Let's think ahead

7 steps to Anticipatory Care Planning in Care Homes:

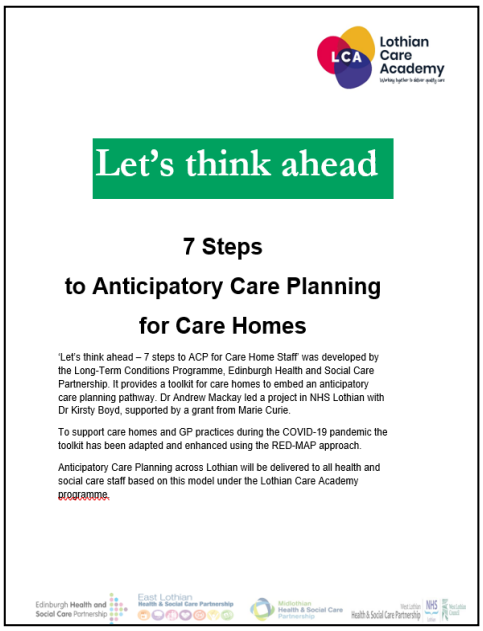
Implementation Guidance & Resources

Published: May 2020

Updated: V1.0 31/03/23

V1.1 18/04/23

Under review



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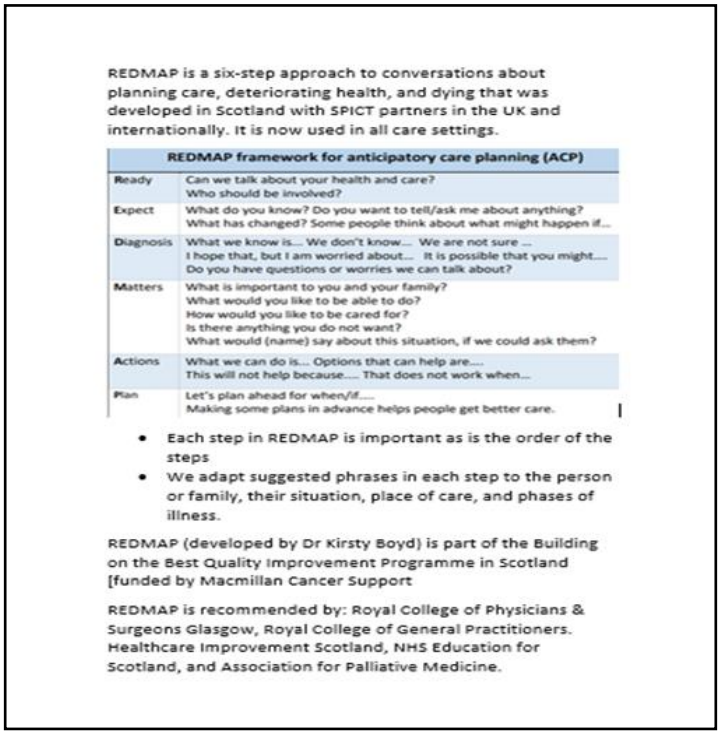
Let's think ahead

7 Steps to Anticipatory Care Planning for Care Homes

'Let's think ahead – 7 steps to ACP for Care Home Staff' was developed by the Long-Term Conditions Programme, Edinburgh Health and Social Care Partnership. It provides a toolkit for care homes to embed an anticipatory care planning pathway. Dr Andrew Mackay led a project in NHS Lothian with Dr Kirsty Boyd, supported by a grant from Marie Curie.

To support care homes and GP practices during the COVID-19 pandemic the toolkit has been adapted and enhanced using the RED-MAP approach.

Anticipatory Care Planning across Lothian will be delivered to all health and social care staff based on this model under the Lothian Care Academy programme.



REDMAP is a six-step approach to conversations about planning care, deteriorating health, and dying that was developed in Scotland with SPICT partners in the UK and internationally. It is now used in all care settings.

REDMAP framework for anticipatory care planning (ACP)

Ready	Can we talk about your health and care? Who should be involved?
Expect	What do you know? Do you want to tell/ask me about anything? What has changed? Some people think about what might happen if...
Diagnosis	What we know is.... We don't know.... We are not sure .... I hope that, but I am worried about.... It is possible that you might.... Do you have questions or worries we can talk about?
Matters	What is important to you and your family? What would you like to be able to do? How would you like to be cared for? Is there anything you do not want? What would (name) say about this situation, if we could ask them?
Actions	What we can do is.... Options that can help are.... This will not help because..... That does not work when....
Plan	Let's plan ahead for when/if..... Making some plans in advance helps people get better care.

- Each step in REDMAP is important as is the order of the steps
- We adapt suggested phrases in each step to the person or family, their situation, place of care, and phases of illness.

REDMAP (developed by Dr Kirsty Boyd) is part of the Building on the Best Quality Improvement Programme in Scotland [funded by Macmillan Cancer Support

REDMAP is recommended by: Royal College of Physicians & Surgeons Glasgow, Royal College of General Practitioners. Healthcare Improvement Scotland, NHS Education for Scotland, and Association for Palliative Medicine.

These resources have been provided through collaboration between Dr Kirsty Boyd and Edinburgh Health and Social Care Partnership (EHSCP) to support care homes and GP practices during the Covid-19 pandemic. Further improvements have been made following feedback from Care Homes and GP practices utilising the resources.

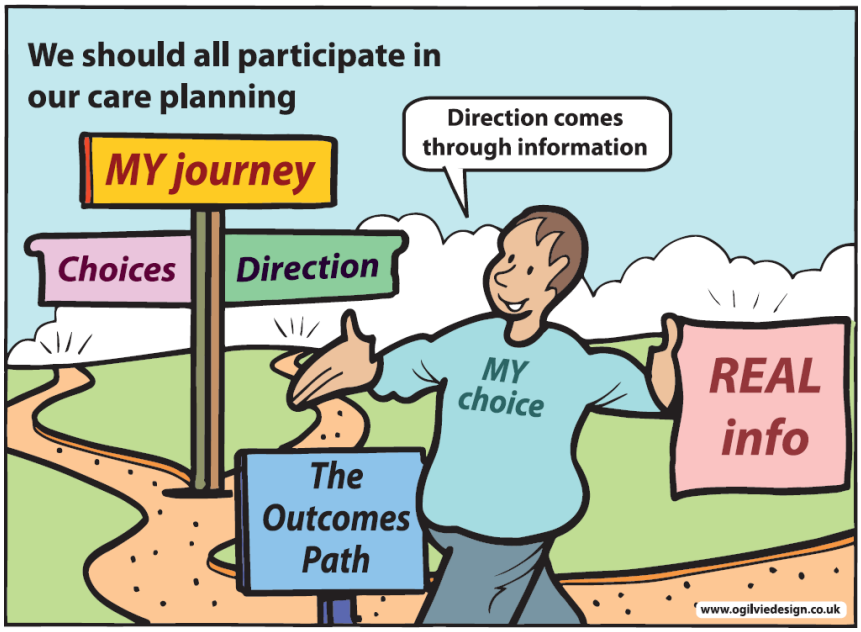
To achieve scale and spread the Lothian Care Academy is providing strategic oversight training and improvement support to embed ACP throughout Lothian through the 7 steps to ACP Approach. The Lothian Care Academy aims to standardise education and training and provide opportunities for all health and social care staff in Lothian.

