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Let's think ahead

Advance Care Planning (ACP) in the Community – Key steps for clinicians

Introduction

ACP helps us deliver proactive 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, life-limiting 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.

Triggers for ACP discussions

- Unplanned hospital admissions.
- Notable decline in function, abilities or overall health.
- Significant new diagnosis.
- Clinical indicators (e.g. SPICT).
- Frailty screening (eFI, Rockwood)
- Many emergency care contacts.

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 existing ACP, advance statement/directive, 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, IV therapies, oxygen.
► CPR status: Does this patient 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/carer, proxy details. Consider family/carer support needs.
► Who should be involved in making decisions and planning care? Person's capacity for decisions?

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

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

We'd like to hear what's important to you, and make some plans for good care with you.
Can we make a time to talk about planning your treatment and care?
Should anyone close to you be involved? What is the best way for us to do that?

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

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

- How would this patient like to be cared for, and is there any treatment or care they do not want?
- Where would this person like to be cared for if their health changes and they are more unwell?
  - Stay in their home - Clinical assessment, and try to contact family -Go to hospital
- Any specific plans for: a) sudden/new illness or complication b) infection (including COVID-19) c) changed or deteriorating health d) care if the person might be dying e) carer support
- If CPR will not work, talk about what we can do that will help including planning ahead.
If CPR has an uncertain outcome or would leave the person in poorer health, discuss personal goals.
- Review medications/current clinical care. Plan for anticipatory medicines, if appropriate.

► Offer to speak with family members/carers or legal proxy (POA holders), as appropriate.

5. PLAN: Record and **share** the care plan. Review and update care plans regularly

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