Let's think ahead

7 Steps to Future Care Planning in Care Homes:

Implementation Guidance & Resources

Created: May 2020

V1.0 Updated

18.03.2025

This 7 steps toolkit enables care home staff to embed future care planning processes, so that decisions about care and support are based on what is important to each individual resident.

Developed by Edinburgh Health and Social Care Partnership and endorsed by the Lothian Care Academy https://services.nhslothian.scot/carehomes/llothian-care-academy.

An electronic version of 7 steps to future care planning in care homes can be found on the Right Decision Service Platform at: https://rightdecisions.scot.nhs.uk/all-resources/

A PDF version can be downloaded for printing at:
https://services.nhslothian.scot/futurecareplanning/care-homes/

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7 Step Process

The 7-Step process for future care planning puts the care home resident at the centre of decisions about their health.

It provides you with a step-by-step framework to support residents and their families to have open and honest discussions about their health and wellbeing and wishes for the future.

You can find more information about Future Care Planning and the development of this toolkit in the appendix (pages 32-39)

You can find further information, support and resources on future care planning for care homes at: https://services.nhslothian.scot/carehomes/education-and-training/acp-training/.

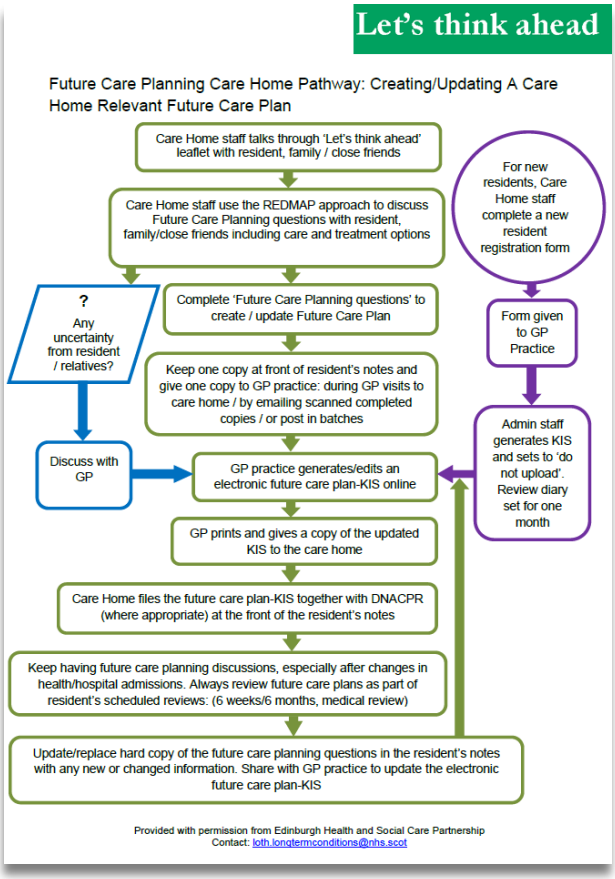
Further information on future care planning is also available on the NHS Inform website at: https://www.nhsinform.scot/care-support-and-rights/decisions-about-care/future-care-planning/.

Step 1: Read ‘Future care planning care home pathway’

Read through the Future Care Planning Care Home Pathway below (Previously referred to as Document 1) and follow the process shown in the flowchart to create and review future care plans. Purple text shows care home activity, black text shows GP activity.

The pathway below can be found in the appendix (page 20) and is available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/Future-care-planning-care-home-pathway-7-Steps-to-FCP.pdf/

It can be helpful to discuss the Future Care Planning Care Home Pathway with your GP practice to agree your roles and responsibilities and discuss ways in which the process of creating and reviewing future care plans will work best. It’s important to agree how you will review and update the electronic future care plan-Key Information Summaries (future care plan-KIS).



Step 2: Discuss and provide a copy of ‘Let’s Think Ahead’ leaflet

Let’s Think Ahead - Resident, families & friends information leaflet.
Use this leaflet to help explain future care planning and why it’s important.

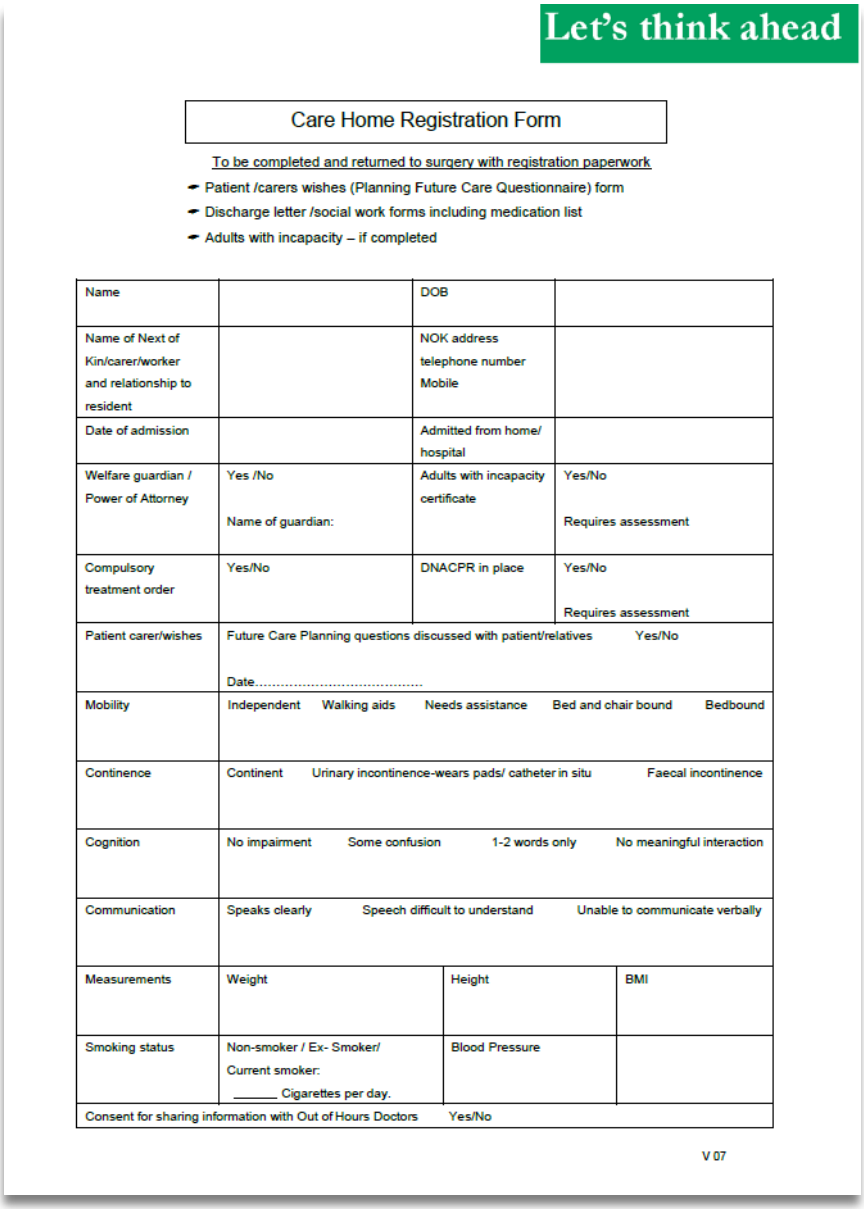
The leaflet can be found in the appendix (page 21-22) and is available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/01/Future-Care-Planning-Care-Homes-V3.0-LOT2070-print-layout.pdf/

Step 3: Complete the ‘Care Home Registration Form’

The care home registration form (previously referred to as Document 2) is how you share information for registering new residents with the GP practice. This information also populates the electronic future care plan-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 future care planning questions to ensure all relevant future care planning information is shared to create a comprehensive and quality future care plan-KIS.