You can find further resources for REDMAP on the Using SPICT webpages: https://www.spict.org.uk/red-map/

You can find further ACP support for care homes on the NHS Lothian Care Homes web page and all resources for other health and social care teams on our dedicated NHS Lothian Anticipatory Care Planning web page.

A toolkit is available on the Care Home Decisions website Homecare Decisions (scot.nhs.uk), An app is also available to download to help support care home staff.

Or contact the Lothian Care Academy at loth.careacademy@nhslothian.scot.nhs.uk



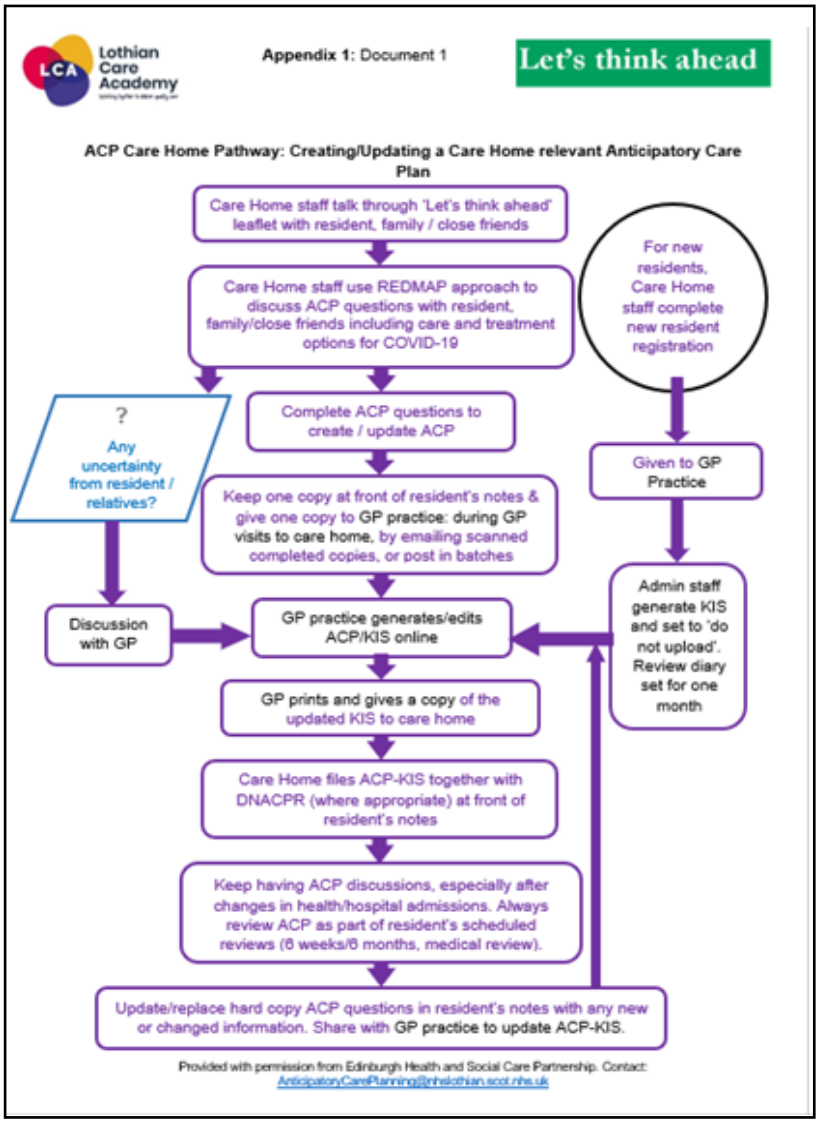
(Image provided courtesy of Ogilvie Design Limited)

Anticipatory Care Planning (ACP)

Supporting residents and their family to have open and honest discussions about their health and wellbeing, and wishes for the future helps put the resident at the centre of decisions about their health, as well as where they might like to be cared for when they are approaching the end of their life.

You can watch a video clip to hear Dr Andrew Mackay explaining ACP in Care Homes. The video gives an overview of what ACP is, the process of creating an ACP with your GP practice, and why it is beneficial for all residents to have an ACP in place. Click here, or copy and paste the following link into your web browser: https://vimeo.com/340150410

Document 1: ACP Care Home REDMAP

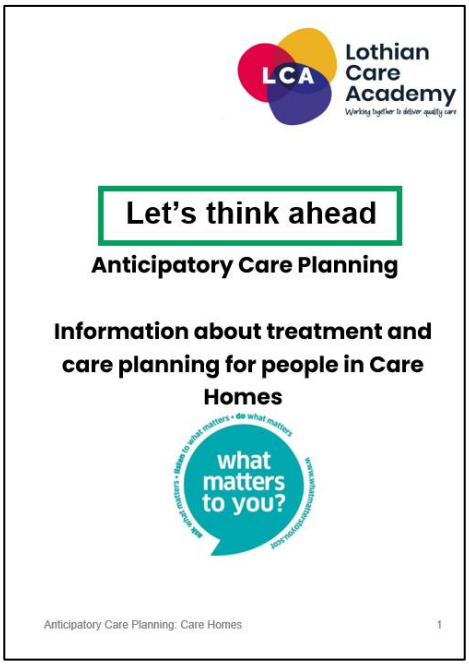


Follow this process to create and review ACPs. Included in Appendix 1. **Purple text** shows **Care Home activity**, **black text** shows **GP activity**.

ACP pathway offers a framework so you and your GP practice can discuss and agree your roles and responsibilities. It helps to clarify ways in which the process of creating and reviewing ACPs will work best, and it is important to agree how you will review and update ACP-Key Information Summaries (ACP-KIS).

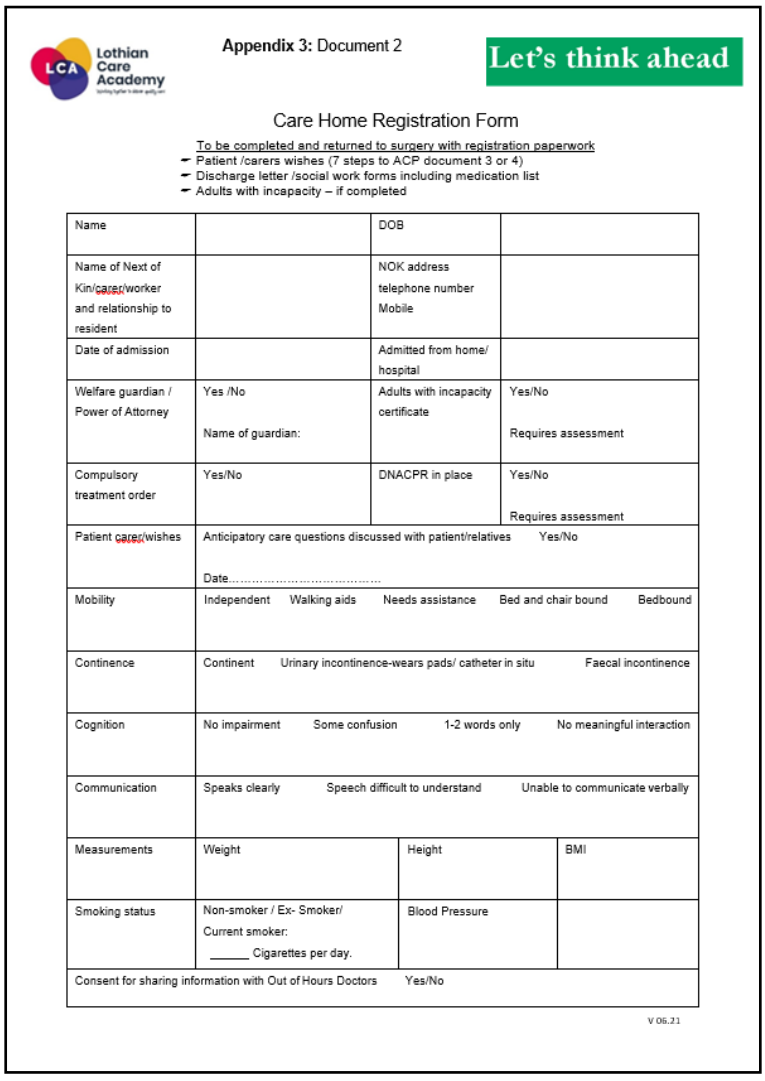
You can find examples of how *7 steps to ACP for Care Homes* has worked well with care homes and GP practices in Edinburgh on the NHS Lothian Care Homes webpage.

