Somerset Health and Social Care Community

NHS

Somerset Treatment Escalation Plan & Resuscitation Decision

This form represents clinical decisions regarding appropriate medical treatments which have been made with patient/carer involvement as far as possible.

Name	
Address	
NHS No	
DOB	

'What is important to me'
If I am unable to speak for myself please contact: **name**:
who is my : **on phone number**:

If a treatment decision is unclear at the time the form is being completed, please tick unclear (see below)

Do not attempt CPR
For a natural and dignified death ☐

Do attempt cardiopulmonary resuscitation (CPR) ☐

If this person is not to have CPR attempted please document rationale:

For hospital transfer ☐

Consider hospital transfer Please state overleaf conditions ☐

Not for hospital transfer unless unmanageable symptoms or emergency
e.g. fall, fracture ☐

Life prolonging treatment ☐
Referral to critical care is appropriate

Life prolonging treatment ☐
Without referral to critical care

May be for life prolonging treatment ☐

Not for life prolonging treatment ☐
Focus on quality of life

Likely to be in the last days of life ☐

Non-invasive Ventilation	*Yes* ☐ *No* ☐ *Unclear* ☐
IV fluids	*Yes* ☐ *No* ☐ *Unclear* ☐
IV antibiotics	*Yes* ☐ *No* ☐ *Unclear* ☐
Oral antibiotics for treatment	*Yes* ☐ *No* ☐ *Unclear* ☐
Symptom control	For all

Names and roles /relationships of those involved in discussions. Please specify if any of these people hold lasting power of attorney	
Doctor, Practitioner or Senior Nurse endorsing form signature	

Full name		Grade		Date	

PLEASE TURN OVER

If you have ticked *'consider hospital transfer'* or *'may be for life prolonging treatment'* please describe how *'what is important to me'* will affect decisions around these issues:

If *'referral to critical care is appropriate'* please complete this section **on admission to acute hospital**

For intubation and invasive ventilation	Yes ☐ No ☐	For inotropes and vasopressors	Yes ☐ No ☐	For renal replacement therapy	Yes ☐ No ☐

Do you believe this patient has the potential to recover from a critical illness back to a reasonable quality of life? Yes ☐ No ☐ Unclear ☐

At this time this person has capacity to decide on their treatment and has been informed of these decisions ☐

At this time this person lacks capacity to decide on their treatment. Decisions have been made in line with the Mental Capacity Act ☐

On completion of this STEP please confirm that medication and treatment have been reviewed and are both necessary and beneficial ☐

Escalation plan review date if appropriate	

Supplementary information

Technical information

- When scanning this document please record it as: **Read code 8CMi or Snomed 2462291000000110**
- All STEP forms must be printed out and given to the patient or carer to keep with them in order to be shared with other services as needed
- Please add a note to ADASTRA to say that this form exists and a copy is at the patient's home and is visible on EMIS viewer.
- We would value any feedback on this form to help us develop it further. To do this please follow the link: https://tinyurl.com/SomersetTEP
- This document will be improved over time.
- This form is valid in black and white or in colour.

Please leave an original form with the patient

See STEP policy for full guidance

This form has been produced by the following organisations:

NHS Somerset Clinical Commissioning Group, Somerset County Council, Somerset Partnership NHS Foundation Trust, South Western Ambulance Service NHS Foundation Trust, Taunton and Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust, St Margaret's Hospice