The ‘Care home registration form’ can be found in the appendix (page 23) and is available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/Care-Home-Patient-Registration-Form-7-Steps-to-FCP.docx



Let’s think ahead

Care Home Registration Form

To be completed and returned to surgery with registration paperwork

- Patient /carers wishes (Planning Future Care Questionnaire) form
- 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	Future Care Planning 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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Step 4: Discuss and complete future care planning in care homes – talking & making a plan

The following guidance provides a conversation model to follow when having your future care planning conversations (REDMAP), and a set of future care planning questions to enable you to make a plan with residents, their families and friends.

Work through each REDMAP step before asking the future care planning scenario-based questions. Both are important and should be followed in this order. Using the REDMAP conversation model and the questions in this way will help you make a plan shared plan after your future care planning discussion. This will ensure everyone is prepared to make a plan which is appropriate and reflects the circumstance and wishes of the resident. Do not ask the future care planning questions without preparing yourself, the resident and their family first. For this reason, the form with the future care planning questions should not be posted to families to complete or given to them without first having a future care planning conversation.

There are two versions of this guidance:

- a version for your discussions with the care home residents, and their families or friends (Step 4.1, previously referred to as Document 3)
- a version for your discussions with families and friends of residents who do not have capacity (Step 4.2, previously referred to as Document 4)

Use the most appropriate version of the REDMAP model (illustrated below) to guide your conversation and then move on to the future care planning questions to start to make a plan.

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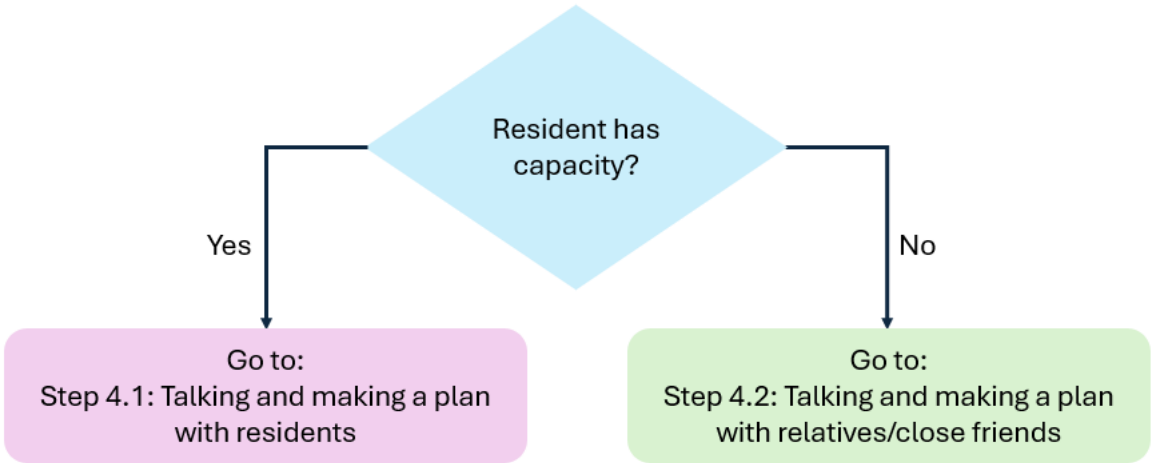


Step 4.1: Talking and making a plan with residents

The REDMAP conversation model and future care planning scenario-based questions for residents are detailed below, included in the appendix (pages 24-26) and is available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/FCP-in-Care-Homes-Questions-for-Residents-7-Steps-FCP.pdf

The REDMAP conversation model for talking with residents

1. 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.	
2. 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. **Note:** When talking about what to expect there is a prompt for the resident to continue with making the plan, or leave the discussion for another time. It's 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 future care plans are not set in stone and can be reviewed.	
3. 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.	
4. 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.	
5. 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.

Either, "You already have a decision recorded about CPR not working/being used for you. But any other treatments that can help will be given."

Or, "There is no CPR decision recorded so the GP Practice team will review this and discuss it with you."

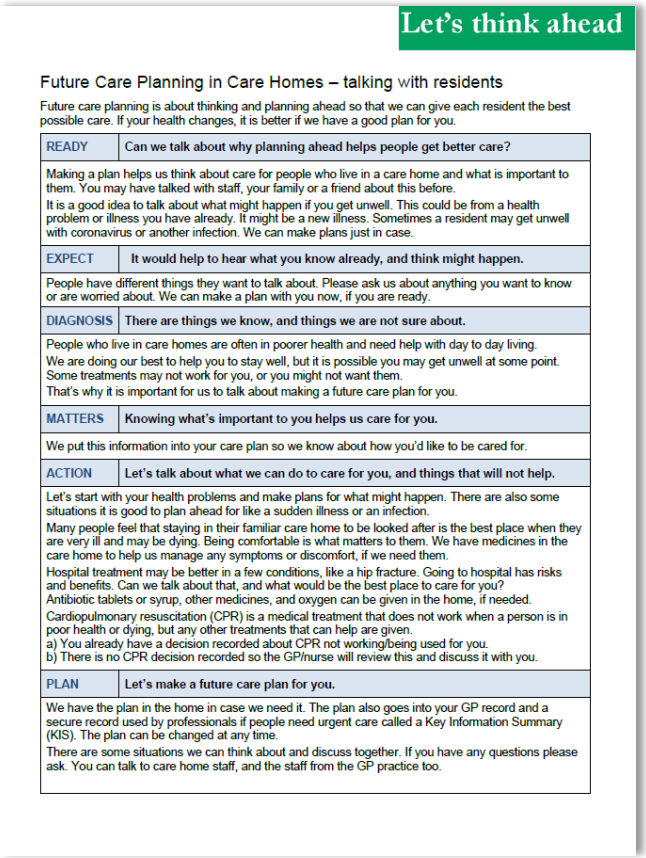
Note:
In the Action section there is some information about CPR. CPR is a medical treatment which is only appropriate when it is going to help. The clinical team should therefore decide if there is any prospect of CPR being successful before CPR is discussed with residents, families/close friends.

Many care home residents have medical conditions which mean CPR would not be effective for them. Any conversation about CPR should take this into account.

6. 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.



