THE JOURNEY TO BETTER HEALTH CARE AND SUPPORT

Anticipatory Care Planning and Polypharmacy Review
Anticipatory Care Planning (ACP) is as logical as it is effective. It gives people greater choice and control over their future care and support, achieves better health and wellbeing outcomes and saves needless costs.

That’s why ACP is now central to health and care in Scotland, and growing through it’s inclusion within new quality indicators in the GP contract.

If we are honest, thinking ahead and planning for our future healthcare and support is something that few individuals achieve. Now in Scotland we want Anticipatory Care Planning (ACP) to be the norm for people likely to experience deterioration in their health or significant deterioration in their health or change in circumstances.

The essence of Anticipatory Care Planning is to give people the confidence, control and choice that comes with knowing what might happen, spotting small indications of change and being ready to do the right things with the right supports from the right people. It exemplifies person centred and holistic care and respects the individual’s goals, wishes and choices.

This information guides practitioners through the anticipatory care planning process, introduces tools that make it easy to identify patients with the most to gain from ACP and allow for timely sharing of information across the health and social care community.

We hope you find it easy to navigate and the information useful.
Anticipatory Care Continuum of Risk

People with lowest risk of emergency admission to hospital. Likely to need simple information, advice and support to help them to stay well and manage their conditions.

20-60% Risk Group – 5% Practice List
40-60% Risk Group – 1.5% Practice List

People at moderate risk of emergency admission. Likely to attend the practice or a nurse specialist for follow up. Their ACP is usually best developed by the GP and the Practice team.

Patients at highest risk, often receiving care or managed by the Community Team. Many already have an ACP. Their ACP is usually developed by the Community Team or nurse specialist involved.
## Sample Anticipatory Care Plan

### Other Agencies:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Description</th>
<th>Date</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>Under care of practice nurse.</td>
<td>27-Sep-2012</td>
<td>DN know patient well. No regular contact but will attend when required.</td>
</tr>
<tr>
<td>Home Help</td>
<td>Home Help Attends</td>
<td>27-Sep-2012</td>
<td>HH attends 7 times a week</td>
</tr>
<tr>
<td>Meals on Wheels</td>
<td>Meals on Wheels Attends</td>
<td>27-Sep-2012</td>
<td>attend 5 times a week, Monday to Friday only</td>
</tr>
</tbody>
</table>

### Medical History:

1. Multiple Sclerosis (01-Jun-1995, relapsing remitting)
2. Multiple Sclerosis (04-Aug-2006, secondary progressive)
3. Migraines (classic) (03-Jul-2010)
4. Depression with anxiety (04-Jun-2012)

### Patient has self management plan:

- **Plan Exists**: Yes
- **Plan Details**: Self management plan covers use of diazepam for anxiety (27-Sep-2012)

### Anticipatory care plan agreed:

- **Plan Exists**: Yes
- **Plan Details**: ACP printed from KIS. (27-Sep-2012)
SPARRA is a secure online tool that helps you plan and co-ordinate the care and support of people with complex or frequently changing needs – achieving a better experience and outcomes for the patient and avoiding emergency hospitalisation.

Put simply, SPARRA helps you identify those at greatest risk of emergency admission to hospital in the upcoming year by drawing on historic data and using predictive techniques.

Regular use of SPARRA data prompt discussions at multi-disciplinary, multi-agency team meetings within Practices or other settings and helps make best use of people, resources and services.

Practitioners can reassess the person-centred care plan, address any gaps and work collaboratively and wholly in the interests of the patient.
### Demography

