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Let's think ahead

Advance Care Planning (ACP) in Care Homes – Key steps for clinical staff

Introduction

ACP helps us deliver proactive, person-centred health and care when someone's health changes.
ACP takes account of what matters to people and their health problems.
RED-MAP supports good ACP conversations.

1. IDENTIFY: people with unstable or deteriorating health

► Progressive conditions: advanced cancer, organ failure, advanced neurological disease, or dementia.
► Progressive frailty in older people.
► New serious illness or infection, or disease complications.
► Multiple, long-term conditions or complex health problems.
► Increasing personal care and support needs due to declining physical and/or mental health.

Times for ACP discussions

- Admission to the care home
- After any hospital admission
- Planned reviews of care plan
- Significant new diagnosis
- Notable decline in function, abilities or general health.

2. ASSESS: clinical and care situation before care planning discussions

► Usual health status: current illnesses and frailty; recent changes, decline since last review.
► Treatment and care plan; review any ACP or other plan.
► 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, oxygen, IV therapies.
► CPR status: Does this resident have a DNACPR form? Is CPR a treatment that would work for them? Has CPR been discussed before, and what happened?
► Check next of kin, family/close friend, legal proxy details. Review capacity for decision-making? Who knows this resident, and who should be involved in planning care?

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

It helps if we plan these conversations so people are better prepared.

'We talk with residents like you about making good plans for your care.
We'd like to hear what's important to you, and make a plan to look after you well.
Can we find a time to talk about this? Should anyone close to you be involved?'

4. ACTIONS: plan current and future care (includes urgent/emergency care plan)

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

- How would this resident like to be cared for, and is there any treatment or care they do not want?
- Where would this resident like to be cared for if they are more unwell?
  - Stay in care home
  - Clinical assessment, and try to contact family
  - Go to hospital
- Specific plans: a) sudden illness/complications b) infection (including COVID-19) c) care if dying
- If CPR will not work, talk about what we can do that will help including planning ahead.
- Review medications/current clinical care. Plan for anticipatory medicines, if appropriate.

► Offer to speak with family members, a close friend or legal proxy (POA holders), as appropriate
► Involve a colleague, another team, or a specialist if additional support is needed.

5. PLAN: **Record** and **share** care plan so it is easy to access. Review and update care plans.

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