This presentation is a resource developed as part of a face to face education event or workshop.

The target audience is health and social care professionals in roles providing palliative and end of life care

The author/facilitator has agreed to share the work to enable best practice in the provision of end of life care

rowcroft hospice education

Hot Topics in Palliative Care - “Does a TEP matter?”

Welcome to this Rowcroft workshop
Whilst you are waiting for the session to commence please can your read the TEP form on your table and identify anything that surprises/stands out for you.

Kerry Macnish & Wendy Sturt
Education Team and RNs

Learning Objectives

- To increase understanding of the purpose of Treatment Escalation Plans (TEP) and clinical judgements.
- To understand the priorities for care in relation to end of life conversations and decisions.
- To explore & clarify your responsibilities around TEP.

Nursing & Midwifery Council

The NMC Code

Four Themes, One Code

Prioritise **People**

Practice **Effectively**

Preserve **Safety**

Promote **Professionalism** and **Trust**

Public

Protection

Activity 1

What is the purpose of a TEP?

The Purpose

- The purpose of TEP is to ensure early communication with patients and their families, respect the patient's wishes and strive for continuity across the health community and to avoid unwanted or futile attempts at CPR.

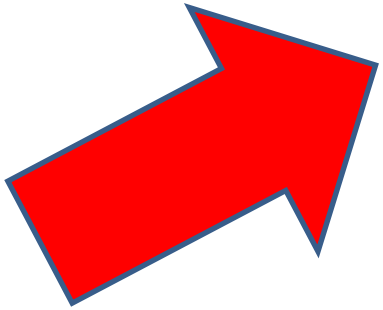
2 purposes:

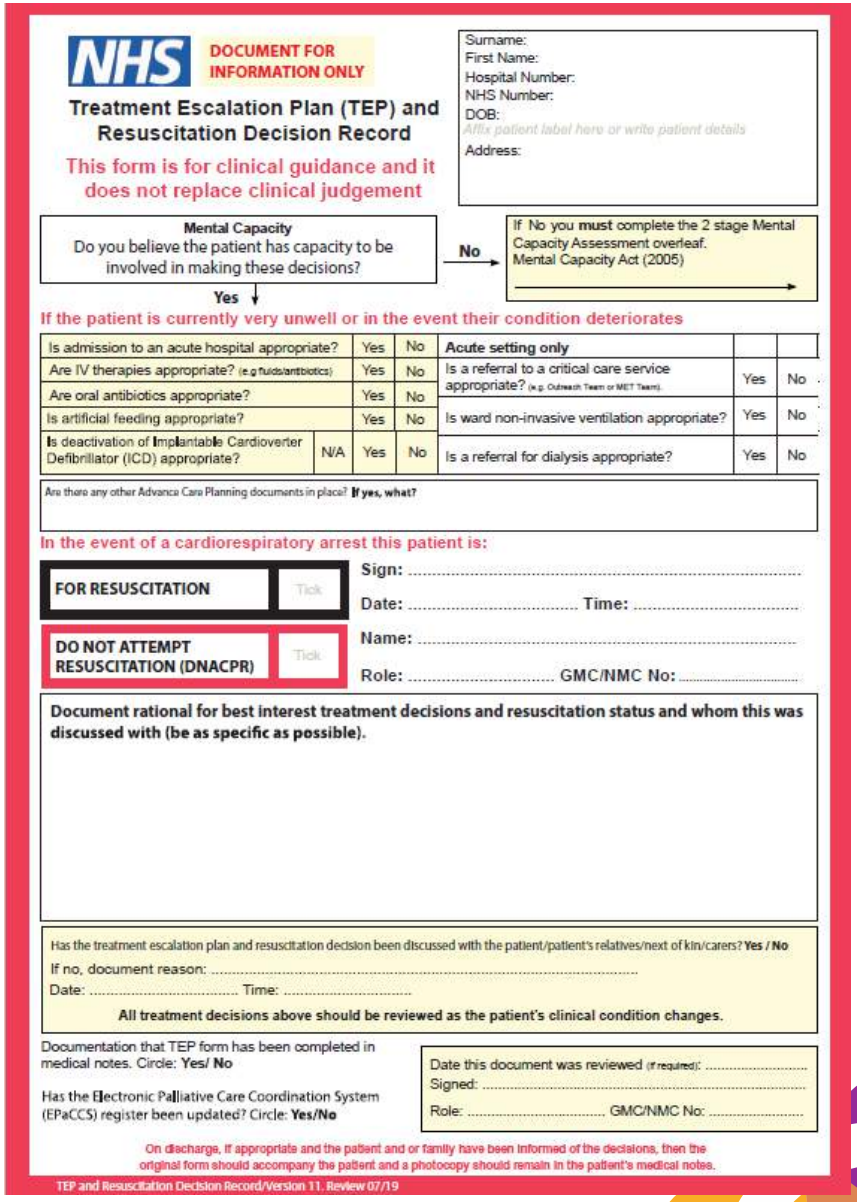
- Communicate a person's wishes
- Communicate clinical decisions

The Purpose and consequence?

- Avoiding unnecessary hospital admissions and /or treatment
- Ensuring a patient's wishes are respected
- Helping HCP's make appropriate treatment decisions and considering ceilings of care
- Clinical guidance that can protect the patient and/or the HCP
- Saving NHS resources

For clinical guidance only and does not replace clinical judgement





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:
DOB:
Affix patient label here or write patient details
Address:

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 overleaf. 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 a referral to a critical care service appropriate? (e.g. Outreach Team or MET Team).		Yes	No
Are oral antibiotics appropriate?		Yes	No				
Is artificial feeding appropriate?		Yes	No	Is ward non-invasive ventilation appropriate?		Yes	No
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	N/A	Yes	No	Is a referral for dialysis appropriate?		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	Tick
DO NOT ATTEMPT RESUSCITATION (DNACPR)	Tick

Sign: .....
Date: ..... Time: .....
Name: .....
Role: ..... GMC/NMC No: .....

Document rational 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. Circle: **Yes/ No**

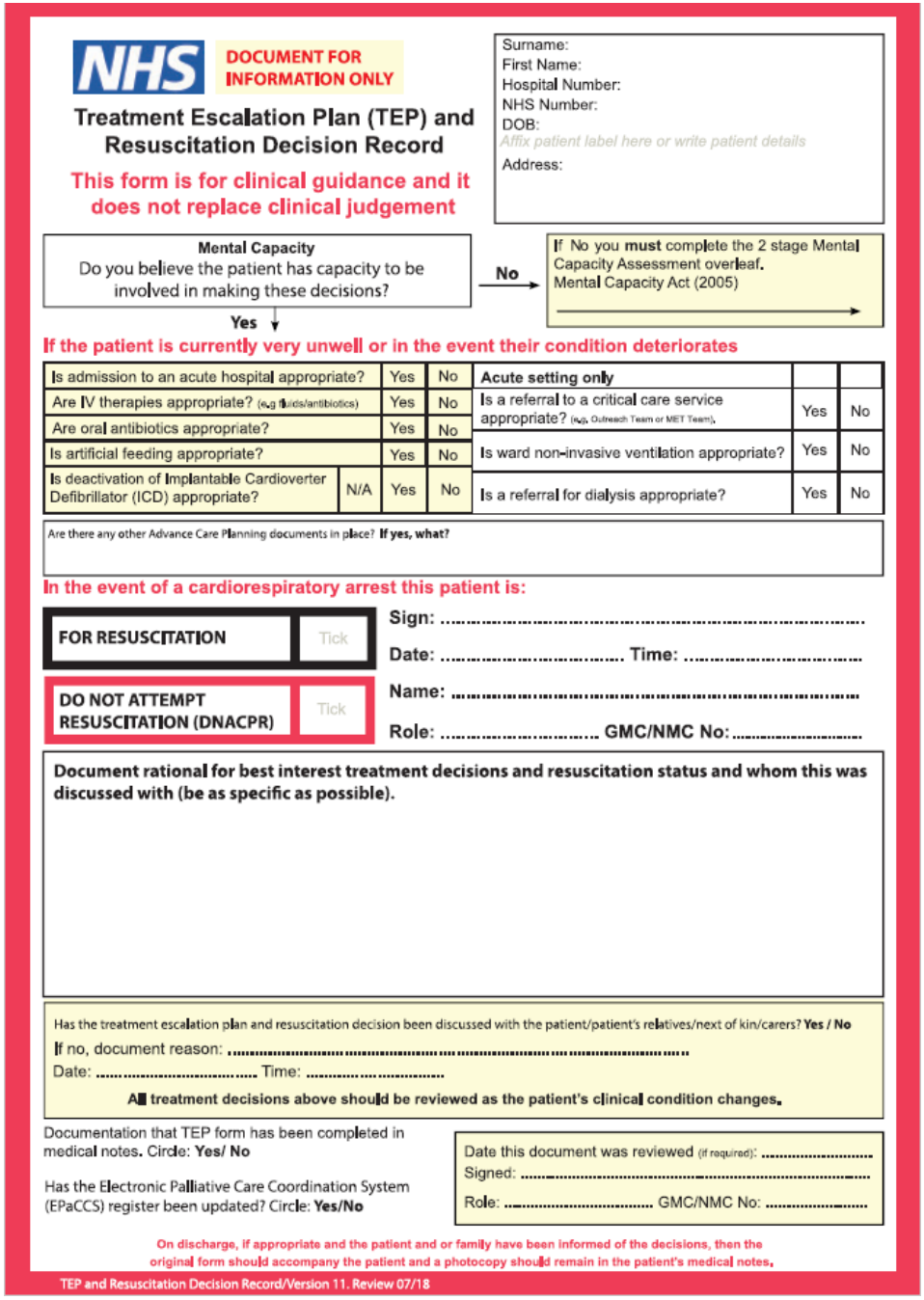
Has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Circle: **Yes/No**

Date this document was reviewed (if required): .....
Signed: .....
Role: ..... GMC/NMC No: .....

On discharge, if appropriate and the patient and 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.

TEP and Resuscitation Decision Record/Version 11. Review 07/19

Activity 2 – your experiences



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

Is admission to an acute hospital appropriate?		Yes	No
Are IV therapies appropriate? (e.g fluids/antibiotics)		Yes	No
Are oral antibiotics appropriate?		Yes	No
Is artificial feeding appropriate?		Yes	No
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	N/A	Yes	No

Acute setting only		
Is a referral to a critical care service appropriate? (e.g. Outreach Team or MET Team).	Yes	No
Is ward non-invasive ventilation appropriate?	Yes	No
Is a referral for dialysis appropriate?	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	Tick
DO NOT ATTEMPT RESUSCITATION (DNACPR)	Tick

Sign: .....
Date: ..... **Time:** .....
Name: .....
Role: ..... **GMC/NMC No:** .....

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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. Circle: **Yes/ No**

Has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Circle: **Yes/No**

Date this document was reviewed (if required): .....
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TEP and Resuscitation Decision Record/Version 11. Review 07/18

Version 11

NHS DOCUMENT FOR INFORMATION ONLY

Treatment Escalation Plan (TEP) and Resuscitation Decision Record

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First Name:
Hospital Number:
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DOB:
Affix patient label here or write patient details
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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 overleaf. 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 a referral to a critical care service appropriate? (e.g. Outreach Team or MET Team)	Yes	No
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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	Tick
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Sign: .....
Date: ..... Time: .....
..... GMC/NMC No: .....

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Has the treatment escalation plan and resuscitation decision been discussed with the patient/patient's relatives/next of kin/carer? Yes / No
If no, document reason: .....
Date: ..... Time: .....

