Please attach sticker here

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

STEP

Somerset Treatment Escalation Plan and Resuscitation Decision

This document forms guidance for people caring for a person if they are very unwell or are unable to speak for themselves. It facilitates sharing of wishes and preferences about their healthcare.

It is important to know what matters to a person because we need to think about the focus of their care, what treatments could help, and where best to have them. Where people are willing and able this guidance should be discussed with them.

IF A CURRENT STEP IS IN PLACE, DO NOT REWRITE UNLESS NEEDED

INVOLVING YOU AND OTHERS

Please tick here if the person themselves was directly involved in the treatment escalation plan ☐

This form is best completed when you are well and at home. If this form has to be completed in an emergency your healthcare worker will fill in as much as possible.

Who else is involved in making this plan? (Person's representative)
(Please note if anyone has Power of Attorney / Deputyship for Health and Welfare in the relationship box)

Name(s)	Telephone number	Relationship(s)

WHAT MATTERS MOST TO YOU

What do you enjoy doing? How/where do you want to spend your time? Are there any treatments or therapies you wouldn't want to receive?

WHERE BEST TO RECEIVE TREATMENT

Thinking about now and into the near future, your healthcare team will guide you on appropriate treatments and where you might best receive them. Please discuss with your healthcare team and let them know your wishes with regards to their suggestions.

For transfer to hospital	Hospital based care with referral to intensive care for assessment	☐
	Hospital based care	☐
	Hospital@home	☐
Staying at home, unless emergency arises e.g. fracture	Supportive care at home, with symptom control	☐

For more information scan QR code for **Somerset Treatment Escalation Plan**

For more information about how the **Mental Capacity Act** relates to **Somerset Treatment Escalation Plan** scan QR Code

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SPECIFIC TREATMENTS

Your healthcare team will explain to you about specific treatments which could be suitable for you. Please discuss with your team if you would like to accept these treatments, so they can record your wishes.

	Give details	Not discussed	No	Yes	Discuss at time of need
IV therapies					
Other treatments that may be suitable for you e.g. NIV					

CARDIOPULMONARY RESUSCITATION (CPR) DECISION

Your healthcare team may advise against a CPR attempt because they believe it would not be successful, considering your clinical situation.

Even if it has been offered, many people decide they would not want CPR attempted. If you are unable to speak for yourself, other people may know your wishes regarding CPR. We will take these into account.

Your healthcare team will explain their CPR decision to you, and if CPR has been offered you can refuse it.

Your representatives involved in the CPR discussion: If carer and family involvement has not occurred, please explain why (outside of emergency circumstances either the individual and/or the family, friend, advocate, legal proxy should be involved).

Not for Cardiopulmonary Resuscitation – Allow Natural Death		**For attempted Cardiopulmonary Resuscitation**	

RATIONALE FOR NOT ATTEMPTING CPR: If this person is not to have CPR attempted, please document rationale:	
CPR would not work and is not clinically indicated	
CPR may work but the burdens outweigh the benefits	
The person has refused CPR, either via a capacitated expression of wishes or via an advance decision	

PRACTITIONER, DOCTOR, OR SENIOR NURSE COMPLETING FORM

Signature:		Full name: (print legibly)
Date:	Time:	Role, grade. Please include professional registration number