Let's think ahead

Future Care Planning in Care Homes – talking with residents

Future 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 us think about care for people who live in a care home and what is important to them. You may have talked with staff, your family or a 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 may get unwell 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 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 for you.	
MATTERS	Knowing what's important to you helps us care for you.
We put this information 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 that, and what would be the best place to 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. a) You already have a decision recorded about CPR not working/being used for you. b) There is no CPR decision recorded so the GP/nurse will review this and discuss it with you.	
PLAN	Let's make a future care plan for you.
We have the 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.	

Questions for residents – making a plan

Notes on the future care planning questions

The 'REDMAP conversation model for talking with residents' and 'Making a plan – future care planning questions for residents' can be found in the appendix (pages 24-26) and is available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/FCP-in-Care-Homes-Questions-for-Residents-7-Steps-FCP.pdf

The below future care planning scenario-based questions and response options enable you to talk about care and treatment preferences should the resident become very unwell. The questions will help you to explore together the three most common deterioration scenarios for which residents are most often unnecessarily admitted to hospital.

There is a free text box on the form to include what is important to the resident. This is also a space to record any other information residents, families or close friends have shared with you during your future care planning discussions about care and treatment preferences.

Scenario-based questions:

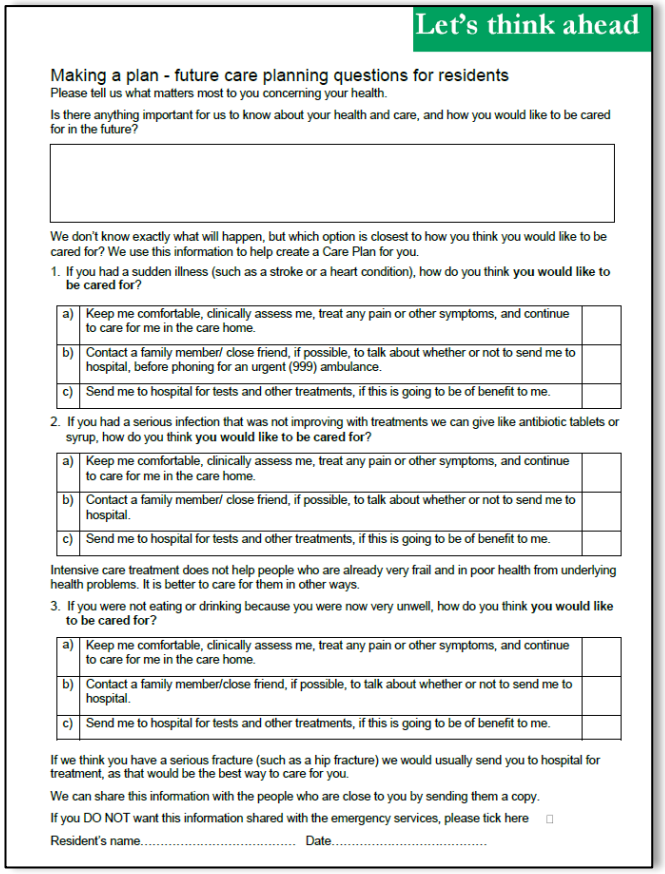
1. If you had a sudden illness (such as a stroke or a heart condition) how do you think you would like to be cared for?
2. If you had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how do you think you would like to be cared for?
3. If you were not eating or drinking because you were now very unwell, how do you think you would like to be cared for?

The scenario-based questions response options:

Each question has three options for the resident to consider which is the closest to the care they would like.

Option 1: Keep me comfortable, assess my health, treat any pain or other symptoms, and continue to care for me in my care home.
• It's important to make it clear to families there are lots of options for treatment that can be delivered in the home. • Option 1 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 2: 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)
• For scenarios described in questions 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 3: Send me to hospital for tests and other treatments, if this is going to be of benefit to me
• When a resident who has opted for Option 3 becomes very unwell it can be useful to confirm with senior members of the team that hospital admission is likely to improve outcomes and is therefore appropriate. • For example, transfer to hospital for those that are very close to death is not going to be helpful and will be distressing for the resident, relatives and staff.



Let's think ahead

Making a plan - future care planning questions for residents

Please tell us what matters most to you concerning your health.

Is there anything important for us to know about your health and care, and how you would 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 would like to be cared for? We use this information to help create a Care Plan for you.

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

a)	Keep me comfortable, clinically assess me, treat any pain or other symptoms, and continue to care for me in the 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 would like to be cared for?**

a)	Keep me comfortable, clinically assess me, treat any pain or other symptoms, and continue to care for me in the 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 does not help people who are already very frail and in poor health from underlying health problems. It is 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 would like to be cared for?**

a)	Keep me comfortable, clinically assess me, treat any pain or other symptoms, and continue to care for me in the 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.....

Step 4.2: Talking and making a plan with relatives/close friends

If the care home resident does not have capacity, use this version of the REDMAP conversation model and future care planning scenario-based questions.

The 'REDMAP conversation model for talking with relatives/close friends' and 'Making a plan – future care planning questions for relatives/close friends' can be found in the appendix (pages 27 -29) and is available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/FCP-in-Care-Homes-Questions-for-Relatives-and-Friends-7-Steps-FCP.pdf

The REDMAP conversation model for talking with relatives/close friends

1. 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.	
2. 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. Note: When talking about what to expect there is a prompt for the resident to continue with making the plan, or leave the discussion for another time. It's 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 future care plans are not set in stone and can be reviewed.	
3. 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.	
4. 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.	
5. 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. Either "Your relative already has a decision recorded about CPR not working/being used for them. But any other treatments that can help are still given" 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."

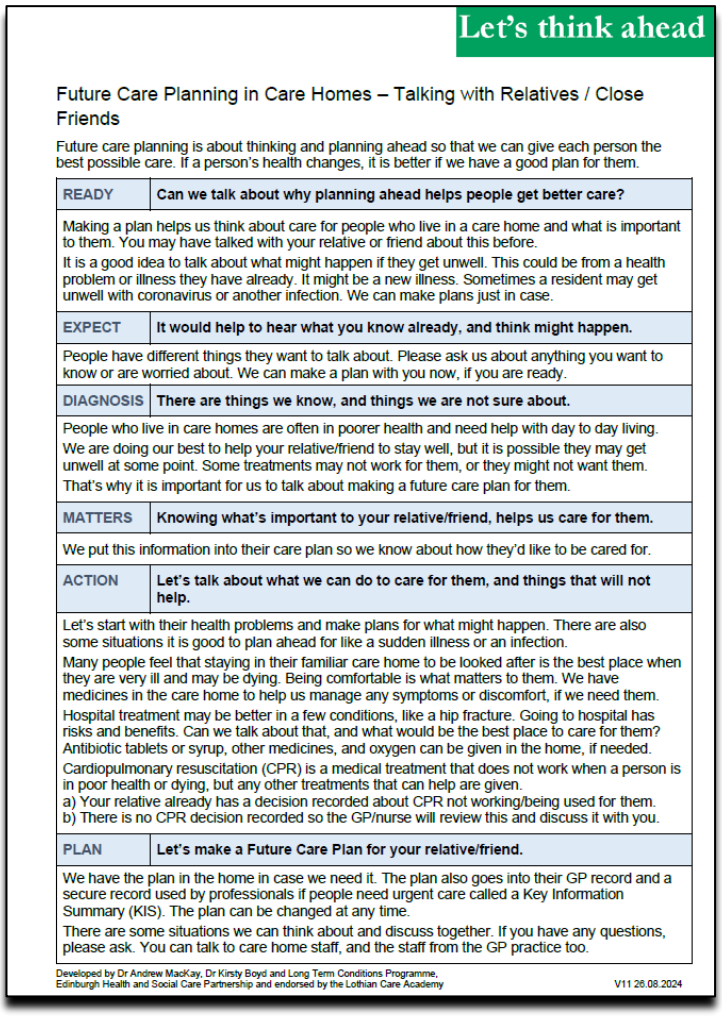
Note
Cardiopulmonary resuscitation (CPR) is a medical treatment which is only appropriate when it is going to help, it does not work when a person is in poor health or dying. The clinical team should therefore decide if there is any prospect of CPR being successful before CPR is discussed with residents, families/close friends.

