This form is NOT legally binding and does not replace a DNACPR, EHCP, AS or ADRT

TEP

This Treatment Escalation Plan (TEP) includes recommendations for treatment, based on my wishes and preferences in the event my health suddenly gets worse (acute deterioration).

NHS

TREATMENT ESCALATION PLAN

Full Name:	NHS no:
Date of Birth:	
Where was this form completed?	

My emergency contacts

Name		**Relationship**		**Tel.**	
Name		**Relationship**		**Tel.**	

Have you given anyone Lasting Power of Attorney (LPA) for your Health & Welfare?

☐ **Yes**, and their details are below.

☐ **No**, I have not given anyone this.

The attorney is the person, or people named on your **LPA for Health and Welfare document**, who can help make decisions for you if you can't. (Leave this blank if you ticked 'No').

Attorney name(s)		**Tel.**	

For children and young people, who has parental/guardianship responsibility?

I was supported to take part in discussions about this plan

If I am able, I will initial or make a mark in the box on the right to show that I was supported to understand and take part in discussions about this plan, and that my ability to be involved was taken into account.

(Someone may initial for me if I ask them to. My initials may be typed.)

This plan remains valid if this box is left blank.

My Initials:

What matters to me in decisions about my care? (please select ONE box)

☐ Living as long as possible matters most to me ⟷ ☐ I would like to live longer, but comfort is important to me ⟷ ☐ Being comfortable matters most to me

Where would I want my care to be delivered? (please select ONE box)

☐ I would like to go to hospital for treatment

☐ Please talk to me or my carers about whether I should go to hospital

☐ I do not want to go to hospital unless symptoms cannot be managed where I am now

☐ Transfer me to my preferred place of care / death

My preferred place of care is

My preferred place of death is

Form developed by the NHS *NENC Deciding Right Group*. **Ver. 1 Print-Ready Build PDFJP03):** developed with stakeholder input 2025-2026.

Name of Individual:		NHS Number:	

The following sections are for HEALTHCARE PROFESSIONAL USE ONLY

The sections include **clinical recommendations for emergency care and treatment**. Whilst these sections **must consider** preferences and values of the individual, they may also detail **medical decisions** relating to which treatments **are not available** to this individual (and so must be completed by a healthcare professional with sufficient knowledge and experience of this individual). Decisions should be discussed appropriately.

Ceilings of care (healthcare professional please select ONE)

Rockwood Frailty Score:

*Any decisions about HDU/ICU escalation will be discussed at the time with critical care, taking into account this TEP.

- ☐ Symptom control **only** (any setting)
- ☐ Active home/ community treatment
- ☐ Ward-based ceiling of care
- ☐ Assess for High-Dependency* (e.g. NIV/vasopressors)
- ☐ Assess for Intensive Care* (e.g. intubation)

Would the following treatments be considered appropriate?

Treatment	Yes	No	Comment
Oral antibiotics	☐	☐	
Intravenous antibiotics	☐	☐	
Intravenous fluids	☐	☐	
Blood transfusion	☐	☐	
Artificial nutrition	☐	☐	
Non-invasive ventilation	☐	☐	
Renal replacement therapy	☐	☐	
Other treatment options			

Details of other relevant care planning documents and where to find them

Select the documents believed to be already in place:

- ☐ Do not attempt cardiopulmonary resuscitation (DNACPR)
- ☐ Advance Decision to Refuse Treatment (ADRT)
- ☐ Advance Statement (AS)
- ☐ Emergency Healthcare Plan (EHCP)

Where to find these:

Discuss / share the information from this TEP with all key services in and out of hours (e.g. Ambulance Service, OOH GP, etc.)

This form is valid when signed. (The authorised healthcare professional is defined by local policy). Digital signatures are permitted. By signing, the healthcare professional records that the principles of the Mental Capacity Act 2005 have been considered and applied in preparing this document, including Best Interests decision-making where individuals lack capacity.

This is an advisory form which does not expire but should be reviewed at available opportunities, whenever this person's condition or situation changes, or at this individual's/clinician's request.

HEALTHCARE PROFESSIONAL

Professional Signature	
Date	
Name (print)	
Role	
Registration Nº.	

TREATMENT ESCALATION PLAN