Resident and family information leaflet



Use the ACP resident and family information leaflet to help explain ACP and why it's important. Included in Appendix 2: Let's think Ahead Leaflet. An editable version is available for others to adapt.

Document 2: New patient registration form



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Appendix 3: Document 2

Let's think ahead

Care Home Registration Form

To be completed and returned to surgery with registration paperwork
- Patient /carers wishes (7 steps to ACP document 3 or 4)
- Discharge letter /social work forms including medication list
- Adults with incapacity – if completed

Name		DOB	
Name of Next of Kin/carer/worker and relationship to resident		NOK address telephone number Mobile	
Date of admission		Admitted from home/ hospital	
Welfare guardian / Power of Attorney	Yes /No Name of guardian:	Adults with incapacity certificate	Yes/No Requires assessment
Compulsory treatment order	Yes/No	DNACPR in place	Yes/No Requires assessment
Patient carer/wishes	Anticipatory care questions discussed with patient/relatives Yes/No Date……		
Mobility	Independent Walking aids Needs assistance Bed and chair bound Bedbound		
Continence	Continent Urinary incontinence-wears pads/ catheter in situ Faecal incontinence		
Cognition	No impairment Some confusion 1-2 words only No meaningful interaction		
Communication	Speaks clearly Speech difficult to understand Unable to communicate verbally		
Measurements	Weight	Height	BMI
Smoking status	Non-smoker / Ex- Smoker/ Current smoker: _____ Cigarettes per day.	Blood Pressure	
Consent for sharing information with Out of Hours Doctors Yes/No			

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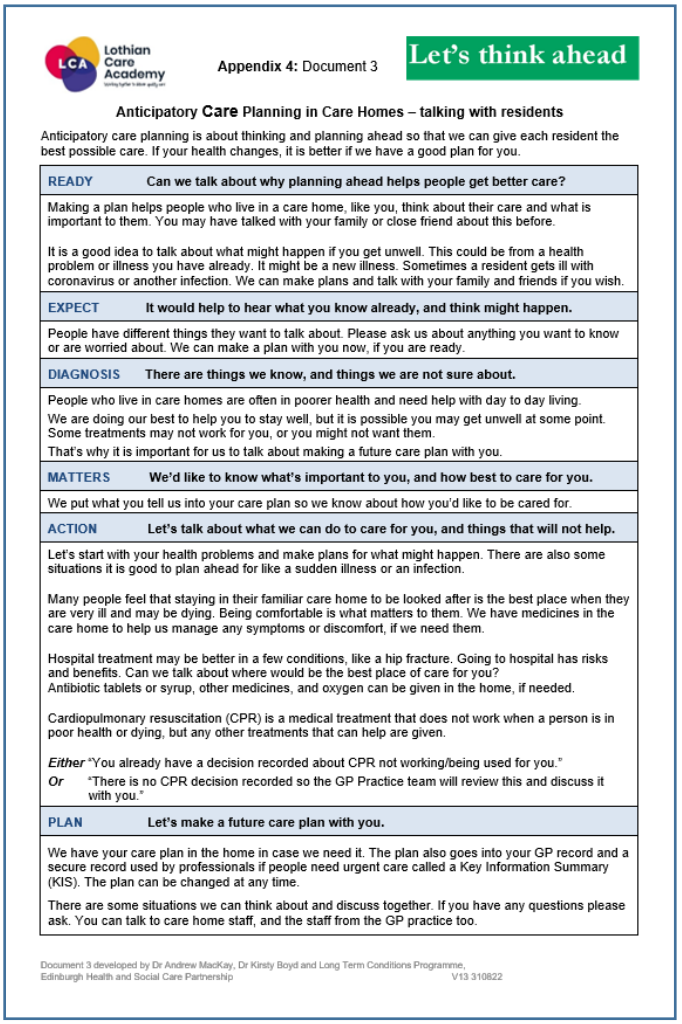
The new patient registration form is how you share information for registering new residents with the GP practice. This information also populates the ACP-KIS at the GP practice. You may have your own version of this form.

The version provided has been designed to be used with the ACP questions to ensure all relevant ACP information is shared to create a comprehensive and quality ACP-KIS. Included in Appendix 3.

Documents 3 & 4: ACP in Care Homes – talking with residents / relatives and friends & making a plan:



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Appendix 4: Document 3

Let's think ahead

Anticipatory Care Planning in Care Homes – talking with residents

Anticipatory care planning is about thinking and planning ahead so that we can give each resident the best possible care. If your health changes, it is better if we have a good plan for you.

READY	**Can we talk about why planning ahead helps people get better care?**
	Making a plan helps people who live in a care home, like you, think about their care and what is important to them. You may have talked with your family or close friend about this before. It is a good idea to talk about what might happen if you get unwell. This could be from a health problem or illness you have already. It might be a new illness. Sometimes a resident gets ill with coronavirus or another infection. We can make plans and talk with your family and friends if you wish.
EXPECT	**It would help to hear what you know already, and think might happen.**
	People have different things they want to talk about. Please ask us about anything you want to know or are worried about. We can make a plan with you now, if you are ready.
DIAGNOSIS	**There are things we know, and things we are not sure about.**
	People who live in care homes are often in poorer health and need help with day to day living. We are doing our best to help you to stay well, but it is possible you may get unwell at some point. Some treatments may not work for you, or you might not want them. That's why it is important for us to talk about making a future care plan with you.
MATTERS	**We'd like to know what's important to you, and how best to care for you.**
	We put what you tell us into your care plan so we know about how you'd like to be cared for.
ACTION	**Let's talk about what we can do to care for you, and things that will not help.**
	Let's start with your health problems and make plans for what might happen. There are also some situations it is good to plan ahead for like a sudden illness or an infection. Many people feel that staying in their familiar care home to be looked after is the best place when they are very ill and may be dying. Being comfortable is what matters to them. We have medicines in the care home to help us manage any symptoms or discomfort, if we need them. Hospital treatment may be better in a few conditions, like a hip fracture. Going to hospital has risks and benefits. Can we talk about where would be the best place of care for you? Antibiotic tablets or syrup, other medicines, and oxygen can be given in the home, if needed. Cardiopulmonary resuscitation (CPR) is a medical treatment that does not work when a person is in poor health or dying, but any other treatments that can help are given. *Either* "You already have a decision recorded about CPR not working/being used for you." *Or* "There is no CPR decision recorded so the GP Practice team will review this and discuss it with you."
PLAN	**Let's make a future care plan with you.**
	We have your care plan in the home in case we need it. The plan also goes into your GP record and a secure record used by professionals if people need urgent care called a Key Information Summary (KIS). The plan can be changed at any time. There are some situations we can think about and discuss together. If you have any questions please ask. You can talk to care home staff, and the staff from the GP practice too.