All treatment decisions above should be reviewed as the patient's …

Documentation that TEP form has been completed in medical notes. Circle: Yes/ No

Has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Circle: **Yes/No**

Date this document was reviewed (if required): .....
Signed: .....
Role: ..... GMC/NMC No: .....

On discharge, if appropriate and the patient and 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.

Looks Complicated!

Not easy to read in a hurry!

Often incorrectly completed!

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.

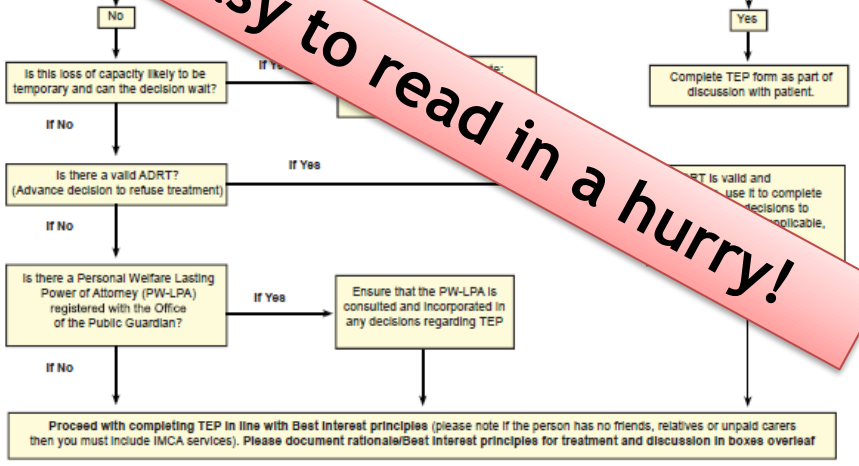
Stage 1:

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. Ret… information in their mind?		
3. U… information as part of the decision making process?		
4. …n (by talking, using sign language or any other means)?		

…response yes to all four Stage 2 questions?

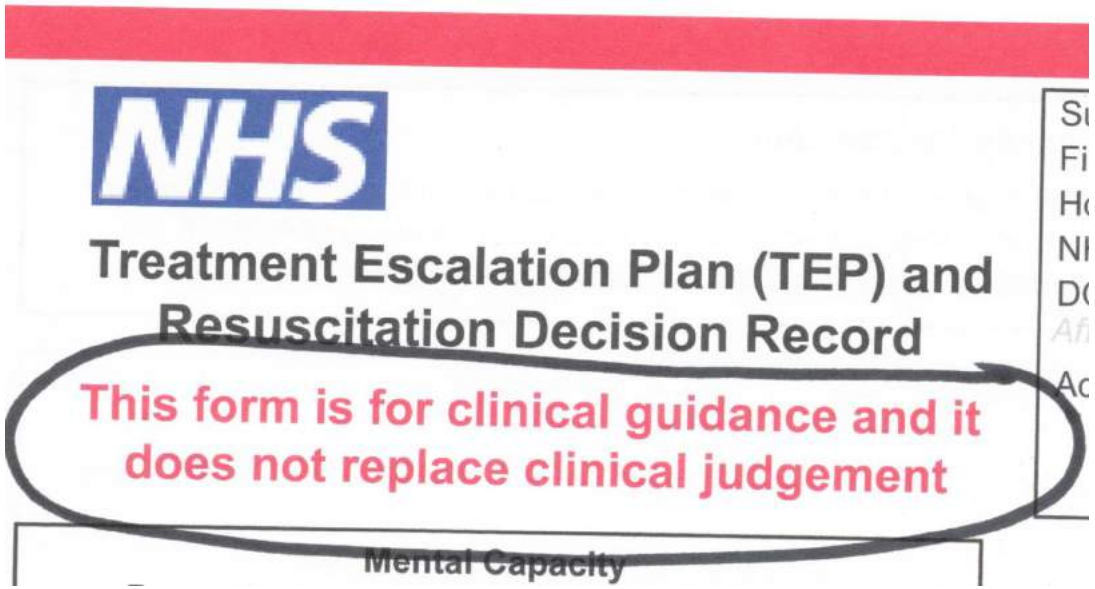


This form should be completed legibly in black ball point ink

- Complete patient details or affix the patient's identification label to the top right hand corner.
- The date and time of writing the 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
- Complete a new form and insert in the patient's medical notes.

TEP Version 11

What does the TEP form say?



• Complete a new form and insert in the patient's medical notes

"On discharge, if appropriate and the patient and 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"

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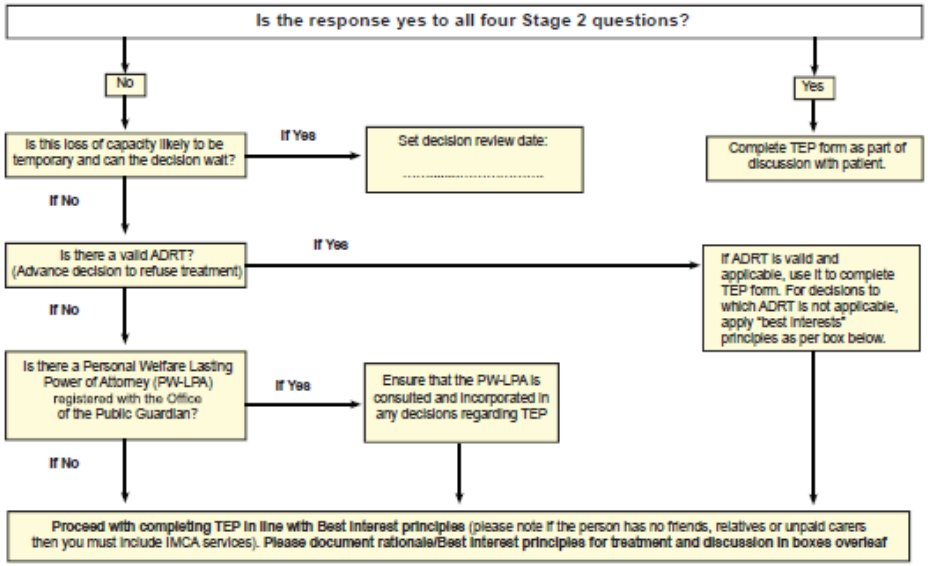
Document the reason you believe the individual has an impairment or disturbance of the functioning of the mind or brain.

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)?		



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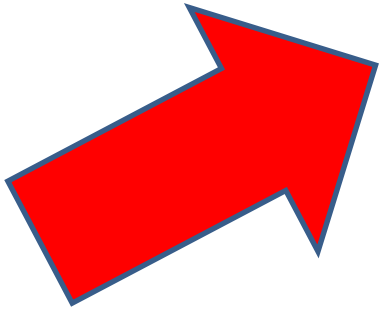
If following clinical review, treatment decisions are changed:

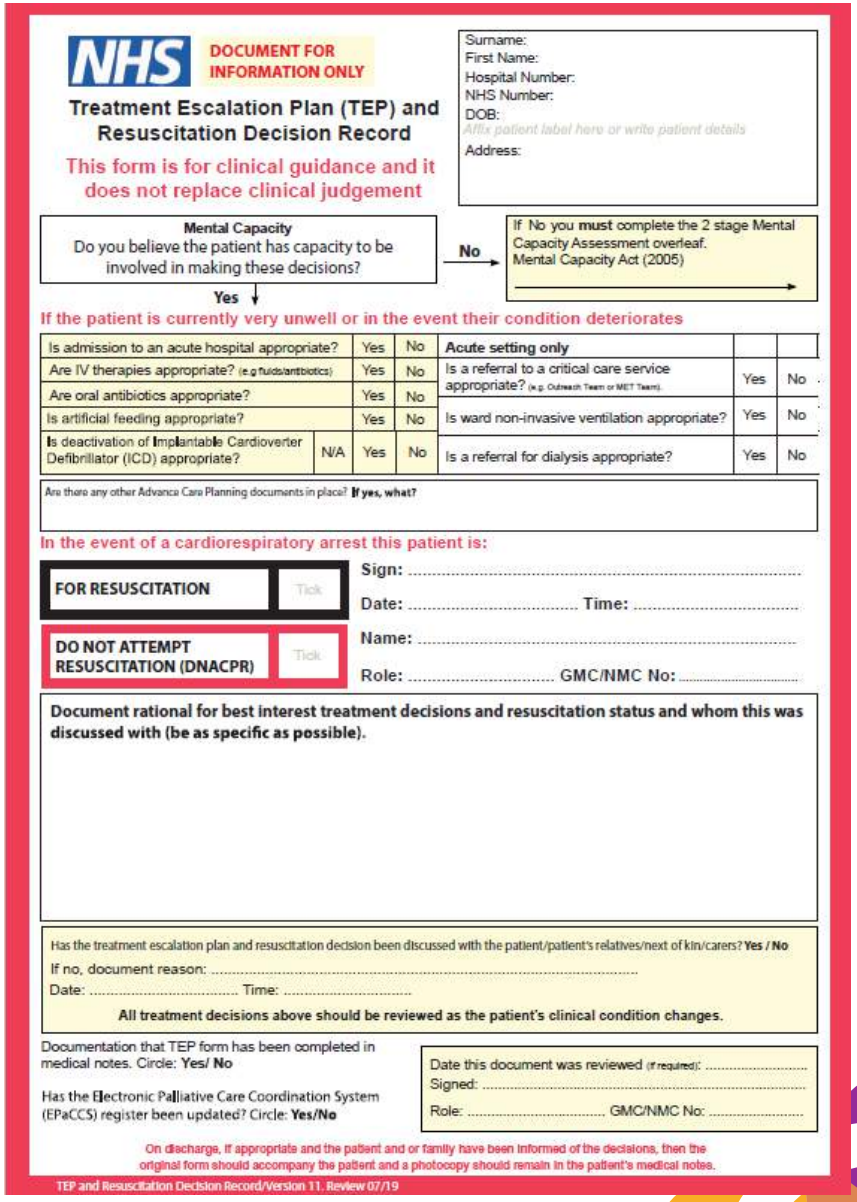
- Clearly score through this form, then sign and date the discontinuation box overleaf.
- File at the back of the patient's medical notes.
- Document the change of decision in the patient's medical notes.
- Complete a new form and insert in the patient's medical notes.

What do Care Quality Commission think about Torbay ?

- There were incidents relating to the poor completion of TEPs where do not attempt cardiopulmonary resuscitation (DNACPR) decisions were recorded. We saw that action had been taken in relation to this, however, we saw it continued to be problematic for community staff.