Many care home residents have medical conditions which mean CPR would not be effective for them. Any conversation about CPR should take this into account.

6. 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 the care home staff and the staff from the GP practice too.



Let's think ahead

Future Care Planning in Care Homes – Talking with Relatives / Close Friends

Future 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 may get unwell 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's important to your relative/friend, helps us 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 that, and what would be the best place to 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.
a) Your relative already has a decision recorded about CPR not working/being used for them.
b) There is no CPR decision recorded so the GP/nurse will review this and discuss it with you.

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.

Developed by Dr Andrew MacKay, Dr Kirsty Boyd and Long Term Conditions Programme, Edinburgh Health and Social Care Partnership and endorsed by the Lothian Care Academy V11 26.08.2024

Questions for relatives/close friends – making a plan

Notes on the future care planning questions

The 'REDMAP conversation model for talking with relatives/close friends' and 'Making a plan – future care planning questions for relatives/friends' is in the appendix (pages 27-29) and available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/FCP-in-Care-Homes-Questions-for-Relatives-and-Friends-7-Steps-FCP.pdf

The below future care planning scenario-based questions and response options enable you to talk about care and treatment preferences should the resident become very unwell. The questions will help you to explore together the three most common deterioration scenarios for which residents are most often unnecessarily admitted to hospital.

There is a free text box on the form to include what is important to the resident. This is also a space to record any other information residents, families or friends have shared with you during your future care planning discussions about care and treatment preferences.

Scenario-based questions:

1. If your relative/close friend had a sudden illness (such as a stroke or a heart condition) how do you think they would like to be cared for?
2. If your relative/close friend had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how do you think they would like to be cared for?
3. If your relative/ close friend were not eating or drinking because they were now very unwell, how do you think they would like to be cared for?

The scenario-based questions response options:

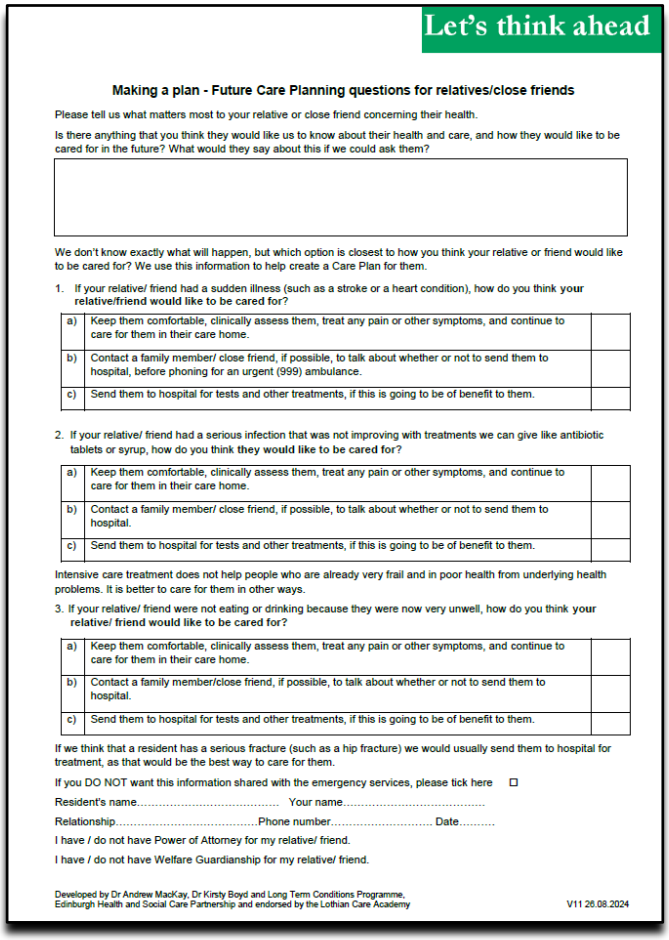
Each question has three response options for the relative/close friend to consider which is the closest to the care the resident would like.

Option 1: Keep them comfortable, assess their health, treat any pain or other symptoms, and continue to care for them in their care home.
• It's important to make it clear to families there are lots of options for treatment that can be delivered in the home. • Option 1 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 2: 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).
• For scenarios described in questions 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 3: Send them to hospital for tests and other treatments, if this is going to be of benefit to them.

- When a resident who has opted for Option 3 becomes very unwell it can be useful to confirm with senior members of the team that hospital admission is likely to improve outcomes and is therefore appropriate.
- For example, transfer to hospital for those that are very close to death is not going to be helpful and will be distressing for the resident, relatives and staff.



Let’s think ahead

Making a plan - Future Care Planning questions for relatives/close friends

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

Is there anything that you think they would like us to know about their health and care, and how they would 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, clinically assess them, 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 **they would like to be cared for?**

a)	Keep them comfortable, clinically assess them, 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 care treatment does not help people who are already very frail and in poor health from underlying health problems. It is 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, clinically assess them, 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.

Developed by Dr Andrew MacKay, Dr Kirsty Boyd and Long Term Conditions Programme, Edinburgh Health and Social Care Partnership and endorsed by the Lothian Care Academy

V11 26.08.2024

Step 5: Copy and file

Make and file a copy of the completed future care planning questions, and the Care Home Registration Form, in your resident's care plan.

Step 6: Sharing future care planning information

Give the original copy of the future care planning questions form, and the Care Home

Registration Form, to the GP practice. The GP practice will use the information in the forms along with other information in their notes to create a future care plan-KIS.

