Patient sticker

Name: ______________________

DOB: ______________________

Hospital Number: ____________

Brighton and Sussex University Hospitals
NHS Trust

DO NOT PHOTOCOPY

FOR INPATIENT USE ONLY

Treatment Escalation Plan

This is a recommended plan to guide future clinical interventions and ceilings of treatment
This is not binding and can be reversed if deemed appropriate

Current Diagnosis:

Relevant Clinical Information and Condition / Co Morbidities:

CEILINGS OF TREATMENT

1. **Is patient for cardiopulmonary resuscitation?** **Y / N** **[Ensure Valid DNACPR form]**
2. **FOR ITU (level 3) opinion if deteriorates:** **Y / N**
3. **FOR HDU (level 2) opinion if deteriorates:** **Y / N**
4. **FOR NIV** (in decompensated hypercapnic respiratory failure with proven COPD) **:** **Y / N**
5. **FOR MET calls:** **Y / N**

If YES to both (1) and (2), patient is for full escalation of treatment. Proceed to communication box

6. **WARD BASED LEVEL OF CARE (please select ONE of the following and update if the patient deteriorates):**

   A. Active treatment within ward based setting **Y / N Date:**

   B. For trial of active treatment, but at high risk of dying during admission **Y / N Date:**

   C. Identified as dying, for end of life care with individualised care plan **Y / N Date:**

RELEVANT INFORMATION REGARDING:

- **MENTAL CAPACITY / POWER OF ATTORNEY / ADVANCE DECISIONS**
- **COMMUNICATION WITH PATIENT / CARERS / FAMILY / NOK**

ST1 or equivalent and above may complete this form, to be discussed with a senior doctor and endorsed by Consultant at the earliest opportunity within 72 hours

Junior name: ____________________________Grade: ________ Signature: _______________________ Date: ________

Consultant name: _______________________________________ Signature: _______________________ Date: ________

Is this an indefinite decision? **Y / N** OR review date: ___________________