NO LONGER VALID AFTER DISCHARGE FROM HOSPITAL

Admission date:

Discharge Date:

GIG CYMRU NHS WALES

Please affix patient label:

Name:

CRN:

DOB:

Address:

Treatment Escalation Plan

(To be used for all current, adult ABUHB inpatients)

This is not a legally binding document but a guide/handover and does not replace clinical judgement. It should be taken into account within the specific clinical context.

For CPR and full treatment escalation ☐

Not for CPR ☐ (Complete All Wales DNACPR) Please indicate the ceiling of treatment by drawing a line above the highest level to be offered and crossing off any above this level. (See reverse for example.)

Discussion with critical care

CCU admission/ Ward based NIV

Transfer to GUH

Transfer to eLGH

Active ward based care

Symptomatic care

Co-Morbidity Burden/Function

Clinical Frailty Scale (1-9) **(Refer to CFS page / NICE guidance on page 4)**

Doctor's signature	Date

Rationale for decision:

Treatment above this ceiling would cause harm to patient/ not be successful. ☐

The patient has capacity and has declined treatment above this level. ☐

The treatment is not in keeping with an existing advance decision to refuse treatment or Adv. Care Plan ☐

The patient lacks capacity and an appointed Lasting Power of Attorney declined treatment above this level ☐

Nursing staff informed	Name of nursing staff:	Position:	Date:

Doctor completing form

Signature:	Name:	GMC no:	Position:	Date:

Consultant endorsing form

Signature:	Name:	GMC no:	Department:	Date:

Review of escalation plan / Second consultant opinion

Signature:	Name:	GMC no:	Department:	Date:

Now complete page 2 of the form

Dignity and Compassion in Care

Does the patient have capacity? (Document full assessment in notes). Yes ☐ No ☐

If the patient lacks capacity there a valid Advance Decision to Refuse Treatment Lasting Power of Attorney (Health & Welfare)? Yes ☐ No ☐

Is there an existing Advance care plan? Yes ☐ No ☐

Discussion with patient: *(please tick which applies)*

I have discussed with the patient (see notes) ☐

I have not discussed with the patient as: they lack capacity ☐

discussion will cause physical/psychological harm ☐

Discussion with next of kin/interested parties (where patient lacks capacity): *(please tick which applies)*

I have discussed with the next of kin/ interested parties (see notes) ☐

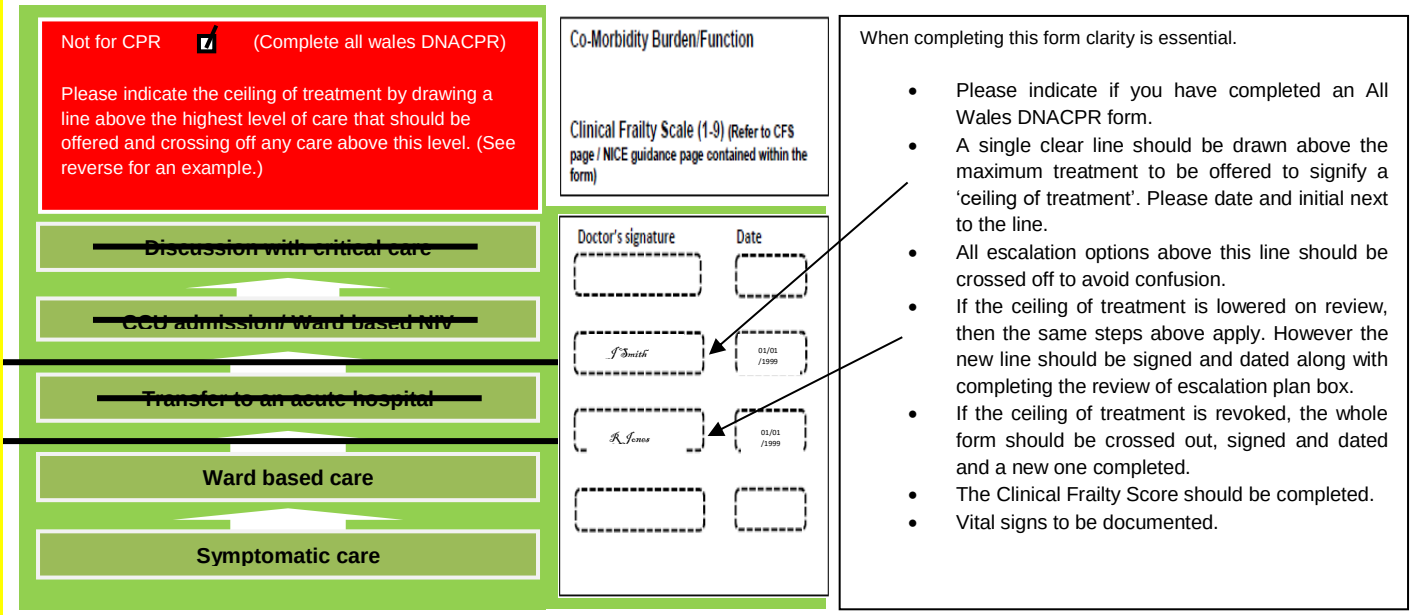
I have not discussed with the next of kin/interested parties as:

The patient has not given consent ☐

We have attempted contact but next of kin/interested parties are not available ☐

(please document contact attempts in notes)

The following is an example for reference only and does not apply to the patient.



Use the free text box below to detail where in clinical notes important documentation can be found with regards to discussions with the patient, lasting power of attorney, next-of-kin, IMCA, or other interested parties; attempts to contact family/legal proxy; outcomes of multi-professional team meetings; discussions with ABUHB clinical ethics committee, reference to advanced decisions to refuse treatment or existing advance care plan.

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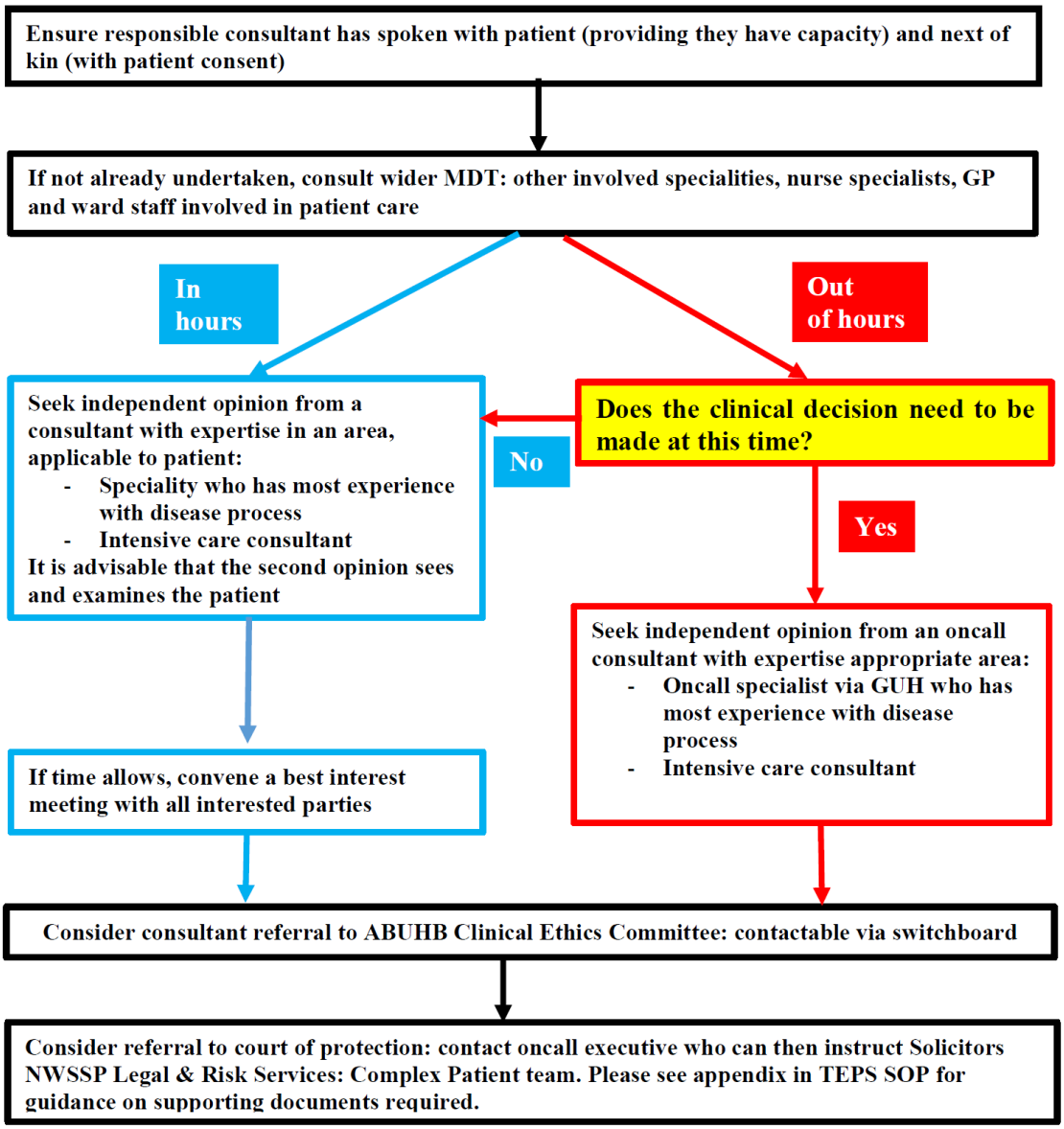
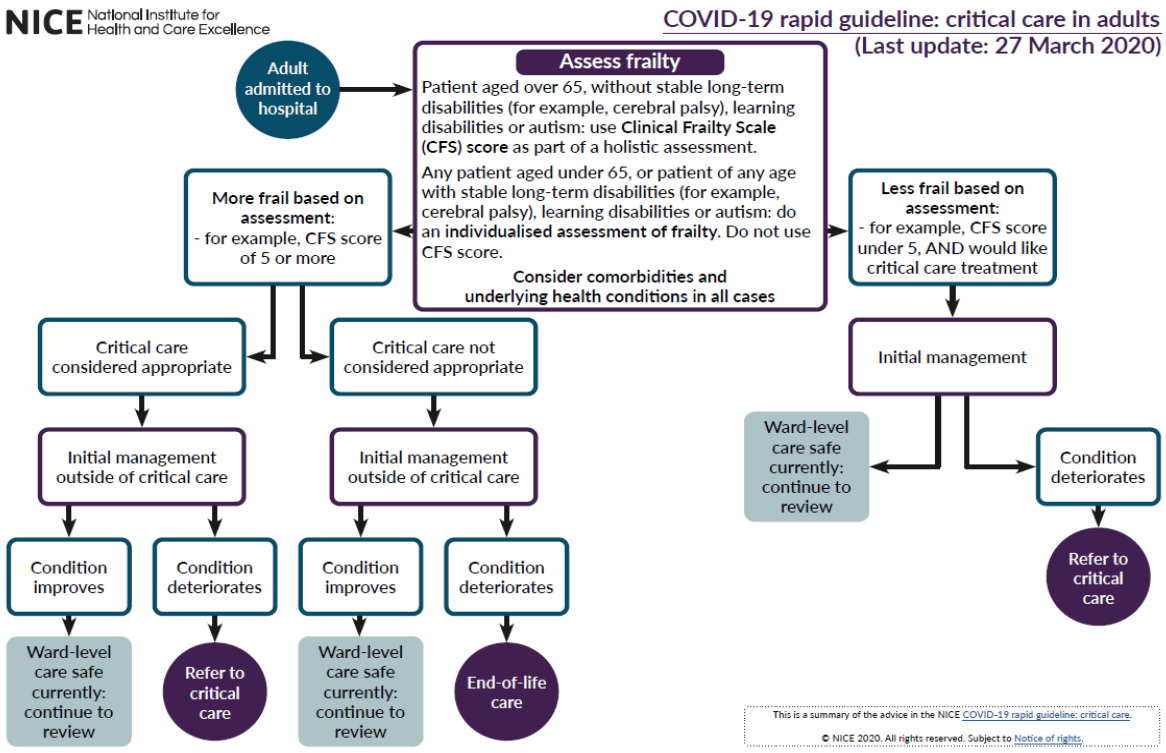
Protocol for when consensus cannot be reached about Treatment Escalation Plan



Overarching principles

- There should be a presumption of patient involvement in discussions.
- If the team do not involve the patient or family in discussions about treatment escalation plans, they should document their reasons very clearly on the form and in the clinical notes.
- A competent adult and a Lasting Power of attorney have the right to refuse treatment.
- Where there is equipoise with regards to the benefit of a particular treatment, patient involvement is paramount.
- No one can demand treatment that a clinician believes to be inappropriate or harmful.
- When there is disagreement between the team and the patient or next of kin about treatment escalation, a second independent consultant opinion should be offered.

The patient has suspected/confirmed Covid 19 ☐



Please check this is the latest version of the NICE Covid-19 critical care flow-chart.

https://www.nice.org.uk/guidance/ng159/resources/critical-care-admission-algorithm-pdf-8708948893

Please note that the Clinical Frailty Scale should not be used for younger people, people with stable long-term disabilities, learning disabilities, Autism or patients with life limiting conditions who have a good level of function.

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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