Care Planning in Care Homes – Key steps for clinical staff

Introduction
Care supports person-centred health and care when a resident's health changes.
Care planning is a process that takes account of what matters to a resident and their health problems.
RED-MAP supports good care planning conversations with residents and their families/close friends.

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 planning 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 & PREPARE: Look at 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 resident 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. PLAN: Plan current and future care (includes an emergency treatment and 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; 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

CPR status; If CPR will not work, talk about what we can do that will help including planning ahead. If CPR has an uncertain outcome or may leave a resident in poorer health, discuss personal goals.
- Review medications and current clinical care. Plan for 'as needed' 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. COORDINATE CARE & REVIEW: Record and **share** care plan. Start or update a **KIS**. Plan a review.

(KIS or equivalent electronic care summary is used to share plan) Kirsty.Boyd@ed.ac.uk – Jan 2021