TEP Completion Guidance Notes

1. The **AIM** of any TEP is to optimise treatment so that in the event of deterioration, it is APPROPRIATE. The **GOALS of TREATMENT** should ensure that a patient's VALUES AND PREFERENCES are respected, and that medical harms are avoided. APPROPRIATE TREATMENT may mean introducing palliative treatments immediately on admission.

2. The Plan should be **INITIALLED BY THE LEAD CLINICIAN** within 24 hours. It should be **REVIEWED REGULARLY** during an admission. Do not make multiple entries on to a Plan - replace the existing one with an updated fresh one. Any old Plan should have "OBSOLETE" written across it with date and initials. REFER TO PLAN IN DISCHARGE LETTER.

3. **DNACPR** Discussing DNACPR in isolation or prior to discussing other treatment choices is fraught with hazard. A TEP must ALWAYS be used when a DNACPR order is put in place. A separate form is required for DNACPR. NB If Clinical Frailty Score is 6 or more, then CPR will not result in survival to hospital discharge.

4. **ESCALATION TO ICU**. If ICU is to be considered, then consultation with the ICU consultant is essential.
Ideally whether or not the patient will be referred to ICU should be decided at the time of admission or during a ward round, and not when a patient "crashes" or the EWS increases. If in doubt, request an early ICU consultation.

5. **AGE***.* Age alone is not a determining factor regarding treatment escalation / limitation. 6. **PRE-ADMISSION HEALTH STATUS***.* The yellow box on page 1 gives you a check list to be considered. The **CONTEXT** is critical for setting the **GOALS OF TREATMENT** and the **TEP PREFERENCES**. ***Frailty*****.** The Clinical Frailty Scale *may* be useful. Consider: If it is 5 or more, then escalation beyond "ward care" or "ward care with palliative treatments" needs to be weighed carefully. For patients of any age with stable long-term disabilities (e.g. autism, cerebral palsy) do not use the Clinical Frailty Scale ©.