



## Anticipatory 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, ReSPECT form, advance statement, 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, POA details. Review resident's 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.