

Patient Details (attach sticky label)

Name:  
Hospital No:  
NHS No:  
DOB:  
Address:

## Stratified Treatment Escalation Plan (STEP)

Appropriate treatment of distressing symptoms is a minimum standard of care for everyone, eg Analgesia/Pain Relief, Antiemetics etc.

- Would intravenous fluid therapy be an appropriate treatment? Yes  No
- Would enteral nutrition be an appropriate treatment? Yes  No
- Would oral antibiotics be an appropriate treatment? Yes  No
- Would intravenous antibiotics be an appropriate treatment? Yes  No
- Would physiotherapy be appropriate? Yes  No
- Would a blood transfusion be an appropriate treatment? Yes  No
- Would cardiovascular support with inotropes and vasoconstrictors be an appropriate treatment? Yes  No
- Would non-invasive ventilation be an appropriate treatment? Yes  No
- Would invasive ventilation be an appropriate treatment? Yes  No
- Would renal replacement therapy be an appropriate treatment? Yes  No
- Would it be appropriate to defibrillate a potentially "shockable" dysrhythmia in a monitored patient? Yes  No
- Would CPR be an appropriate treatment? Yes  No

**IS THIS PATIENT FOR A CARDIAC ARREST CALL?** Yes  No

**If No, please complete a DNAR form in addition to this STEP and file them together in the notes**

Signature ..... Print Name ..... Position ..... GMC .....  
Date ..... Time ..... Review Date ..... Time .....

In addition to the planned review, this decision must be reviewed if the clinical condition alters or the patients views are changed.

Decision reviewed: reconfirmation/cancelled/changed - if changed complete new form (see over)

Signed ..... Print Name ..... Date ..... Time .....  
Signed ..... Print Name ..... Date ..... Time .....  
Signed ..... Print Name ..... Date ..... Time .....  
Signed ..... Print Name ..... Date ..... Time .....

Decision discussed with

Patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Relative/NOK/lasting power of attorney	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other medical team involved	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If no, why?

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Does the patient have a valid and applicable advance decision to refuse treatment or a future care plan? Yes  No  Don't know

If yes, please ensure that this plan reflects the contents of the advance decision and ensure the advance decision is filed in the health care records.

Any apparent contraindications must be explained and documented below

Please document any salient points or questions raised to clarify decisions made:

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**Review**

If the clinical circumstances change significantly this plan may need to be changed. If this occurs please score a line across the sheet and beside the line write 'reviewed' and the date. Then complete a new plan. Do not alter or change the plan as corrections can be confusing.

This document is intended as a plan of appropriate escalations in treatment and is entirely separate from the End of Life Care protocol. Any patients who require End of Life Care should have the appropriate paperwork completed in addition to his document.

This plan should be completed by the most senior doctor available (not FY1 or FY2). For assistance or advice with these discussions, please seek help from a senior colleague.