Treatment Escalation Plans (TEP)
Important Information for Staff

This information sheet provides a summary of important information only. ALL staff who have patient contact as part of their role **MUST** read the Trust's Treatment Escalation Plan & Resuscitation Decision Record policies[1, 2] along with the National guidance (references at the end). The information in this leaflet ONLY pertains to its use within the Royal Cornwall Hospitals NHS Trust.

The primary goal of healthcare is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If a treatment fails or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, that treatment is no longer justified. This principle applies as much to cardiopulmonary resuscitation (CPR) as to any other treatment.

The Trust has introduced Treatment Escalation Plans (TEP) for adults and a separate TEP form and policy for children and neonates (<18 yrs). The TEP is the form used to document relevant treatment escalation or ceilings of care including whether to attempt cardiopulmonary resuscitation or not. There is also an assessment for mental capacity if applicable on the back of the adult form and an organ donation discussion question on the back of the paediatric. TEP forms are slowly being adopted by all Cornwall Healthcare community stakeholders to document relevant treatment escalation or ceilings of care including whether to attempt cardiopulmonary resuscitation or not.

The overwhelming purpose of TEP is to ensure we promote early communication with patients and their families, respect patient wishes, strive for continuity/clarity across the health communities and to avoid unwanted or futile attempts at CPR. Also just as important, that we document those decisions/discussions including a capacity assessment if it was required.

Key points about TEP:-

- Life expectancy question to encourage completion.
- CPR decision documented; FOR and NOT FOR.
- Other treatment decisions considered including whether admission to an acute hospital is appropriate.
- Capacity assessment on the back (adult).
- The form should remain with the patient (wherever possible/applicable). A photocopy will be kept in the hospital patient notes if form originated/completed by clinicians during an in-hospital admission.

RCHT POLICY – STANDARDS & PRACTICE

The following information represents a summary of the Trust's policy which outlines the responsibilities for the individual staff groups.

DOCTORS & NURSES

Which Patient?

- A TEP **must** be completed if the answer to the life expectancy question "Would you be surprised if this patient died within next 6-12 months?" is no.
- A TEP **must** be completed for all patients who are at risk of deterioration/cardiac arrest.

Who decides?

- The responsibility for making treatment decisions including resuscitation rests with the consultant in charge of the patient's care.
- In the absence of a consultant, other doctors with at least 3 or more years registration with the GMC (deputy) may make these decisions in urgent circumstances for adult patients only; CT1 and above. If there are any doubts about the right course of action, a consultant should always be contacted to discuss what to do.
- Decisions relating to children under 18 yrs must be made by a paediatric consultant, associate specialist or SpR.

Patients with Capacity

An adult, over 18 years, with capacity can refuse treatment. A consultant (or suitable deputy – 6.3) is responsible for determining whether a patient lacks capacity to refuse resuscitation which would otherwise be offered.

If there is a realistic chance that CPR would be successful (burden vs benefit) and the patient has capacity then the patient must be involved in deciding whether or not CPR will be attempted. A consultant or deputy should use their clinical judgement about initiating discussions around resuscitation and other treatment decisions.

A patient cannot demand resuscitation which is not clinically indicated. If a DNACPR decision is made on clear clinical grounds that CPR would not be successful (futility) there should be a presumption in favour of informing the patient of the decision and explaining the reason for it.

Details of any discussions with the patient regarding resuscitation must be documented on the TEP form (and if more room needed further reference made in the medical notes).

Discussion with family and carers should be undertaken and their views documented, unless the patient who has capacity has stated that they do not want anyone else informed. Discussions with family are carers are most relevant when a patient is unable to express his/her wishes and they might have information indicating that the patient

would not have wanted attempts at resuscitation (Advance Decision to Refuse Treatment (ADRT)).

If the decision has NOT been discussed with either the adult with capacity, their family or IMCA then the reason for withholding this information **MUST** be documented. Protecting individuals from distress is not sufficient reason for not holding the discussion.

Patients who lack Capacity

If the patient lacks capacity under the Mental Capacity Act (2005), all treatment decisions should be in the patients best interests. If you suspect a patient lacks the capacity to make the decision in question then you are required to complete the mental capacity assessment on the back of the TEP form.

