

Name: .....

CHI Number: .....

*Patient Information  
Label here*

# Treatment Escalation Plan (TEP)

## ACUTE DETERIORATION MANAGEMENT

(Check TEP valid dates on reverse of page. This form only applies during the current admission)

**Patients who may benefit from a TEP when admitted to hospital include those with:**

- Risk of deterioration or instability
- Very severe frailty, completely dependent for ADLs
- Progressive organ failure with or without multiple co-morbidities
- Advanced cancer (not receiving potentially curative treatment)
- Progressive incurable illness e.g. Dementia, MS, MND in the final stages
- At request of patient/welfare attorney or guardian/ nearest relative or carers

MAIN DIAGNOSIS:

Patient's understanding of condition and issues:

(If this section, and the sections below, cannot be completed at time TEP agreed then please document plan for discussion and update as appropriate, with date and signature beside any subsequent entries).

**Indicate appropriate escalation of treatment if required; select one of the four boxes below:**

ITU referral and possibility of mechanical ventilation (If DNACPR in place d/w ITU before selecting)	
HDU care (including CCU) and possibility of NIV, inotropes etc	
Ward based care including antibiotics and fluids	
Comfort care aimed at relieving symptoms only	

**INVESTIGATIONS & INTERVENTIONS: Consider and indicate the most appropriate options below. Changes can be made at any time later if necessary – please date and sign changes.**

	YES	NO	Comments/Instructions / Plan of Care
<b>Invasive Procedures</b> e.g surgery, drain insertion, endoscopic and interventional radiology procedures, central lines (Please state)			
<b>Intravenous Access</b>			
<b>Intravenous Fluids</b>			
<b>Subcutaneous Fluids</b>			
<b>Intravenous Medication</b>			
<b>Antibiotics IV / oral</b> (delete as appropriate)			
<b>Blood transfusion</b>			
<b>NG, TPN, PEG feeding</b> (delete as appropriate)			
<b>Oral feeding appropriate with accepted aspiration risk</b>			
<b>Blood sampling</b>			
<b>Clinical Observations</b>			
<b>NIV</b>			
*Other relevant investigations / interventions / treatments can be detailed in row below.			

Has a DNACPR order been completed: YES  NO

Communication with the patient and their family regarding this plan is important. If it is not possible to have the discussion at the time of completion, then it must be planned for the first available time. You must ensure that the patient has mental capacity if you are asking the patient to make choices about which treatments they would elect to have. Where the patient does not have capacity, decisions will be made by any existing welfare attorney/guardian with relevant powers and an agreed care plan documented in the patients AWI treatment plan. In communication, please note who had the discussion and when (date/time), also documenting any support offered to patient / carer / family member (Chaplaincy / Support & Information Service / Carers Support Service).

**An existing Anticipatory Care Plan (ACP) eg Community ACP or ReSPECT should be respected, but must be reviewed with the patient and family with each new admission or change of care setting.**

**MUST BE COMPLETED IN ALL CASES:**

Has been discussed with the patient: YES  NO

If no state reason (e.g. Lack of capacity): .....

Section 47 AWI and Treatment plan completed? YES  NO

Is there a PoA / Welfare Guardian in place? YES  NO

Name of patient/welfare attorney or guardian/nearest relative or designated other & relationship to patient whom this has been communicated with:

.....

If patient has existing ACP, please ensure this information is also considered.

Patient preferences for care and statement of wishes (including goals, spiritual needs, place of care, and 'What matters to me'):
Family / carer understanding of patient's condition and issues:

**On discharge/transfer request update to community ACP/update KIS via discharge summary**

Signed: _____
Print Name: _____
Position: _____
Date commencing TEP: _____
<b>Responsible senior clinician</b>
Signed: _____
Print Name: _____
Date: _____
<b>TEP VALID UNTIL:</b> _____

Date Reviewed	Signed / Print	Valid Until

\* If significant changes are made to TEP please use a new document (and score through existing document) to ensure instructions are clear.

\* **'Indefinite'** can be added to the valid until box if no further review required.