Step 7: Accessing and using the KIS

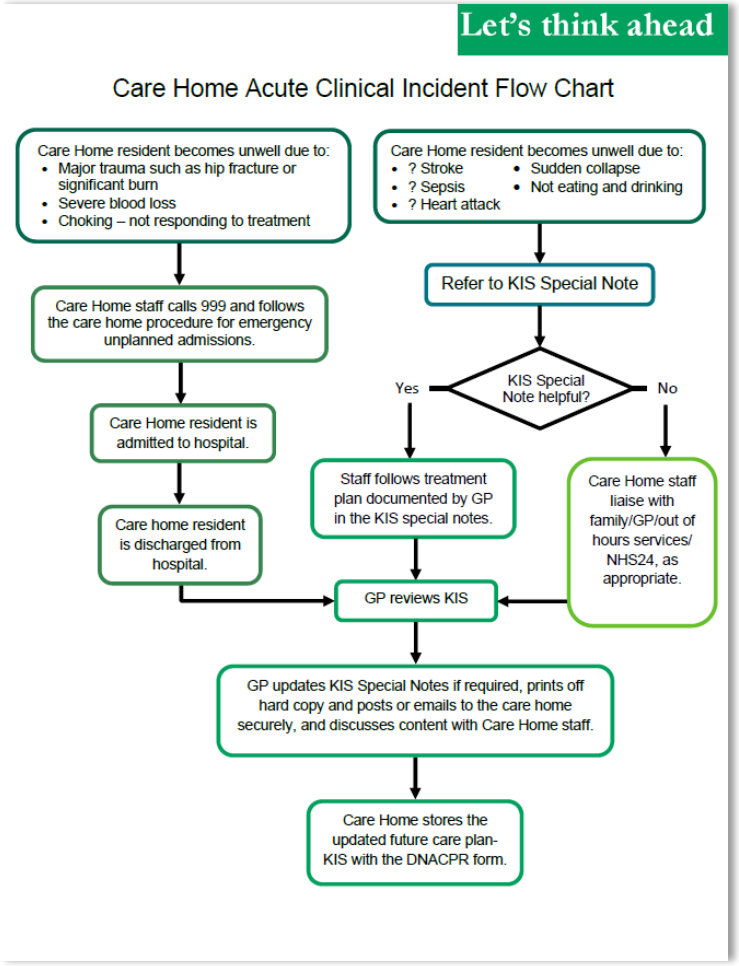
When the GP practice returns a copy of the future care plan-KIS, file it with the DNACPR (where appropriate) at the front of your resident's care plan.

Make sure everyone knows where the KIS is kept and when to access it. Share the future care plan-KIS with professionals (e.g. NHS 24, Out of Hours, Paramedics, GPs, District Nurses, Care Home Support Teams, Therapists, Hospital Teams) when decisions about the resident's care and treatment are being made.

Care home clinical incident flow chart

This flowchart (previously referred to as Document 5) illustrates how to use the future care plan-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.

The full size acute clinical incident flowchart is in the appendix (pages 27-29) and available to download for printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/Care-home-acute-clinical-incident-flowchart.pdf.



Call 999 in the case of:

- major trauma such as hip fracture or significant burn
- severe blood loss
- choking – not responding to treatment

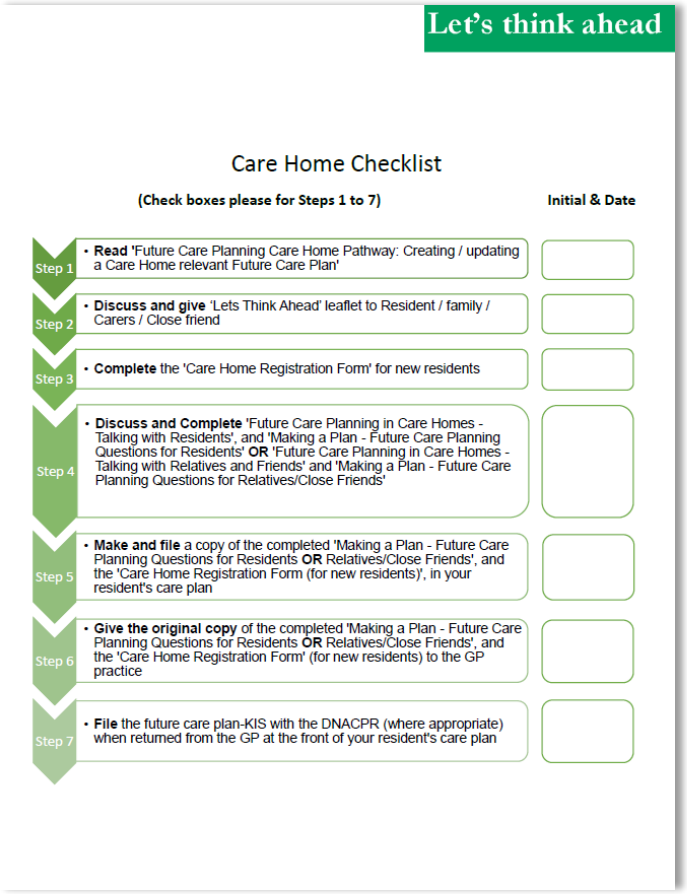
7 steps to future care planning-KIS in care homes checklist

This checklist will help you to keep a record of each step in the future care planning process. Use it to help implement the **7 steps to future care planning** in care homes for each resident.

The Care Home Checklist can be found in the appendix (page 38) and is also available for downloading and printing at: https://services.nhslothian.scot/futurecareplanning/wp-content/uploads/sites/45/2025/02/7-Steps-care-home-checklist.pdf

Key points to remember

- use the future care plan-KIS at points of deterioration
- bring and use the future care plan – KIS at reviews, and
- return all reviews dated and signed.

