# 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.

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