For clinical guidance only and does not replace clinical judgement





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Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	N/A	Yes	No	Is a referral for dialysis appropriate?		Yes	No

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

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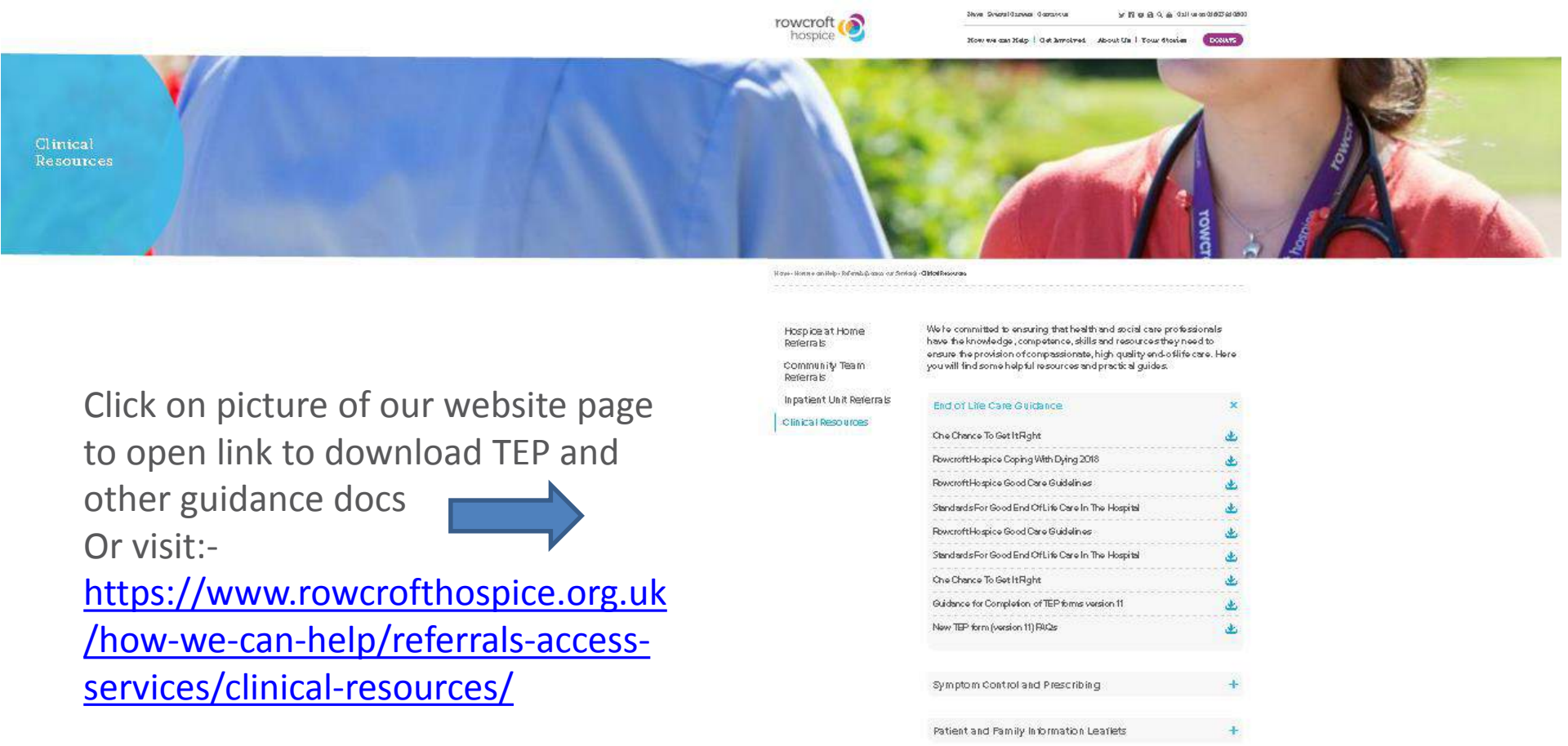
TEP and Resuscitation Decision Record/Version 11. Review 07/19

Common **myths** about TEPS

- TEP is a legal document that must be followed
- If you follow the TEP document you can't be wrong!
- A patient with known terminal illness cannot be transported without an original TEP form
- CPR should be commenced on any patient without a TEP
- A TEP form should have an expiry date
- An original TEP form should remain in the hospital notes
- All boxes on the TEP form must be completed

Guidance for Completion of TEP forms version 11

New TEP form (version 11) FAQs

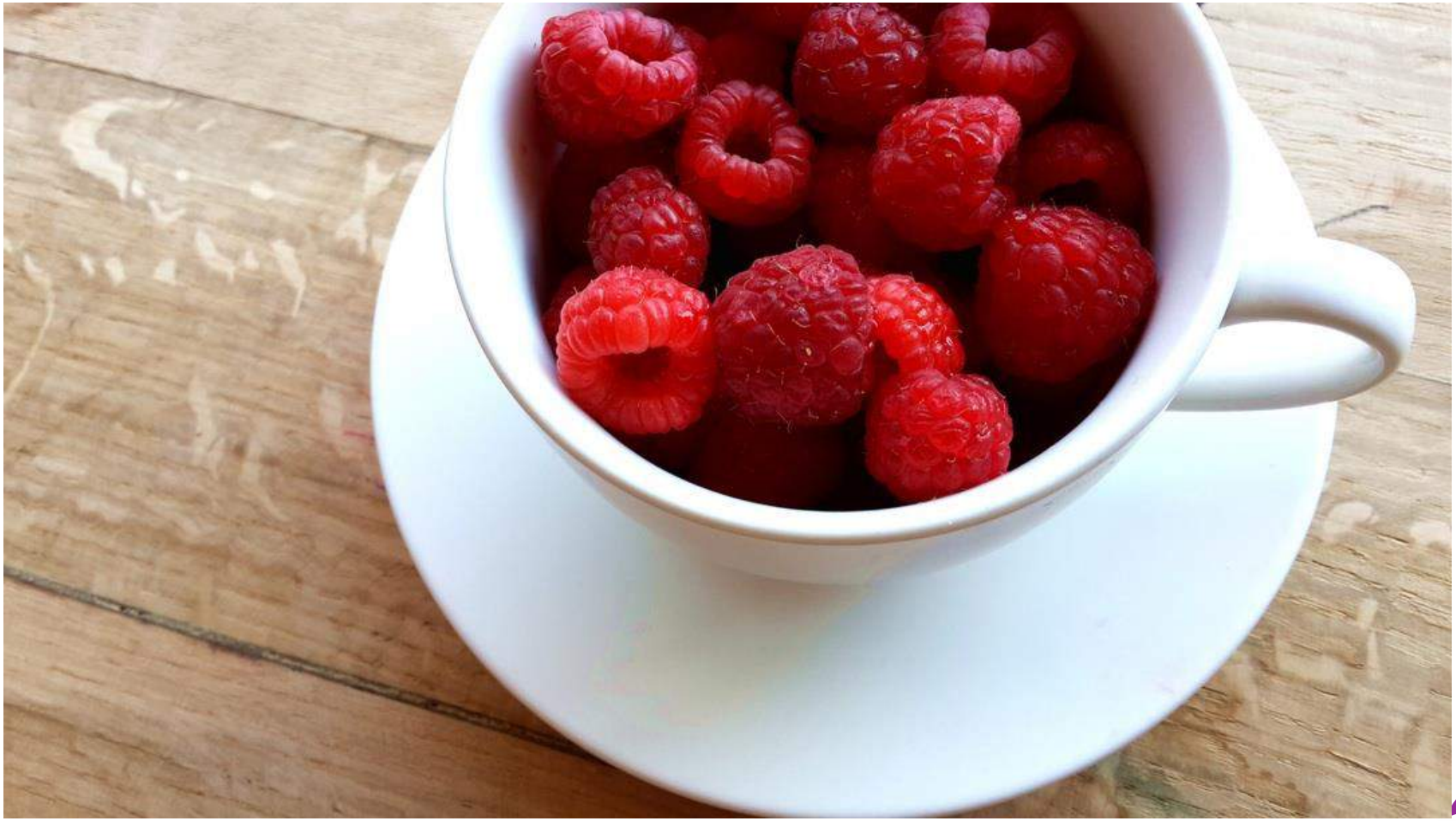


Click on picture of our website page to open link to download TEP and other guidance docs

Or visit:-

https://www.rowcrofthospice.org.uk/how-we-can-help/referrals-access-services/clinical-resources/

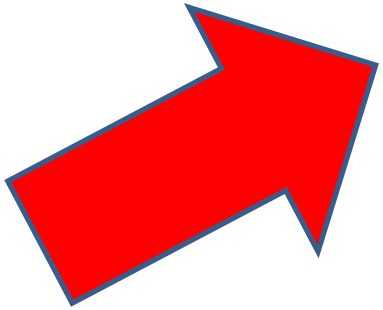
Time to refresh?

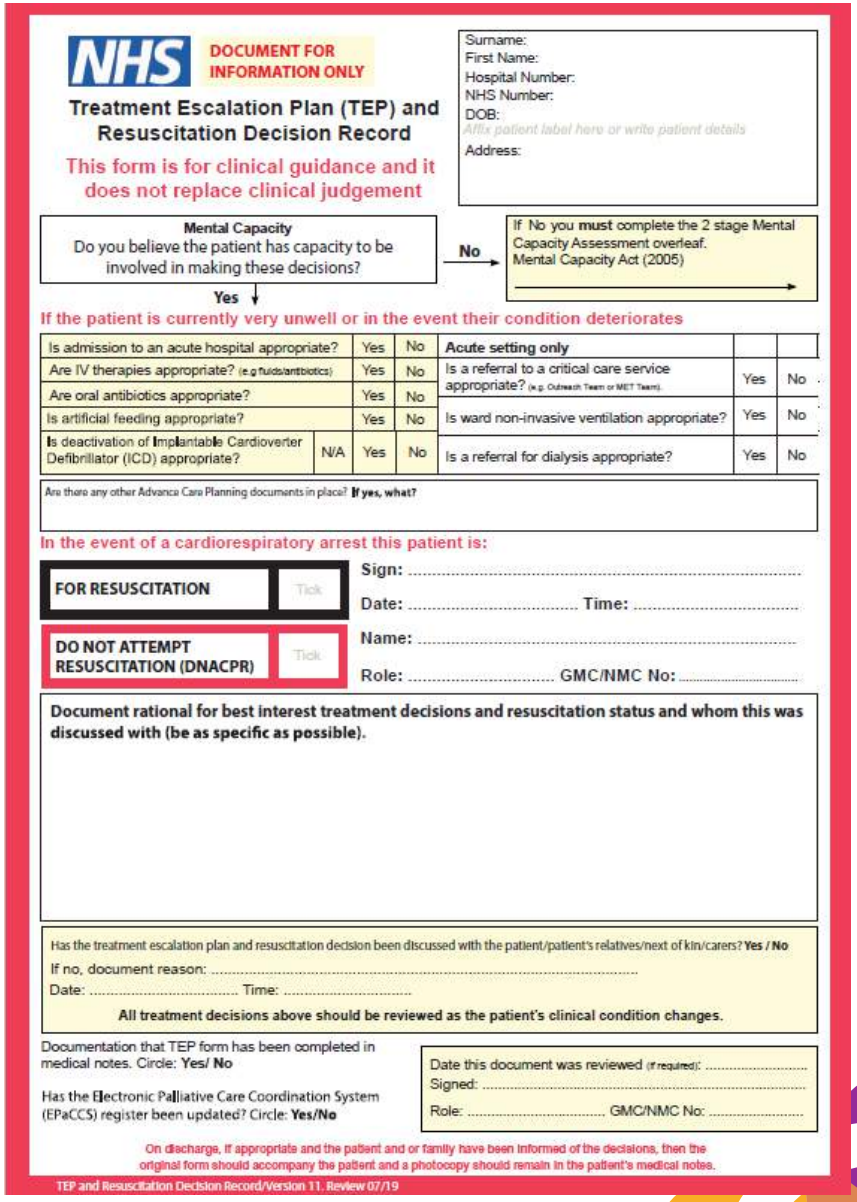


Therefore TEP is not

- compulsory
- legally binding
- a document that “trumps” clinical judgement
- a form that covers all possibilities

For clinical guidance only and does not replace clinical judgement





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TEP and Resuscitation Decision Record/Version 11. Review 07/19


TEST
YE
CUNNING

Resus Quiz:

1. When CPR is attempted, approximately what proportion of these patients have their breathing and circulation re-established (however transiently)?
   a) 90%
   b) 40%
   c) 20%
   d) 5%

2. Approximately what percentage of all patients on whom CPR is attempted recover sufficiently to leave hospital?
   a) 25%
   b) 20%
   c) 18%
   d) 15%

