

This Treatment Escalation Plan (TEP) includes recommendations for treatment, based on my wishes and preferences in the event my health suddenly gets worse (acute deterioration).



Full Name: _____ NHS no: _____
Date of Birth: _____
Where was this form completed? _____

My emergency contacts

Name	_____	Relationship	_____	Tel.	_____
Name	_____	Relationship	_____	Tel.	_____

Have you given anyone Lasting Power of Attorney (LPA) for your Health & Welfare?

Yes, and their details are below. **No**, I have not given anyone this

The attorney is the person, or people named on your **LPA for Health and Welfare document**, who can help make decisions for you if you can't. (Leave this blank if you ticked 'No').

Attorney name(s) _____ Tel. _____

For children and young people, who has parental/guardianship responsibility?

I was able to participate in making the decisions around this plan

Yes No If **no**, please detail reason **and** details of family/legal/welfare proxy below

Names, roles and relationships of individuals involved in these discussions:

What matters to me in decisions about my care? (Please select ONE box)

Living as long as possible matters most to me I would like to live longer, but comfort is important to me Being comfortable matters most to me

Where would I want my care to be delivered? (Please select ONE box)

I would like to go to hospital for treatment Please talk to me or my carers about whether I should go to hospital I do not want to go to hospital unless symptoms cannot be managed where I am now Transfer me to my preferred place of care / death

My preferred place of care is _____ My preferred place of death is _____

TREATMENT ESCALATION PLAN

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Name of Individual: NHS Number: **The following sections are for HEALTHCARE PROFESSIONAL USE ONLY**

The sections include **clinical recommendations for emergency care and treatment**. Whilst these sections **must consider** preferences and values of the individual, they may also detail **medical decisions** relating to which treatments **are not available** to this individual (and so must be completed by a healthcare professional with sufficient knowledge and experience of this individual). Decisions should be discussed appropriately.

Ceilings of care (healthcare professional please select ONE)Rockwood Frailty Score: Symptom control **only** (any setting) Active home/ community treatment Ward-based ceiling of care

*Any decisions about HDU/ICU escalation will be discussed at the time with critical care, taking into account this TEP.

 Assess for High-Dependency* Assess for Intensive Care*

(e.g. NIV/vasopressors) (e.g. intubation)

Would the following treatments be appropriate to consider?

Treatment	Yes	No	Comment
Oral antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Intravenous antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Intravenous fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Artificial nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Non-invasive ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Renal replacement therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other treatment options	<input type="text"/>		

Details of other relevant care planning documents and where to find them

Select the documents believed to be already in place:

 Do not attempt cardiopulmonary resuscitation (DNACPR) Advance Decision to Refuse Treatment (ADRT) Advance Statement (AS) Emergency Healthcare Plan (EHCP)Where to find these:

Discuss / share the information from this TEP with all key services in and out of hours (e.g. Ambulance Service, OOH GP, etc.)

This form is valid when signed. (The authorised healthcare professional is defined by local policy). Digital signatures are permitted.

This is an advisory form which does not expire but should be reviewed at available opportunities, whenever this person's condition or situation changes, or at this person's/clinician's request.

HEALTHCARE PROFESSIONALProfessional Signature Date Name (print) Role Registration N^o