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Guidance for completing Treatment Escalation Plan (TEP)
A TEP form is for clinical guidance and does not replace clinical judgement.
Conversations about DNACPR decisions are often difficult for clinicians, patients and those close to them but must not be avoided just because they may cause some unavoidable distress.
Resuscitation should not be offered if felt to be clinically inappropriate.
If there is disagreement around the decision made, seek a second senior clinical opinion.
An electronic or paper version should be available with the patient (if printed version is required, this can be in black and white if colour printer not available).

Healthcare professional completing the TEP
The form can be completed by a suitably experienced, trained and competent registered healthcare professional as defined within an organisation's own resuscitation policy. When completing the form, the date, time, role and professional registration number must be documented.
These clinical decisions must be discussed with the senior responsible medical clinician, and their agreement with the plan documented ideally on the form and in the patient's record. The senior responsible medical clinician will usually be the patient's GP or Consultant.

TEP Review
The form should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another. A fixed review date is not recommended; the TEP is considered as 'indefinite' unless clearly cancelled.

Mental Capacity Assessment
If there is any reason to doubt the capacity of the patient, a Mental Capacity Assessment must be completed. The 2 stage Mental Capacity Test is on the form. If capacity changes, the form must be reviewed. If the patient lacks capacity their relatives, carers or friends must be consulted to form a best interest decision. Independent Mental Capacity Advocate (IMCA) services should be involved to help form best interest decisions in there is no other person to fulfil the role.
For further information and guidance please refer to the 'Mental Capacity Act 2005 Code of Practice' (2007). If the patient has made a Lasting Power of Attorney (LPA) for health and welfare, ensure that the LPA is valid. Further information can be found at www.gov.uk/power-of-attorney

Summary box
Please include as much clinical information as possible, as this will inform decision making in an emergency. Documentation of the patient and relative discussions is of particular importance.

Summary of communication with patient's relatives/carers/friends
You should actively seek to involve patients and families in decisions around DNA-CPR and treatment plans. Discussions with the patient's relatives or advocate are essential to provide information and support, unless confidentiality restrictions prevent this. In a minority of cases, explaining a DNA-CPR decision will impose an unnecessary burden by causing such distress that the dying person suffers harm. In this situation you must clearly document your reasons for not involving patients in discussions about DNA-CPR.

Sharing TEP information across healthcare settings
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. This can be achieved through EPACCS and shared care record and must be included as part of the discharge summary paperwork.

If following clinical review treatment decisions are changed:
- Clearly score through this form, then sign and date the discontinuation.
- For paper copies file at the back of the patient's medical notes.
- Document the change of decision in the patient's medical records.

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Decision-making framework

Is cardiac or respiratory arrest a clear possibility for the patient?

No → It is not necessary to discuss CPR with the patient unless they express a wish to discuss it.

Yes

Is there a realistic chance that CPR could be successful?

No → If a DNACPR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it (see section 5). Those close to the patient should also be informed and offered explanation, unless a patient's wish for confidentiality prevents this.

Where a patient lacks capacity and has a welfare attorney or court-appointed deputy or guardian, this representative should be informed of the decision not to attempt CPR and the reasons for it, as part of the ongoing discussion about the patient's care.

Where a patient lacks capacity, the decision should be explained to those close to the patient without delay. If this is not done immediately, the reasons why it was not practicable or appropriate must be documented (see section 5).

If the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered.

Yes

Does the patient lack capacity **AND** have an advance decision specifically refusing CPR **OR** have an appointed attorney, deputy or guardian?

Yes → If a patient has made an advance decision refusing CPR, and the criteria for applicability and validity are met, this must be respected.

If an attorney, deputy or guardian has been appointed they must be consulted (see sections 9.1 and 10).

No

Does the patient lack capacity?

Yes → Discussion with those close to the patient must be used to guide a decision in the patient's best interests (see section 10). When the patient is a child or young person, those with parental responsibility should be involved in the decision where appropriate, unless the child objects (see section 11).

No

Is the patient willing to discuss his/her wishes regarding CPR?

No → Respect and document their refusal (see section 6.3). Discussion with those close to the patient may be used to guide a decision in the patient's best interests, unless confidentiality restrictions prevent this.

Yes

The patient must be involved in deciding whether or not CPR will be attempted in the event of cardiorespiratory arrest.

- If cardiorespiratory arrest occurs in the absence of a recorded decision there should be an initial presumption in favour of attempting CPR.
- Anticipatory decisions about CPR are an important part of high-quality health care for people at risk of death or cardiorespiratory arrest.
- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team with appropriate competence.
- Decisions about CPR require sensitive and effective communication with patients and those close to patients.
- Decisions about CPR must be documented fully and carefully.
- Decisions should be reviewed with appropriate frequency and when circumstances change.
- Advice should be sought if there is uncertainty.

Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing