NHS

DOCUMENT FOR INFORMATION ONLY

Treatment Escalation Plan (TEP) and Resuscitation Decision Record

This form is for clinical guidance and it does not replace clinical judgement.

Surname:

First Name:

Hospital Number:

NHS Number:

Address:

DOB:

Mental Capacity
Do you believe the patient has capacity to be involved in making these decisions?

No → If No you **must** complete the 2 stage Mental Capacity Assessment on page 2. Mental Capacity Act (2005).

Yes ↓

If the patient is currently very unwell or in the event their condition deteriorates:

Is admission to an acute hospital appropriate?	Yes ☐	No ☐	**Acute setting only**			
Are IV therapies appropriate? (e.g fluids/antibiotics)	Yes ☐	No ☐	Is referral to a critical care service appropriate? (e.g Outreach Team or MET Team.)	Yes ☐	No ☐
Are oral antibiotics appropriate?	Yes ☐	No ☐	Is ward non-invasive ventilation appropriate?	Yes ☐	No ☐
Is artificial feeding appropriate?	Yes ☐	No ☐	Is a referral for dialysis appropriate?	Yes ☐	No ☐
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate? N/A ☐	Yes ☐	No ☐			

Are there any other Advance Care Planning documents in place? **If yes, what?**

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION ☐

DO NOT ATTEMPT RESUSCITATION (DNACPR) ☐

Date: Time:

Name:

Role: GMC/NMC No:

Document rationale for best interest treatment decisions and resuscitation status and whom this was discussed with **(be as specific as possible).**

Has the treatment escalation plan and resuscitation decision been discussed with the patient/patient's relatives/next of kin/carers? Yes ☐ No ☐

If no, document reason:

Date: Time: **All treatment decisions above should be reviewed as the patient's clinical condition changes.**

Documentation that TEP form has been completed in medical notes. ☐ Yes ☐ No

Has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? ☐ Yes ☐ No

On discharge, if appropriate and the patient or family have been informed of the decisions, then the original form should accompany the patient and a photocopy should remain in the patient's medical notes.

Date this document was reviewed (if required):

Name of reviewer:

Role: GMC/NMC No:

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. It also 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 you believe the individual has an impairment or disturbance of the functioning of the mind or brain.

Reason:

Stage 2: Can the individual:	**Yes**	**No**
1. Understand information about the decision to be 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?)	☐	☐

Is the response YES to all four Stage 2 questions?

No

Is this loss of capacity likely to be temporary and can the decision wait?

If Yes → Set decision review date:

If No

Is there a valid ADRT? (Advance decision to refuse treatment)

If Yes → If ADRT is valid and applicable, use it to complete TEP form. For decisions to which ADRT is not applicable, apply "best interests" principles as per box below.

If No

Is there a Personal Welfare Lasting Power of Attorney (PW-LPA) registered with the Office of the Public Guardian?

If Yes → Ensure that the PW-LPA is consulted and incorporated in any decisions regarding TEP.

If No

Yes

Complete TEP form as part of discussion with patient.

Proceed with completing TEP in line with Best Interest principles (please note if the person has no friends, relatives or unpaid carers then you must include IMCA services). **Please document rationale/Best Interest principles for treatment and discussion in boxes overleaf.**

Guidance for filling in this form

- Complete patient details.
- The date and time of filling in this 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.
- Further guidance on the use of TEP Version 11 can be found on the Devon local joint formularies.
- Upon completion, **upload this document to your patient clinical system.**