General Guidance Notes for the use of a Treatment Escalation Plan (TEP) with a structured approach to Realistic Conversations in People at Risk of Deterioration

This document is intended to inform clinicians of the purpose of Treatment Escalation Plans, how to complete them and the benefits of realistic conversations with a structured communication skills approach.

Purpose of Treatment Escalation Plans

1. To help minimise harm due to over-treatment or under-treatment
2. To help ensure continuity of care – especially for on-call staff out-of-hours
3. To help ensure that the goals of treatment of the people we are looking after and their families are understood and respected

Treatment Escalation Plan completion

- In all but exceptional circumstances (i.e. when it is not possible to discuss treatment but clear that a particular intervention would be futile, burdensome or contrary to patient's known wishes), treatment plans are jointly agreed with patients and/or family and/or legally appointed representatives and documented in the record. The TEP form clearly captures and records this information.
- The TEP is normally guided by and the responsibility of the consultant responsible for the person's care but, where appropriate, can be initiated by senior or trainee medical staff, Charge Nurses or Advanced Nurse practitioners.
- It is important to establish whether patients have mental capacity. Patients who are physiologically unstable and undergoing active stabilising treatment may not be in a position to fully consider the implications of such discussions
- Please refer to Palliative Care Register, or Key Information Summary (KIS) as there may be an existing Anticipatory Care Plan (ACP). Existing ACP's should be respected and honoured, though their provisions may need to be updated.
- A standard DNACPR form should still be completed. At this time, we must also consider the risk to staff in relation to droplet / aerosol formation and COVID transmission. The TEP form is not a replacement for the DNACPR even although reference to CPR is included in the document.

- The intervention options list is not a "menu" but a prompt. ITU referral must be preceded by a consultation with a senior clinician. Careful consideration should be given to other interventions or procedures that may be either appropriate or inappropriate.
- The relevant consultant / senior clinician must review and sign the plan within 24 hours of its completion. He / she carries ultimate responsibility for its provisions.
- The plan should be reviewed regularly during an admission. It can be amended but if multiple amendments are being made - replace the existing one with an updated fresh one.
- Where full explanations of discussions or decisions are documented in the record, the TEP should be annotated in the comments section to cross reference with that date in the record.

Health Records Guidance

- The TEP only applies to the current admission. At the time of any subsequent admission a new TEP should be completed. Any old Plan should have OBSOLETE written across it in block capitals with date and initials.
- Although it is recognised that there are minor variations in practice between wards, the TEP should be placed prominently within the patient's hard copy hospital records, generally at the front of the at the front of the clinical notes, along with any DNACPR document if completed.
- On discharge the TEP must be scanned with the in-patient record (in the same way as a documented medical note of a discussion). This is to underline the point that the TEP only applies to that admission and while it may inform an ACP it is not an ACP

Ethics and medico-legal issues

- The TEP is not a binding advanced directive.
- The TEP does not provide for the withdrawal of any treatment.
- The medico-legal requirements for TEP are identical to those that apply to DNACPR

Realistic Conversations: a structured approach to talking with people in hospital and families about planning care, death and dying (RED-MAP and DECIDE)

These conversations can be difficult to initiate but are important and necessary. Communication at this time should focus on ascertaining concerns and information needs. Active listening and empathy are key. There are a number of suggested approaches, all broadly similar and intended to ensure that people are prepared for the conversation, that current understanding of the situation is fully appreciated and options for most appropriate treatment are explored. It is most important that the conversation is focused around what can and will be done. CPR, when it is discussed, is therefore placed in a context of joint overall understanding of the situation and should come towards the end of the discussion when its appropriateness as an intervention should be much clearer.

RED-MAP (from Building on Best and EC4H) has 6-steps:

Ready	Can we talk about your health and care? What's changed?
Expect	What do you **know** / want to ask / **expect**?
Diagnosis	We **know**… / we don't know… **Questions** or **worries**?
Matters	What is **important** to you now and in future?
Actions	What can help … **Options** we have are …
	This does not work … / will not help you because …
Plan	Let's plan ahead for when / if …

A detailed poster giving more examples of this approach is included in the Appendix to this document.