Question 3 True or False

A. 28% of those who arrest in hospital are alive a year later

True or False

B. 10% of those who arrest outside hospital are alive a year later

True or False

C. The chance of survival in patients who spend more than half their time in bed before the arrest is less than 4%

True or False

Question 4 What do you think the success rate for re-establishing breathing and circulation on some drama series is?(e.g. Holby City)

a) 100%
b) 75%
c) 50%
d) 25%

Resus Quiz Answers:

1. When CPR is attempted, approximately what proportion of these patients have their breathing and circulation re-established (however transiently)?

b) About 40% falling to less than 30% after 24 hours

2. Approximately what percentage of all patients on whom CPR is attempted recover sufficiently to leave hospital?

c)18%

Question 3 True or False

A. 28% of those who arrest in hospital are alive a year later

False 10%

B. 10% of those who arrest outside hospital are alive a year later

False only 5%

C. The chance of survival in patients who spend more than half their time in bed before the arrest is less than 4%

True

Question 4 What do you think the success rate for re-establishing breathing and circulation on some drama series is?(e.g. Holby City)

75%

Taken from e elca module Discussing “Do not attempt CPR decisions”

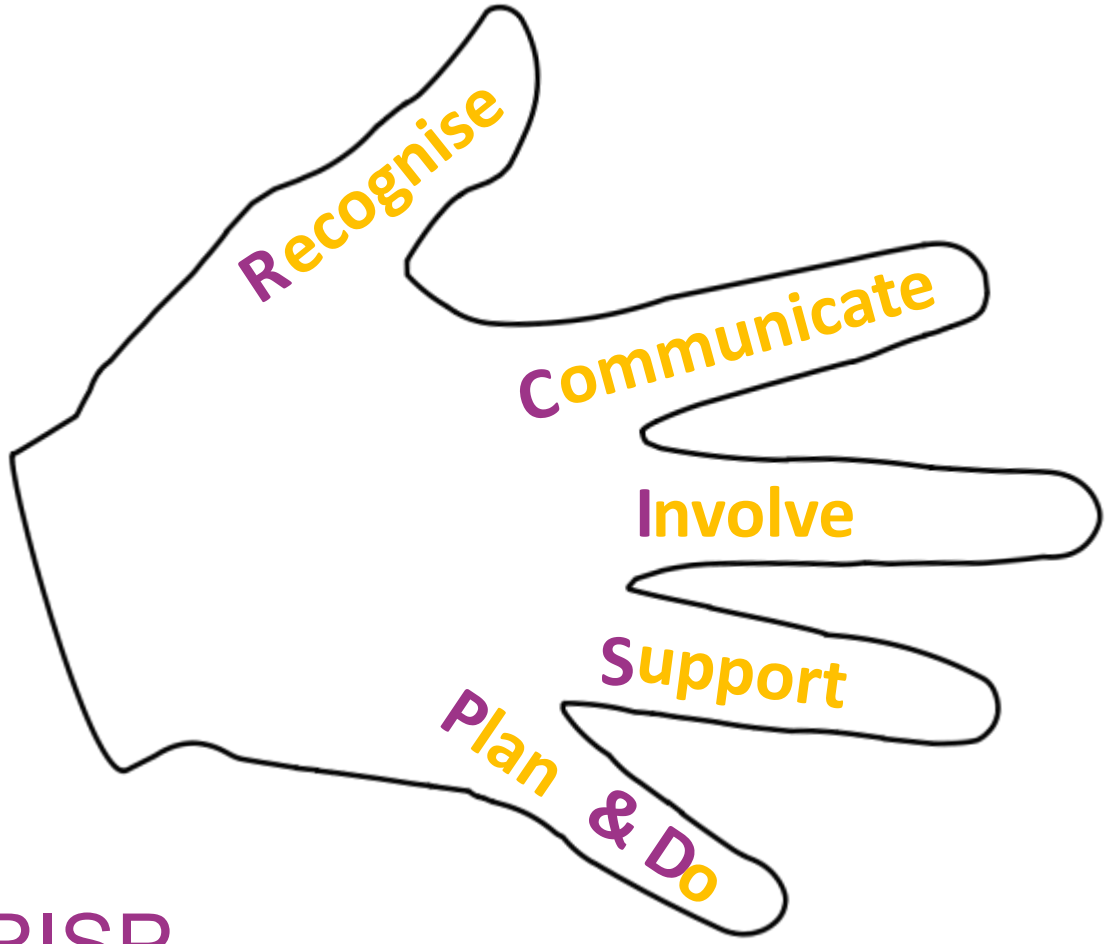
Free access to end of life e learning

e-ELCA
End of Life Care for All

e-Learning to enhance education and training for end of life care

http://www.e-lfh.org.uk/programmes/end-of-life-care/

Really **C**urious **I**ndividuals **S**upport **P**eople who are **D**ying



Or…CRISP

Priorities for Care of the Dying Person

Duties and Responsibilities of Health and Care Staff

Published June 2014 by the
Leadership Alliance for the Care of Dying People

RECOGNISE	The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly. Always consider reversible causes, e.g. infection, dehydration, hypercalcaemia, etc.
COMMUNICATE	Sensitive communication takes place between staff and the dying person, and those identified as important to them.
INVOLVE	The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
SUPPORT	The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
PLAN & DO	An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

Local palliative care contact:

http://www.rowcrofthospice.org.uk/resources

What decisions are legally binding?

DAILY Mirror

Gran has ‘Do Not Resuscitate’ tattooed onto her chest to tell docs to let her die

COMPASSION IN DYING.
SUPPORTING YOUR CHOICES

Advance Decision Pack

Your document contains:

- **Advance Decision to Refuse Treatment**
  This form sets out the situations in which you want to refuse medical treatment if you are unable to make or communicate that decision in the future.

- **Guidance Notes**
  This gives information to help you complete your form. The notes explain when an Advance Decision would be used and offers support to consider your wishes.

You can contact us to order a wallet-sized '**Notice of Advance Decision**' card. This explains that you have made an Advance Decision and where a copy can be found.

To order a card contact us on:

0800 999 2434

info@compassionindying.org.uk

https://compassionindying.org.uk/making-decisions-and-planning-your-care/planning-ahead/advance-decision-living-will/

Click here to reset form Click here to print form

Office of the Public Guardian

Form
LP1H

Lasting power of attorney

Registering an LPA costs
£82
This fee is means-tested: see the application Guide part B

Health and care decisions

Use this for:

- the type of health care and medical treatment you receive, including life-sustaining treatment
- where you live
- day-to-day matters such as your diet and daily routine

How to complete this form

PLEASE WRITE IN CAPITAL LETTERS USING A BLACK PEN

☒ Mark your choice with an X

■ If you make a mistake, fill in the box and then mark the correct choice with an X

Don't use correction fluid. Cross out mistakes and rewrite nearby. Everyone involved in each section must initial each change.

Making an LPA online is simpler, clearer and faster

Our smart online form gives you just the right amount of help exactly when you need it: **www.gov.uk/power-of-attorney**

Before you start...

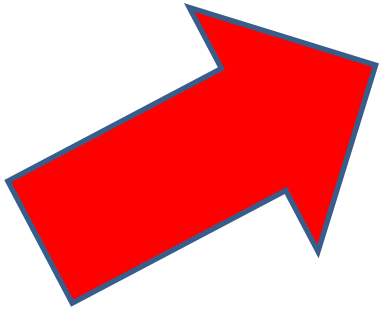
This form is also available in Welsh. Call the helpline on 0300 456 0300.

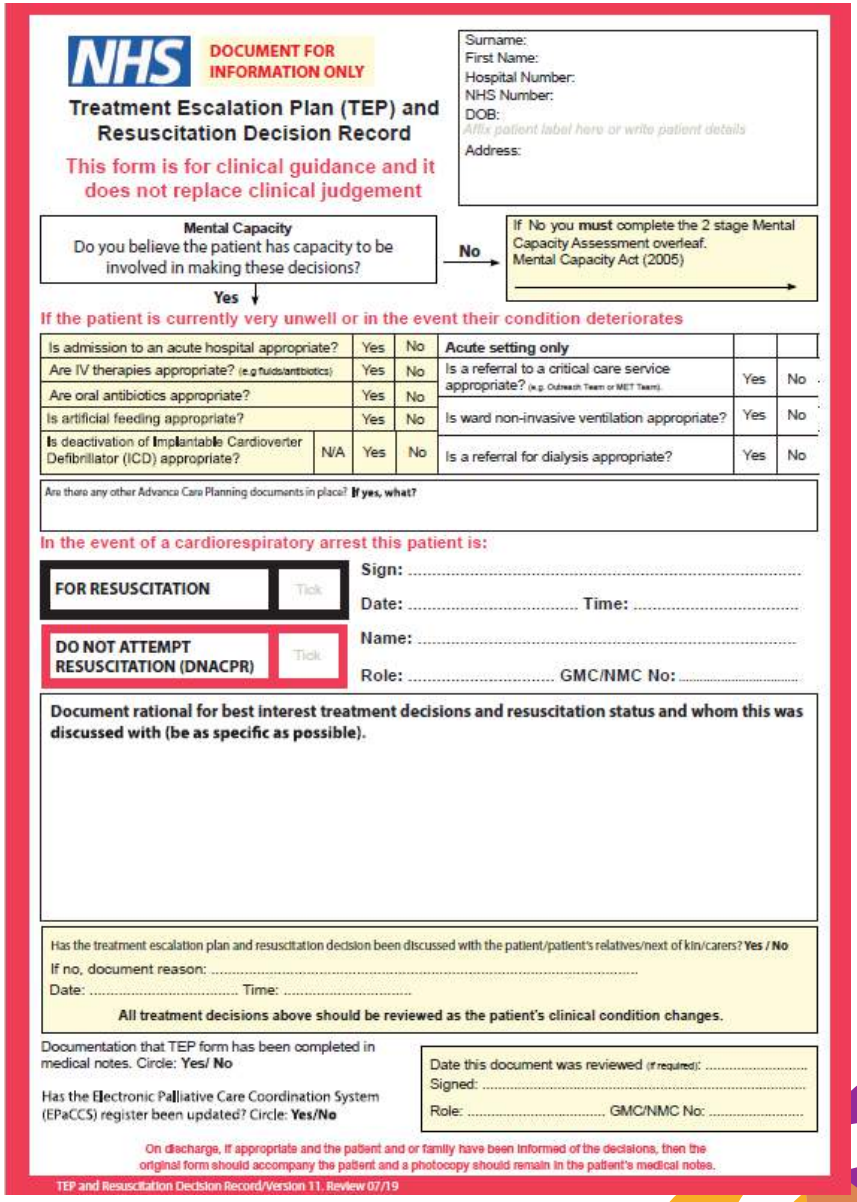
This page is not part of the form

LP1H Health and welfare (03.17)

https://www.gov.uk/government/publications/make-a-lasting-power-of-attorney

For clinical guidance only and does not replace clinical judgement





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:
DOB:
Affix patient label here or write patient details
Address:

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 overleaf. 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 a referral to a critical care service appropriate? (e.g. Outreach Team or MET Team).		Yes	No
Are oral antibiotics appropriate?		Yes	No				
Is artificial feeding appropriate?		Yes	No	Is ward non-invasive ventilation appropriate?		Yes	No
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	N/A	Yes	No	Is a referral for dialysis appropriate?		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	Tick
DO NOT ATTEMPT RESUSCITATION (DNACPR)	Tick

Sign: .....
Date: ..... Time: .....
Name: .....
Role: ..... GMC/NMC No: .....

Document rational 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. Circle: **Yes/ No**

Has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Circle: **Yes/No**

Date this document was reviewed (if required): .....
Signed: .....
Role: ..... GMC/NMC No: .....