Document 3 developed by Dr Andrew MacKay, Dr Kirsty Boyd and Long Term Conditions Programme, Edinburgh Health and Social Care Partnership V13 310822

There are two versions of this guidance: one for your discussions with residents and their families or friends, and one for your discussions with families and friends of residents who do not have capacity. Use the most appropriate version to guide your discussion. Please see Appendix 4, and Appendix 5 respectively.

The REDMAP 6 step approach on the first page will guide you, residents and their families through ACP conversations. All of these steps are important and need to be followed in order. **1. Ready, 2. Expect, 3. Diagnosis, 4. Matters, 5. Action** and **6. Plan.**

The ACP questions on the second page enable you to make a plan with residents, their families and friends. If you start with the REDMAP steps followed by the ACP questions it is far more likely the resulting plan will be appropriate and reflect the circumstances and preferences of the resident. For this reason, the form should not just be posted to families, it is intended to be a guide for you to facilitate an ACP conversation.

Notes on REDMAP steps 2 & 5

Step 2: Expect

When talking about what to expect (step 2) there is a prompt for the resident to continue with making the plan, or leave the discussion for another time. It is important that the resident, family/close friend is ready to have the conversation with you.

Getting family or close friends together can be difficult. They can have different or unrealistic expectations regarding care home residents' deteriorating health. It is helpful to have a shared understanding of a resident's health before starting to make plans for the future.

Knowing that the care and treatment preferences can be changed and reviewed gives residents and family reassurance that ACPs are not set in stone and can be reviewed.

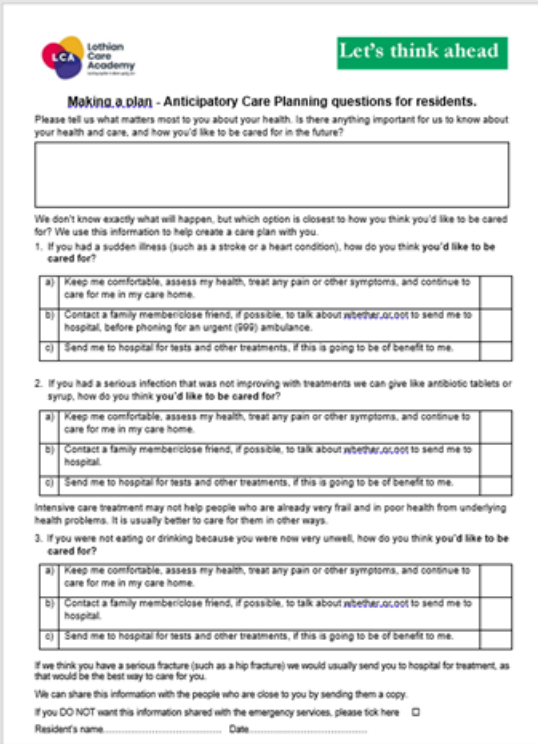
Step 5: Action

In the action section (step 5) there is some information about CPR. CPR is a medical treatment that is only appropriate when it is going to help. The clinical team should therefore decide if CPR treatment would work or not, before CPR is discussed with residents, families/close friends.

Many care home residents have medical conditions which mean CPR would not work or might leave them in much poorer health. Any conversation about CPR should take this into account.

Notes on the ACP questions

The ACP questions on the second page enable residents, their family/close friends to talk with you about their care and treatment preferences should they become very unwell. Please include what is important to the resident, family and close friends in the free text box. This is also a space to record any other information residents, families or close friends have shared with you during your ACP discussions about their care and treatment preferences in general and about any specific health problem they may have.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Let's think ahead

Making a plan - Anticipatory Care Planning questions for residents.

Please tell us what matters most to you about your health. Is there anything important for us to know about your health and care, and how you'd like to be cared for in the future?

We don't know exactly what will happen, but which option is closest to how you think you'd like to be cared for? We use this information to help create a care plan with you.

1. If you had a sudden illness (such as a stroke or a heart condition), how do you think you'd like to be cared for?

a)	Keep me comfortable, assess my health, treat any pain or other symptoms, and continue to care for me in my care home.	
b)	Contact a family member/close friend, if possible, to talk about whether or not to send me to hospital, before phoning for an urgent (999) ambulance.	
c)	Send me to hospital for tests and other treatments, if this is going to be of benefit to me.	

2. If you had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how do you think you'd like to be cared for?

a)	Keep me comfortable, assess my health, treat any pain or other symptoms, and continue to care for me in my care home.	
b)	Contact a family member/close friend, if possible, to talk about whether or not to send me to hospital.	
c)	Send me to hospital for tests and other treatments, if this is going to be of benefit to me.	

Intensive care treatment may not help people who are already very frail and in poor health from underlying health problems. It is usually better to care for them in other ways.

3. If you were not eating or drinking because you were now very unwell, how do you think you'd like to be cared for?

a)	Keep me comfortable, assess my health, treat any pain or other symptoms, and continue to care for me in my care home.	
b)	Contact a family member/close friend, if possible, to talk about whether or not to send me to hospital.	
c)	Send me to hospital for tests and other treatments, if this is going to be of benefit to me.	

If we think you have a serious fracture (such as a hip fracture) we would usually send you to hospital for treatment, as that would be the best way to care for you.

We can share this information with the people who are close to you by sending them a copy.

If you DO NOT want this information shared with the emergency services, please tick here ☐

Resident's name..... Date.....

These questions help you to explore together the three most common deterioration scenarios for which residents are admitted to hospital unnecessarily.

Care home teams who use the ACP questions say that having these conversations early leads to a shared understanding with residents, families and the health teams involved in their care. They have found this reduces stress in times of crisis and gives them the confidence to communicate clearly and act on residents' preferences, leading to better outcomes.

Three options: a) b) c)

a)	**Keep me comfortable, assess my health, treat any pain or other symptoms, and care for me in my care home.**
b)	**Contact a family member/ close friend, if possible, to talk about whether or not to send me to hospital, before phoning for an urgent (999) ambulance.**
c)	**Send me to hospital for tests and other treatments, if this is going to be of benefit to me.**

Each question has three options for the resident, their family or close friend to consider and choose which one is the closest to the care they would prefer.

Option a): It's important to make it clear to families there are lots of options for treatment that can be delivered in the home. Option a) does not imply that there would be a lack of treatment. Instead it is about what the focus of treatment should be and where that treatment is delivered.