**PLEASE READ CAUTIONARY NOTE ON GENERAL NOTES TAB BEFORE USING THESE DATA**

<table>
<thead>
<tr>
<th>Patient Name (Age)</th>
<th>CHI Number</th>
<th>SPARRA Risk Score (Last Qtr)</th>
<th>Patient Status</th>
<th>Care Home Flag</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Post code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon Snyder (31)</td>
<td>2607858096</td>
<td>76 (77)</td>
<td>&lt;=</td>
<td>N</td>
<td>F</td>
<td>26/07/1985</td>
<td>XF57 3UE</td>
</tr>
<tr>
<td>Hermione Sears (82)</td>
<td>1909880813</td>
<td>76 (77)</td>
<td>&lt;=</td>
<td>N</td>
<td>F</td>
<td>19/09/1988</td>
<td>NG4Y 9HU</td>
</tr>
<tr>
<td>Mechelle Harrell (38)</td>
<td>3107746902</td>
<td>78 (82)</td>
<td>&lt;=</td>
<td>N</td>
<td>F</td>
<td>31/07/1974</td>
<td>N40 1GL</td>
</tr>
<tr>
<td>Melodie King (78)</td>
<td>2311317934</td>
<td>77 (75)</td>
<td>&lt;=</td>
<td>Y</td>
<td>F</td>
<td>23/11/1931</td>
<td>UD70 7QF</td>
</tr>
<tr>
<td>Petra Logan (61)</td>
<td>0411546018</td>
<td>75 (79)</td>
<td>&lt;=</td>
<td>N</td>
<td>F</td>
<td>04/11/1954</td>
<td>UF10 8UN</td>
</tr>
<tr>
<td>Herman Benton (67)</td>
<td>0707613938</td>
<td>75 (71)</td>
<td>&lt;=</td>
<td>N</td>
<td>M</td>
<td>07/07/1961</td>
<td>X207 7VH</td>
</tr>
<tr>
<td>Fuller Gallegos (81)</td>
<td>3001587715</td>
<td>73 (73)</td>
<td>&lt;=</td>
<td>N</td>
<td>M</td>
<td>30/01/1958</td>
<td>J8 9PF</td>
</tr>
<tr>
<td>Kasper Simpson (84)</td>
<td>3107745886</td>
<td>73 (72)</td>
<td>&lt;=</td>
<td>N</td>
<td>M</td>
<td>31/07/1974</td>
<td>R96 2TF</td>
</tr>
<tr>
<td>Ray Daniel (70)</td>
<td>0905445915</td>
<td>70 (75)</td>
<td>&lt;=</td>
<td>N</td>
<td>M</td>
<td>09/05/1944</td>
<td>LJ27 0ZH</td>
</tr>
<tr>
<td>Meghan Winters (75)</td>
<td>0706861962</td>
<td>70 (52)</td>
<td>=&gt;</td>
<td>N</td>
<td>F</td>
<td>07/05/1986</td>
<td>N39 6YS</td>
</tr>
<tr>
<td>Charles Kramer (81)</td>
<td>2805383725</td>
<td>69 (69)</td>
<td>&lt;=</td>
<td>Y</td>
<td>M</td>
<td>28/05/1938</td>
<td>H42 1LN</td>
</tr>
<tr>
<td>Gannon Bray (73)</td>
<td>09068614384</td>
<td>69 (69)</td>
<td>&lt;=</td>
<td>N</td>
<td>F</td>
<td>09/08/1961</td>
<td>EV3Z 8ME</td>
</tr>
<tr>
<td>Flavia Meyer (63)</td>
<td>1711808894</td>
<td>68 (68)</td>
<td>&lt;=</td>
<td>N</td>
<td>F</td>
<td>17/11/1980</td>
<td>S5 9DV</td>
</tr>
<tr>
<td>Quincy Webster (79)</td>
<td>1905385095</td>
<td>68 (69)</td>
<td>&lt;=</td>
<td>N</td>
<td>M</td>
<td>19/05/1936</td>
<td>OK4 7UV</td>
</tr>
<tr>
<td>Vernon Campbell (74)</td>
<td>1101531490</td>
<td>67 (67)</td>
<td>&lt;=</td>
<td>N</td>
<td>M</td>
<td>11/01/1953</td>
<td>JA5P 7J</td>
</tr>
<tr>
<td>Reese Hartman (69)</td>
<td>0301499398</td>
<td>66 (55)</td>
<td>=&gt;</td>
<td>N</td>
<td>F</td>
<td>03/01/1949</td>
<td>U08 9NT</td>
</tr>
</tbody>
</table>
Key Information Summary (KIS) is a simple and accessible way for health and care professionals to record and share information for people with complex care needs or long-term conditions.

KIS stores important information about patients that can be shared with health care professionals, NHS 24, A&E, Scottish Ambulance Service, Out of Hours, Hospital and Pharmacies. Information includes future care plans, medications, allergies, diagnoses, patient wishes, carer and next of kin details.
### Key Information Summary (KIS) Sample

<table>
<thead>
<tr>
<th>Upload Decision:</th>
<th>Yes</th>
<th>21-Aug-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Consent:</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Patient Aware:</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Special Patient Note:</td>
<td>01-Jan-2100</td>
<td>OCCASIONAL DETERIORATION IN HEALTH WITH POSSIBLE vascular event. This has usually been relieved with increased fluids as possible and nursing care. Family aware that only for hospital treatment in extreme circumstances as will usually be of no advantage to patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical History:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type 2 diabetes mellitus (28-Jan-2000)</td>
<td></td>
</tr>
<tr>
<td>2. Anxiety states (01-Jan-1990)</td>
<td></td>
</tr>
<tr>
<td>4. Left ventricular failure (21-Aug-2006)</td>
<td></td>
</tr>
<tr>
<td>5. Cerebrovascular disease (01-Jan-1997)</td>
<td></td>
</tr>
<tr>
<td>6. Cirrhosis of liver NOS (21-Jun-2011, Cause unknown)</td>
<td></td>
</tr>
<tr>
<td>7. Vascular dementia (25-Jul-2011)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anticipatory care plan agreed:</th>
<th>Yes</th>
<th>Has anticipatory care plan (07-Feb-2012)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Preferred Place of Care:</th>
<th>Place</th>
<th>Description</th>
<th>Date</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Place of Care</td>
<td>Preferred place of care - nursing home</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult with incapacity form:</th>
<th>Yes</th>
<th>Incapacity (Scotland) Act 2000 certificate (07-Feb-2012)</th>
</tr>
</thead>
</table>
Combined with a review of medicines for people prescribed multiple drugs, anticipatory care planning also reduces the risk of medication harm – a major cause of hospital admissions. That’s why Polypharmacy is integral to Anticipatory Care Planning.