On discharge, if appropriate and the patient and 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.

TEP and Resuscitation Decision Record/Version 11. Review 07/19

E-Elca


Treatment and Care Towards the End of Life: Good Practice in Decision Making
NHS
Session Overview
Menu
Previous
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Next
Treatment and Care Towards the End of Life: Good Practice in Decision Making
Description
This session introduces the General Medical Council's guidance covering decision making in the last year of life. It highlights the key principles and good practice standards set out in the guidance, illustrating how they can be applied using examples from practice. This session was reviewed by Andrew Thorns and Christina Faull and last updated in December 2014.
Authors
Andrew Thorns, General Medical Council (see acknowledgements)
Module
Integrating Learning
Duration
30 min
e-LfH
e-Learning for Healthcare
NHS
Health Education England

Clinical judgement

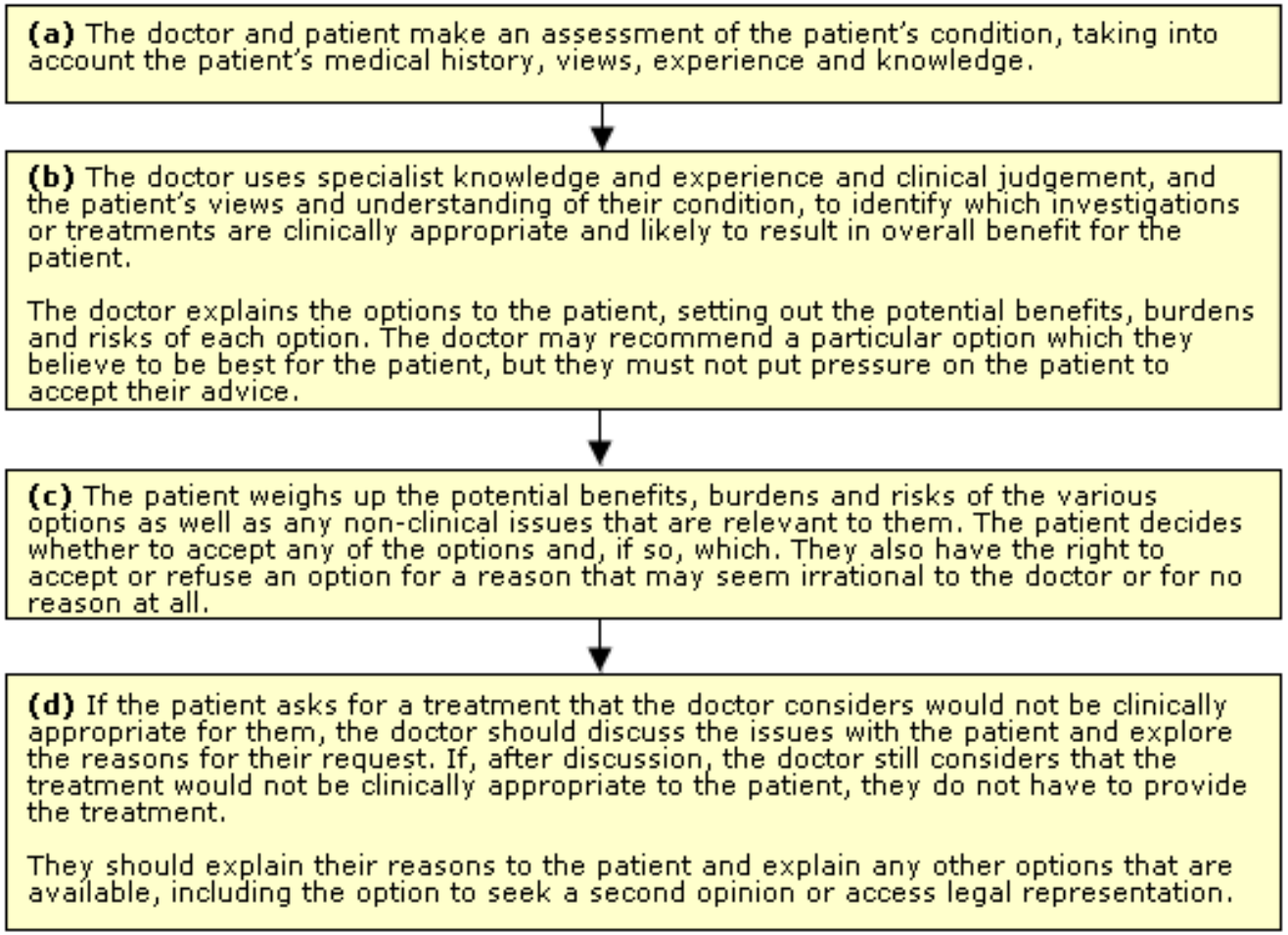
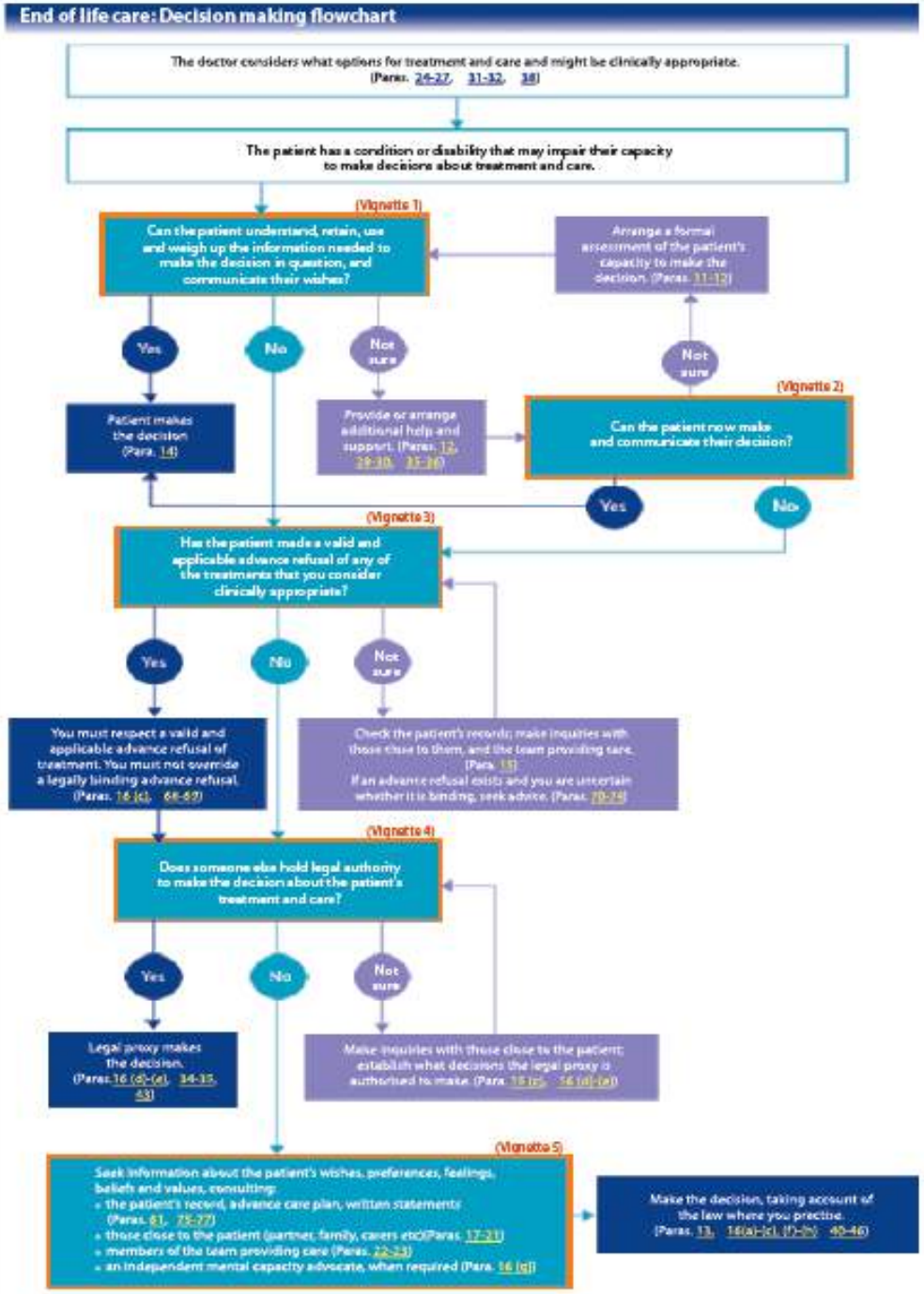


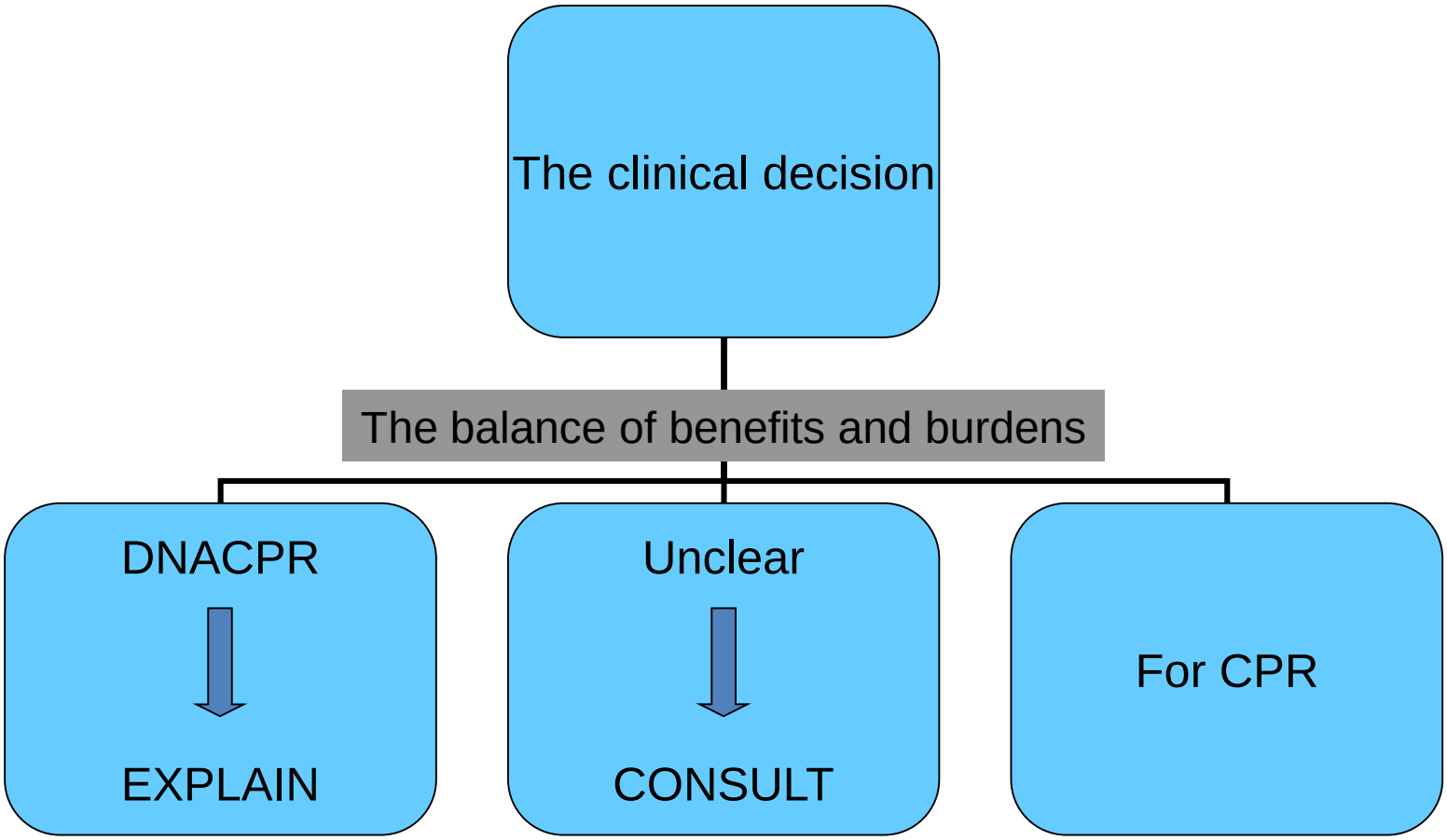
Fig 1: GMC decision making model for a patient who has the capacity to make a decision

