Advance Care Planning (ACP) in Hospital - Key Steps

Introduction
ACP helps us deliver 'realistic medicine' when a person's health is unstable or deteriorating.
ACP takes account of what matters to people as well as their current and underlying health problems.
The RED-MAP model supports good ACP conversations with patients and families.

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)
- Episodes of unscheduled care .

2. ASSESS: clinical and care situation before having care planning discussions
▶Usual health status: current illnesses and frailty; recent changes; decline since last clinical review.
▶Treatment and care plan; review any ACP, ReSPECT form, advance directive, or other plan.
▶ Do we know what treatment and care this person would like or does not want?
▶Likely clinical outcomes of available tests and interventions? Are they of overall benefit or not?
▶CPR status: Does this patient have a DNACPR form or recorded decision? Is CPR a treatment that would work for them? Has CPR been discussed before, and what happened then?
▶Check next of kin, family/close friend/carer, POA (proxy) details. Consider family support needs.
▶Who should be involved in decision-making and planning care? Patient's capacity for decisions?

3. TALK: with the patient and those close to them (use **RED-MAP Guide**)
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 a **Treatment Escalation Plan**)
Tailor planning to each person. Actions taken must always be of overall benefit to the person.
- How would this person like to be cared for, and is there any treatment or care they do not want?
- What would this person say about their treatment and care, if we could ask them?
- Make specific plans for: a) sudden/new illness or complication b) infection (including COVID-19) c) deteriorating health d) care if the person is dying e) carer support

CPR status: If CPR will not work, explain why and talk about what we can do that will help. If CPR has an uncertain outcome or would leave the person in poorer health, discuss personal goals.
- Review all medications and current clinical care. Plan for anticipatory medicines, if appropriate.

▶Offer to speak with family members/carers 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** the care plan. Review and update care plans in hospital and on discharge.

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