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Talking with people and families about planning care, death and dying

RED-MAP has 6-steps. Suggested phrases are adapted to the person, family and context of the discussion. Ask for help and support from colleagues, senior staff or a specialist. Second opinion if needed.

RED-MAP Guide for Community Professionals

R eady — Can we talk about why thinking and planning ahead helps people get better care?

Plan these conversations in advance so everyone is prepared, and the right people are involved.
**Hello, are you Mr RT? My name is…, I am (your title). My role in the team/GP practice is...*
**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?*
**We'd like to hear about what is important to you, and talk about what we can do to help you.*
**Do you have any kind of care plan or Power of Attorney already?*
**We can think about what (*person's name*) would like to happen and what will be of help to them.*

E xpect — It would help to hear what you know about your health and think might happen.

**Can I ask what you know about your health problems and how you are now? How have you been doing recently, and has anything changed? Is there anything you think we should know about?*
Has anyone talked with you about planning ahead **if you are less well?*
**You may have thoughts or ideas, questions or some worries we can discuss.*
**Have you thought about what the Coronavirus situation might mean for you (and your family)?*

D iagnosis — There are things we know about your health, and things we are not sure about.

Share information; tailored to people's understanding and how they are feeling.
Explain what we know in 'short chunks with pauses' to check for people's reactions or questions.
Acknowledge and share uncertainty. Use clear language that supports shared decision-making.
You are less well than you were because… *It **is possible he will not get better **if**…*
We **hope you will stay well/ improve with.., but **I am worried** about….*
We **don't know exactly what will happen or when, but **we can plan** for how to manage...*

M atters — We'd like to know what's important for you.

Can we talk about how you **would like to be cared for, and any things **you do not want** to happen?*
Can you tell us **what you think (*person's name*) **would say** in this situation, if we could ask him?*

A ctions — Let's talk about what we can do to care for you, and things that may not help.

Talk about realistic, available options for treatment, care and support for this person/family.
Be honest and clear about what can help or will not work. Options depend on place of care.
What we **can do to help you at home is…. *We'd like to have a good plan in place for you.*
**Going to hospital has benefits and risks so can we talk about what that might mean for you?*
****I wish** we were able to give you that treatment (or care). The **options we do have** are…*

**Can I ask if you know anything about cardio-pulmonary resuscitation or CPR?*
CPR is treatment to restart the heart/breathing. CPR does not work when a person is in very poor health or dying, so we plan good care. With these health problems, CPR may work but can leave a person in much poorer health. Any other treatments that can help are given.

P lan

Use available forms and online systems to record and share care plans and DNACPR decisions
We record and share plans we make for treatment and care so everyone knows about them.

Avoid language that can make people feel confused, abandoned or deprived of treatment and care.
There is 'nothing more' we can do. *'Ceiling' of treatment or care for a person.*
We are 'withdrawing' treatment. *Treatment is 'futile'.* *Would he 'want to be' resuscitated?*

Dr Kirsty Boyd (kirsty.boyd@ed.ac.uk)