In Scotland, four in five people over 75 years take a prescription medicine, while 36% take four or more.

Up to half of these drugs however are not taken as prescribed and many commonly used drugs can cause problems. Adverse reactions to medicines are now implicated in 5-17 per cent of hospital admissions – patients on multiple medications are especially at risk.

That’s why polypharmacy reviews have been combined with Anticipatory Care Planning for a range of positive outcomes:

- Its focus on Person centred care increases dignity, choice and control.
- Better co-ordination between the individual, their family and the health and social care professionals involved.
- Increased possibility of care at home or care closer to home.
- Safer use of medicines and reduced harm from inappropriate interventions.
Polypharmacy review for each drug

1. Is there a valid and current indication? Is the dose appropriate?

2. Is the medicine preventing rapid symptomatic deterioration?

3. Is the medicine fulfilling an essential replacement function?

4. Consider medication safety. Is the medicine causing:
   - Any actual or potential ADRs?
   - Any actual or potentially serious drug interactions?

5. Consider drug effectiveness in this group/person?

6. Are the form of medicine and the dosing schedule appropriate? Is there a more cost effective alternative with no detriment to patient care?

7. Do you have the informed agreement of the patient/carer/welfare proxy?

The Polypharmacy review should be based on the guidance issued within CEL36 (2012).
Anticipatory Care Planning/Polypharmacy Review

Use risk tool to identify 5% of practice patients for ACP/Polypharmacy Review.

Select those without an ACP who would most benefit from one.

Invite those patients to participate (and encourage carer participation).

Discuss current and future support needs, review polypharmacy and record ACP in KIS.

Discuss ACP with relevant disciplines and services.

Arrange and undertake monitoring and review.

Signpost / refer / provide the relevant interventions
• Support for self-management
• Homecare / re-ablement
• Carer support
• Peer support / befriending
• Falls prevention
• Exercise
• Telehealth / telecare
• Housing adaptations and equipment
• Other health and care supports
STEP 1
Produce a list of 5% of patients at risk of emergency admission.

Use a tool that predicts risk of emergency admission eg SPARRA. Scottish Patients At Risk of Re-admission and Admission

Review your practice SPARRA data to produce your list of 5%

Identify those with a moderate (20-60%).

Which patients should I select for this list?

You can also identify people using your own clinical judgement and information from your team.

STEP 2
Select 15% of patients on this list and arrange ACP and medicines review. For 2014/15, select 30% of patients on this list.

For the 40-60% risk group, ask your team which patients already have an ACP or palliative care summary? Discuss who needs one.

If you haven’t identified enough patients who need an ACP and polypharmacy review to meet your QOF requirements, discuss patients with 20-40% risk.

STEP 3
Each ACP will vary according to the complexity of care and support needed. You may record discussion about: self management plan; ‘just in case’ prescribing; wishes on resuscitation / future treatment; preferred place of care; contact for the carer / care manager; info on Power of Attorney.

Complete an ACP and Polypharmacy Review

QP007

STEP 4
Complete an electronic summary of the ACP. This Key Information Summary (KIS) will automatically be shared with other health and care providers to ensure they are aware of preferred actions and responses should a sudden deterioration occur.

Share the ACP using the Key Information Summary (KIS)

QP007

STEP 5
Regular multidisciplinary reviews of ACP cohort

Discuss the practice patients who have an ACP at least quarterly at multidisciplinary meetings. Refer them to the range of people and supports that will help them to stay well.

Step 6
Meet with others in the practice to review your data on emergency admissions and to discuss the learning from at least 25% of the ACPs developed.

Peer Review QP004 and QP005

Step 7
Report to Board QP009

By March, complete up to three Significant Event Reviews (SER) for people who had an ACP and were then admitted as an emergency.

Submit these SER to the Board along with a report about the changes that the practice and others could make to improve quality for those with ACP.

QP009