Option b): For scenarios described in 2 & 3, if the decision is made to go to hospital, it would not be by blue light ambulance. That is why 'before phoning for an urgent (999) ambulance' is included only in scenario 1.

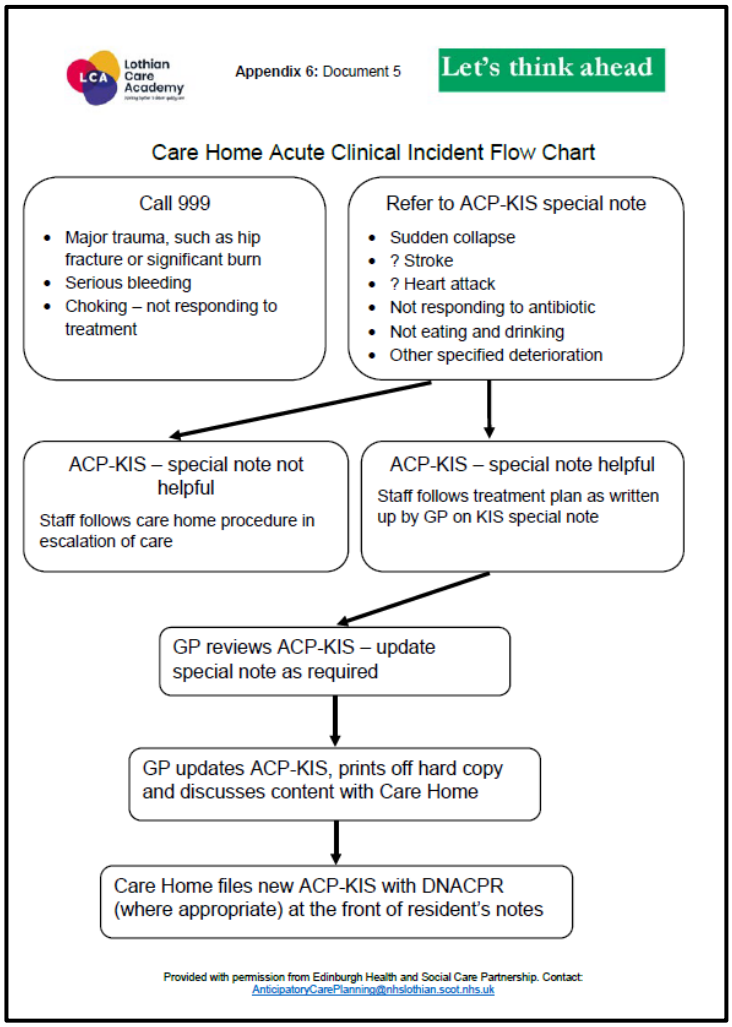
Option c): When a resident who has option c) selected becomes very unwell, it is important to check with a senior staff member at the care home and/or a primary care clinician (GP/ community nurse) that hospital admission is still going to be of benefit to the person. For example, transfer to hospital for a resident who is very close to death is not going to be helpful.

Recording and sharing the ACP Questions

Make and file a copy of the ACP questions form in your resident's care plan**.** Give the original copy of the ACP questions form to the GP practice.

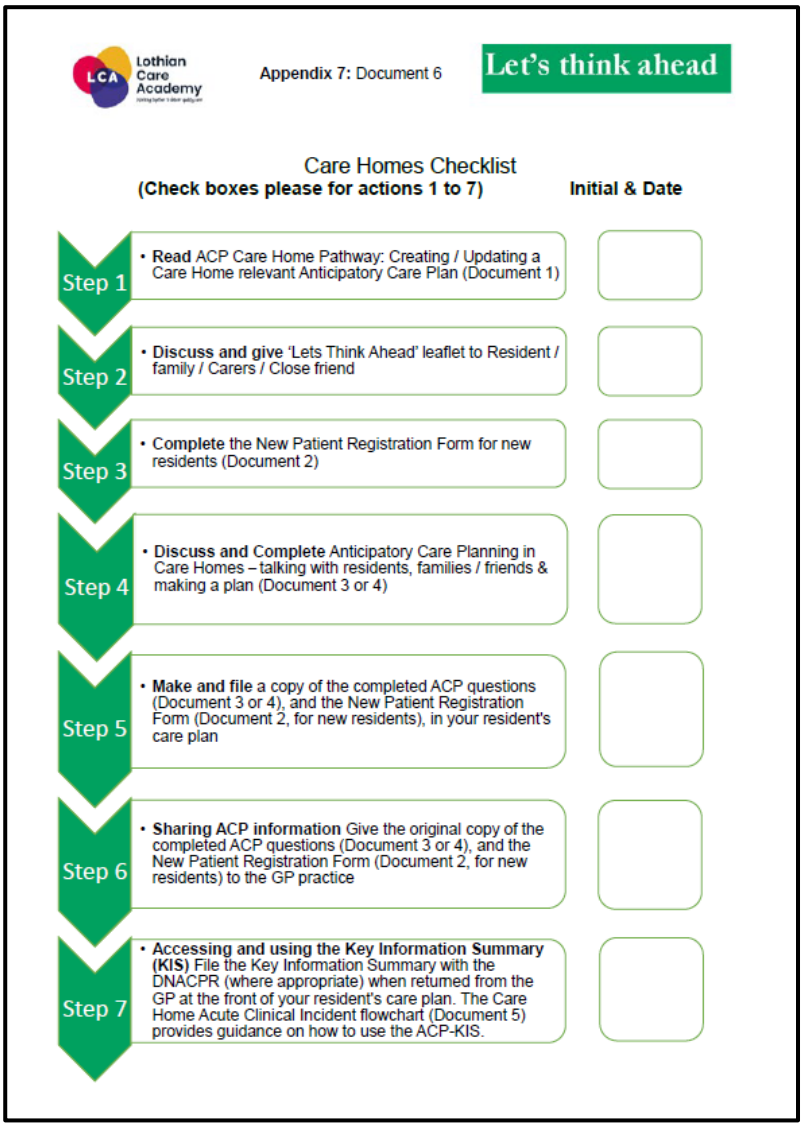
The GP practice will use the information in the form along with other information in their notes to create a Key Information Summary (KIS). When the GP practice returns a copy of the Key Information Summary, file it with the DNACPR record (where one is appropriate) at the front of your resident's care plan. Follow the ACP Pathway described in Document 1 (included as Appendix 1).

Document 5: Care Home Acute Clinical Incident Flow Chart



This flowchart (Document 5) illustrates how to use the ACP-KIS when there is an acute clinical incident. It can be helpful to share this with all of the care home team, including agency staff. Included in Appendix 6.

7 steps to ACP in Care Homes checklist



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Appendix 7: Document 6

Let's think ahead

Care Homes Checklist

(Check boxes please for actions 1 to 7) **Initial & Date**

Step 1 • **Read** ACP Care Home Pathway: Creating / Updating a Care Home relevant Anticipatory Care Plan (Document 1)

Step 2 • **Discuss and give** 'Lets Think Ahead' leaflet to Resident / family / Carers / Close friend

Step 3 • **Complete** the New Patient Registration Form for new residents (Document 2)

Step 4 • **Discuss and Complete** Anticipatory Care Planning in Care Homes – talking with residents, families / friends & making a plan (Document 3 or 4)

Step 5 • **Make and file** a copy of the completed ACP questions (Document 3 or 4), and the New Patient Registration Form (Document 2, for new residents), in your resident's care plan

Step 6 • **Sharing ACP information** Give the original copy of the completed ACP questions (Document 3 or 4), and the New Patient Registration Form (Document 2, for new residents) to the GP practice

Step 7 • **Accessing and using the Key Information Summary (KIS)** File the Key Information Summary with the DNACPR (where appropriate) when returned from the GP at the front of your resident's care plan. The Care Home Acute Clinical Incident flowchart (Document 5) provides guidance on how to use the ACP-KIS.

