TREATMENT ESCALATION PLAN (TEP)

St George's University Hospitals NHS
NHS Foundation Trust

Name _____
Address _____
Date of Birth _____
NHS or hospital number _____
Affix patient label here or write patient details

DO NOT PHOTOCOPY OR REMOVE FROM TRUST

Ward

Does the patient have mental capacity to make relevant decisions? **YES / NO**
(If no, see overleaf for link to Mental Capacity Assessment)

If the patient is currently very unwell, or in the event their condition deteriorates, should the following be considered? *(please circle)*

Referral to critical care?	**Yes**	**No**	Antibiotics?	**Yes**	**No**
Referral for dialysis?	**Yes**	**No**	IV fluids?	**Yes**	**No**
Non-invasive ventilation?	**Yes**	**No**	*Other:*	**Yes**	**No**
Other cont:					

In the event of a **cardiopulmonary arrest** this patient is: *(please tick)*

FOR CARDIOPULMONARY RESUSCITATION ☐

NOT FOR CARDIOPULMONARY RESUSCITATION ☐

MUST complete separate DNACPR form. Please be aware if not completed the patient will remain for resuscitation.

If Implantable Cardioverter Defibrillator (ICD) in place consider discussion with cardiology.

Summarise the main clinical problems and rationale for decisions above. Be as specific as possible. _____

_____

_____

_____

Has this been discussed with: **Patient?** YES / NO **Relatives/NOK?** YES / NO (include name)

*Summary of communication (if **not** discussed state why)* _____

_____

_____

Please document any further information, wishes or concerns which the patient would like known (including Advance Decision to Refuse Treatment if present) _____

_____

_____

Print name	Signature	Date & Time	Contact No.	Designation
				ST3 or above
				Consultant*
				Nurse In Charge*

(*mandatory)

Review date (e.g. within 24 hours, or specify date) _____

Review must occur whenever clinically appropriate, or transfer of care to another clinical area

Once reviewed, document overleaf

Date of review	Print name	Signature	Contact No.	Designation (ST3 or above)	Ward name	Date of next review

This form should be completed legibly in black ballpoint ink
File the TEP form in the front of the medical notes
All sections should be completed

- **The patient's full name, date of birth and address must be written clearly**
- **Date and time of writing the order should be entered**
- **If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the form**

Capacity
Please access the Mental Capacity Assessment guidance. Record the assessment of capacity if completed in the clinical notes. Available on the Intranet homepage → 'Quick Links' → 'Mental Capacity Assessment and DOLS'.

Suggested treatments to be considered
Please clearly circle which treatments the senior medical team consider would be most appropriate in the event of deterioration. If needed add any further information regarding additional treatments in the 'other' box.

DNACPR decision
If a DNACPR decision is made for a patient then a separate DNACPR form **must** be completed. Please be aware if this is not done the patient will remain for resuscitation. This TEP form should be kept in the front of the medical notes, just behind the DNACPR form.

Rationale for decisions
Summarise the main clinical problems, and reasons why the decisions have been made. Be as specific as possible.

Communication with patient and relatives or NOK
State clearly what was discussed and agreed. If not discussed with the patient state the reason why. If the patient does not have capacity, their relatives or friends should be consulted and may be able to help indicate what the patient would decide if they were able to do so. State the names and relationships of relatives or friends or other representatives with who this decision has been discussed. More detailed description of all discussions should be recorded in the clinical notes where appropriate.

Further information, wishes or concerns, including Advance Decision to Refuse Treatment
This section can include any further relevant information not included elsewhere. For example the presence of an Advance Decision to Refuse Treatment and where it is located; any specific concerns e.g. finances, or worries about a loved one; a patients preferred place of care etc.

Healthcare professionals completing this TEP
Any appropriate healthcare professional may initiate the TEP discussions, but the form must be endorsed by at least an ST3 doctor. Ensure decisions have been communicated to all relevant members of the team. The decision must be signed by the responsible consultant for the patients' care at the earliest opportunity.

Review
Clearly specify a review date. If any information has changed, this form must be cancelled and a new one written.

Discharge
This form must not be photocopied, it is for trust use only. Please include any relevant information the discharge letter, and also communicate this to any relevant community team. Consider starting a Coordinate My Care (CMC) record if appropriate.