File on front of current clinical notes

NHS number: _____

Name: _____

Address: _____

_____ Affix patient label

Date of birth: _____

CR number: _____

Preferred name:

NHS

CORNWALL
Treatment Escalation Plan (TEP) and Resuscitation Decision Record

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

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

Is admission to hospital appropriate?		Yes	No
Are IV/SC fluids appropriate?		Yes	No
Are antibiotics appropriate?		Yes	No
Is artificial feeding appropriate?		Yes	No
Is deactivation of Implantable Cardioverter (ICD) therapies appropriate?	N/A	Yes	No

Acute setting only		
Is non-invasive ventilation appropriate?	Yes	No
Is a referral to critical care appropriate?	Yes	No
Is a referral for dialysis appropriate?	Yes	No

Please put an asterisk against any of the above and provide further information below if required.

Please provide any additional clinical guidance on specific interventions that may or may not be clinically appropriate including further details about being taken or admitted to hospital. This may also include the patient's wishes and/or a statement of their preference for priority of care; sustaining life or ensuring comfort.

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION ☐ **DO NOT ATTEMPT RESUSCITATION (DNACPR)** ☐

All treatment decisions above should be reviewed as the patient's clinical condition changes

Summary of relevant information including **rationale for treatment decisions** including diagnosis and appropriate PMH:

Does the patient have the mental capacity to be involved in making these decisions?

Please tick: Yes ☐ No ☐

If you tick NO it is a statutory requirement that a Mental Capacity Assessment has been completed overleaf.

Please now complete either the HAVE or HAVE NOT box below accordingly

These decisions **HAVE** been discussed with patient/relatives/partner/IMCA (Please state whom and give brief overview):

Date: Time:

These decisions **HAVE NOT** been been discussed with the above for the following reasons:

affix patient label

Mental Capacity Assessment relating to the CPR decision documented in this Treatment Escalation Plan (TEP)

It is confirmed that in carrying out this capacity assessment the starting point was to assume that the person had capacity and the outcome was not based on the person's age, appearance or an aspect of their behaviour alone. ☐

It is believed that the person's impairment might be affecting their ability to make this decision because of the person's behaviour, circumstances or content of communication and/or concerns raised by another regarding the person's capacity. ☐

Stage 1:

It has been established that the person does have a mental impairment or disturbance meaning they satisfy the two-stage test of capacity as defined by the Mental Capacity Act. The Impairment or disturbance is:

Reason: _____

Relevant information - All reasonable attempts were made to provide information relevant to the decision making including the nature, purpose and consequences of the decision. ☐

Support provided - The person was fully supported to ensure wherever possible they could make the decision themselves. ☐

Information was communicated:

Verbally ☐ In writing ☐

In an environment suitable for the person ☐ At a time most suitable for the person ☐

Support was provided by the person giving the information / by another (Please state:)

Stage 2: The person was able to:	**Yes**	**No**		**Yes**	**No**
Understand all the relevant information?	☐	☐	Retain all of the relevant information?	☐	☐
Weigh all of the relevant information?	☐	☐	Communicate all the relevant information?	☐	☐

Consultation - As this decision is life changing and complex and the person has been assessed as lacking the mental capacity to make the decision consultation has been undertaken with family/friends/unpaid carers, or an Independent Mental Capacity Advocate (IMCA). See overleaf.

Best interest decision	**Yes**	**No**
Does the person have a Lasting Power of Attorney for health and welfare or a Court appointed deputy?	☐	☐
Has the person made an Advance Decision to refuse this treatment?	☐	☐
Is it likely that the person will regain capacity in relation to the decision in question?	☐	☐
Can the decision wait until the person regains mental capacity?	☐	☐
Has the person been helped to participate in the decision making process as fully as possible?	☐	☐

Considering the statutory checklist (above) and taking all factors into account (Physical health and wellbeing, emotional health and wellbeing, risk of serious injury, social contacts and finances) the most appropriate decision has been made in the person's best interests.

Healthcare professional / doctor making the decision:

Name (Caps): Signature: Grade:

GMC No: Date: Time: Ward:

Consultant / GP (Signature or Endorsement):

Name: Signature: Date:

Names of members of multidisciplinary team contributing to this decision including name of nurse informed (if applicable):

Review date	Grade	Clinician name	GMC / NMC	Signature

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.