This checklist, included in Appendix 7, will help you to keep a record of each step in the ACP process. Use the checklist to help implement the *7 steps to ACP* for each resident.

Key points to remember:

- use the Key Information Summary at points of deterioration
- bring and use the Key Information Summary at reviews, and
- return all reviews dated and signed.

Further support

Click here to watch a short video clip of care homes sharing their experiences of implementing the *7 Steps to ACP for Care Homes*, or copy and paste this link into your web browser: https://vimeo.com/340150721

The Care Home Decisions website Homecare Decisions (scot.nhs.uk), can be accessed through the internet or downloaded as an app.

You can read about what care homes have learnt from using the *7 Steps to ACP for Care Homes* approach at Care Homes – Anticipatory Care Planning (nhslothian.scot)

- ACP Improvement Programme Learning Report

Appendices: 7 Steps to ACP in Care Homes Resources

Appendix 1	Document 1: ACP Care Home Pathway: Creating / Updating a Care Home relevant Anticipatory Care Plan
Appendix 2	Let's Think Ahead - Resident, Families & Friends Information Leaflet
Appendix 3	Document 2: Care Home Registration Form
Appendix 4	Document 3: Anticipatory Care Planning in Care Homes – Talking with Residents & Making a plan - Anticipatory Care Planning Questions for Residents
Appendix 5	Document 4: Anticipatory Care Planning in Care Homes – Talking with Relatives/ Friends & Making a Plan - Anticipatory Care Planning Questions for Relatives/Friends
Appendix 6	Document 5: Care Home Acute Clinical Incident Flow Chart
Appendix 7	Care Homes Checklist

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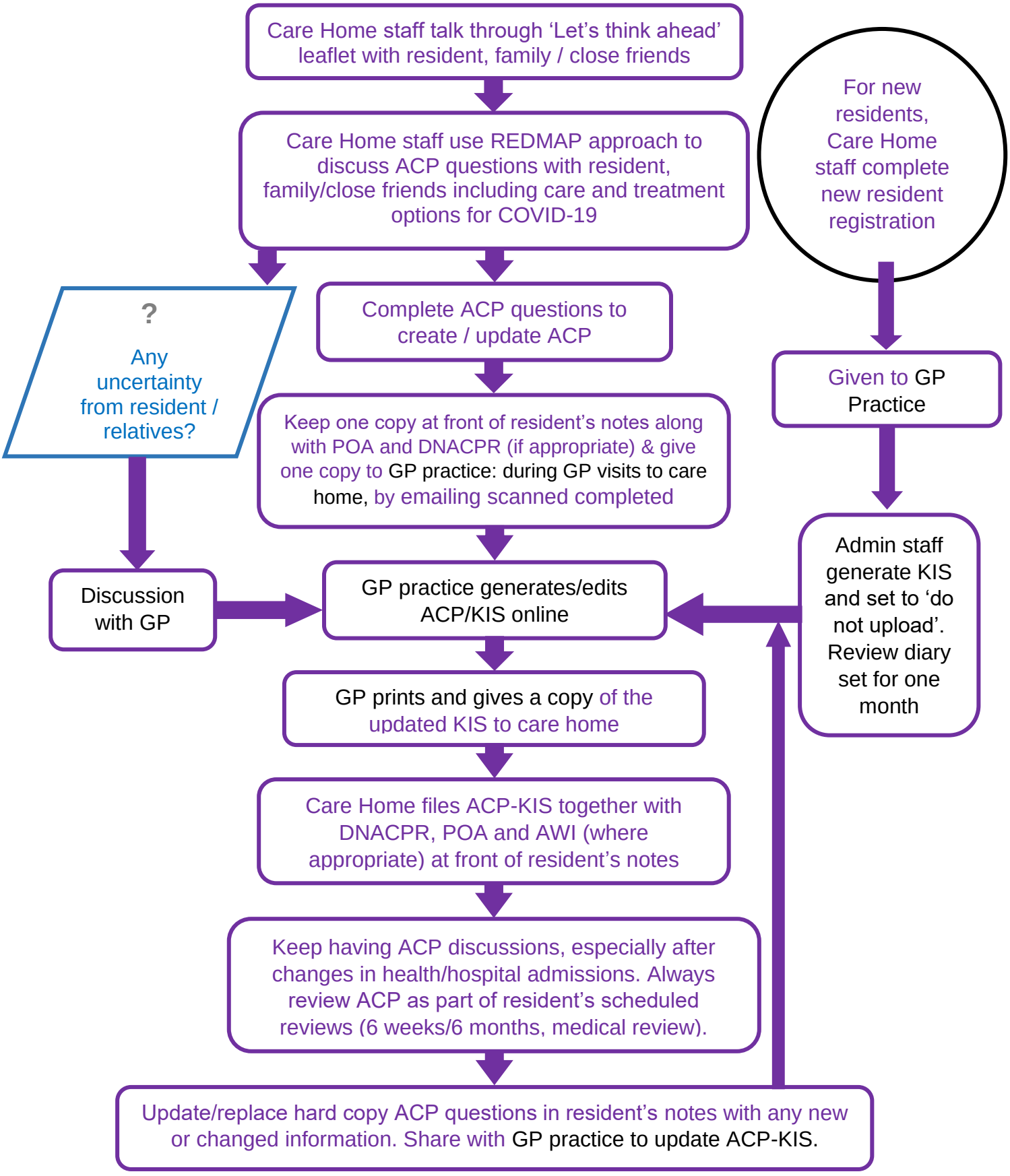
Appendix 1: Document 1

Let's think ahead

ACP Care Home Pathway: Creating/Updating a Care Home relevant Anticipatory Care Plan



Provided with permission from Edinburgh Health and Social Care Partnership. Contact: AnticipatoryCarePlanning@nhslothian.scot.nhs.uk

Appendix 2:

Care home staff providing your care might ask you:

- Who are the key people we can contact if you become very unwell (for example family or close friends, someone you have given Power of Attorney to)?
- If you become very unwell, how and where would you like to be cared for?
- Are there other things we can do to help you?
- Is there anything else about your health and care that is important for us to know?

Adapted from Building on the Best Scotland leaflet, 2020

Logos used with permission from Healthcare Improvement Scotland
July 2020

For further information please go to
http://www.whatmatterstoyou.scot/

https://www.nhsinform.scot/acp

The leaflet may be made available in a larger print, Braille or your community language. Please email anticipatorycareplanning@nhslothian.scot.nhs.uk

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Let's think ahead

Anticipatory Care Planning

Information about treatment and care planning for people in Care Homes

ask what matters • listen to what matters • do what matters
what matters to you?
www.whatmatterstoyou.scot

Introduction

Anticipatory Care Planning (ACP) means thinking and planning ahead and understanding what is happening with your health and care.

