Guidance for completing Treatment Escalation Plan and Resuscitation Decisions

- This form should be completed legibly in black ball point pen
- Complete patient details (including address) or affix patient's identification stick

Healthcare professional making the Treatment Escalation Plan (TEP) and Resuscitation Decision

The TEP form must be signed (inserting also the date, time, role and their GMC or NMC registration number) by the professional completing the form. If that is not the senior responsible medical clinician, they should be consulted around the forms completion, and at the earliest practicable opportunity they should review and endorse the recommendations by adding their signature to the form or recording their agreement within the person's medical record. The senior responsible medical clinician will usually be the person's GP or consultant. The form can be completed by a suitably experienced and competent nurse as defined within an organisation's own resuscitation policy.

TEP and Resuscitation Decision Review

A fixed review date is not recommended; the TEP is considered as 'indefinite' unless 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.

Capacity/advance decisions

If there is any reason to doubt capacity of the patient, a Mental Capacity Assessment must be completed. The 2 stage Mental Capacity Test is on the back of the form. The assessment of mental capacity is only in relation to the decisions made at the time of completing the form. If capacity changes, the form (including capacity) must be reviewed and documented. Clearly document any Best Interest Decision in relation to the Treatment Escalation Plan and Resuscitation Decision. For further information and guidance please refer to your local multiagency safeguarding policy and procedures and the 'Mental Capacity Act 2005 Code of Practice' (2007)

Summary of communication with patient

State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why. It is good and recommended practice to discuss treatment decisions with every patient but if this would cause distress without any likelihood of benefit for the patient or if the patient lacks capacity this should be recorded.

Summary of communication with patient's relatives or friends

If the patient does not have capacity their relatives, friends or an IMCA must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney (LPA) for health and welfare to make health-related decisions on their behalf, the doctor must ensure that the LPA is valid before consulting the Welfare Attorney (WA). A WA may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original LPA. That person will make decisions as if they are the patient themselves. All their decisions must be in the patient's best interest. If it is felt the WA is not acting in the patient's best interest the Office of the Public Guardian must be informed along with the local Safeguarding Team. Ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. A more detailed description of such discussion should be recorded in the clinical notes. For further guidance on Best Interests Principles see overleaf.

The Multidisciplinary Team

Ensure that the TEP decisions have been communicated to all relevant members of the multidisciplinary health and social care teams involved in caring for the patient.

Communication across other healthcare settings

For End of Life patients, the original of this form should accompany the patient on transfer if appropriate. This document remains valid until reviewed / endorsed by the receiving healthcare professional.

Discharge and TEP / Resuscitation Decision Record

Prior to discharge the content of the form should be reviewed and if the patient and / or family are informed about its contents and it is relevant to the clinical situation the original form should accompany the patient. Ensure conversations with the patient and family regarding this are documented. Ensure a photocopy of the form remains in the medical notes and it is communicated to the GP in the discharge letter.

Ambulance and TEP

In the community the most recent TEP form should be placed at the front of the patient's record.

Organ donation

Patient and family wishes regarding organ / tissue donation after death should be ascertained and documented. It is essential for staff to establish if the patient has previously expressed the wish to be a donor and if the patient is on the NHS Organ Donor register or carries a Donor Card. Please refer to your organisation's guidelines relating to organ donation.

If following clinical review treatment decisions are changed:

