**Treatment Escalation Plan (TEP)**

Name: ……………………………

NHS No: …………………………………

DOB: …………………………………………

**This form is for clinical guidance it does not replace clinical judgement**

A TEP describes the interventions that would be considered in the event of a clinical deterioration.

Review TEP whenever clinically appropriate.

Complete TEP form and document patient to be added to the Gold Standard Framework (GSF). If the patient is thought to be in the last days/hours of life, start Last Day of Life Care Plan.

If No

**LIFE EXPECTANCY**

Would you be surprised if this patient died within the next 12 months?

Complete the Stage2 Mental Capacity Assessment on SystmOne.

**MENTAL CAPACITY**

Do you have any reason to doubt the capacity of the individual to be involved in making these decisions?

If Yes

|  |  |  |
| --- | --- | --- |
| **SECTION 1 – All Patients (please tick)** | **Yes** | **No** |
| Is the patient for Cardiopulmonary resuscitation (CPR)?  If YES – For full escalation of care  If NO – Complete HERTS DNACPR form and complete all sections of TEP below |  |  |
| In the event of a sudden deterioration should the patient be transferred to an acute hospital?**CTI2pleaseck)** |  |  |
| Would invasive ventilation be appropriate? |  |  |
| Would intravenous fluids be appropriate? |  |  |
| Would artificial nutrition support be appropriate? |  |  |
| Would intravenous antibiotics be appropriate? |  |  |
| Would oral antibiotics be appropriate? |  |  |
| Would blood products be appropriate? |  |  |
| Would oxygen therapy be appropriate? |  |  |
| Would subcutaneous fluids be appropriate? |  |  |
| Would the patient accept urinary catheterisation? |  |  |
| Does the patient have an advanced decision to refuse treatment?  If so, where is it kept: |  |  |
| Does the patient have a lasting power of attorney for health?  Name: Relationship:  Contact number:  Have you seen a copy of the LPA? |  |  |
| Is there anything else to consider? |  |  |
| Summary of discussion with **patient and those that are important to the patient**: (if not discussed, document reason) or summary of discussion with NOK/relative/carers if patient lacks capacity.  Has a discussion with other members of the multi-disciplinary team occurred and documented on system one?  **ENSURE DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) form is completed and with patient** | | |

**Has an Advance Care Plan been discussed with patient / NOK?**

**YES**

**NO**

|  |  |  |
| --- | --- | --- |
| **Clinician completing TEP** | | |
| **Name**: | **Role**: | **Date**: |
| **Signature**: | | **Time**: |

|  |  |  |
| --- | --- | --- |
| **Review and endorsement by responsible Senior Clinician** | | |
| **Name**: | **Role**: | **Date**: |
| **Signature**: | | **Time**: |