No one knows when their health and care needs may change. It is important for care home staff and the GP practice providing your care and treatment to talk with you about:

- How you are
- What might happen if your condition changes and you are less well.

Together you can talk about **what matters to you**, to make sure you are involved as much as possible in planning your treatment and care. What you discuss will go into your care plan and can be shared with your family or a close friend.

If you already have a care plan, please share it with the care home staff.

When you are creating a care plan, you or your relative/close friend might want to ask the care home staff looking after you:

Can we talk about what is important to me?

Can we talk about what might happen in the future?

Can we talk about things I would like and the things I do not want to happen to me?

Can we talk about the treatment and care options I have and any decisions I need to make with you?

Appendix 3: Document 2

Let's think ahead

Care Home Registration Form

To be completed and returned to surgery with registration paperwork

- Patient/carers' wishes (7 steps to ACP document 3 or 4)
- Discharge letter /social work forms including medication list
- Adults with incapacity – if completed

Name		DOB	
Name of Next of Kin/carer/worker and relationship to resident		NOK address telephone number Mobile	
Date of admission		Admitted from home/ hospital	
Welfare guardian / Power of Attorney	Yes /No Name of guardian:	Adults with incapacity certificate	Yes/No Requires assessment
Compulsory treatment order	Yes/No	DNACPR in place	Yes/No Requires assessment
Patient carer/wishes	Anticipatory care questions discussed with patient/relatives Yes/No Date……		
Mobility	Independent Walking aids Needs assistance Bed and chair bound Bedbound		
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Measurements	Weight	Height	BMI
Smoking status	Non-smoker / Ex- Smoker/ Current smoker: _____ Cigarettes per day.	Blood Pressure	
Consent for sharing information with Out of Hours Doctors Yes/No			

Anticipatory Care Planning in Care Homes – talking with residents

Anticipatory care planning is about thinking and planning ahead so that we can give each resident the best possible care. If your health changes, it is better if we have a good plan for you.

READY	**Can we talk about why planning ahead helps people get better care?**
Making a plan helps people who live in a care home, like you, think about their care and what is important to them. You may have talked with your family or close friend about this before. It is a good idea to talk about what might happen if you get unwell. This could be from a health problem or illness you have already. It might be a new illness. Sometimes a resident gets ill with coronavirus or another infection. We can make plans and talk with your family and friends if you wish.	
EXPECT	**It would help to hear what you know already, and think might happen.**
People have different things they want to talk about. Please ask us about anything you want to know or are worried about. We can make a plan with you now, if you are ready.	
DIAGNOSIS	**There are things we know, and things we are not sure about.**
People who live in care homes are often in poorer health and need help with day to day living. We are doing our best to help you to stay well, but it is possible you may get unwell at some point. Some treatments may not work for you, or you might not want them. That's why it is important for us to talk about making a future care plan with you.	
MATTERS	**We'd like to know what is important to you, and how best to care for you.**
We put what you tell us into your care plan so we know about how you'd like to be cared for.	
ACTION	**Let's talk about what we can do to care for you, and things that will not help.**
Let's start with your health problems and make plans for what might happen. There are also some situations it is good to plan ahead for like a sudden illness or an infection. Many people feel that staying in their familiar care home to be looked after is the best place when they are very ill and may be dying. Being comfortable is what matters to them. We have medicines in the care home to help us manage any symptoms or discomfort, if we need them. Hospital treatment may be better in a few conditions, like a hip fracture. Going to hospital has risks and benefits. Can we talk about where would be the best place of care for you? Antibiotic tablets or syrup, other medicines, and oxygen can be given in the home, if needed. Cardiopulmonary resuscitation (CPR) is a medical treatment that does not work when a person is in poor health or dying, but any other treatments that can help are given. ***Either*** "You already have a decision recorded about CPR not working or not being used for you ***Or*** "There is no CPR decision recorded so the GP Practice team will review this and discuss it with you."	
PLAN	**Let's make a future care plan with you.**
We have your care plan in the home in case we need it. Your plan also goes into your GP record and a secure record used by professionals if people need urgent care called a Key Information Summary (KIS). Your plan can be changed at any time. There are some situations we can think about and discuss together. If you have any questions please ask. You can talk to care home staff, and the staff from the GP practice too.	

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Let's think ahead

Making a plan - Anticipatory Care Planning questions for residents.

Please tell us what matters most to you about your health. Is there anything important for us to know about your health and care, and how you'd like to be cared for in the future?

We don't know exactly what will happen, but which option is closest to how you think you'd like to be cared for? We use this information to help create a care plan with you.

1. If you had a sudden illness (such as a stroke or a heart condition), how do you think **you'd like to be cared for**?

a)	Keep me comfortable, assess my health, treat any pain or other symptoms, and continue to care for me in my care home.	
b)	Contact a family member/close friend, if possible, to talk about whether or not to send me to hospital, before phoning for an urgent (999) ambulance.	
c)	Send me to hospital for tests and other treatments, if this is going to be of benefit to me.	

2. If you had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how do you think **you'd like to be cared for**?

a)	Keep me comfortable, assess my health, treat any pain or other symptoms, and continue to care for me in my care home.	
b)	Contact a family member/close friend, if possible, to talk about whether or not to send me to hospital.	
c)	Send me to hospital for tests and other treatments, if this is going to be of benefit to me.	

Intensive care treatment may not help people who are already very frail and in poor health from underlying health problems. It is usually better to care for them in other ways.

3. If you were not eating or drinking because you were now very unwell, how do you think **you'd like to be cared for?**

a)	Keep me comfortable, assess my health, treat any pain or other symptoms, and continue to care for me in my care home.	
b)	Contact a family member/close friend, if possible, to talk about whether or not to send me to hospital.	
c)	Send me to hospital for tests and other treatments, if this is going to be of benefit to me.	

If we think you have a serious fracture (such as a hip fracture) we would usually send you to hospital for treatment, as that would be the best way to care for you.

We can share this information with the people who are close to you by sending them a copy.

If you DO NOT want this information shared with the emergency services, please tick here ☐

Resident's name…… Date……

Document 3 developed by Dr Andrew MacKay, Dr Kirsty Boyd, Long Term Conditions Programme, Edinburgh Health and Social Care Partnership - V14 12.10.2022 ENDORSED by Lothian Care Academy 2023 V1

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Appendix 5: Document 4

Let's think ahead

Anticipatory Care Planning in Care Homes – talking with relatives/friends

Anticipatory care planning is about thinking and planning ahead so that we can give each person the best possible care. If a person's health changes, it is better if we have a good plan for them.

READY	**Can we talk about why planning ahead helps people get better care?**

Making a plan helps us think about care for people who live in a care home and what is important to them. You may have talked with your relative or friend about this before.

It is a good idea to talk about what might happen if they get unwell. This could be from a health problem or illness they have already. It might be a new illness. Sometimes a resident gets ill with coronavirus or another infection. We can make plans just in case.

EXPECT	**It would help to hear what you know already, and think might happen.**

People have different things they want to talk about. Please ask us about anything you want to know or are worried about. We can make a plan with you now, if you are ready.

DIAGNOSIS	**There are things we know, and things we are not sure about.**

People who live in care homes are often in poorer health and need help with day to day living.

