The Treatment Escalation Plan (TEP)

and

Resuscitation Decision Record for Wiltshire

Across all health sectors into the home

Wiltshire TEP Education Group

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Aims

- Advance Care Planning (ACP) is essential for patients wishes to be discussed and recorded. TEP is a document that supports early recognition of patient's wishes and needs to support end of life decisions.
- ACP and TEP conversations should be completed with engagement of patient/family thus empowering patients.
- Clear decisions and rational are discussed and identified to support future treatments and wishes.
- A county wide document that travels with the patient (if appropriate). Reducing inappropriate treatment and supporting patients wishes.
- ACP and TEP forms should be used to record discussions in and between family members so that wishes are known.
- Increased engagement with the family.

Recognition and planning for patients end of life wishes

- "All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan"

  The NHS End of Life Care Strategy (2010)

- We should all ask ourselves "would I be surprised if this patient were to die within the next 6-12 months?" If the answer is no we need to begin the TEP discussion.

  DH (2010) *Second Annual report of the End of Life Care Strategy*

Looking to a broader plan

"Many people are still needlessly sent to hospital to die simply because care home staff do not know what else to do."

- *The Second Annual Report of the End of Life Care Strategy, Department of Health. London, August 2010.*

"Senior clinicians should make treatment decisions close to the patient, intervening early and managing uncertain prognosis."

- *National End of Life Care Programme. Improving end of life care. The route to success in end of life care – achieving quality in acute hospitals. Department of Health. London, 2010*

The NHS Wiltshire TEP

Why is the form itself useful?

- Improvement upon DNAR process as it reassures and enables patients to make decisions about not restarting their heart but having their symptoms controlled.
- An overall plan.
- Adoption of one form across **ALL OF WILTSHIRE'S** health community ensures continuity of care approach.
- A guide for future clinicians that will inform their decision making regarding treatment options for the patient when their condition deteriorates.

TEP – How to do it

- Document the plan discussed in the TEP and on the patients notes.
- Keep a ***copy*** of the original TEP in the clinical notes.
- Let the original TEP stay with the patient
  - On their fridge at home (consider message in a bottle).
  - With their care home manager.
- If the TEP is changed ensure the patient has the new original and an updated copy is kept for the clinical notes.
- Cancel preceding TEPs.
- Log on any relevant electronic database.

This is not really about forms.....
It's about a conversation.

Key points

- Part of the process of Advance Care Planning.
- Conversations about TEPs are not compulsory.
- Timing needs to be right, it can be lead by the patient.
- This is about patient engagement and empowerment as well as appropriate future care that we want to give for the 'best interests' of the patient .
- Remember TEP documents are for clinical guidance and it does not replace clinical judgement.
- Patients and families need to be informed with decisions about them made with them.

Discussions with the patient/family

- Things you might say…..
  - “Have you considered your next stages of treatment”
  - “What are your feelings and wishes”
  - “I don’t think Intensive Care has anything to offer you that will get you better”
  - “Readmitting you to the hospital again may not be the best thing for you. Can we talk about ways of looking after you at home?”

Sending the TEP home with the patient

- This *must* be discussed with patents, encourage the patient to inform family members of the discussions had.
- There may be times when it is burdensome for the patient to have that conversation, if so, consider what is in the best interest for that patient, is there someone else who may be appropriate to have the conversation with.

What if it's not right to send a TEP form home?

- Communicate with the GP/Care Home Manager.
- Let them know what decisions were made about the patient whilst in your care.
- The patients GP can then continue the process of planning at home.

Sending the TEP home with the patient: some words to try.....

- We work closely with Out-of-Hospital doctors, ambulance teams and community nurses and matrons.
- If an emergency happened and a 999 ambulance was called, they would be duty bound to start CPR if you haven't said somewhere that you didn't want it.....they follow protocols and guidelines.
- There is a form which we can put in your house/send home with you that can let ambulance crews know what treatment plan we've decided together.

What other tools do we have available?

- Preferred Priorities of Care document
- Advance Decisions to Refuse Treatment document

Key Messages

- The Treatment Escalation Plan (TEP) and Resuscitation Decision Record is a clinical decision making tool. Common sense and a patients best interest judgement should be applied to who should have one.
- Only need to complete appropriate boxes.
- The TEP should be completed in collaboration with the patient and family where possible and should be reviewed over time.
- The TEP is only good if everyone knows it exists – update the Electronic End of Life Register or any other relevant electronic database. Request an Alert to be placed on the GWH patient file Email: TEP.ResusDecision@gwh.nhs.uk
- The TEP travels with the patient wherever they go.

Other TEP resources

- See http://www.wiltshireccg.nhs.uk/about-us/treatment-escalation-plan-tep
  - Enquiries regarding TEP can be sent to Communications.wiltshireccg@nhs.net