Patient details (attach sticky label)
Name:
Hospital Number:
NHS number:
DoB:
Address:

The Northern Neonatal Network
An Operational Delivery Network

Neonatal Stratified Treatment Escalation Plan (nSTEP)

Appropriate treatment of distressing symptoms is a **minimum** standard of care for everyone.

Please refer to NCCB checklists (www.nornet.org.uk) for guidance in parallel care planning.

Would enteral nutrition be an appropriate treatment?	Yes ☐ No ☐
Would oral antimicrobials be an appropriate treatment?	Yes ☐ No ☐
Would siting further IV access be an appropriate treatment	Yes ☐ No ☐
Would intravenous fluid therapy (including TPN) be appropriate treatment?	Yes ☐ No ☐
Would intravenous antimicrobials be an appropriate treatment?	Yes ☐ No ☐
Would a blood transfusion be an appropriate treatment?	Yes ☐ No ☐
Would cardiovascular support with inotropes and vasoconstrictors be appropriate treatment?	Yes ☐ No ☐
Would non-invasive ventilation be an appropriate treatment?	Yes ☐ No ☐
Would tracheal intubation/reintubation be an appropriate treatment?	Yes ☐ No ☐
Is invasive conventional ventilation an appropriate treatment?	Yes ☐ No ☐
Is invasive advanced ventilation (HFOV/iNO) an appropriate treatment?	Yes ☐ No ☐
Would chest compressions while correcting reversible causes of arrest be an appropriate treatment?	Yes ☐ No ☐
Would bolus resuscitation drugs (adrenaline) be appropriate treatment?	Yes ☐ No ☐
Would transfer for escalation of care be appropriate (i.e. RVI for surgery or Freeman Hospital for ECMO)	Yes ☐ No ☐

IS THIS PATIENT FOR A CARDIAC ARREST (2222) CALL? **Yes ☐ No ☐**

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

Signature ..... Print Name:..... Position:..... GMC:.....

Date:…./…./……. Time:.....hrs Planned Review Date:…./…./……. Time:.....hrs

In addition to the planned review, this decision must be reviewed every 48 hours or 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/GMC..... Date:…./…./……. Time:.....hrs

Signed ..... Print Name/GMC..... Date:…./…./……. Time:.....hrs

Decision discussed with:

a) Person(s) with parental responsibility (including shared care) Yes ☐ No ☐

(details; if **no**, explain why and with whom discussion has been had)……
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b) The following members of the NICU/SCBU MDT (list below):

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Any apparent contraindications or other specific limitations on potential treatment 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 for unwell neonates who are inpatients on NICU/SCBU. For any infant where there is significant risk of dying, the Neonatal Comfort Care Bundle Checklists (www.nornet.org.uk) should be consulted and consideration given to commencing good, parallel, comfort-care planning. This nSTEP form should be completed by the most senior doctor available (not tier 1 doctor/staff). 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