Northumbria Healthcare NHS
NHS Foundation Trust

Treatment Escalation Plan

Write in Black Ink

This plan is intended to guide clinical staff, especially out of hours. It is not a substitute for a full patient assessment, use of clinical judgement and discussion/ review by senior colleagues. Please be aware that the clinical situation may have changed from when this plan was written.
PLEASE SEEK HELP IF UNSURE.
Adults aged 18 years and over

Affix patient label or

NHS Number: .....
Trust Number: .....
Surname: .....
Forename: .....
Date of Birth: .....
Address: .....

Main diagnoses:

Grade	WHO Performance Grade- Explanation of activity	Please Tick
0	Fully active, able to carry out activities without restriction	
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light nature	
2	Ambulatory & capable of all selfcare, unable to carry out work activities. Up & about > 50% of waking hours	
3	Capable of only limited selfcare, confined to bed or chair > 50% of waking hours	
4	Completely disabled. Cannot carry out any selfcare. Totally confined to bed or chair	

1

Patient for <u>full active treatment</u> including cardiopulmonary resuscitation and consideration of critical care ☐

Please go to box 3

Patient for <u>supportive/ end of life care only</u> ☐

Please go to box 3- do not transfer patients to more acute settings except in exceptional circumstances. If a patient is discharged, communicate this plan with community teams

Patient for <u>active medical</u> <u>management</u> BUT with limits as set out below ☐

Please go to box 2

2

	YES	NO	Consider at time
Would oral antibiotic therapy be an appropriate treatment?	☐	☐	☐
Would intravenous antibiotic therapy be an appropriate treatment?	☐	☐	☐
Would intravenous fluid resuscitation be appropriate?	☐	☐	☐
Would a blood transfusion be an appropriate treatment?	☐	☐	☐
Would cardiovascular support with inotropes/ vasopressors be an appropriate treatment?	☐	☐	☐
Would non-invasive ventilation of the lungs be an appropriate treatment?	☐	☐	☐
Would invasive ventilation of the lungs be appropriate?	☐	☐	☐
Would renal replacement therapy be an appropriate treatment?	☐	☐	☐
Would you transfer this patient to an acute hospital setting?	☐	☐	☐
IS THIS PATIENT FOR CARDIOPULMONARY RESUSCITATION? If no, please complete DNAR form	☐	☐	☐

Author P Paes Version 3 Created Date 09/02/2012 Review Date 09/02/2013

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3 **Please document any other escalation decisions or the management plans for any specific anticipated problems**

4 **Please discuss/ communicate this plan with patients and/ or next of kin unless doing so is inappropriate in the individual circumstances**

Has this plan been discussed with the patient? **YES** ☐ **NO** ☐

If "YES" go to box 5

If "NO", does the patient have capacity to discuss this plan? **YES** ☐ **NO** ☐

If "NO" please discuss this plan with the next of kin, Lasting Power of Attorney, IMCA, close family or friends.

5 **Does this patient have an active, applicable Advance Decision to Refuse Treatment (ADRT)?** **YES** ☐ **NO** ☐

If "YES" this plan should reflect the ADRT. If there are any contradictions between the two documents, please document the reasons for this in box 6.

6 **Please document any important discussions that have taken place**

Healthcare professional completing this form:

Name: **Position:**

Signature: **Date:** **Time:**

Review and endorsement by most senior health professional:

Signature: **Name:** **Date:**

- ***Please ensure this plan is discussed with other members of the team***
- ***If circumstances change and this plan is modified, please put a line through the form, file it in the medical notes and complete a new form.***
- ***For assistance/ advice please contact a senior colleague. The critical care and palliative care teams are happy to advise/ support decision making.***