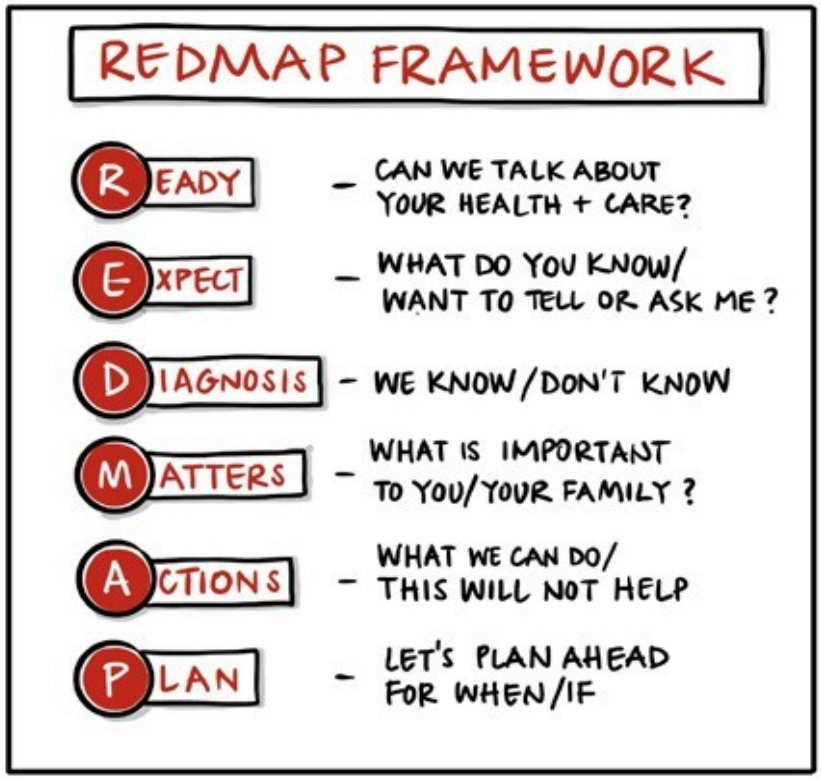
Future Care Planning conversations



Future Care Planning involves conversations between people, families and carers, health and care staff.

It helps people discuss what matters for them if their health or situation change. We talk about what people would like to happen and anything they don't want or worry about.

People can find out more about their health and how to get the right help. Plans and available options for future care and support can be recorded in a health record, shared and reviewed.

Care planning helps people of any age living with a serious illness, health conditions or disabilities that get worse, and older people who are getting frailer.

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REDMAP Framework for Care Planning

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 anything?
DIAGNOSIS	We **know**… We **don't know**… We are **not sure**…
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 *(person's name)* say about this? Why?
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…
	Planning helps people get better care….

Starting care planning

READY:

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

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

Should anyone close to you be involved?

Have you talked about care planning before?

Is there anything you would like help with now?

EXPECT:

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

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

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

MATTERS:

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

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

ACTIONS:

Let's start making a plan for you.

People with declining health benefit from care planning

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

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

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

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

Symptoms: persist despite optimal treatment of underlying conditions.

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

Talking about being less well

READY:
Start or continue conversations about care planning.

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

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

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

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

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

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

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

That does not work/help people when…

PLAN:
Having a plan helps us know what to do if things change. We review it regularly and share it so people know about you.

Helpful, realistic language

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

If things change or you get less well…

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

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

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

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

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

(Language to avoid: 'ceiling of treatment', 'futile', 'treatment withdrawal'.)

Talking about dying

READY & EXPECT:
Find out what people know already.

DIAGNOSIS:
We know you are less well because…

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

It is possible you will not get better…

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

Do you have questions or worries we can talk about?

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

How would you like to be cared for?
Is there anything you would not want?

What would *(person's name)* say about this situation, if we could ask them? Why?

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

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

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

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

Cardiopulmonary resuscitation

Make a clinical assessment of the outcomes of CPR for the person.
Talk about other treatments, if relevant (e.g. hospitalisation, intensive care, surgery)

Can I ask if you know anything about cardiopulmonary resuscitation or CPR?
CPR is a treatment to restart the heart and breathing after they have stopped.
CPR helps in some situations but does not work for everyone.

- CPR does not work when a person is in very poor health or is dying. Planning good care is the right thing to do.
- CPR may work but can leave some people in much poorer health if they have certain underlying health conditions.
- Some people choose not to have a treatment like CPR.

Talking about CPR helps people get better care. We record decisions about CPR and share those with other teams and services.

Even when CPR is not going to help, other treatments that can help continue.

Can we talk about your situation?