Somerset Health and
Social Care Community

NHS

NHS No:
Surname:
First Name(s):
D.O.B: / / Gender: M / F
Address:

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.

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

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:

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

For hospital transfer ☐

Consider hospital transfer
Please state conditions overleaf ☐

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	/ / 20

'What is important to me?'

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 ☐

STEP review date (if appropriate): / / 20

Supplementary information

Information for completion

- This form is valid in black and white or in colour and must be printed
- Give the original form to the patient/carer to keep with them and to be shared with other services as needed
- When scanning this document please record it as: Read code 8CMi or Snomed 2462291000000110
- Please add a note to ADASTRA to confirm STEP has been completed, a copy is at the patient's home, and is visible on EMIS viewer

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

Feedback is welcomed to help improve this form. Follow the link: https://tinyurl.com/SomersetTEP