Patient Details (attach sticky label)

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

South Tees Hospitals NHS
NHS Foundation Trust

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 .....

MICC3516

Decision discussed with

Patient	Yes ☐	No ☐
Relative/NOK/lasting power of attorney	Yes ☐	No ☐
Other medical team involved	Yes ☐	No ☐

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.

TO BE FILED AT THE FRONT OF THE HEALTH CARE RECORD