Recommended e elca module "treatment and Care towards the end of life: good practice in decision making"



GMC guidance
End of life care
Decision making flowchart
Taken from e elca module “treatment and Care towards the end of life: good practice in decision making”

Making the decision about CPR



Monday 2 May 2016 ... telegraph.co

Leicester hold their nerve
Ranieri heads home to
Rome as title beckons

Total Football, pages 1-5

The Daily T

NEWS BRIEFING

BUSINESS

Green firm's chairman to face MPs over BHS

The chairman of Arcadia – Sir Philip Green's retail group – is to be called in to help MPs get to the bottom of the tycoon's sale of BHS for £1 before its collapse. Lord Grabiner will be asked to appear before the Commons business, innovation and skills committee. MPs also want to question Sir Philip and Dominic Chappell, the head of Retail Acquisitions, as they investigate whether the consortium was a responsible owner.
Business: Page 1

NEWS

BBC 'scaremongering' over popular shows

The BBC has been accused of "scaremongering" after reports that it was about to be banned from showing *Doctor Who* and *Strictly Come Dancing* in prime weekend slots. Whitehall sources dismissed as "nonsense" claims that John Whittingdale, the Culture Secretary, who will publish a White Paper on the BBC's future this month, was to demand the broadcaster stop screening its most popular shows at the same time as hits on ITV.
Page 3

SPORT

Mercedes defiant over

Families in dark as doctors let patients die

'DNR' notices left on up to 40,000 people each year without loved ones being told

By **Laura Donnelly** HEALTH EDITOR

UP to 40,000 patients a year are having do not resuscitate orders secretly imposed without their families being told, it can be disclosed today.

A national audit of dying patients has highlighted a failure by authorities to tell relations about the plans put in place for their loved ones.

It is estimated that every year, more than 200,000 patients are issued with DNR orders, instructing doctors not to

age, patients had been in hospital five days before they were identified as likely to be dying, and half were dead by the next day. "This is being done very late in the day – as doctors we just don't like to face up to it," he said.

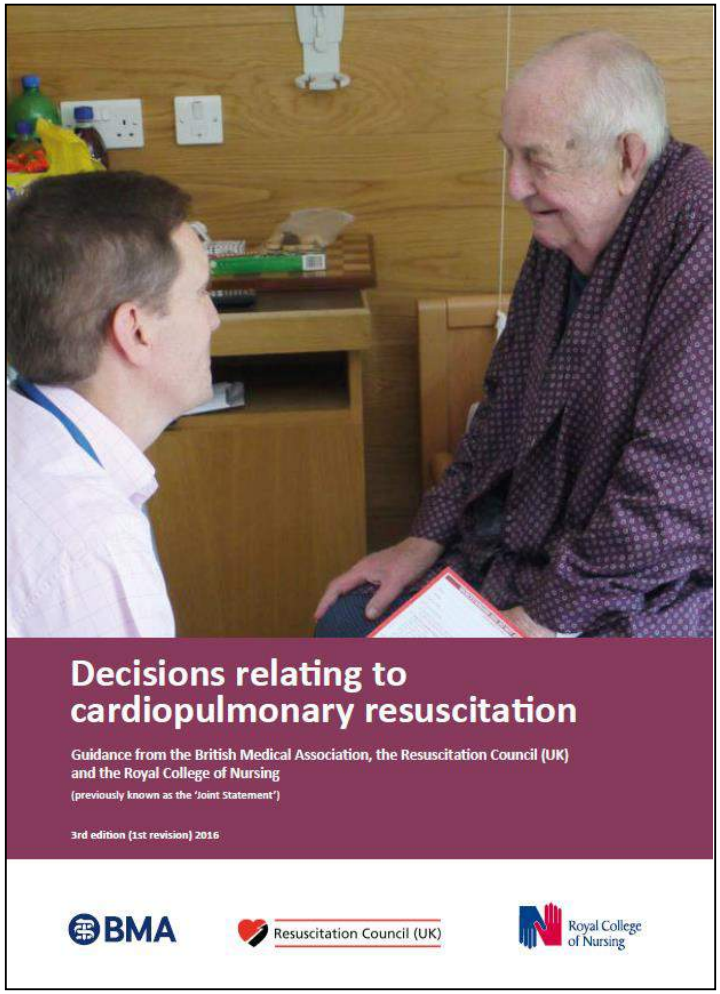
The Royal College of Physicians and Royal College of Nursing also expressed concern that too many staff were letting patients down, by ignoring distress and pain and failing to alert them to life-or-death decisions.

Amanda Cheesley, RCN lead nurse

Report by Royal College of Physicians May 2016

https://www.rcplondon.ac.uk/news/new-rcp-end-life-care-audit-shows-steady-progress-care-dying-people

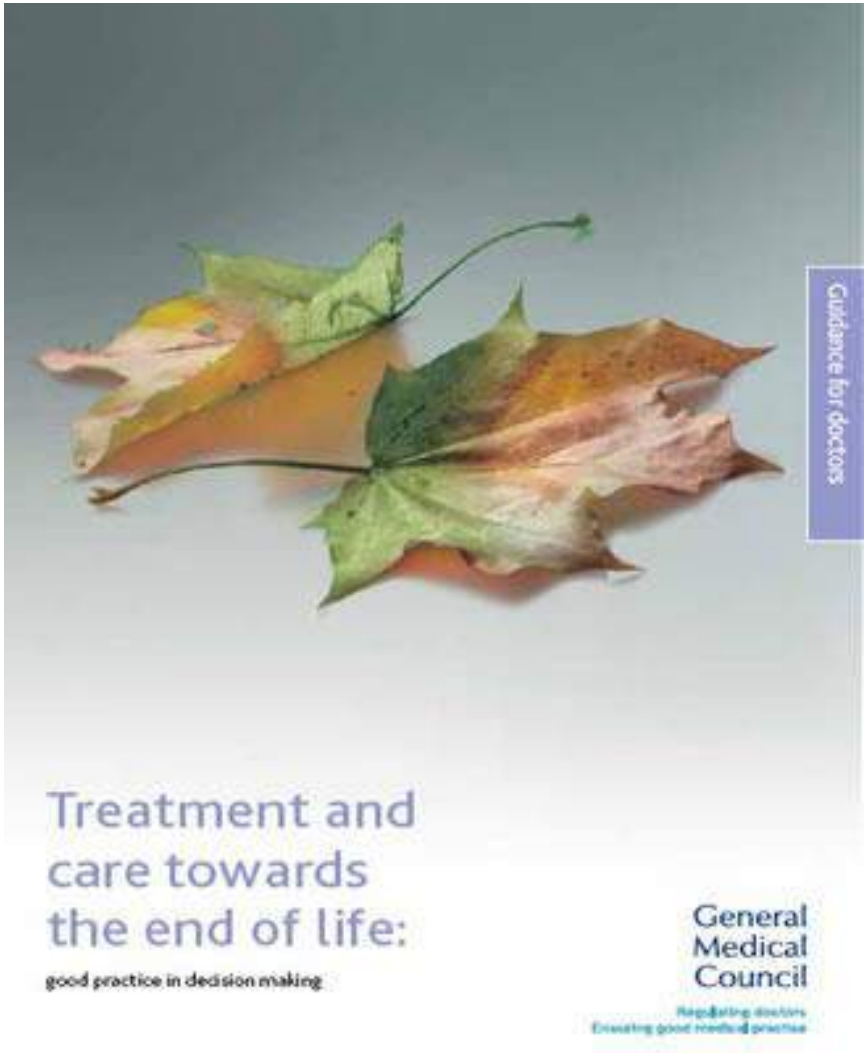
Guidance



Decisions relating to cardiopulmonary resuscitation; Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. June 2016 3rd edn 1st revision

https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Guidance



Treatment and care towards the end of life: good practice in decision making. GMC 2010 http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

What changed in guidance?

- **Presumption in favour of patient involvement** – it is no longer the case that doctors do not have to discuss DNACPR decisions when a clinical decision is made that CPR would be futile
- There must be **particularly convincing justification not to consult the patient** – more than patient distress. To do so would cause physical or psychological harm

Click on picture of Janet to hear her family discussing her high court judgement in a BBC interview

Mrs Janet Tracey

Analysis

Resuscitation policy should focus on the patient, not the decision

BMJ 2017 ; 356 doi: https://doi.org/10.1136/bmj.j813 (Published 28 February 2017)
Cite this as: *BMJ* 2017;356:j813

Click for a link to the article

Article Related content Metrics Responses Peer review

Zoë Fritz, Wellcome fellow in society and ethics and consultant in acute medicine [1 2],
Anne-Marie Slowther, reader in clinical ethics [1], *Gavin D Perkins, professor of critical care medicine* [1 3]

Author affiliations

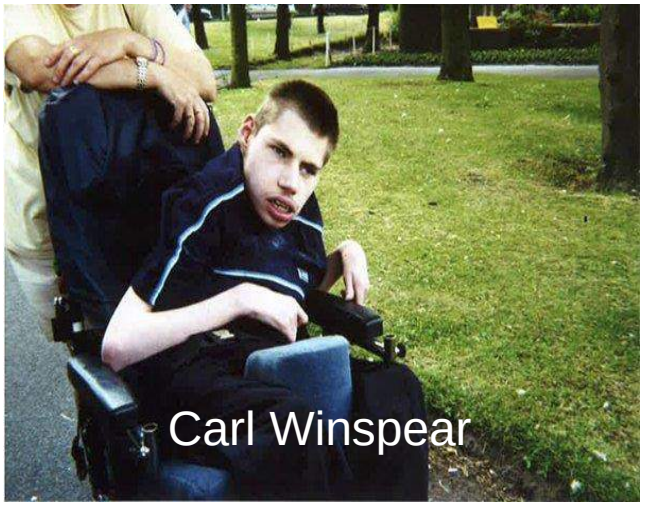
Correspondence to: zoe.fritz@addenbrookes.nhs.uk

