# Guidance for Completing Treatment Escalation Plan and Resuscitation (TEP&RD) Decisions

* This form should be completed legibly in black ball point pen.
* Complete patient details (including address) or affix patient’s identification sticker.

**Life Expectancy**

The Second Annual Report of the End of Life Care Strategy (DH, 2010) (Ref 24) recognised the challenge of identifying who is approaching end of life, and acknowledged that we need to do more to improve the present situation. One of its recommendations was the adoption of the ‘surprise question’, where a health professional asks themselves, ‘Would I be surprised if this patient were to die within the next 6–12 months?’ If the answer is no it should lead the professional to consider completing the TEP&RD form. When completing this form it is important that the healthcare professional has knowledge of end of life procedures and documents. If in doubt refer to your organisation’s End of Life Policy.

**Healthcare professional making the TEP&RD**

Ideally the TEP&RD should be made by the most senior medical clinician looking after the patient. However, if a more junior member of staff is completing the form it must be in consultation with their registrar or consultant, and documented as such in the medical notes. The form should be countersigned by the Consultant/GP at the earliest opportunity.

**TEP&RD review**

A fixed review date is not recommended, the TEP is considered as “infinite” unless cancelled. The order should be reviewed whenever clinically appropriate, whenever the patient is transferred from one healthcare institution to another and whenever the patient is admitted to a GWH site or discharged home.

**Capacity/advance decisions**

If there is any reason to doubt the mental capacity of the patient, a Metal Capacity Assessment must be completed. The two stage Mental Capacity Test is on the back of the form. This assessment is only relevant to the decisions made in relation to TEP&RD, and only at the time of the assessment. If capacity changes, the whole form must be reviewed, and a new TEP&RD completed. Clearly document any best interest decision in relation to the TEP&RD. For further information and guidance please refer to your local multiagency safeguarding policy and procedure and the ‘Mental Capacity Act 2005 Code of Practice’ (2007).

**Summary of communication with patient**

State clearly what was discussed and agreed, when and with whom. 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 Health & Welfare Lasting Power of Attorney (HWLPA) to make health-related decisions on their behalf, the doctor must ensure that the HWLPA is valid before consulting them. A HWLPA may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original HWLPA document. 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 HWLPA 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 relationship of relatives and friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes. For further guidance on Best Interests Principles see overleaf.

**Members of multidisciplinary team**

Ensure that the TEP&RD has 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 TEP&RD or 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&RD**

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 notes and it is communicated to the GP in the discharge letter. Ensure that Ambulance/Transport staff are aware of the TEP&RD before transfer.

**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, TEP&RD are changed:**

* Clearly score through this form, then sign and date the discontinuation box in the lower right hand corner of the front page.
* File the scored-through form at the back of the patient’s notes.
* Document the change of decision in the patient’s notes.
* Complete a new form and insert a photocopy in the patient’s notes, give the original to the patient/relatives as appropriate.

**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 two 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 to make this decision should be assessed by four functional tests:

**1. Can they understand the information?** This must be imparted in a way the patient can understand.   
**2. Can they retain the information?** This only needs to be long enough to use and weigh the information.  
**3. Can they use or weigh up the information?** 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?** Every adjustment possible should be made to enable this i.e. use of an interpreter, providing a pen and paper.

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

**YES**

**YES**

**NO**

**NO**

Ask the patient.   
NB. An eccentric or unwise decision does not imply a lack of capacity.

Does the patient have the capacity to make this decision for themselves?

• **If the ADRT is the most recent decision:**   
- Check that the circumstances of the ADRT match the current circumstance and that the ADRT is valid and applicable.  
- This ADRT then overrides any previous ADRT or HWLPA appointment.  
- Follow the decision(s) stated in the ADRT.

**• If the appointment of a HWLPA is the most recent decision:**- Check with the Office of the Public Guardian that it has been registered and includes the authority to decide on serious medical conditions.  
- The HWLPA then overrides any previous ADRT or LPA appointment.  
- Fully inform the HWLPA of the clinical facts.  
- Ask the HWLPA for their decision.  
NB. There may be more than one HWLPA.

If there an Advance Decision to Refuse Treatment (ADRT) and/or a Health and Welfare Lasting Power of Attorney (HWLPA) in place?

• In an emergency, act in the patient’s Best Interests (see below).  
• For any other serious medical decisions, involve an Independent Mental Capacity Advocate (IMCA) which are available locally.

**YES**

Is the patient without anyone who could be consulted about their Best Interests?

**NO**

**• 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 HWLPA, 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