In reaching a best interests decision clinicians must try to seek the views of anyone named by the patient as being someone to be consulted, and anyone engaged in caring for the person or interested in the patient's welfare. In these circumstances it should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient but to help the healthcare team to make an appropriate decision in the patient's best interests. They should be assured that their views on what the patient would want will be taken into account but they cannot insist on treatment or on withholding or withdrawal of a treatment.

If the patient has appointed a valid Lasting Power of Attorney for Personal Welfare, this attorney has the same legal right to refuse an attempt at resuscitation as a competent adult. They do not have the right to compel treatment.

Under the same Act, a patient who lacks capacity and who does not have any family or friends should have an Independent Mental Capacity Advocate (IMCA) appointed to them. Consideration must be given to the involvement of an IMCA especially in cases where an attempt as resuscitation is likely to be successful.

If the patient does not have capacity then this discussion should take place with their family or IMCA. Any discussions with relatives and others close to the patient must reflect the patient's right to confidentiality and must be documented on the TEP form with further reference made if needed in the medical notes.

It is recognised that in urgent situations sometimes a decision NOT to attempt resuscitation will need to be made before the family can be contacted.

Disagreement When there is disagreement or clearly opposing views with the patient and/or family/carer and a deputy is making the decision the consultant should be informed. The consultant should attempt to achieve consensus and consider whether a second opinion from another consultant would benefit the discussion. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

If there is disagreement within the healthcare team regarding the appropriateness of resuscitation, a second opinion must be obtained from a registered medical practitioner of consultant status.

If a disagreement cannot be resolved between clinical team, patient and/or relatives then legal advice should be sought from the Trust Risk Manager Legal Services (via switchboard).

Until disagreement is resolved an attempt at resuscitation will be made.

Patient information leaflet. It is actively encouraged that the patient information leaflet RCHT 802 *Talking to your doctor about treatments (inc. CPR)* is given to the patient and/or relatives/carers to support the communication process. This **MUST** be done if there is a disagreement about the decisions being made.

TEP form completion It is the policy of the Royal Cornwall Hospitals NHS Trust to use a purple TEP form. Once completed, this is filed at the front of the current volume of the patient's medical notes. Reference should be made in the current medical notes. This reference should be written "TEP completed" and "FOR OR NOT FOR CPR". This entry should be signed and dated.

Any subsequent change necessitates a new TEP form being completed (see cancellation of TEP).

Decisions relating to resuscitation of a patient in the Critical Care Unit should be documented in the clinical notes.

When a deputy makes a written order on a TEP in accordance with policy, a consultant must countersign the decision at the earliest opportunity. The expectation is that this will be within 48 hours, but in most cases will be sooner.

Communication. The purple TEP form in the patient's case notes is to be regarded by all staff as the authoritative statement. It is therefore important this record is reviewed and kept up to date and most importantly communicated to other staff.

The clinician making a TEP (or amending or cancelling it) is responsible for ensuring that a trained member of the nursing team on that shift is informed. The name of that nurse should be documented on the TEP form.

Care must be taken when checking the TEP documentation for current resuscitation status.

Review TEP and resuscitation status should be considered as part of regular patient review, BUT the decision will remain unless the order is cancelled.

It remains the consultant's responsibility to ensure that appropriate review of the TEP occurs and that such review(s) are documented in the medical notes. Wherever possible

other members of the nursing and medical team should be involved and informed.

The frequency of reviews should take into account the clinical circumstances.

It would generally be expected that patients and relatives/carers/attorneys (where available) would be informed of any change in outcome. Exceptions apply when a patient has indicated a wish, and it is recorded, not to take part in such discussions or that his relatives and carers should not be involved.

Temporary suspension. It may be appropriate to suspend a decision not to attempt CPR temporarily during some procedures, if the procedure itself could precipitate a cardiopulmonary arrest e.g. cardiac catheterization, surgical operations etc. The clinician should ensure all appropriate staff are aware of the details of the suspension to include the resuscitation status and the duration of the suspension. This should be documented in the medical notes.

Death If the patient dies, the top copy of the purple TEP should be filed in the medical notes (in the legal documentation section).

Cancellation If a TEP is cancelled, the purple form should be crossed through with 2 diagonal lines in black ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the order. The TEP should be filed in the medical notes (in the legal documentation section). An entry in the patient's medical notes must be made stating that "*TEP has been cancelled and patient is FOR ACTIVE CPR*; written in black ink, dated & signed.