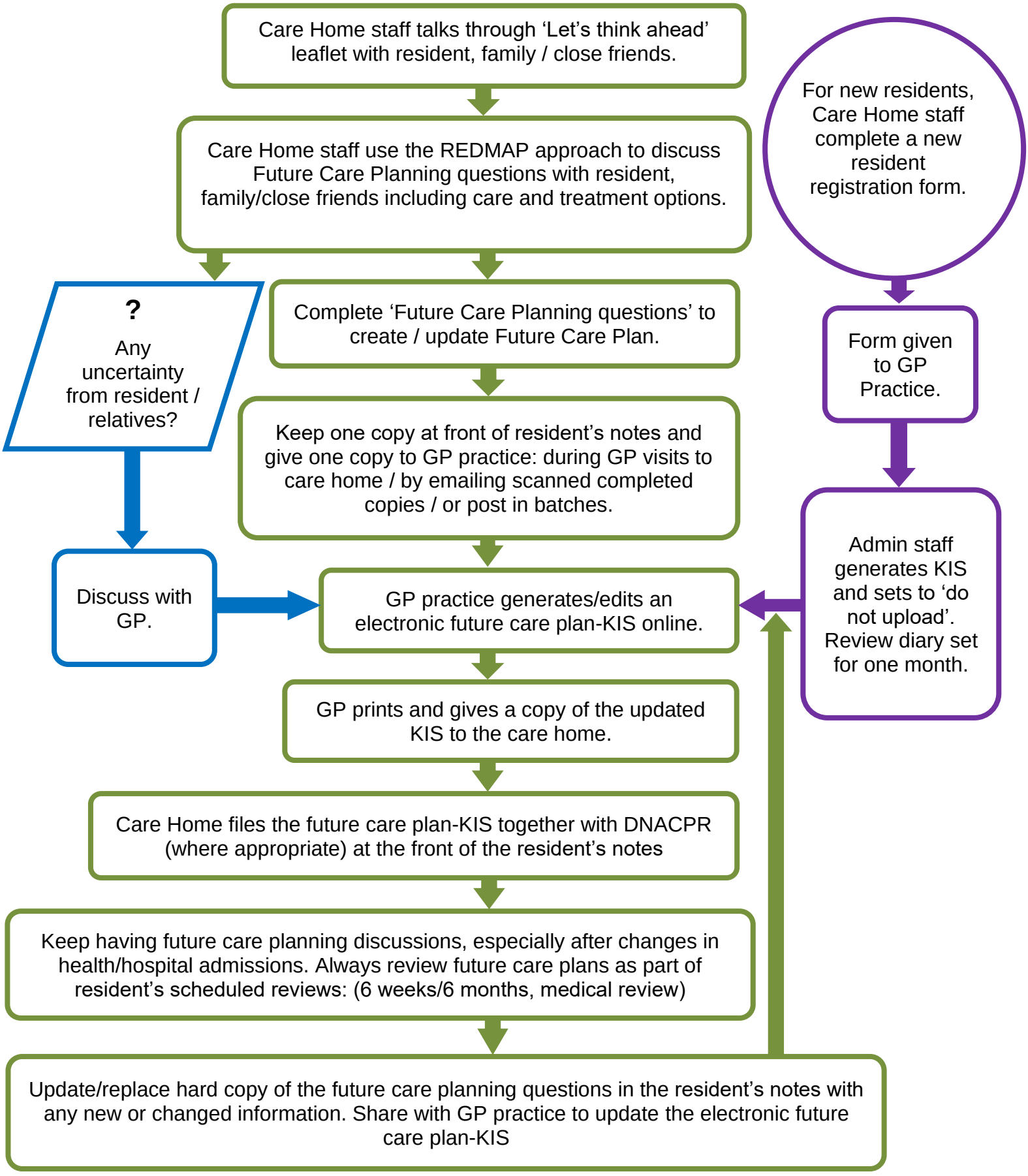

Let's think ahead

Care Home Checklist

(Check boxes please for Steps 1 to 7)	Initial & Date
Step 1 • **Read** 'Future Care Planning Care Home Pathway: Creating / updating a Care Home relevant Future Care Plan'	
Step 2 • **Discuss and give** 'Lets Think Ahead' leaflet to Resident / family / Carers / Close friend	
Step 3 • **Complete** the 'Care Home Registration Form' for new residents	
Step 4 • **Discuss and Complete** 'Future Care Planning in Care Homes - Talking with Residents', and 'Making a Plan - Future Care Planning Questions for Residents' **OR** 'Future Care Planning in Care Homes - Talking with Relatives and Friends' and 'Making a Plan - Future Care Planning Questions for Relatives/Close Friends'	
Step 5 • **Make and file** a copy of the completed 'Making a Plan - Future Care Planning Questions for Residents **OR** Relatives/Close Friends', and the 'Care Home Registration Form (for new residents)', in your resident's care plan	
Step 6 • **Give the original copy** of the completed 'Making a Plan - Future Care Planning Questions for Residents **OR** Relatives/Close Friends', and the 'Care Home Registration Form' (for new residents) to the GP practice	
Step 7 • **File** the future care plan-KIS with the DNACPR (where appropriate) when returned from the GP at the front of your resident's care plan	

Appendices

Future Care Planning Care Home Pathway: Creating/Updating A Care Home Relevant Future Care Plan



(Previously referred to as Document 1)

Care home staff providing your care might ask you:

- What you know about your health and how it might change?
- 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?
- Is there anything else about your health and care that is important to you and you think we should know?

Lothian Care Academy
Working together to deliver quality care

Let’s think ahead

Future Care Planning

Information about treatment and care planning for residents in Care Homes

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 www.whatmatterstoyou.scot

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

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

Introduction

Future Care Planning 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?

Care Home Registration Form

To be completed and returned to surgery with registration paperwork

- Patient /carers wishes (Planning Future Care Questionnaire) form
- 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	Future Care Planning 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			

V 07

REDMAP guide for talking with residents and questions for making a future care plan

Future Care Planning in Care Homes – Talking with Residents

Future 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 us think about care for people who live in a care home and what is important to them. You may have talked with staff, your family or a 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 may get unwell 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 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 for you.	
MATTERS	**Knowing what's important to you helps us care for you.**
We put this information 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 that, and what would be the best place to 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. a) You already have a decision recorded about CPR not working/being used for you. b) There is no CPR decision recorded so the GP/nurse will review this and discuss it with you.	
PLAN	**Let's make a future care plan for you.**
We have the 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.	

Making a plan - future care planning questions for residents

Please tell us what matters most to you concerning your health.

Is there anything important for us to know about your health and care, and how you would 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 would like to be cared for? We use this information to help create a Care Plan for you.

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

a)	Keep me comfortable, clinically assess me, treat any pain or other symptoms, and continue to care for me in the 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 would like to be cared for**?

a)	Keep me comfortable, clinically assess me, treat any pain or other symptoms, and continue to care for me in the 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 does not help people who are already very frail and in poor health from underlying health problems. It is 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 would like to be cared for?**

a)	Keep me comfortable, clinically assess me, treat any pain or other symptoms, and continue to care for me in the 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……

REDMAP guide for talking with relatives/close friends and questions for making a future care plan

Future Care Planning in Care Homes – Talking with Relatives / Close Friends

Future 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 may get unwell 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's important to your relative/friend, helps us 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 that, and what would be the best place to 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. a) Your relative already has a decision recorded about CPR not working/being used for them. b) There is no CPR decision recorded so the GP/nurse will review this and discuss it with you.	
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.	

Making a plan - Future Care Planning questions for relatives/close friends

Please tell us what matters most to your relative or close friend concerning their health.
Is there anything that you think they would like us to know about their health and care, and how they would like to be cared for in the future? What would they say about this if we could ask

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, clinically assess them, treat any pain or other symptoms, and continue to care for them in their care home.	
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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 **they would like to be cared for**?

a)	Keep them comfortable, clinically assess them, 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 care treatment does not help people who are already very frail and in poor health from underlying health problems. It is 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, clinically assess them, 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.