Another approach is DECIDE (from the NES Realistic Conversations Shared Decision Making modue – see below)

Define	the decision we should be considering
Explain	the situation
Consider	all the available options
Invite	views, values, beliefs, what's important
Decide	together, weighing up person's priorities and preferences
Evaluate	the decision: review, check understanding, offer follow-up discussion

Whichever approach you favour, these mnemonics offer a useful aide-memoire to help plan and guide the conversation

What is not helpful …

Avoid language that can make people feel abandoned or deprived of treatment and care. Phrases like "There is nothing more we can do" or "we are withdrawing treatment" are neither helpful or true. There is always something that can be done - see Palliative care Guidance at End of Life guidelines https://www.palliativecareggc.org.uk/wp-content/uploads/2015/08/Guidance-At-End-of-Life-Care-for-Health-Care-Professionals.pdf

Frequently Asked Questions and Comments

1. *I thought that the TEP was meant to be used only for patients who are terminally ill.*

   No, the scope for using the TEP is wider. Any patient who has the potential to deteriorate and need out-of-hours treatment should have a TEP. The TEP is not an end of life care plan.

2. *Should the TEP be used for everyone?*

   Not necessarily. However, where there is a risk of deterioration, completion of a TEP is strongly advised.

   In some places, the TEP is used for all patients – most commonly in units looking after elderly people. You and your team should discuss whether "TEP for all" may have significant benefits in your area.

3. *What if I don't have time to have a conversation with every patient (or their family) that is unstable or at the end of life?*

   If you are pressed for time then be selective. Identify patients for whom the **absence of a TEP puts them at risk of harm**. Time spent on such conversations is an investment – apart from being best practice, it can prevent a bad death or the consequences of a poor relationship with a family that results in a stressful complaint.

4. *If the patient lacks capacity and a family member is not present, what should I do?*

   Having a discussion with a family member / the person holding Welfare Power of Attorney is strongly recommended. But if the patient is clearly unstable and further escalation of treatment is felt likely to cause distress or suffering and not in the patient's best interests, then the TEP should be completed with documentation of the reasons for going ahead in the patient's notes. Lack of capacity is **not** a contra-indication to making an TEP.

5. *Is filling in an TEP to say "for full escalation" not a bit superfluous? After all, for full escalation is the default position anyway.*

   It can be very helpful to on-call staff to know for sure that a patient is indeed for full escalation. If they arrive at a bedside in response to an increasing NEWS score, then knowing that full treatment escalation is already agreed provides a secure basis for emergency decision making. The greatest fans of the TEPs are junior clinicians and Hospital at Night team members.

6. *What about DNACPR?*

   It is still often the case that DNACPR orders are completed without a TEP. Why? In fact cardio-respiratory arrest is uncommon. DNACPR in isolation is often insufficient. Knowing in advance whether or not it would be appropriate to undertake major interventions other than CPR e.g. transfer to HDU / ICU, is much more relevant. So the TEP is more practical – and it covers DNACPR anyway.

   Some concerns with DNACPR in isolation are:
   - It's much more appropriate to focus on treatments and interventions that may help and which will be provided.
   - Having a conversation about one intervention, i.e. CPR, can be uncomfortable for patients / families if this is unexpected and can cause perplexity and distress.
   - It can lead to a perception in the minds of some that DNACPR is code for "do not treat".

7. *Why are there different versions of the TEP?*

   Following discussions with teams representing as many relevant areas as possible across the board area, we have now agreed to promote the generic TEP for all situations including COVID-19. The Beatson use the same TEP with minor wording changes reflecting their local arrangements.

8. *It's a nice idea and I agree with the concept, and but does the TEP work?*

   Yes. The evidence to support the use of the TEP concerns medical harms. In a Cambridge study, using the local version of the TEP achieved a reduction in treatment-related harms of nearly 40%. There is just as much ethical responsibility to avoid harm as there is to achieve good, especially in situations where the potential for harm outweighs the potential for good.

