File on front of current clinical notes   NHS number:						7
Name:				L		
Address:				COL	RNWA	
Address:						
Date of hirth:			Treatm	nent Escalation Pla	an (Tl	EP)
CR number:			and Resu	scitation Decision	Reco	ord
This form is for clinical guida	) ance	and	it does not	replace clinical judgen	nent	
				Complete a TEP form for this p		
Life expectancy Would you be surprised if this patient died		If No		Please also refer to the END OF LIFE CARE		
within the next 6 - 12 months?				guidance overleaf.		
Mental Capacity		You m		ou <b>must</b> complete the 2 stage Mental		
Does the patient have the mental capacity to	be	If No		capacity assessment overleaf. MCA 2005		
involved in making these decisions?						
Circle: Yes / No						→
If the patient is currently very unwell or	in th	e ev	ent their condi	ition deteriorates		
Is admission to an acute hospital appropriate?	Yes	No	Acute settin	g only		
Are IV fluids appropriate?	Yes	No	Is non-invasiv	ve ventilation appropriate?	Yes	No
Are antibiotics appropriate?	Yes	No	Is a referral to	o critical care appropriate?	Yes	No
Is artificial feeding appropriate?	Yes	No	Is a referral fo	or dialysis appropriate?	Yes	No
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	Yes	No				
In the event of a cardiorespiratory arres	t this	nati	ent is:			
FOR RESUSCITATION				TEMPT RESUSCITATION (DI	NACPR)	
All treatment decisions above sho	uld be	e revi	ewed as the pa	tient's clinical condition cha	nges	
Rationale for treatment decisions and resu	uscita	tion s	status:			
These decisions HAVE been discussed with pat	ient /	relati	ves / partner / IM	CA (give brief overview):		
				,		
Date:			Time:			
These decisions have NOT BEEN been discussed	d with	the a	bove for the follo	owing reasons:		
Names of members of multidisciplinary team co	ntribu	tina to	o this decision:			
······································		ung t				
Documentation that the TEP form has been com	pletec	d in th	e medical notes.	Circle: Yes / No		
Healthcare professional / doctor making the dec						
Name (Caps):	Sig	gnatu		Grade:		
GMC No: Date:			Time:	Ward:		
Consultant / GP: Name:	c:	gnatu	<b>70</b> '	Date:		
On discharge, if appropriate and the pati		-			than t	
original form should accompany the patie						
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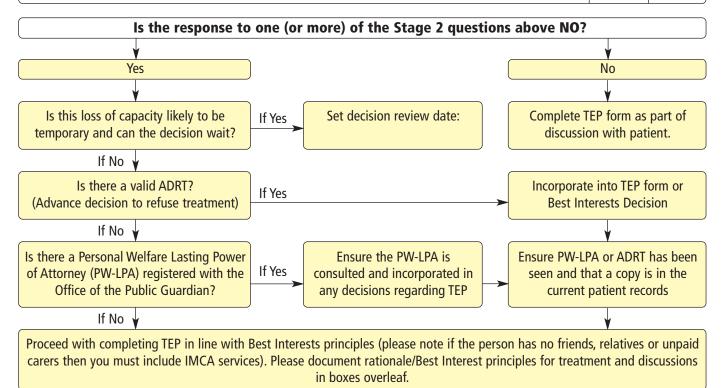
# **Mental Capacity Assessment**

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:		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)?				



# END OF LIFE CARE:

- 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).</li>
- 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).