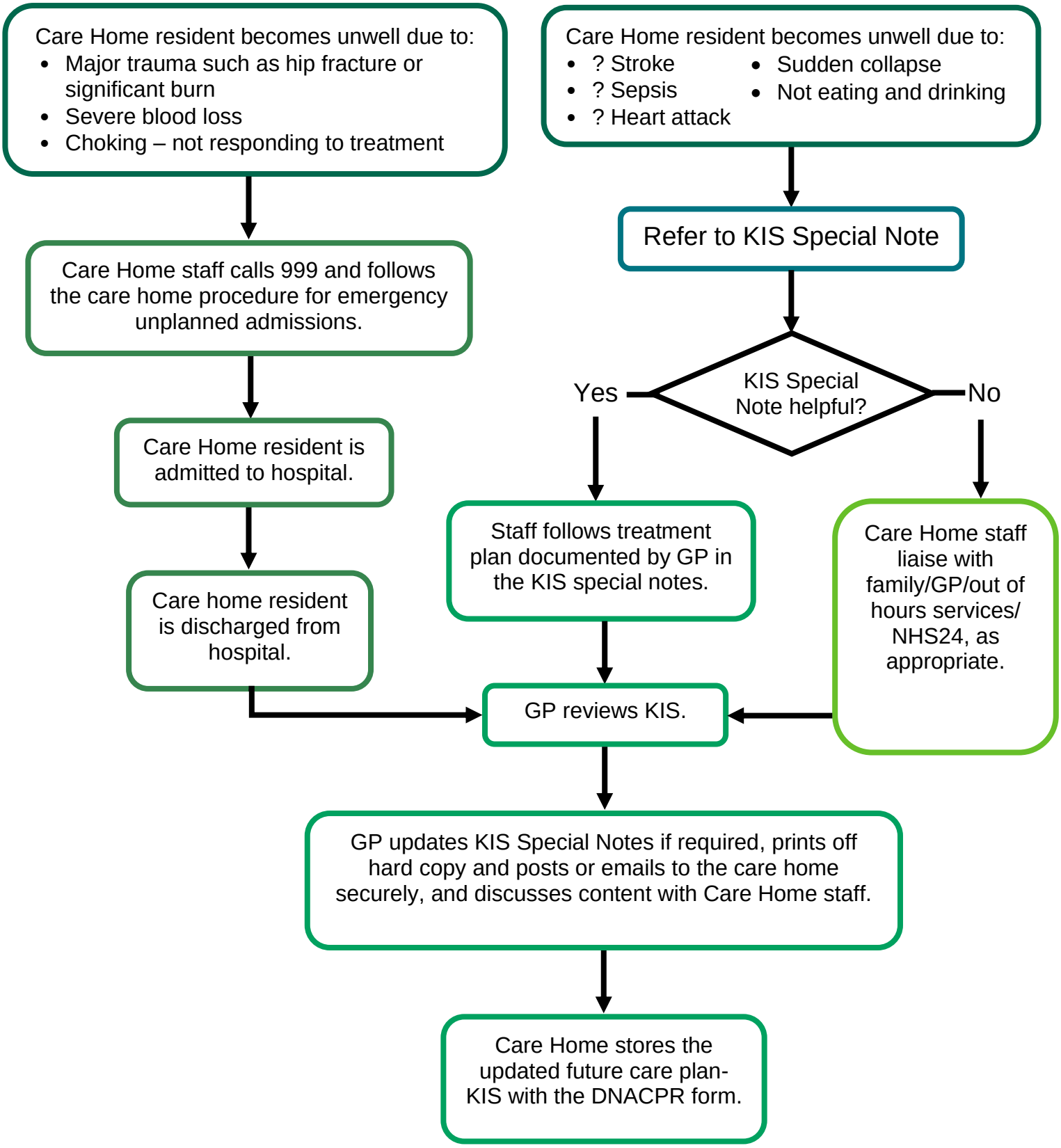
If you DO NOT want this information shared with the emergency services, please tick here ☐

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



Care Home Checklist

(Check boxes please for Steps 1 to 7)

		Initial & Date
Step 1	• **Read '**Future Care Planning Care Home Pathway: Creating / updating a Care Home relevant Future Care Plan'	
Step 2	• **Discuss and give** 'Lets Think Ahead' leaflet to Resident / family / Carers / Close friend	
Step 3	• **Complete** the 'Care Home Registration Form' for new residents	
Step 4	• **Discuss and Complete** 'Future Care Planning in Care Homes - Talking with Residents', and 'Making a Plan - Future Care Planning Questions for Residents' • **OR** 'Future Care Planning in Care Homes - Talking with Relatives/Close Friends' and 'Making a Plan - Future Care Planning Questions for Relatives/Close Friends'	
Step 5	• **Make and file** a copy of the completed ''Making a Plan - Future Care Planning Questions for Residents **OR** Relatives/Close Friends', and the 'Care Home Registration Form' (for new residents, in your resident's care plan	
Step 6	• **Give the original copy** of the completed 'Making a Plan - Future Care Planning Questions for Residents **OR** Relatives/Close Friends', and the 'Care Home Registration Form ' (for new residents) to the GP practice	
Step 7	• **File** the future care plan-KIS with the DNACPR (where appropriate) when returned from the GP at the front of your resident's care plan	

About future care planning

Please note that until September 2023 future care planning was referred to as anticipatory care planning (ACP). Some website resources produced before this date retain the language of ACP but remain useful and relevant for those working on future care planning.

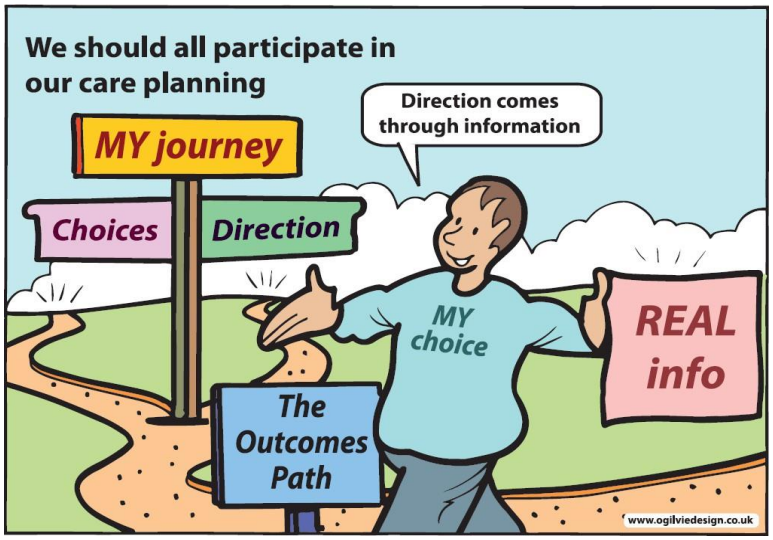


Image provided courtesy of Ogilvie Design Ltd

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.

What is future care planning?

Future care planning means thinking and planning ahead and understanding what is happening with your health and care.

Watch this short animation explaining what we mean by future care planning in health and care in Scotland.

https://www.youtube.com/embed/oikuiojrpll?feature=oembed

Why put a plan in place?

No one knows when their health and care may change. Planning ahead can help people to have more control and choice over their care and support. Sometimes, when a person is unwell, they are not able to explain what is important to them. We can support people to think, understand and plan ahead for their health & care, recording shared decisions in a future care plan.

