



Anticipatory Care Planning (ACP) in the Community – Key steps for clinicians

Introduction

ACP in Scotland is part of Realistic Medicine and person-centred care. ACP helps us deliver proactive health and care for when someone's health changes. ACP takes account of what matters to people and their health problems. RED-MAP communication supports good ACP conversations.

1. IDENTIFY: people with unstable or deteriorating health

- ▶ Progressive, life-limiting conditions: some cancers, organ failure, advanced neurological disease or dementia.
- ► Older people with progressive frailty.
- ▶ New serious illness or infection, or disease complications.
- ► Multiple, long-term conditions or complex health problems.
- ▶ People with increasing personal care and support needs due to physical and/or mental health problems.

Triggers for ACP discussions

- •Unplanned hospital admissions.
- •Notable decline in function, abilities or overall health.
- •Significant new diagnosis.
- •Clinical indicators (e.g. SPICT).
- Frailty screening (e.g. eFI).
- Multiple NHS24 or A&E contacts.

2. ASSESS: before a care planning discussion

- ► Usual health status: current illnesses and/or frailty; illness trajectory; changes since last review.
- ► Treatment and care plan (including KIS): review any ACP (e.g. ReSPECT form, MyACP, ACP-Questions, Hospital Passport (people with learning disabilities), advance statement.)
- Likely clinical outcomes of interventions: e.g. hospital attendance or admission, IV therapies.
- ▶ CPR status: Is CPR a treatment that would work or not? Does this patient have a DNACPR form?
- ► Check next of kin, family/close friend/carer, POA details; consider family/carer support needs.
- ► Shared decision-making: Who should be involved in planning care, if the person agrees?
- ► Known preferences for treatment and care if health changes or deteriorates.

3. TALK: with the patient and those close to them (use RED-MAP)

It helps if we plan these conversations so people are better prepared.

'We talk with people like you about making good plans for your care.

We'd like to know what's important to you, and make plans for good care with you.

Can we find a time to talk about this? Is there anyone you'd like us to speak to?'

4. ACTIONS: plan current and future care (includes urgent/emergency care plan)

Tailor planning to each person. Actions chosen must always be of overall benefit to them.

- •How would this patient like to be cared for, and is there any treatment/care they do not want?
- •Where would this patient like to be cared for if their health changes and/or they are more unwell?
 - Stay in their home Clinical assessment and contact family -Go to hospital
- Any specific plans for: a) sudden/new illness or complication b) infection (including COVID-19)
 c) changed or deteriorating health d) care if might be dying
- •If CPR will not work or help, talk about what we can do that will help including planning ahead. If CPR has an uncertain outcome or would leave the person in poorer health, discuss personal goals.
- Review medications/current clinical care. Plan for anticipatory medicines, if appropriate.
- ▶ Offer to speak with family members, a close friend or POA holder, as appropriate.
- 5. PLAN: Record and share Anticipatory Care Plans so they are easy to access; always update KIS.