9. *Won't making an TEP damage the doctor / patient relationship?*

   This is an understandable concern, however there is no evidence to support this. On the contrary, many patients welcome the opportunity to discuss their prognosis but only a small minority take the initiative. The TEP conversation is the key to facilitating this. Patient's hopes for their future and their priorities can be established at this point too.

10. How can I find out more about TEP and related training?

Excellent resources (including RED-MAP) posters can be found on the Effective Communication for Healthcare (EC4H) website :https://www.ec4h.org.uk/covid-19-effective-communication-for-professionals/

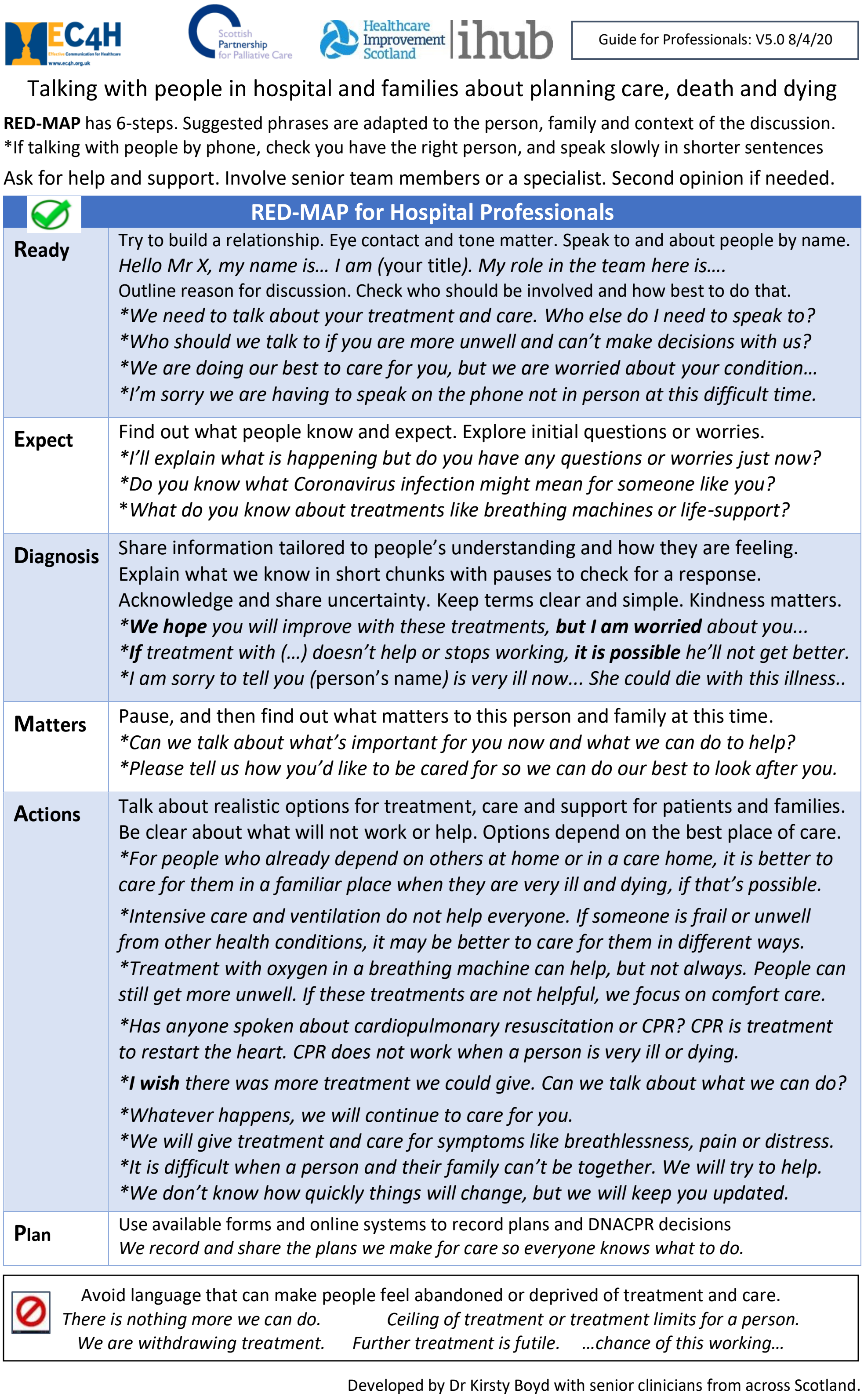
The Difficult Conversations infographic and short explanatory video from NHSGGC's Dr Lara Mitchell are excellent https://www.ec4h.org.uk/wp-content/uploads/2020/03/Difficult-Conversations-poster.pdf

