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Talking with people in hospital and families about care planning, death and dying

RED-MAP has 6-steps. Suggested phrases are adapted to the person, family and context of the discussion.
Ask for help and support from colleagues, senior staff or a specialist. Second opinion if needed.

RED-MAP Guide for Hospital Professionals

R eady — Can we talk about why care planning helps people get better care?

Plan conversations, even if the same day, so everyone is prepared and the right people are involved.
**Hello, Mr RT? My name is…, I am (*your title*). My role in the team here is...*
**Can we make a time to talk about your treatment and care? Who else do we need to speak to?*
We'd like to talk about what we are doing to help you, and hear about **what is important for you.*
**We are doing our best to care for you, but we are worried about your condition…*
Who should we talk to **if you are more unwell or not able to make decisions with us?*

E xpect — It would help to hear what you know about your health, and think might happen.

** I'll explain what we think is happening, but do you want to tell/ask me anything important first?*
**How have you been doing recently/today? What has changed with your health?*
Has anyone talked with you about what might happen **if you get less well, or are very ill?*
**You may have thoughts, questions or worries we can discuss. What do you know about coronavirus?*

D iagnosis — There are things we know about your health, and things we are not sure about.

Share information tailored to people's understanding, and how they are feeling.
Explain what we know in 'short chunks with pauses' to check for people's reactions and questions.
Acknowledge and share uncertainty. Use clear language with no jargon and short sentences.
You are less well because…*It **is possible you will not get better **if**… * I'm afraid she is seriously ill...*
We **hope you will improve with..., but **I am worried** about… *I am sorry, but she could die with this.*
We **don't know exactly what will happen or when, but **we can plan** for what to do **if...***

M atters — We'd like to know what's important to you and your family.

Can we talk about how you **would like to be cared for? Anything you **do not want/wish to avoid?***
Can you tell us **what you think (*person's name*) **would say** in this situation, if we could ask him?*

A ctions — Let's talk about what we can do, and things that may not help.

Talk about realistic, available options for treatment, care and support for this person/family.
Be honest and clear about what can help or will not work. Options depend on the best place of care.
** For people who are already in poor health and need help from others at home or in a care home, it may be better to look after them in a familiar place when they are very ill and dying, if that's possible.*
**Intensive care, ventilation, or oxygen through a breathing machine does not help everyone. For people with some kinds of health problems, it is better for us to care for them in different ways.*
****I wish** there was more treatment we could give for this. Could we talk about **what we can do**?*
**We give treatments and care for any symptoms a person has like breathlessness, pain or distress.*

****Has anyone talked with you about cardio-pulmonary resuscitation or CPR?***
CPR is treatment to restart the heart and breathing. CPR does not work when a person is in very poor health or dying, so it is better for us to plan good care. With these health problems, CPR may work but can leave a person in much poorer health. Any other treatments that can help are given.

P lan

Use available forms and online systems to record and share care plans and DNACPR decisions
We record and share plans we make for treatment and care so everyone knows what to do.

Avoid language that can make people feel confused, abandoned or deprived of treatment and care.
There is 'nothing more' we can do. *'Ceiling' of treatment or care for a person.*
We are 'withdrawing' treatment. *Treatment is 'futile'.* *Would he 'want to be' resuscitated?*

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