishes, leading to better outcomes.
### Three options: a) b) c)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>a)</td>
<td>Keep you comfortable, clinically assess you, treat any pain or other symptoms, and care for you in your care home.</td>
</tr>
<tr>
<td>b)</td>
<td>Contact a family member/ close friend, if possible, to talk about whether or not to send you to hospital</td>
</tr>
<tr>
<td>c)</td>
<td>Send you to hospital for tests and other treatments, if this is going to be of benefit to you.</td>
</tr>
</tbody>
</table>

Each question has three options for the resident/their family or close friend to consider which is the closest to the care they would like.

Option a): It’s important to make it clear to families there are lots of options for treatment that can be delivered in the home. Option a) does not imply that there would be a lack of treatment. Instead it is about what the focus of treatment should be and where that treatment is delivered.

Option b): For scenarios described in 2 & 3 if the decision is made to go to hospital it would not be by blue light ambulance. That is why ‘before phoning for an urgent (999) ambulance’ is included only in scenario 1.

Option c): When a resident who has opted for option c) becomes very unwell it can be useful to confirm with senior members of the team that hospital admission is likely to improve outcomes and is therefore appropriate. For example, transfer to hospital for those that are very close to death is not going to be helpful and will be distressing for the resident, relatives and staff.

### Recording and sharing the ACP Questions

In the free text box record any other information residents, families or close friends have shared with you during your ACP discussions about their care and treatment preferences.

Make and file a copy the ACP questions form in your resident’s care plan. Give the original copy of the ACP questions form to the GP practice.

When the GP practice returns the Key Information Summary, file it with the DNACPR (where appropriate) at the front of your resident’s care plan.

Follow the ACP pathway described in the flow chart on page 3, and included in Appendix 6, Document 5.
7 steps to ACP checklist

This checklist, included in Appendix 1, will help you to keep a record of each step in the ACP process. Use the checklist to help implement the 7 steps to ACP for each resident.

Key points to remember:

- use the Key Information Summary at points of deterioration
- bring and use the Key Information Summary at reviews, and
- return all reviews dated and signed.

Further support

Click here to watch a short video clip of care homes sharing their experiences of implementing the 7 Steps to ACP for Care Homes, or copy and paste this link into your web browser: https://vimeo.com/340150721

You can read about what care homes have learnt from using the 7 Steps to ACP for Care Homes approach in:

- ACP Improvement Programme Learning Report and
- Case study – Improving ACP with care homes and GP practices in Edinburgh
Appendix 1: 7 Steps to ACP Covid-19 Care Homes Checklist

(Check boxes please for actions 1 to 7)       Initial & Date

Step 1  • Read Creating Covid-19 relevant ACPs in Care Homes Guidance

Step 2  • Discuss and give ‘Lets Think Ahead’ leaflet to Resident / family / Carers / Close friend

Step 3  • Complete the New Patient Registration Form for new residents (Document 2)

Step 4  • Discuss and Complete Anticipatory Care Planning in Care Homes – talking with residents, families / friends & making a plan (Document 3 or 4)

Step 5  • Make and file a copy of the completed ACP questions (Document 3 or 4), and the New Patient Registration Form (Document 2, for new residents), in your resident’s care plan

Step 6  • Give the original copy of the completed ACP questions (Document 3 or 4), and the New Patient Registration Form (Document 2, for new residents) to the GP practice

Step 7  • File the Key Information Summary with the DNACPR (where appropriate) when returned from the GP at the front of your resident’s care plan
Appendix 2: 7 Steps to ACP Covid-19 Let’s Think Ahead: Resident, Families & Friends Information Leaflet
We want to know your preferences if you become very unwell. We will discuss with you.....

You may choose not to go to hospital to have further treatment. Would you prefer having treatment to make you comfortable in the care home?

Would you like staff to help you to look for treatment to prolong your life?

For further information please go to http://www.whatmattersyouth.scot/

The leaflet may be made available in a larger print, Braille or your community language, please email anticipatorycareplanning@nhslothian.scot.nhs.uk

Readability & layout reviewed by NHSL Patient and Carer Information Group May 2018 – Review May 2021

V 1.18
Introduction

‘Anticipatory’ care planning means thinking and planning ahead and understanding what is happening with your health and care.

Care Home staff want to find out what matters to you and involve you in planning your care and treatment, as much as you are able and want to.

Care home staff will discuss your wishes with your family or a friend if you are unwell, unless you do not want this.

Some people may have already made a plan about their treatment and care. If you have one it would be very helpful to show this to the care home staff.

Please remember to tell Care Home staff if you have chosen someone to have a Power of Attorney.

Here are some things you might want to ask Care Home staff:

Can we talk about options I have and decisions I need to make?

Can we talk about what I would like and what I wouldn't like?

What may happen if my health deteriorates?

