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Treatment Escalation Plan (TEP) form Version 12 Frequently Asked Questions

What has changed?

There have been some significant changes to the form to reflect the approach to care for an individual rather than focusing on specific treatments that are often difficult to anticipate in advance. The language encourages you to think about symptom management for all patients no matter where the setting.

Specific treatment boxes (e.g. IV fluids) have been removed as these were rarely used and encouraged 'tick box' conversations rather than person centered goals. Details about relevant treatments can still be captured in the summary box, enabling care to be guided in an acute clinical event.

Why has it been changed?

These changes were made after audit of previous versions and review of significant learning events. It reflects national advancements in care planning such as the Ambitions for End of Life Care, 'What Matters Conversations' movement, Resuscitation Council guidance and updates in NICE guidance.

Do I need to change all my patients over to the new version?

No, previously completed forms are still valid, provided they have been filled in correctly. It is also acceptable to use up any existing supplies of Version 11.

Have the key messages about TEP forms changed?

No, the principles remain the same. The key messages have been updated:

1. **TEP is a form for recording your clinical decision making and discussions around this. It is not a legal document.**

- Professional judgment should be applied to whom should have one.
- Prognostic indicator tools are helpful in identifying clinical deterioration to prompt use of TEP forms (e.g. SPICT /Rockwood score).
- The Resuscitation Council decision-making tool is at the end of this document.

2. **All forms should be filled out as fully as possible and reflect the individual needs of each patient at that particular point in time.**

- Patient demographics, clinicians details (including professional registration number) and Mental Capacity status must be recorded.
- Please complete the summary box – **detailed and relevant information** significantly improves clinical decision making at the time when it is needed.
- For patients lacking capacity, **a capacity assessment** and a best-interests decision, involving the person's relatives or advocate should always be clearly documented. Documentation of the patient and relative discussions is of particular importance.
- If an individual's situation changes the TEP form should be reviewed and amended to reflect this.

3. **You should actively seek to involve patients and families in decisions around DNA-CPR and treatment plans**. Conversations about DNA-CPR decisions are often difficult for clinicians, patients and those close to them but must not be avoided just because they are difficult or because they may cause some unavoidable distress.

- **Clinicians are not obliged to offer medical treatments that would be unsuccessful** and would cause harm, including CPR. CPR is often inappropriate in people with severe organ failure, severe frailty or advanced metastatic disease where a natural

process of dying is occurring and the damaged organs can't survive a cardiac arrest, no matter how promptly CPR is started.

- Sensitive conversations describing the dying process (a lot of people have not seen a natural death) and alternative care to provide support for a natural death should go alongside explaining the reasons for DNA-CPR. This 3 minute video is a useful resource for clinicians and patients.
- In a minority of cases, explaining a DNA-CPR decision to a patient 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.
- Discussion with the patient's relatives or advocate are essential to provide information and support, unless confidentiality restrictions prevent this.
- If there is disagreement about a clinical decision with the patient or their advocate you should offer a senior clinical second opinion.

4. **The Treatment Escalation Plan (TEP) is only effective if everyone knows it exists** – please update EPaCCS/ summary care record if able to do so, update your colleagues involved in caring for the patient.

5. **The, most up-to-date TEP form should accompany the patient when moving across different healthcare settings.**

6. **As agreed at the start of the COVID-19 Pandemic, Black and White printed version of the TEP form might be in circulation and are acceptable**.

Where can I find out more?

The Hospice UK planning ahead tool supports people through decisions about their future care including medical interventions and CPR. It can be used by the person and their advocates to underpin advance care planning discussions.

If you still have any unanswered questions then please contact your organizations resus lead.

Where do I get more supplies of the Version 12 TEP form?

St Luke's Community Team community@stlukes-hospice.org.uk 01752 964200

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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]