Future care planning in care homes

The 7 steps to future care planning toolkit will support open and honest discussions with residents and their family about their health and wellbeing and wishes for the future, putting the resident at the centre of decisions about their health.

Watch the video clip below to hear Dr Andrew Mackay explaining future care planning in Care Homes. The video gives an overview of what future care planning is, the process of creating a future care plan with your GP practice, and why it is beneficial for all residents to have a future care plan in place.

https://vimeo.com/1065843014/9463a67d1c?ts=0&share=copy

Feedback from care homes

"From our point of view the ACP tools are a great foundation for us to build a more person-centred anticipatory care plan for our residents, it's a really good sensitive prompt of topic. They are simple and straight to the point in a professional caring way. When we have used them with the GPs during this pandemic, they allowed us to gather the information we needed quickly and allowed us to prepare for the inevitable. Families who have used them directly have said they were an easy guide to follow but still allowed them to get their relatives wishes down. Having the ACP-Key Information Summaries in place with the up-to-date relevant information has been a godsend!" *Care home manager*

"If you want to enhance your practice you have to buy-in to this process. We are supporting person-centred care and this supports us from the very beginning. They're telling us what they want and we are here to facilitate that." *Care home manager*

"It's a very good process and I think this kind of support should be there for all care homes all the time because care is always evolving - care home staff are supported, GPs are involved, we will continue to see positive results." *Care home manager*

Click play on the video image below to watch a short video clip of care homes sharing their experiences between 2018/19, of implementing the **7 Steps to future care planning for care homes**.

https://player.vimeo.com/video/340150721?app_id=122963

You can read about what care homes have learnt from using the **7 Steps to future care planning for Care Homes** approach in:

- ACP Improvement Programme Learning Report and
- Case study – Improving ACP with care homes and GP practices in Edinburgh

Further resources are available on the NHS Lothian Future Care Planning in Care Home webpage.

Developing the 7 steps to future care planning toolkit

'Let's think ahead - 7 steps to future care planning for care home staff' was developed by The Long Term Conditions Programme within Edinburgh Health and Social Care Partnership (EHSCP). It provides a toolkit for care homes to embed future care planning and improve outcomes for residents. Dr Andrew Mackay, GP Advisor for future care planning, EHSCP, led a project in NHS Lothian, supported by a grant from Marie Curie, and in 2016 began working in partnership with care homes and GP practices in Edinburgh. Together they worked to ensure that residents have greater choice and control over their care and treatment should their condition deteriorate.

Implementing the 7 steps to future care planning in care homes – implementation guides and resources

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.

https://services.nhslothian.scot/carehomes/education-and-training/acp-training/

To achieve scale, spread and sustainability, the Lothian Care Academy is providing strategic oversight, training and improvement support to embed the **7 steps to future care planning** throughout Lothian. The Lothian Care Academy aims to standardise education and training & provide opportunities for all Healthcare Support Workers across health & social care.

In the Healthcare framework for adults living in care homes: My Health – My Care – My Home (June 2022), the Scottish Government describes (on page 27) the benefits of implementing the **7 steps to future care planning.**

Contact details

Edinburgh Health & Social Care Partnership
Canaan Park | Astley Ainslie Hospital | 133 Grange Loan | Edinburgh EH29 2HL

Loth.longtermconditions@nhs.scot

About this toolkit

Key contacts

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Accessibility checks

Content has been checked for accessibility in line with the relevant RDS standard operating procedure.

Content management and governance

Content management processes initially defined by ACP Resources Editorial Group, a subgroup of NHS Lothian ACP Steering Group, under Lothian Care Academy. Processes are being reviewed as part of current capacity discussions.

Content review

Content of toolkit designed, tested and clinically reviewed through iterative improvement projects, please see evaluation reports: https://services.nhslothian.scot/carehomes/services-anticipatory-care-planning/

7 steps to future care planning in care homes referenced as best practice in Scottish Government's My Health, My Care, My Home healthcare framework for adults living in care homes.

7 steps to future care planning in care homes ongoing review and reciprocal learning through input to Scottish Government's Future Care Planning working group, informing ongoing/future developments.

Continued partnership working and content review with GP practices and care homes in Edinburgh, with clinical review led by EHSCP's Future Care Planning GP Advisor.

Review dates and responsibilities initially defined by ACP Resources Editorial Group, a

subgroup of NHS Lothian ACP Steering Group, under Lothian Care Academy. Processes are being reviewed as part of current capacity discussions.

Copyright

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Evidence base

Evidence for toolkit content reviewed through iterative improvement projects, please see learning and evaluation reports: https://services.nhslothian.scot/carehomes/services-anticipatory-care-planning/

7 steps to future care planning informing, and being informed by, evidence gathered through Scottish Government's Future Care Planning working group.

Continued partnership working and content review with care homes & GP practices, informing real time assurance & improvement data.

Governance sign-off and ongoing development

The content in this toolkit was signed off by Lothian Care Academy, ACP Steering Group in December 2022.

The Lothian Care Academy, Future Care Planning Steering Group will oversee ongoing development.

Monitoring and acting on feedback and complaints

Feedback sought and acted on as part of iterative improvement projects, please see https://services.nhslothian.scot/carehomes/services-anticipatory-care-planning/

Planned evaluation of online Care Home Education & Training, Improvement & Assurance will provide further feedback and inform improvements.

Feedback received by RDS via the online form will be forwarded by the RDS team to the key contact named above.

Risk assessment

The app has been risk assessed, and mitigations put in place where required.

User testing

Content tested throughout design and testing phase, please see evaluation reports: https://services.nhslothian.scot/carehomes/services-anticipatory-care-planning/

Further functional and usability testing planned as part of planned evaluation of online Care Home Training & Education, Improvement & Assurance package (this toolkit forms part of the broader online package): https://services.nhslothian.scot/carehomes/education-and-training/acp-training/

Document Control Sheet

Title:	7 steps to future care planning in care homes: Implementation Guidance & Resources
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Revision History:

Version:	Date:	Summary of Changes:	Name:
1.0	19.03.25	• Removal of ACP abbreviation throughout documentation • Replacement of "anticipatory care planning"/ "anticipatory care plan/s" with "future care planning" or "future care plan/s". • Addition of content page and numbering to improve navigation though document • Refresh of document content ordering/layout/format • 'Documents' amended so now refer to the actual name of the document instead of referencing them as' Documents 1', 'Document 2' etc. Reference is still made to 'Document' in brackets to support users with this transition. • Tightening up of guidance relating to 'Step 4'	LTCP

Distribution: This document has been distributed to:

Name:	Completion	Date of Issue:	Version:
Future Care Planning in Care Homes – NHS Lothian Website	In progress	19/03/2025	1.0
Right Decision Service Website	Completed	19/03/2025	1.0
Right Decision Service Mobile App	In Progress	19/03/2025	1.0
Edinburgh Care Homes	In Progress	19/03/2025	1.0