

## Consider

**Consider** whether the patient has an uncertain prognosis or is nearing end of life?

Consider:

- Rockwood Clinical Frailty Scale
- SPICT - Supportive and Palliative Care Indicator Tool
- GSF Proactive Indicator Guidance - Gold Standards Framework
- The 'Surprise Question'
- The patient's narrative
- Information from family or carer
- Add patient to GSF register and discuss at MDT / GSF meetings

## Have

**Have** conversations with the patient & their family / carers to support Advance Care Planning (ACP):

- Think about the environment and your approach
- Check their understanding
- Acknowledge uncertainty of recovery and the future
- Have honest conversations and explore 'what matters to you?'
- Listen compassionately to concerns, wishes and preferences
- Discuss recommendations for future anticipatory care and treatment - ReSPECT
- Offer 'Planning ahead' leaflet and/or 'My wishes'

## Advise

**Advise** the MDT following ACP conversations:

- Share information on what matters to the patient, their wishes and preferences
- Complete a ReSPECT form and give to the patient
- Include information from ACP discussions in the plan of care
- Document ACP and ReSPECT conversations in the MDT records - SystemOne / ICR
- Discuss at MDT / GSF meetings

## Transfer

**Transfer** information to support continuity of care:

- Offer use of 'Planning Ahead' and/or 'My Wishes' leaflets to patient and family / carers
- Ensure outcome of ACP and ReSPECT are recorded on SystemOne / ICR
- Ensure the patient and family / carer are aware that ReSPECT is the patient's property and should accompany them on any transfer of care
- Review ReSPECT if circumstances or patient's preferences change

### For information on the Conversation Project:

- See the RUH website [www.ruh.nhs.uk/For\\_Clinicians](http://www.ruh.nhs.uk/For_Clinicians)
- The Conversation Project CHAT Bundle and resources have been developed by the RUH Palliative Care Team