Can we talk about what is important to me and my family?
## Appendix 3: 7 Steps to ACP Covid-19 Document 2

### Care Home Registration Form

To be completed and returned to GP practice with registration paperwork

- Patient /carers wishes (completed ‘Making a Plan: ACP questions’ form)
- Discharge letter /social work forms including medication list
- Adults with incapacity – if completed

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Next of Kin/carer /worker and relationship to resident</td>
<td>NOK address telephone number Mobile</td>
</tr>
<tr>
<td>Date of admission</td>
<td>Admitted from home/hospital</td>
</tr>
<tr>
<td>Welfare guardian / Power of Attorney</td>
<td>Yes /No</td>
</tr>
<tr>
<td>Name of guardian:</td>
<td>Adults with incapacity certificate Yes/No</td>
</tr>
<tr>
<td>Compulsory treatment order</td>
<td>Yes/No</td>
</tr>
<tr>
<td>DNACPR in place</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Patient carer/wishes</td>
<td>Anticipatory care questionnaire given to patient/relatives Yes/No</td>
</tr>
<tr>
<td>Date…………………………………</td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>Independent Walking aids Needs assistance Bed and chair bound Bedbound</td>
</tr>
<tr>
<td>Continence</td>
<td>Continent Urinary incontinence-wears pads/ catheter in situ Faecal incontinence</td>
</tr>
<tr>
<td>Cognition</td>
<td>No impairment Some confusion 1-2 words only No meaningful interaction</td>
</tr>
<tr>
<td>Communication</td>
<td>Speaks clearly Speech difficult to understand Unable to communicate verbally</td>
</tr>
<tr>
<td>Measurements</td>
<td>Weight Height BMI</td>
</tr>
<tr>
<td>Smoking status</td>
<td>Non-smoker / Ex- Smoker/ Current smoker: ______ Cigarettes per day. Blood Pressure</td>
</tr>
<tr>
<td>Consent for sharing information with Out of Hours Doctors</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
Anticipatory Care Planning in Care Homes – talking with residents & making a plan

Anticipatory Care Planning is about thinking and planning ahead so that we can give each person the best possible care. If a person’s health changes, it is better if we have a good plan for them.

**READY** Let’s talk about why planning ahead is so important.

Making a plan helps people who live in a care home, like you, think about their care and what is important to them. You may have talked with your family or a close friend about this before. It is a good idea to talk about what might happen if you get unwell. This could be from a health problem or illness you have already. It might be a new illness. Some residents may get unwell with coronavirus or another infection. We can make plans and talk with your family if you wish.

**EXPECT** You may have thoughts/ideas, questions or worries about what might happen.

People have different things they want to talk about. Please do ask us about anything you want to know or are worried about. We can make a plan with you now, if you are ready.

**DIAGNOSIS** There are things we know about your health, and things we’re unsure about.

People who live in care homes are often in poorer health and need help with day to day living. We are doing our best to help you to keep you well, but it is possible you may get unwell at some point. Some treatments may not work for you, or you might not want them. That’s why it is important for us to talk about making an Anticipatory Care Plan with you.

**MATTERS** We’d like to know what’s important to you, and how best to care for you

We can put what you tell us in your care plan so we know how you would like to be cared for.

**ACTION** Let’s talk about what we can do to care for you and things that will not help.

Many people feel that staying in their familiar care home to be looked after is the best place when they are very ill and may be dying. Being comfortable is what matters to them. We have medicines in the care home to help us manage any symptoms or discomfort, if we need them. Hospital treatment may be better in a few conditions, like a hip fracture. Going to hospital has benefits and risks. Can we talk about why that is, and how it might affect your care plan? Antibiotic tablets or syrup, other medicines, and oxygen can be given in the home, if needed. Has anyone talked with you about cardiopulmonary resuscitation or CPR? CPR is treatment to restart the heart. CPR does not work when a person is in very poor health or dying. If CPR will not help, it is better to record this information and focus on planning good care. Any other treatments that can help the person are still given. (*CPR is generally a GP/nurse discussion.*)

**PLAN** Let’s make an Anticipatory Care Plan for you.

We keep your plan in the home in case we need it, and send a copy to your GP practice. The plan goes into your GP record and a secure record used by professionals if people need urgent care called a Key Information Summary (KIS). Your plan can be changed at any time. There are some situations we can think about and discuss together. If you have any questions please ask me. You can talk to care home staff and people at the GP practice too.
Making a plan: Anticipatory Care Planning questions for residents

There are changes in health that do sometimes happen in frail older people. Please tell us which option is closest to how you think you would like to be cared for. We will use this information to help us make a Care Home Anticipatory Care Plan for you.

1. If you had a sudden illness (such as a stroke or a heart condition), how do you think you would like to be cared for?

   - a) Keep you comfortable, clinically assess you, treat any pain or other symptoms, and care for you in your care home.
   - b) Contact a family member/ close friend, if possible, to talk about whether or not to send you to hospital, before phoning for an urgent (999) ambulance.
   - c) Send you to hospital for tests and other treatments, if this is going to be of benefit to you.

2. If you had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how do you think you would like to be cared for?

   - a) Keep you comfortable, clinically assess you, treat any pain or other symptoms, and care for you in your care home.
   - b) Contact a family member/ close friend, if possible, to talk about whether or not to send you to hospital.
   - c) Send you to hospital for tests and other treatments, if this is going to be of benefit to you.