Amendment If a TEP and/or resuscitation decision is amended, the TEP form should cancelled as above and a new TEP form completed. An entry in the patient's medical notes must be made stating that the TEP has been amended and the patient is now *FOR OR NOT FOR CPR*, written in black ink, dated and signed.

Discharge and Transfer from RCHT

Discharge home A TEP and RDR may remain in place if the patient is discharged home from hospital. If not going with the patient then it is to be kept filed at the front of the patient's notes.

If appropriate the TEP form may accompany the patient home. It is important if the TEP is to go with the patient that they and preferably their family/carers have been involved in the TEP/RDR process. In this case a photocopy of the TEP should remain in the patient's medical notes. Communication of the TEP and where the form is must be made to any transferring team and the family doctor with responsibility for the continuing care of the patient.

Transfer to another healthcare organisation If the TEP and RDR decisions are still current then the TEP form should accompany the patient. A photocopy of the TEP should remain in the patient's medical notes. Communication of the TEP must be made to any transferring team and those with responsibility for the continuing care of the

patient. It will be up to the receiving organisation to review the TEP and resuscitation status of the patient upon their arrival.

Patients Admitted with a TEP

Patients admitted with a TEP When a patient is admitted to the Royal Cornwall Hospital with a TEP, whether it is a new admission or a re-admission, the decision should be reviewed at the earliest opportunity by the clinical team. If the TEP is to remain in place, a new TEP form must be completed.

Cornwall community-wide TEP form - It is acknowledged that patients cared for by the Trust cross boundaries between primary and secondary care. The purple TEP form has been accepted for use by both the Peninsula Community Health and Cornwall Foundation Trust (although these organisations have their own specific policy relating to implementation within their organisation).

It remains our intention to continue to work with colleagues across the healthcare community to achieve a county-wide approach to advance care planning and resuscitation decisions. To this end wherever possible and appropriate the TEP form will remain with the patient.

Critical Care & Neonatal Unit

Please note treatment decisions including CPR relating to patients in the Critical Care Unit or babies in NNU must be documented in the medical notes; a TEP form will only need to be completed if the patient is transferred out.

NURSES

The nurse who is informed of a TEP and especially a DNACPR decision is then responsible for informing the other members of the nursing team by documenting the TEP & RDR in the 'alert section' of section one of the RCHT Nursing Documentation Framework. When handing over the nurse must ensure the resuscitation decision is clarified if saying "the patient has a TEP." E.g. "the patient has a TEP and is (FOR CPR or) NOT FOR CPR."

If the TEP is cancelled the trained nurse informed of this decision must ensure the previous order on the 'alert section' is crossed out with 2 diagonal lines in black ink and "CANCELLED" written clearly between them. Similarly if the resuscitation status is changed, the nurse must ensure the previous statement on the 'alert section' is crossed out with 2 diagonal lines in black ink and "AMENDED" written clearly between them. The nurse should endorse these changes using the format: date, signature and name in capitals.

It is essential that nurses communicate these decisions with any other members of the allied healthcare team who come into contact with their patient. This should also include staff that are transporting their patient to and from ward areas.

Be aware - Review: TEP should be considered as part of regular patient review, BUT the decisions will remain for the current admission period unless the order is cancelled.

Booking Transport: When requesting transportation only request NOT FOR CPR **IF** the clinical team have decided the TEP is going with the patient e.g. the decision still stands during transportation.

ALLIED HEALTH PROFESSIONALS/HEALTHCARE SUPPORT WORKERS & PORTERING STAFF

Professions allied to medicine e.g. physiotherapists are responsible for keeping themselves updated by checking the medical notes prior to treating the patient at each visit. If CPR status is not known then an attempt at resuscitation will be made.

REFERENCES

1. Treatment Escalation Plan & Resuscitation Decision Record (in relation to adults 18 yrs and over). 2015 http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CriticalCareAndResuscitation/DNARPolicy2009AllDocs.pdf
2. Treatment Escalation Plan & Resuscitation Decision Record (in relation to children and neonates). 2015 http://intra.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Paediatrics/AllowNaturalDeathPolicyForChildrenOnly.pdf
3. British Medical Association. (2016). Decisions relating to cardiopulmonary resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. London: BMA. www.resus.org.uk .
4. The Association of Anaesthetists of Great Britain and Ireland. (2009). Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period. London. www.aagbi.org

Resuscitation Council (UK) – Framework (2016 Joint Statement)

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.

