Talking with people and families about Care Planning

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.
*Can we make a time to talk about planning for future **changes in your health and care**?*
Should anyone close to you be involved? What is the best way for us to arrange this?
*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 health or care plan, or someone with a Power of Attorney for you 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? How have you been doing recently, and has anything changed? Do you want to tell/ask me about anything important?
*Has anyone talked with you about planning ahead, **if** you are less well in the future?*
You may have thoughts, questions or some worries we can discuss.
Have you thought about what coronavirus 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 and 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, and your family.**

*Can we talk about how you **would like** to be cared for if you were unwell or seriously ill?*
*Are there things you would **like to do**, or go on doing? Is there anything **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 the best 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). Could we talk about **what we can do**?*

*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 it is better for us to 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** will be 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?

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