Anticipatory Care Planning (ACP)

Identify the right people.
Find out what matters.
Talk about what we can do.
Explain what does not help.
Plan care together.

PATCH Palliation And The Caring Hospital · Scottish Partnership for Palliative Care · Marie Curie · MACMILLAN CANCER SUPPORT · NHS SCOTLAND

Healthcare Improvement Scotland | ihub

Anticipatory Care Planning (ACP) involves conversations between individuals, their families, carers, and professionals.

It helps people communicate goals and preferences, and gives them opportunities to consider realistic options and plan for future changes in their health and care that can be recorded, shared and reviewed.

Thinking ahead about 'what matters to me' is relevant at any age or stage of life.

https://ihub.scot/acp

SPICT | THE UNIVERSITY of EDINBURGH

www.spict.org.uk

Identify: people with deteriorating health

Unplanned hospital attendance or admission(s); more unscheduled care contacts.

Performance status poor or deteriorating: spends more than half the day in bed or a chair.

Depends on others increasingly for care due to physical and/or mental health problems.

Progressive **weight loss;** remains underweight; loss of muscle mass.

Symptoms: persist despite optimal treatments of underlying conditions.

Person (and family) focusing on **quality of life**, less interventions, palliative care.

Prioritise these people (and their carers) for anticipatory care planning (including Key Information Summary) and palliative care assessment.

RED-MAP: Talking about care planning

READY — Can we talk about your health and care?

EXPECT — What do you **know**/want to **tell**/**ask** me?

DIAGNOSIS — We **know**… We **don't know**… We are **not sure**…

MATTERS — What is **important** to and your family?

- How would you like to be cared for?
- Is there anything you would not want?
- What would she say if we could ask her?

ACTIONS — What we **can do** is… Options that **can help** are..

This will **not help** because…

This **does not work** for people when…

PLAN — Let's plan ahead for when/if…

Helpful, realistic language

Sometimes people choose family members or close friends to help make decisions for them if they get less well in the future…
Have you thought about that?

If things change or you get less well… It **is possible** he could die with this.

Can we talk about **what's important**? That will help us make better decisions.

We **hope** the (treatment) will help, but I am **worried** that at some stage, you will not get better… What would be important if that happens?

I **wish** there was… treatment. Could we talk about what we **can do**?

We are **continuing to care** for her, and stopping treatments that are **not helping**.

Ask — Talk — Ask
Clear language — Short sentences — Pauses

ACP-TALK 1: Starting care planning

READY:
Can we talk about what is happening with your health and care in case things change in future?

Thinking ahead and talking about what matters helps people make some plans.

Should anyone close to you be involved?

Have you talked about care planning before?

EXPECT:
Can I ask about how you are doing, and if anything has changed?

How do you see things going in the next weeks/months/years?

What do you like doing/would you like to be able to do?

MATTERS:
Can we talk about what is important to you now and if you get less well?

Do you have questions or worries you'd like to talk about?

ACTIONS:
Let's start making a plan for you.

ACP-TALK 2: Talking about getting less well

READY:
Start or continue conversations about care planning

EXPECT:
Find out what people know and are thinking or worried about.

DIAGNOSIS:
What we know is that…
We are not sure about…

We hope you will stay well/improve, but I am worried that/about…

We don't know exactly what will happen, but having a plan helps.

MATTERS:
What is important to you (and your family) that we should know about?

Are there things you'd like, or would not want to happen?

ACTIONS:
What we can do is…
Options that can help you are…

That does not work/help people when…

PLAN:
Having a plan helps us know what to do if things change. We review it regularly.

ACP-TALK 3: Talking about dying

READY & EXPECT:
Find out what people know already.

DIAGNOSIS:
We know you are less well because…

We hope you will improve, but I am worried that…

It is possible you will not get better…

I'm sorry but you could die with this illness.

Do you have questions or worries we can talk about?

MATTERS:
What's important to you and your family?

How would you like to be cared for?

Is there anything you would not want?

What would she say about this situation, if we could ask her?

ACTIONS:
What we can do is…
That does not work/help when…

I wish that was possible…, let's talk about what we can do.

PLAN:
Can we talk about how we care for someone who is dying?

We are not sure how quickly things will change, but we can make a plan.

CPR-Talk: Cardiopulmonary resuscitation

Talk about CPR, if appropriate.
Make a clinical assessment of medical outcomes of CPR for the person.

Can I ask if you know anything about cardiopulmonary resuscitation or CPR?

CPR is a treatment to restart the heart and breathing after they have stopped.

CPR helps in some situations but does not work for everyone.

- CPR does not work when a person is in very poor health, or is dying. We focus on planning good care for the person and their family.
- CPR may work but can leave a person with some health conditions in much poorer health. Some people choose not to have CPR.

We use a DNACPR record to share information about CPR decisions. Any other treatments that can help will be given/continued.

Can we talk about your situation?

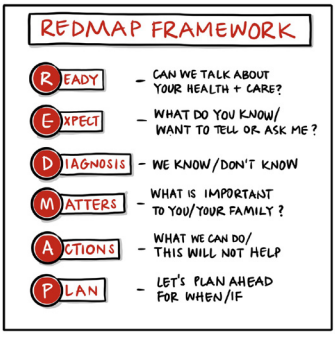
Care planning resources

RED-MAP Resources
www.spict.org.uk/usingspict

NHS Education for Scotland: Support Around Death
www.sad.scot.nhs.uk

Realistic Medicine (NHS Scotland)
www.realisticmedicine.scot

NHS Inform (ACP public information)
www.nhsinform.scot/acp



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