Accepted 13 February 2017

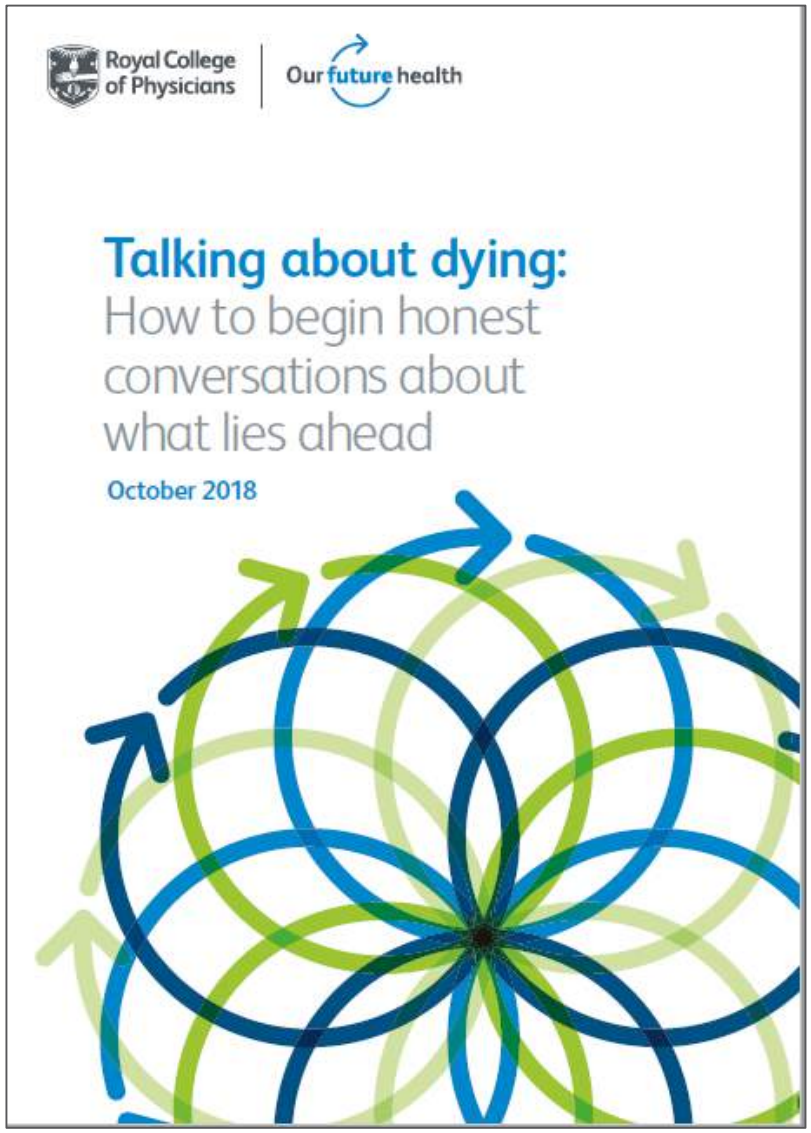
What's new in guidance?

Where both practicable and appropriate, they should not delay contacting those close to the patient in order to do this. Of note, in the recent judgment it was stated by the judge that **"a telephone call at 3.00 am may be less than convenient or desirable than a meeting in working hours, but that is not the same as whether it is practicable".**

"I was Carl's voice and I feel that I was left out of a critical decision in his life, a decision which I should have been consulted on as his mother and his carer."
Mrs Winspear



Talking about decisions and dying



Click on picture to open link to document for you to download

Talk CPR- Doctors Speak about Sharing and Involving and challenges in our approach to DNACPR

14,196 views

9 0 SHARE

portal.e-lfh.org.uk/LearningContent/Launch/405135

Discussing 'Do Not Attempt CPR' Decisions

NHS

Session Overview

Menu | Previous | 1 / 45 | Next

Discussing 'Do Not Attempt CPR' Decisions

e-LfH

Description

This session explores the evidence and perceptions about attempts at cardiopulmonary resuscitation (CPR). It suggests effective ways of facilitating discussions with patients and their families about decisions related to attempting CPR. This session was reviewed by Andrew Thorns and Christina Faull and last updated in July 2015.

Author Jackie Fisher

Module Communication Skills

Learning Objectives

By the end of this session you will be able to:

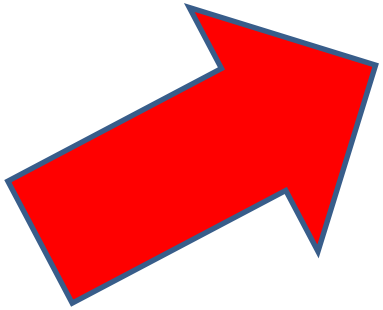
- Identify why discussions on end of life care create a challenge for professionals
- Evaluate the evidence for CPR success in patients approaching the end of life
- Outline the perceptions of patients, the general public and professionals on the success of CPR
- Identify accepted decision making pathways incorporating professional guidance and the legal position
- Apply the necessary skills to effectively and sensitively communicate CPR decisions
- Describe how to respond to challenging questions and scenarios regarding CPR decision making
- Assess your confidence in discussing end of life issues with patients

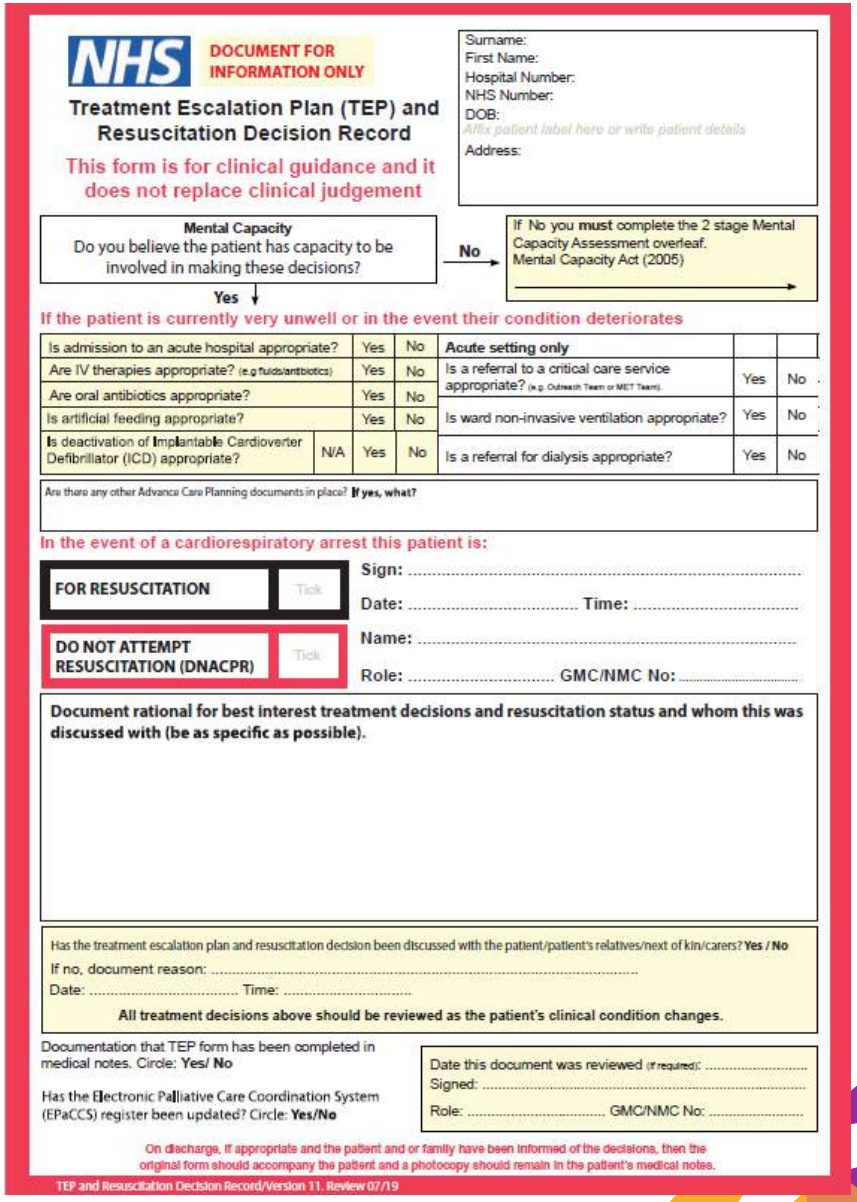
Prerequisites

Before commencing this session you should complete the following:

- Session – Communication Skills / Principles of Communication
- Session – Communication Skills / Skills Which Facilitate Good Communication
- Session – Communication Skills / Things Which Block Good Communication
- Session – Communication Skills / Information Giving
- Session – Communication Skills / Breaking Bad News

For clinical guidance only and does not replace clinical judgement





NHS DOCUMENT FOR INFORMATION ONLY

Treatment Escalation Plan (TEP) and Resuscitation Decision Record

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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 overleaf. 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 a referral to a critical care service appropriate? (e.g. Outreach Team or MET Team).		Yes	No
Are oral antibiotics appropriate?		Yes	No				
Is artificial feeding appropriate?		Yes	No	Is ward non-invasive ventilation appropriate?		Yes	No
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	N/A	Yes	No	Is a referral for dialysis appropriate?		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	Tick
DO NOT ATTEMPT RESUSCITATION (DNACPR)	Tick

Sign: .....
Date: ..... Time: .....
Name: .....
Role: ..... GMC/NMC No: .....

Document rational 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. Circle: **Yes/ No**

Has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Circle: **Yes/No**

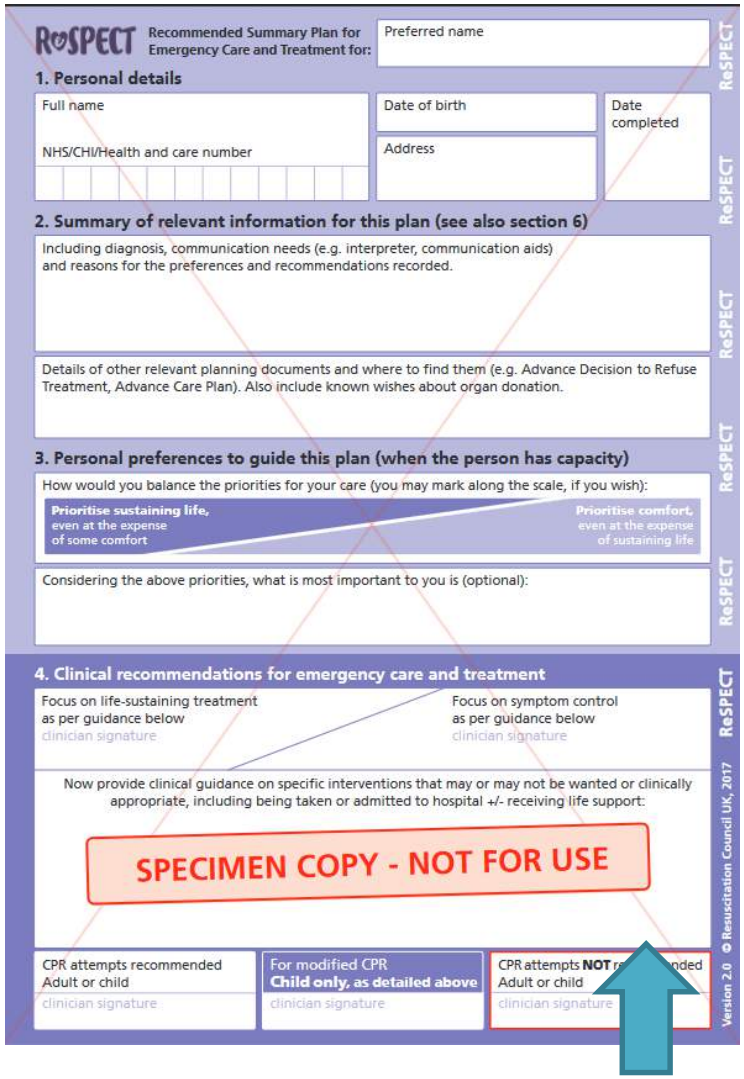
Date this document was reviewed (if required): .....
Signed: .....
Role: ..... GMC/NMC No: .....

On discharge, if appropriate and the patient and 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.

TEP and Resuscitation Decision Record/Version 11. Review 07/19

ReSPECT – a new national initiative (not Devon!)

