Somerset Health and Social Care Community



•				
NHS No:				
Surname:				
First Nam	e(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.

	involvement as far as possible.					
'What is important to me?'						
If I am unable to speak for mys	alf place 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 CP	R attempted please d	ocument ratio	nale:			
If a treatment decision is uncle	ar at the time the for	m is being con	npleted, p	lease tick unclear (see below)	
For hospital transfer	Life prolonging treatment Referral to critical care is appropriate			Non-invasive Ventilation	Yes No Unclear	
	Life prolonging trea without referral to critical			IV fluids	Yes No Unclear	
Consider hospital transfer Please state conditions overleaf	May be for life prolonging treatment			IV antibiotics	Yes	
Not for hospital transfer	Not for life prolonging treatment Focus on quality of life			Oral antibiotics for treatment	Yes No Unclear	
unless unmanageable symptoms or emergency e.g. fall, fracture	Likely to be in the last days of life			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 n endorsing form signature	urse					
Full name		Grade		Date	/ /20	

'What is important to me?'						
	pital transfer' or 'may be for life prolonging treatment' pl will affect decisions around these issues:	ease describe				
If 'referral to critical care is appro	ropriate' please complete this section on admission to acu	te hospital				
For intubation and invasive ventilation No	Tol motropes — Tol relial replace	ment Yes 🗌				
Do you believe this patient has the potential to recover from a critical illness back to a reasonable quality of life? Yes No 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