Intensive care treatment does not help people who are already very frail and in poor health from underlying health problems. It is better to care for them in other ways.

3. If you were not eating or drinking because you were now very unwell, how do you think you would like to be cared for?

   - a) Keep you comfortable, clinically assess you, treat any pain or other symptoms, and care for you in your care home.
   - b) Contact a family member/ close friend, if possible, to talk about whether or not to send you to hospital.
   - c) Send you to hospital for tests and other treatments, if this is going to be of benefit to you.

If we think you have a serious fracture (such as a hip fracture) we would usually send you to hospital for treatment, as that would be the best way to care for you.

Is there anything else about your health and care that it is important for us to know? (Any specific illness or treatment that needs a plan such as epilepsy, diabetes or tube feeding)

We can share this information with the people who are close to you by sending them a copy.

If you DO NOT want this information shared with the emergency services, please tick here □

Resident’s name…………………………………   Date…………………………………
Anticipatory Care Planning in Care Homes – talking with relatives/ friends & making a plan

Anticipatory Care Planning is about thinking and planning ahead so that we can give each person the best possible care. If a person’s health changes, it is better if we have a good plan for them.

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<th>Knowing what’s important to your relative/friend, helps us to care for them.</th>
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<tbody>
<tr>
<td></td>
<td>We put this information into their care plan so we know about how they’d like to be cared for.</td>
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Making a plan - Anticipatory Care Planning questions for relatives/friends

There are changes in health that do sometimes happen in frail older people. Please tell us which option is closest to how you think your relative or friend would like to be cared for. We will use this information to help us make a Care Home Anticipatory Care Plan for them.

1. If your relative/ friend had a sudden illness (such as a stroke or a heart condition), how do you think your relative/friend would like to be cared for?

   a) Keep them comfortable, clinically assess them, treat any pain or other symptoms, and care for them in their care home.
   b) Contact a family member/ close friend, if possible, to talk about whether or not to send them to hospital, before phoning for an urgent (999) ambulance.
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   c) Send them to hospital for tests and other treatments, if this is going to be of benefit to them.

Intensive care treatment does not help people who are already very frail and in poor health from underlying health problems. It is better to care for them in other ways.

3. If your relative/ friend were not eating or drinking because they were now very unwell, how do you think your relative/ friend would like to be cared for?

   a) Keep them comfortable, clinically assess them, treat any pain or other symptoms, and care for them in their care home.
   b) Contact a family member/ close friend, if possible, to talk about whether or not to send them to hospital.
   c) Send them to hospital for tests and other treatments, if this is going to be of benefit to them.

If we think that a resident has a serious fracture (such as a hip fracture) we would usually send them to hospital for treatment, as that would be the best way to care for them.

Is there anything else about health and care for your relative/friend it is important for us to know?
(Any specific illness or treatment that needs a plan such as epilepsy, diabetes or tube feeding)

If you DO NOT want this information shared with the emergency services, please tick here ☐

Resident’s name........................................ Your name........................................
Relationship........................................ Phone number........................................ Date........

I have / do not have Power of Attorney for my relative/ friend.
I have / do not have Welfare Guardianship for my relative/ friend.

Creating / updating a Care Home Covid-19 relevant Anticipatory Care Plan

Care Home staff talk through ‘Let’s think ahead’ leaflet with resident, family / close friends

Care Home staff use RED-MAP approach to discuss ACP questions with resident, family/close friends including care and treatment options for COVID-19

? Any uncertainty from resident / relatives?

Discussion with GP

Complete ACP questions to create / update ACP

Keep one copy at front of resident’s notes & give one copy to GP practice: during GP visits to care home, by emailing scanned completed copies, or post in batches

Given to GP Practice

GP practice generates/edits ACP/KIS online

Admin staff generate KIS and set to ‘do not upload’. Review diary set for one month

GP prints and gives a copy of the updated KIS to care home

Care Home files ACP-KIS together with DNACPR (where appropriate) at front of resident’s notes

Keep having ACP discussions, especially after changes in health/hospital admissions. Always review ACP as part of resident’s scheduled reviews (6 weeks/6 months, medical review).

Update/replace hard copy ACP questions in resident’s notes with any new or changed information. Share with GP practice to update ACP-KIS.
Appendix 7: 7 Steps to ACP Covid-19

Document 6

Care Home Acute Clinical Incident Flow Chart

Call 999
- Major trauma such as hip fracture or significant burn
- Serious bleeding
- Choking – not responding to treatment

Refer to ACP-KIS special note
- Sudden collapse
- ? Stroke
- ? Heart attack
- Not responding to antibiotic
- Not eating and drinking

ACP-KIS – special note not helpful
Staff follows care home procedure in escalation of care

ACP-KIS – special note helpful
Staff follows treatment plan as written up by GP on KIS special note

GP reviews ACP-KIS – update special note as required

GP updates ACP-KIS, prints off hard copy and discusses content with Care Home

Care Home files new ACP-KIS with DNACPR (where appropriate) at the front of resident’s notes