Recommended Summary Plan for Emergency Care and Treatment



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for: Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort — Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below — clinician signature

Focus on symptom control as per guidance below — clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

SPECIMEN COPY - NOT FOR USE

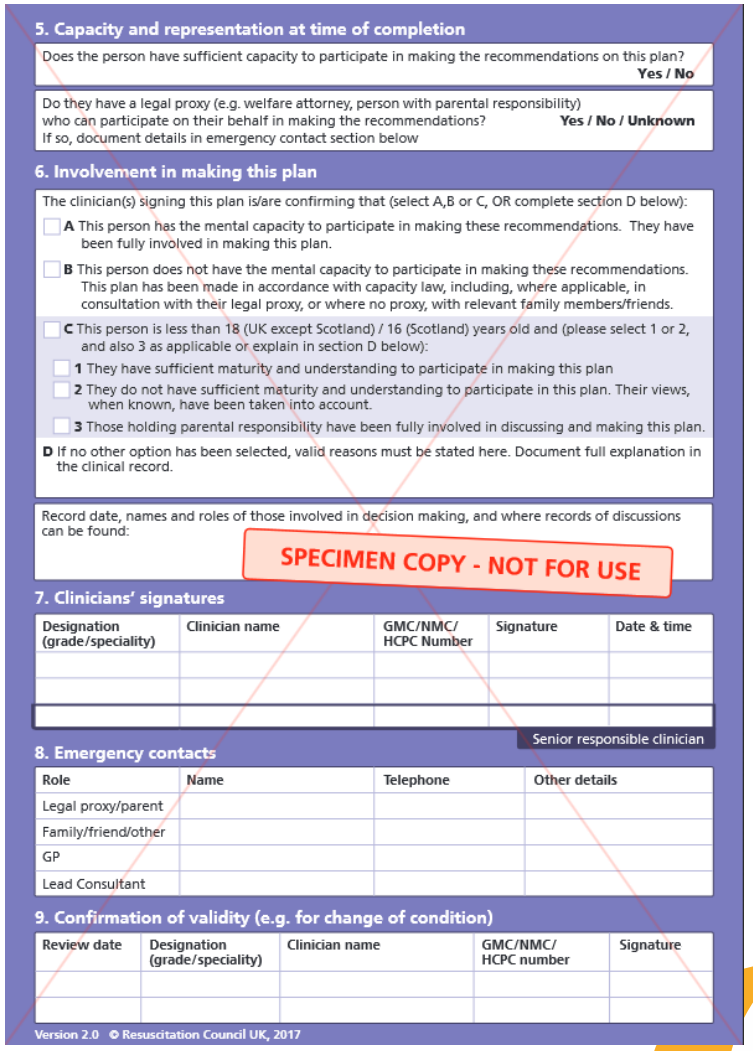
CPR attempts recommended Adult or child — clinician signature

For modified CPR **Child only, as detailed above** — clinician signature

CPR attempts **NOT** r… nded Adult or child — clinician signature

ReSPECT

Version 2.0 © Resuscitation Council UK, 2017



5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

- **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan.
- **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
- **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below):
  - **1** They have sufficient maturity and understanding to participate in making this plan
  - **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
  - **3** Those holding parental responsibility have been fully involved in discussing and making this plan.
- **D** If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record.

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

SPECIMEN COPY - NOT FOR USE

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time

Senior responsible clinician

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend/other			
GP			
Lead Consultant			

9. Confirmation of validity (e.g. for change of condition)

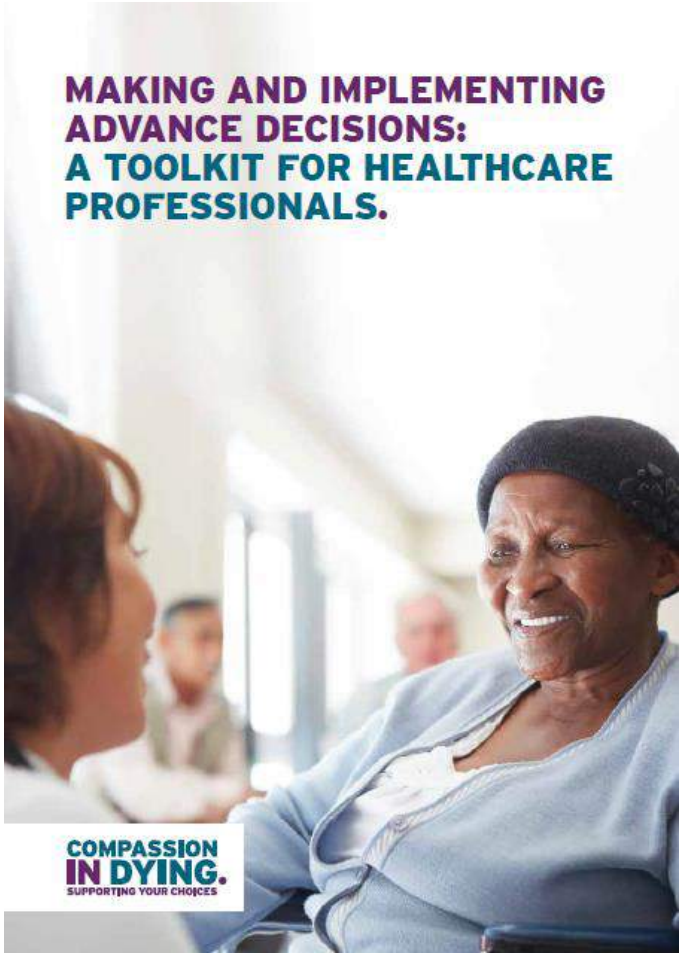
Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

Version 2.0 © Resuscitation Council UK, 2017

Click document for a link to the website

Visit the Hive to watch 2 films discussing TEP

ACP Resources for TEP



http://www.compassionindying.org.uk
0800 999 2434
http://compassionindying.org.uk/library/healthcare-professionals-toolkit/

Summary

- Engage in conversations about clinical decision making with patients (and those that are important to them) is a vital aspect of great end of life care
- Make decisions now about what might happen in the future (‘ceilings of care’) and capture these in advance of crisis or when capacity is affected
- Communicate decisions between health care professionals/teams
- Guidance is there


The following slides
contain additional
resources related to this
workshop

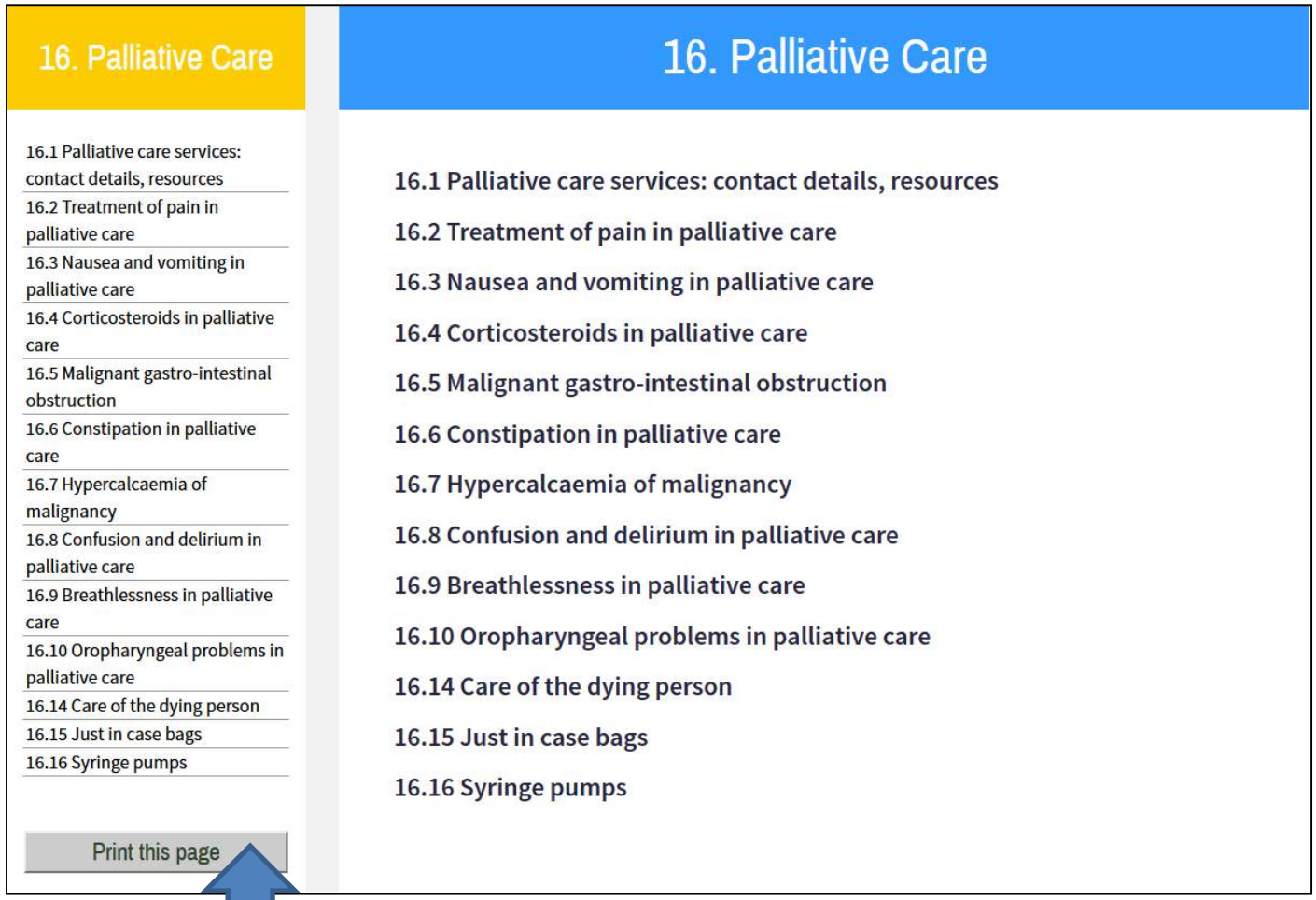
Treatment Escalation Plan (TEP)
Top tips for care homes

- The TEP travels with the patient
- The original TEP must be available and accessible day and night
- Remember some admissions to hospital are appropriate and should be considered. Examples could be a resident falling and sustaining an injury e.g. a suspected fracture, laceration, or a choking episode. If in doubt call for help as the resident will need to be assessed for possible hospital admission and treatment
- Check the name and date of birth is correct
- Mental Capacity question is on both sides of the form, check it is filled in
- If a person has a TEP it must not be assumed they are not for resuscitation
- The TEP must be signed and dated by a Doctor with the GMC (General Medical Council) or registered senior nurse (NMC) also assessed competent in TEP discussions. Number filled in
- If the patient or the family has concerns regarding the contents of the TEP discuss this with the GP and refer to the GP for discussion
- Staff should be aware of, and understand, the treatment decisions outlined in the TEP form
- Staff need to know which family members have been involved with the discussions about the form
- Be aware of resident's specific wishes regarding organ and tissue donation. Then correct procedures can then be followed when the patient dies
- If a patient is being discharged from hospital, ask for the TEP form to be sent with them if appropriate. Contact the nurse in charge if it has not been returned to the home with the resident. There may be a valid reason or it could have been overlooked
- It states on the back of the form - This form will be regarded as 'INDEFINITE' unless it is clearly cancelled

Electronic Palliative Care co-ordination systems (EPaCCS)

Click on this link below to watch a film about EPaCCS
https://www.youtube.com/watch?v=_MaHbhs80jw

South & West Devon Formulary Chapter 16



Click image for a link to the website
Also available in an app for smart phones

Our ambition is for everyone across Torbay and South Devon to view this short film. The purpose of the video is to discover people's comfort in talking about death and dying. Talking about dying may not be easy, but could be one of the most important conversations you will ever have. Click on the picture to watch the 6 minute film


www.rowcroft.org.uk
Contact number: 01803 210800