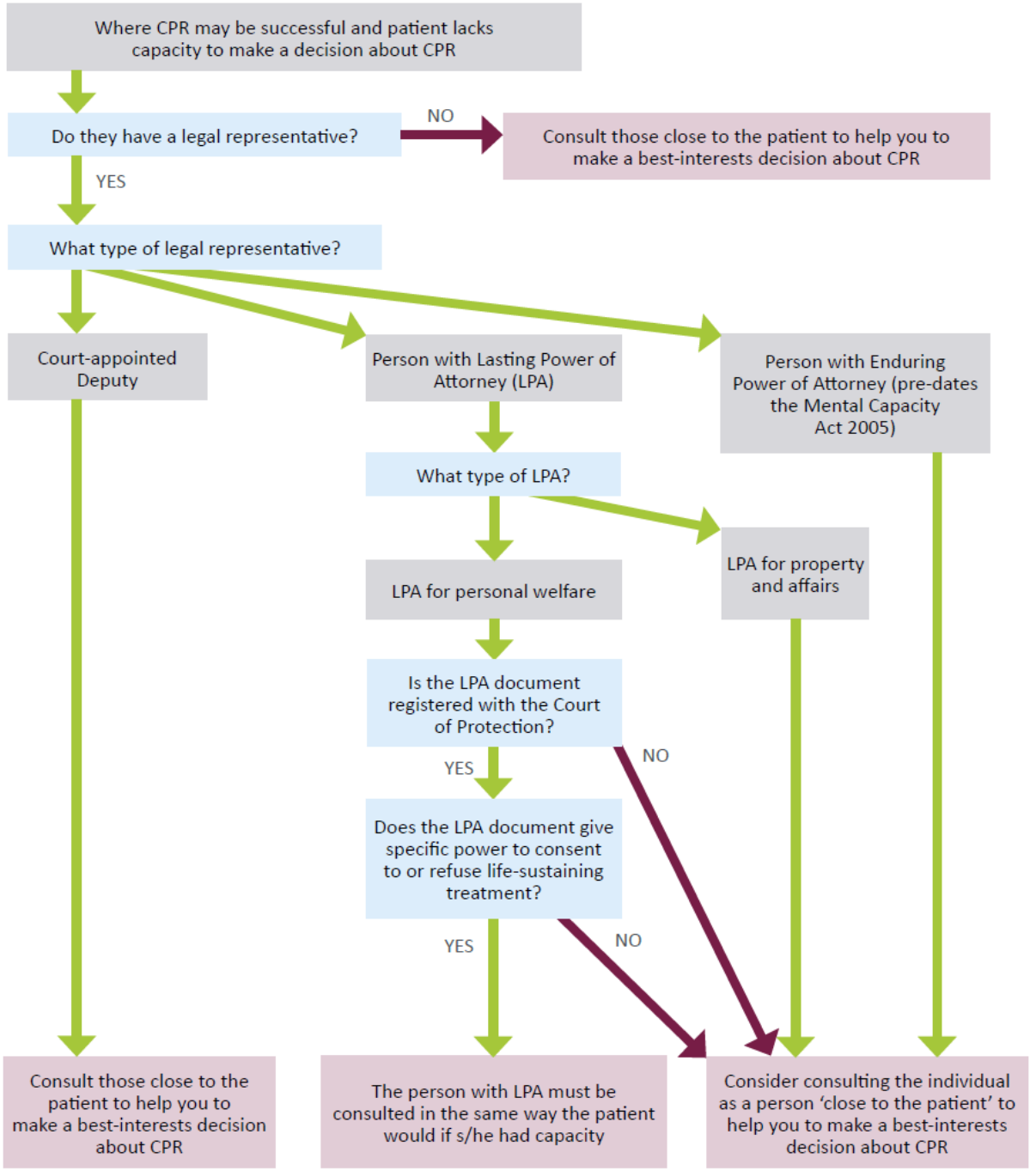
Yes

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.

Decision-making and legal representatives

ENGLAND & WALES



In all situations, where CPR will not work it should not be offered. This decision and the reasons for it should be explained carefully to those representing and those close to the patient. Where there is objection to or disagreement with this decision, a second opinion should be offered. The court may be asked to make a declaration if it is not possible to resolve the disagreement.