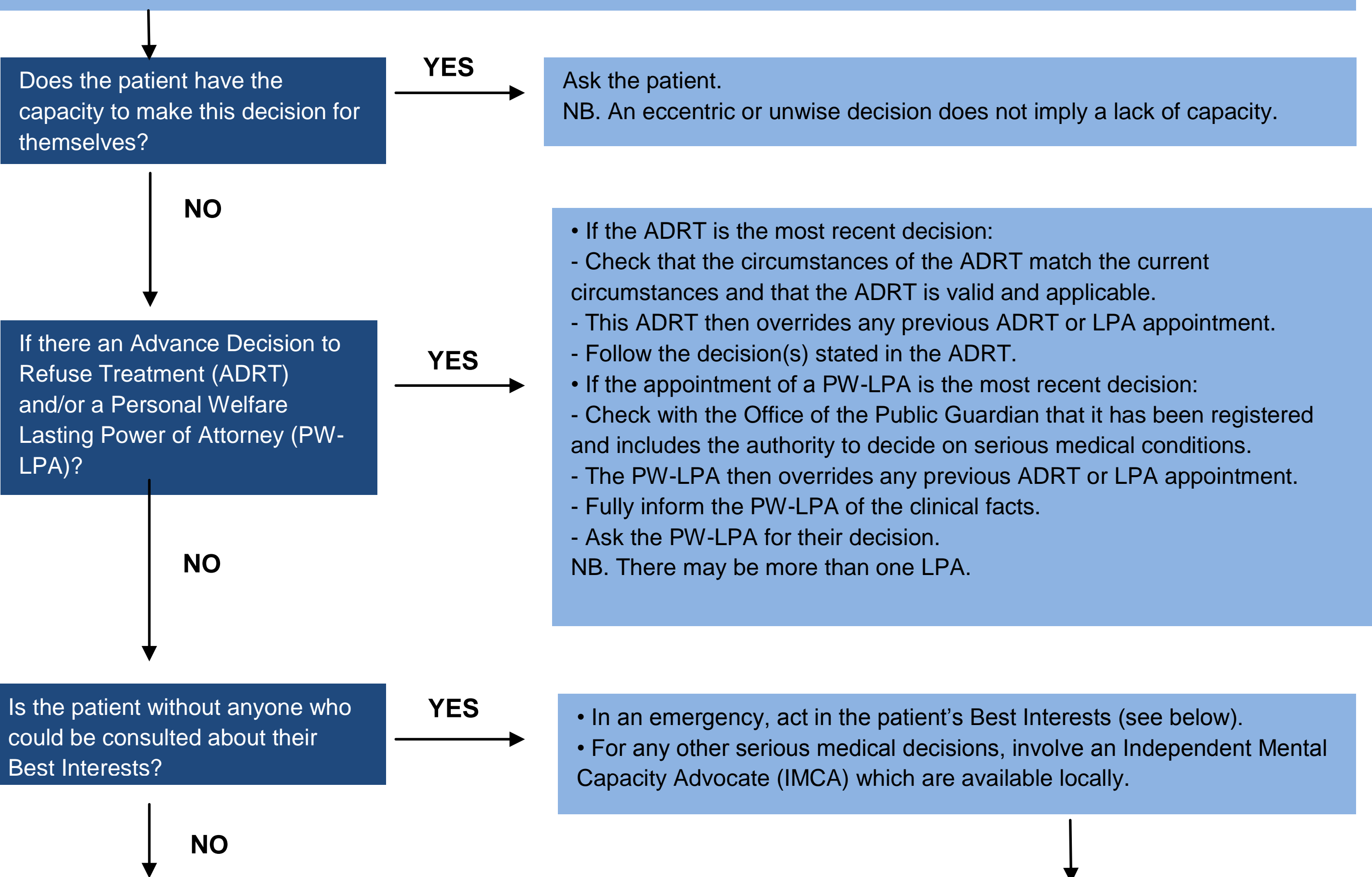
- Clearly score through this form, then sign & date the discontinuation.
- File at the back of the patient's medical notes.
- Document the change of decision in the patient's medical notes.
- Complete a new form and insert in the patient's medical note.

The process for making best interest decisions in serious medical conditions in patients over 18 years

Start by assuming that the person has capacity. If there is doubt, proceed to the 2 stage test of capacity:
Stage 1: Does the person have an impairment of, or a disturbance in the functioning of their mind or brain? Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? Their capacity for this decision can be assessed by four functional tests:

1. Can they understand the information? NB. This must be imparted in a way the patient can understand.
2. Can they retain the information? NB. This only needs to be long enough to use and weigh the information.
3. Can they use or weigh up the information? NB. They must be able to show that they are able to consider the benefits and burdens of the alternatives to the proposed treatment.
4. Can they communicate their decision? NB. The carers must try every method possible to enable this.

The result of each step of this assessment should be documented, ideally by quoting the patient.



- **Appoint a decision maker (usually after an interdisciplinary team discussion) who should:**

- Encourage the participation of the patient.
- Identify all the relevant circumstances.
- Find out the person's views (i.e. wishes, preferences, beliefs and values); these may have been expressed verbally previously, or exist in an ADRT or Advanced Care Plan made when the patient had capacity.
- Avoid discrimination and avoid making assumptions about the patient's quality of life.
- Assess whether the person may regain capacity.
- If the decision concerns life-sustaining treatment, not be motivated in any way by a desire to bring about the patient's death.
- Consult others (within the limits of confidentiality): This may include an LPA, IMCA or Court Appointment Deputy.
- Avoid restricting the person's rights.
- Take all of this into account (i.e. weigh up all these factors in order to work out the person's Best Interests).

- **Record the decisions.**
- **Agree review dates and review regularly.**

If there is unresolved conflict, consider involving:
- The Local Ethics Committee.
- The Court of Protection, possibly through a Court Appointment Deputy (CAD).

Reproduced with kind permission from the NHS Improving Quality Team. © NHS Improving Quality (2008). From Regnard, Dean and Hockley (2009) - A Guide to Symptom Relief in Palliative Care. 6th Edition. Oxford Radcliffe Publishing