https://vimeo.com/404554818

This NES TURAS module explores Shared Decision Making and the DECIDE model:https://learn.nes.nhs.scot/24729/realistic-medicine/realistic-conversations-shared-decision-making-in-practice

Scottish Palliative Care Guidelines are here and contain a range of resources: https://www.palliativecareguidelines.scot.nhs.uk/

Appendix: REDMAP poster



Guide for Professionals: V5.0 8/4/20

Talking with people in hospital and families about planning care, death and dying

RED-MAP has 6-steps. Suggested phrases are adapted to the person, family and context of the discussion.
*If talking with people by phone, check you have the right person, and speak slowly in shorter sentences

Ask for help and support. Involve senior team members or a specialist. Second opinion if needed.

✓	**RED-MAP for Hospital Professionals**
Ready	Try to build a relationship. Eye contact and tone matter. Speak to and about people by name. *Hello Mr X, my name is… I am (your title). My role in the team here is….* Outline reason for discussion. Check who should be involved and how best to do that. **We need to talk about your treatment and care. Who else do I need to speak to?* **Who should we talk to if you are more unwell and can't make decisions with us?* **We are doing our best to care for you, but we are worried about your condition…* **I'm sorry we are having to speak on the phone not in person at this difficult time.*
Expect	Find out what people know and expect. Explore initial questions or worries. **I'll explain what is happening but do you have any questions or worries just now?* **Do you know what Coronavirus infection might mean for someone like you?* **What do you know about treatments like breathing machines or life-support?*
Diagnosis	Share information tailored to people's understanding and how they are feeling. Explain what we know in short chunks with pauses to check for a response. Acknowledge and share uncertainty. Keep terms clear and simple. Kindness matters. *****We hope*** *you will improve with these treatments,* ***but I am worried*** *about you...* *****If*** *treatment with (…) doesn't help or stops working,* ***it is possible*** *he'll not get better.* **I am sorry to tell you* (person's name) *is very ill now... She could die with this illness..*
Matters	Pause, and then find out what matters to this person and family at this time. **Can we talk about what's important for you now and what we can do to help?* **Please tell us how you'd like to be cared for so we can do our best to look after you.*
Actions	Talk about realistic options for treatment, care and support for patients and families. Be clear about what will not work or help. Options depend on the best place of care. **For people who already depend on others at home or in a care home, it is better to care for them in a familiar place when they are very ill and dying, if that's possible.* **Intensive care and ventilation do not help everyone. If someone is frail or unwell from other health conditions, it may be better to care for them in different ways.* **Treatment with oxygen in a breathing machine can help, but not always. People can still get more unwell. If these treatments are not helpful, we focus on comfort care.* **Has anyone spoken about cardiopulmonary resuscitation or CPR? CPR is treatment to restart the heart. CPR does not work when a person is very ill or dying.* *****I wish*** *there was more treatment we could give. Can we talk about what we can do?* **Whatever happens, we will continue to care for you.* **We will give treatment and care for symptoms like breathlessness, pain or distress.* **It is difficult when a person and their family can't be together. We will try to help.* **We don't know how quickly things will change, but we will keep you updated.*
Plan	Use available forms and online systems to record plans and DNACPR decisions *We record and share the plans we make for care so everyone knows what to do.*

🚫 Avoid language that can make people feel abandoned or deprived of treatment and care.
There is nothing more we can do. *Ceiling of treatment or treatment limits for a person.*
We are withdrawing treatment. *Further treatment is futile.* *…chance of this working…*

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