# Annex 5a Example of a treatment escalation plan

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| Patient’s full name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of birth | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| NHS number  \*Or place sticker | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Example of a treatment escalation plan \*For adults aged 16 and over

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| **Documentation of discussion around treatment escalation plan (TEP) (please state who discussed with):** The patient should be involved and supported when making these decisions. If the patient lacks capacity his/her Lasting Power of Attorney (LPA) for Health and Welfare / Independent Mental Capacity Advocate (IMCA) / family members should be involved, to help determine what is in the patient’s best interests, ie what the patient would most likely choose for themselves if they had capacity. |

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| **\*Please date, time and sign.** |

## Treatment escalation plan – inpatient settings \*For adults aged 16 and over

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| Patient’s full name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date and time of TEP | \_\_\_\_\_\_\_\_\_ |
| Date of birth | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Does the patient have capacity to make decisions re TEP? Y □ N □ | |
| NHS number  \*Or place sticker | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Documentation of discussion with patient/family overleaf: Y □ **PTO** | |

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| Is this patient for FULL ESCALATION (resuscitation and for **consideration** of intensive care? YES □ NO □  **For patients with limited ceilings of treatment (ie if not for full escalation):**  **Is this patient for resuscitation?** YES □ SHORT resus (form completed) □ NO (DNACPR form completed) □  NB: If DNACPR form is completed, it should be signed by a consultant within 24hrs  **Is this patient for** **consideration of intensive care?** YES □ NO □ NB: If yes, Intensive care team will review patient and decide on interventions offered.  **Is this patient for consideration of HDU admission?** YES □ NO □ NB: If yes, HDU Team will review patient and decide on interventions offered.  **Is this patient for medical emergency team (MET) calls?** YES □ NO □ If not for MET Calls please indicate who staff should escalate care to (eg ward-based responsible team)  Team to contact if patient not for MET calls: ………………………………………………………………………………………………………………..  Other emergency calls the patient may be for (eg major haemorrhage call): ……………………………………………………………  **Is this patient for ward-based care only?** YES □ NO □  **Is this patient for antibiotics in case of life-threatening infection?** YES □ High threshold □ NO □ NB: If high threshold, antibiotics should be discussed with RHRU consultant, ideally with known organism sensitivities.  **Is this patient for consideration of further neurosurgery?** YES □ NO □  NB: If yes, neurosurgical advice would be sought to decide on interventions offered.  The patient’s usual neurosurgical team is (hospital and consultant): ..………………………..………………………………………………….  **Is this patient for consideration of other major surgery?** YES □ NO □ NB: If yes, advice from the on-call surgical team would be sought to decide on interventions offered.  **Is this patient for consideration of tracheostomy reinsertion?** N/A (no tracheostomy) □ YES □ NO □  NB: If yes, ENT advice would be beneficial to decide on interventions offered.  **Is this patient for symptom control only (ie for palliation)?** YES □ NO □  **Is this patient dying (ie for last days of life care)?**  YES □ NO□ NB: If yes, commence ‘Last Days of Life Care’ booklet and consider referral to palliative care team. |

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| **Form completed by (ST3 or above):**  Name: Signature: Grade: Time and date: |

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| **Responsible consultant’s review, within 24hrs (if not completed by consultant)**  Name: Signature: Time and date: |

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| **IF TEP NO LONGER VALID: Please cross through whole page, file in notes and complete new TEP**  Name: Signature: Time and date: **\*PTO\*** |

## Treatment escalation plan – community settings \*For adults aged 16 and over

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| Patient’s full name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date and time of TEP | \_\_\_\_\_\_\_\_\_ |
| Date of birth | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Does the patient have capacity to make decisions re TEP? Y □ N □ | |
| NHS number  \*Or place sticker | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Documentation of discussion with patient/family overleaf: Y □ **PTO** | |

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| Is this patient for FULL ESCALATION (resuscitation and for considerationof 999 call / hospital transfer)? YES □ NO □  **For patients with limited ceilings of treatment (ie if not for full escalation):**  **Is this patient for resuscitation?** YES □ NO (DNACPR form completed) □  **Is this patient for** **consideration of 999 ambulance call** YES □ NO □  **Is this patient for consideration of Blue light transfer to hospital?** YES □ NO □  **Is this patient for home-based care only?** YES □ NO □  **Is this patient for IV antibiotics in case of life-threatening infection?** YES □ High threshold □ NO □  **Is this patient for PEG / oral antibiotics in case of life-threatening infection?** YES □ High threshold □ NO □  **Is this patient for consideration of further neurosurgery?** YES □ NO □  NB: If yes, neurosurgical advice would be sought to decide on interventions offered.  The patient’s usual neurosurgical team is (hospital and consultant): ..………………………..……………  **Is this patient for consideration of other major surgery?** YES □ NO □  **Is this patient for consideration of tracheostomy reinsertion?**  N/A (no tracheostomy) □ YES □ NO □  NB: If yes, ENT advice would be beneficial to decide on interventions offered.  **Is this patient for symptom control only (ie for palliation)?** YES □ NO □  **Is this patient dying (ie for last days of life care)?** YES □ NO □  NB: If yes, commence ‘Last Days of Life Care’ booklet and consider referral to palliative care team. |

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| **Form completed by hospital staff on transfer to community**  Name: Signature: Grade: Time and date: |

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| **Form completed by GP / nursing home staff after transfer to community**  Name: Signature: Time and date: |

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| **IF TEP NO LONGER VALID: Please cross through whole page, file in notes, and complete new TEP**  Name: Signature:  Time and date: **\*PTO\*** |