Treatment Escalation Plans

Updated July 2024

What is a Treatment Escalation Plan (TEP)?

A TEP gives guidance on what treatment should be offered if the patient's condition were to deteriorate. These advanced decisions are aimed at **supporting patient wishes** and form part of the advance care planning process. The use of a TEP helps to **reduce distressing, inappropriate investigations, procedures and interventions** that may occur without pro-active early planning and decision-making by appropriate clinicians.

Whilst a TEP form does not go out of date, it is good practice to complete or update a TEP form **whenever a conversation takes place or if there is a change in a patient's condition**. Although it is not a legally binding document, it is crucial that the completion a TEP form is with full involvement of patients and their families. **Professional judgment** should be applied to who should have one and how it is interpreted, but this should be with the full knowledge of patients.

Who can complete a TEP form?

The form can be completed by a **suitably experienced, trained and registered healthcare professional**. These clinical decisions must be discussed with the senior responsible medical clinician (usually GP or Consultant) and their agreement with the plan documented.

TEPs can be completed by Advanced Practitioners (Nurse and Allied Health) if they have advance communication skills training and have undertaken an additional TEP training course, which will be available locally.

In addition to NHS staff, NICE recommends registered managers of care homes can support advance care planning process by sharing relevant information with you to support TEP conversations.

Who should have a TEP form?

Any patient with significant frailty, unplanned hospital admissions, multiple co-morbidities or advanced disease should be offered a TEP conversation. The SPICT tool is a useful guide to signs of deteriorating illness.

Asking **'what matters to you'** can help guide conversations. Ask the person what their goals are and work with them to achieve them. In people lacking capacity ask those close to them what would matter to the person. Consider Just in Case (JIC) medication, nursing and social care to support this.

What should I consider when making care planning / CPR decisions?

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 organs can't survive a cardiac arrest, no matter how promptly CPR is started.

Have sensitive conversations describing the dying process (a lot of people have not seen a natural death). Describing supportive care for a natural death should go alongside explaining the reasons for DNA-CPR. If there is disagreement around the decision made, seek a second opinion form a senior clinician.

When writing the TEP, think of a newly qualified paramedic crew, seeing a person with severe frailty in a care home at 3am. If the patient does not wish to die in hospital, write "patient should only be admitted if community based care is impossible e.g. in order to exclude fractures."

Reversibility and prognosis are difficult to predict in acute illness. Consider which treatments or care settings would cause more harm than benefit. Consider hospitalisation can be linked with over treatment, prolonged inpatient admissions and dying in an unfamiliar environment. State if community care options are preferred instead.

Should I discuss with the 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.

There is a leaflet for patient and their loved ones available to be printed out on the DCCR and there are resources including a video for patient and their loved ones on the One Devon End of Life website here

What if I am not sure if someone has capacity to discuss their TEP?

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 here

Appendix 1

Further guidance can be found here – Joint guidance from the BMA, Resuscitation Council (UK) and Royal College of Nursing (RCN) on decisions about CPR – including decisions not to attempt CPR. Below is a useful framework:

Decision-making framework