File on front of current clinical notes

NHS number: _____
Name: _____
Address: _____
_____
Affix patient label
Date of birth: _____
CR number: _____

NHS

CORNWALL
Treatment Escalation Plan (TEP) and Resuscitation Decision Record

This form is for clinical guidance and it does not replace clinical judgement

Life expectancy
Would you be surprised if this patient died within the next 6 - 12 months?

If No → Complete a TEP form for this patient. Please also refer to the END OF LIFE CARE guidance overleaf. →

Mental Capacity
Does the patient have the mental capacity to be involved in making these decisions?
Circle: Yes / No

If No → You **must** complete the 2 stage Mental capacity assessment overleaf. MCA 2005 →

If the patient is currently very unwell or in the event their condition deteriorates

Is admission to an acute hospital appropriate?	Yes	No
Are IV fluids appropriate?	Yes	No
Are antibiotics appropriate?	Yes	No
Is artificial feeding appropriate?	Yes	No
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	Yes	No

Acute setting only		
Is non-invasive ventilation appropriate?	Yes	No
Is a referral to critical care appropriate?	Yes	No
Is a referral for dialysis appropriate?	Yes	No

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION ☐ | DO NOT ATTEMPT RESUSCITATION (DNACPR) ☐

All treatment decisions above should be reviewed as the patient's clinical condition changes

Rationale for treatment decisions and resuscitation status:

These decisions HAVE been discussed with patient / relatives / partner / IMCA (give brief overview):

Date: Time:

These decisions have NOT BEEN been discussed with the above for the following reasons:

Names of members of multidisciplinary team contributing to this decision:

Documentation that the TEP form has been completed in the medical notes. Circle: **Yes / No**

Healthcare professional / doctor making the decision:
Name (Caps): Signature: Grade:
GMC No: Date: Time: Ward:

Consultant / GP:
Name: Signature: Date:

On discharge, if appropriate and the patient and or family have been informed of the decisions, then the original form should accompany the patient and a photocopy should remain in the patient's medical notes.

affix patient label

Mental Capacity Assessment

The Mental Capacity Act (2005) requires you to assume that individuals have capacity, unless you suspect the person has an impairment or disturbance of the mind or brain which affects their ability to make the decision. It requires any assessment to be decision specific. If you suspect someone lacks capacity you are required to complete the 2 stage Mental Capacity Assessment.

Stage 1:
Document the reason why you believe the individual has an impairment or disturbance of the functioning of the mind or brain.
Reason: _____

Stage 2: Can the individual:	**Yes**	**No**
1. Understand information about the decision made?		
2. Retain that information in their mind?		
3. Use or weigh that information as part of the decision making process?		
4. Communicate their decision (by talking, using sign language or any other means)?		

Is the response to one (or more) of the Stage 2 questions above NO?

Yes

Is this loss of capacity likely to be temporary and can the decision wait?

If Yes → Set decision review date:

If No

Is there a valid ADRT? (Advance decision to refuse treatment)

If Yes → Incorporate into TEP form or Best Interests Decision

If No

Is there a Personal Welfare Lasting Power of Attorney (PW-LPA) registered with the Office of the Public Guardian?

If Yes → Ensure the PW-LPA is consulted and incorporated in any decisions regarding TEP → Ensure PW-LPA or ADRT has been seen and that a copy is in the current patient records

If No

Proceed with completing TEP in line with Best Interests principles (please note if the person has no friends, relatives or unpaid carers then you must include IMCA services). Please document rationale/Best Interest principles for treatment and discussions in boxes overleaf.

No

Complete TEP form as part of discussion with patient.

END OF LIFE CARE:

1. If inpatient RCHT, refer as needed to Guidelines for Transfers and Discharges in the Last Few Weeks of Life, End of Life Care Strategy, or Organ and Tissue Donation Policy (RCHT Intranet Document Library) or Sister's Shelf; End of Life Care (RCHT Intranet A-Z Resources, S) If patient achieves discharge from RCHT, advise GP to place on practice Gold Standards Framework Register (includes all patients identified as having prognosis of <12 months).
2. Establish if any Advance Care Plans already made and record details – including obtain copy of any Advance Decision to Refuse Treatment document in place if patient lacks capacity.
3. Discuss TEP decisions / AMBER care bundle decisions / ceiling of care with patient and/or important other(s) whenever possible.
4. If appropriate discuss Preferred Priorities of Care at end of life (including Place of Care).

This form should be completed legibly in black ball point ink

- Complete patient details or affix the patient's identification label to the top left hand corner
- The date and time of writing the form should be entered
- This form will be regarded as 'INDEFINITE' unless it is clearly cancelled
- The form should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another, and admitted from home or discharged home.

If following clinical review, treatment decisions are changed:

- Clearly score through this form with two diagonal lines and write 'CANCELLED' in between the lines
- Sign and date just below the diagonal lines
- Complete a new form and insert in the patient's medical notes (unless cancelled completely).