Treatment Escalation Plan (TEP)

For adults ≥18 years

Hospital number:

NHS number:

Name:

D.O.B:

Use addressograph label

- This form is for guidance and **DOES NOT** replace clinical judgement.
- The TEP is only valid for the duration of this current admission.
- The TEP should be reviewed as the patient's clinical condition changes and a new form completed appropriately. Score through the old form.

✓

Level 2/3

CONSIDER CRITICAL CARE AFTER DISCUSSION Comment
- **Advanced respiratory support**
- **Multi-organ support**

Level 2

- **Single organ support e.g. NIV on HDU** Comment
- **Post operative care**
- **Critical care step down**

Level 1

- **Patients at risk of their condition deteriorating**
- **Level 2 / 3 step down**
- **e.g. Patients monitored on an observable bay with CCOT input**

Level 0 Active Ward

IV antibiotics	Y	N
PO antibiotics	Y	N
IV fluids	Y	N
Blood transfusion	Y	N
Oxygen	Y	N
Blood tests	Y	N
Artificial feeding	Y	N

NEWS 2 activation Y N

IF NO, perform observations to inform subsequent patient management:

BD ☐ **TDS** ☐ **QDS** ☐

Comment

SYMPTOM DIRECTED / PALLIATIVE ***Complete EOL care bundle if appropriate***

The following types of procedures should be considered in an emergency situation

Any procedure necessary	Medium intensity procedures	Less intense procedures	Endoscopic or interventional procedures	This patient woudn't benefit from or does not wish to have invasive procedures	Not discussed as part of the TEP at this time - Use clinical judgement if the situation arises
Comment	Comment	Comment	e.g. OGD or drain insertion		
✓ ☐	☐	☐	☐	☐	☐

There is a requirement that the TEP is discussed with the patient or their health and welfare attorney (if patient lacks capacity). Has the discussion been documented in the patient notes. Yes ☐ No ☐

Healthcare professional making this TEP

Name _____ Position _____ Registration _____

Signature _____ Date ___/___/_____ Time ____ : ____

If decision has been made by a delegated professional, the decision needs to be verified by a consultant at the earliest opportunity:

Name _____ Position _____ GMC _____

Signature _____ Date ___/___/_____ Time ____ : ____

Review

Review date if appropriate ___/___/_____ Outcome of review: TEP to continue Yes ☐ No ☐

Name _____ Position _____ GMC _____

Signature _____ Date ___/___/_____ Time ____ : ____