We are doing our best to help your relative/friend to stay well, but it is possible they may get unwell at some point. Some treatments may not work for them, or they might not want them.

That's why it is important for us to talk about making a future care plan for them.

MATTERS	**Knowing what is important to your relative/friend helps us to care for them.**

We put this information into their care plan so we know about how they'd like to be cared for.

ACTION	**Let's talk about what we can do to care for them, and things that will not help.**

Let's start with their health problems and make plans for what might happen. There are also some situations it is good to plan ahead for like a sudden illness or an infection.

Many people feel that staying in their familiar care home to be looked after is the best place when they are very ill and may be dying. Being comfortable is what matters to them. We have medicines in the care home to help us manage any symptoms or discomfort, if we need them.

Hospital treatment may be better in a few conditions, like a hip fracture. Going to hospital has risks and benefits. Can we talk about where would be the best place of care for them?
Antibiotic tablets or syrup, other medicines, and oxygen can be given in the home, if needed.

Cardiopulmonary resuscitation (CPR) is a medical treatment that does not work when a person is in poor health or dying, but any other treatments that can help are given.

> **Either** "Your relative already has a decision recorded about CPR not working or not being used for them. **Or** "There is no CPR decision recorded so the GP practice team will review this and discuss it with you and your relative/friend, if they are able to do that."

PLAN	**Let's make a future care plan for your relative/friend.**

We have the plan in the home in case we need it. The plan also goes into their GP record and a secure record used by professionals if people need urgent care called a Key Information Summary (KIS). The plan can be changed at any time.

There are some situations we can think about and discuss together. If you have any questions please ask. You can talk to care home staff, and the staff from the GP practice too.

Document 4 developed by Dr Andrew MacKay, Dr Kirsty Boyd and Long Term Conditions Programme, Edinburgh Health and Social Care Partnership V14 12.10.2022 - ENDORSED by Lothian Care Academy 2023 V1

Making a plan - Anticipatory Care Planning questions for relatives/friends

Please tell us what matters most to your relative or close friend about their health.

Is there anything that you think they'd like us to know about their health and care, and how they'd like to be cared for in the future? What would they say about this if we could ask them?

We don't know exactly what will happen, but which option is closest to how you think your relative or friend would like to be cared for? We use this information to help create a care plan for them.

1. If your relative/ friend had a sudden illness (such as a stroke or a heart condition), how do you think **your relative/friend would like to be cared for**?

a)	Keep them comfortable, assess their health, treat any pain or other symptoms, and continue to care for them in their care home.	
b)	Contact a family member/ close friend, if possible, to talk about whether or not to send them to hospital, before phoning for an urgent (999) ambulance.	
c)	Send them to hospital for tests and other treatments, if this is going to be of benefit to them.	

2. If your relative/ friend had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how do you think **your relative/friend would like to be cared for**?

a)	Keep them comfortable, assess their health, treat any pain or other symptoms, and continue to care for them in their care home.	
b)	Contact a family member/ close friend, if possible, to talk about whether or not to send them to hospital.	
c)	Send them to hospital for tests and other treatments, if this is going to be of benefit to them.	

Intensive treatments may not help people who are already very frail and in poor health from underlying health problems. It is usually better to care for them in other ways.

3. If your relative/friend were not eating or drinking because they were now very unwell, how do you think **your relative/ friend would like to be cared for?**

a)	Keep them comfortable, assess their health, treat any pain or other symptoms, and continue to care for them in their care home.	
b)	Contact a family member/close friend, if possible, to talk about whether or not to send them to hospital.	
c)	Send them to hospital for tests and other treatments, if this is going to be of benefit to them.	

If we think that a resident has a serious fracture (such as a hip fracture) we would usually send them to hospital for treatment, as that would be the best way to care for them.

If you DO NOT want this information shared with the emergency services, please tick here ☐

Resident's name…… Your name……

Relationship……Phone number…….. Date…….

I have / do not have Power of Attorney for my relative/ friend.

I have / do not have Welfare Guardianship for my relative/ friend.

Care Home Acute Clinical Incident Flow Chart

Call 999

- Major trauma, such as hip fracture or significant burn
- Serious bleeding
- Choking – not responding to treatment

Refer to ACP-KIS special note

- Sudden collapse
- ? Stroke
- ? Heart attack
- Not responding to antibiotic
- Not eating and drinking
- Other specified deterioration

ACP-KIS – special note not helpful

Staff follows care home procedure in escalation of care

ACP-KIS – special note helpful

Staff follows treatment plan as written up by GP on KIS special note

GP reviews ACP-KIS – update special note as required

GP updates ACP-KIS, prints off hard copy and discusses content with Care Home

Care Home files new ACP-KIS with DNACPR (where appropriate) at the front of resident's notes

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Appendix 7: Document 6

Let's think ahead

Care Homes Checklist

(Check boxes please for actions 1 to 7) **Initial & Date**

Step 1	• **Read** ACP Care Home Pathway: Creating / Updating a Care Home relevant Anticipatory Care Plan (Document 1)	
Step 2	• **Discuss and give** 'Lets Think Ahead' leaflet to Resident / family / Carers / Close friend	
Step 3	• **Complete** the New Patient Registration Form for new residents (Document 2)	
Step 4	• **Discuss and Complete** Anticipatory Care Planning in Care Homes – talking with residents, families / friends & making a plan (Document 3 or 4)	
Step 5	• **Make and file** a copy of the completed ACP questions (Document 3 or 4), and the New Patient Registration Form (Document 2, for new residents), in your resident's care plan	
Step 6	• **Sharing ACP information** Give the original copy of the completed ACP questions (Document 3 or 4), and the New Patient Registration Form (Document 2, for new residents) to the GP practice	
Step 7	• **Accessing and using the Key Information Summary (KIS)** File the Key Information Summary with the DNACPR (where appropriate) when returned from the GP at the front of your resident's care plan. The Care Home Acute Clinical Incident flowchart (Document 5) provides guidance on how to use the ACP-KIS.	

Document Control Sheet

Key Information:

Title:	7 steps to Anticipatory Care Planning in Care Homes: Implementation Guidance & Resources
Date Published/Issued:	31/03/23
Date Effective From:	31/03/23
Version/Issue Number:	1.0 – New versioning as per responsibility handed over LCA
Document status:	Live
Author:	Lothian Care Academy – Documentation Group
Owner:	Lothian Care Academy
Approver:	ACP Documentation Group
Approved by and Date:	ACP Documentation Group – Meeting 16/03/23 Meeting 18/04/23
Contact:	loth.careacademy@nhslothian.scot.nhs.uk
File Location:	\\sjh-app1\Shared\CareHomeCovid19\Care Homes - covid19\19 Care Academy\14 - Monitoring and Control Projects - Post Oct 22\Aim 1 - Training and Education\ACP\Documentation Group\7 step guide

Revision History:

Version:	Date:	Summary of Changes:	Name:
1.0	31/03/23	New version control for LCA – changes made reflective of ACP group meeting on 160323	LCA
1.1	18/04/23	Additional wording reflective of ACP Documentation meeting – accessibility to be reviewed further	LCA

Distribution: This document has been distributed to:

Name:	Complete	Date of Issue:	Version:
LCA website	No – to be done		1.0
Home care decision app	No – to be done		1.0