POLICY UNDER REVIEW
Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Treatment Escalation Plan
&
Resuscitation Decision Record
(In relation to children and neonates)

V4.0

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1. Introduction

This policy sets out the framework to support healthcare professionals when making decisions in relation to escalation of care should a child deteriorate and suffer a cardiorespiratory arrest. It includes information on the documentation required and the ethical and legal framework guiding decisions on withdrawing and withholding life-sustaining treatments such as cardiopulmonary resuscitation (CPR). This policy fully supports the national guidance and recommendations published in a joint statement by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2014) and the latest General Medical Council guidance (2010). The Royal College of Paediatrics and Child Health (RCPCH) have produced guidelines identifying certain circumstances where it may be appropriate to consider withholding or withdrawing life-saving treatment. This policy **MUST** be read in conjunction with this guidance.

The situations are as follows:

**The no benefit situation**: A patient’s condition is such that resuscitation is unlikely to restore cardiopulmonary function

**The no hope/chance situation**: Resuscitation would temporarily delay an inevitable death without improving life quality or potential

**The no purpose situation**: If the child experiences such a degree of impairment that it would not be reasonable to expect him or her to bear it, then it is appropriate to withhold or withdraw treatment. This is described by the Ethics advisory Committee of the RCPCH as an “impossibly poor life”.

**The informed decision**: The mentally competent patient has made an informed decision that they do not wish to be resuscitated, and they have expressed this wish on an on-going basis. Those with parental responsibility for the patient are in agreement with the child’s wishes, as are the medical team.

It is always a Health Professionals duty to act in a patient’s best interest. All treatment and care that is appropriate for a child will be offered. For the vast majority of patients the over-riding aim is to return them to their pre-illness level of health, or as near as possible.

Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the child. Moreover, to begin a therapeutic intervention that the patient will clearly not survive is not in their best interests. This implies that not all treatment modalities are appropriate for every patient. For all patients we must ensure that appropriate resuscitation policies which respect patients’ rights are in place, understood by all relevant staff, and accessible to those who need them. Importantly, all children who are at risk of a cardiorespiratory arrest should have a clear and explicit resuscitation plan.

Much of the guidance in respect of treatment and care towards the end of life encourages early involvement and good communication with the child (where applicable) and the parents/carers. All the guidance acknowledges that these discussions are often difficult
and sensitive as it most likely involves deciding whether to start or stop potentially life-sustaining treatments such as CPR. However, involving a patient in advance care planning, where they are willing and able, puts them back at the centre of their care.

The Treatment Escalation Plan (TEP) is where all appropriate treatment options for the patient are laid out with a note made of those modalities which may be inappropriate. The TEP should be initiated and completed in any of the possible healthcare settings (acute or community).

The term Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) indicates that in the event of cardiopulmonary arrest, neither basic nor advanced resuscitation will be instigated.

UNLESS A TEP FORM HAS BEEN COMPLETED AND THE DNACPR BOX HAS BEEN TICKED THE ROYAL CORNWALL HOSPITALS NHS TRUST WILL ATTEMPT TO RESUSCITATE ANY PERSON (STAFF/VISITOR/PATIENT) IN WHOM CARDIAC OR RESPIRATORY FUNCTION CEASES.

IF ANY DOUBT EXISTS, THE PATIENT WILL BE RESUSCITATED.

The Trust recognises that a written TEP with a DNACPR order does not preclude any other treatment (not specified on the TEP as inappropriate) and care including basic care that are appropriate for our patients. These will not be affected by a TEP and/or DNACPR decision.

This policy supersedes the Allow Natural Death Policy and any previous versions of this document.

2. Purpose of this Policy/Procedure

- To acknowledge the right of every competent child to be involved in decisions regarding CPR.
- To acknowledge the rights of the parent(s)/carers to be involved in decisions regarding treatments and CPR.
- To ensure that healthcare professionals properly decide and document a DNACPR decision in children to whom resuscitation would not be appropriate.
- To provide a framework to guide staff, patients, families and carers regarding resuscitation decisions.
- To bring the Royal Cornwall Hospitals NHS Trust policy in line with other local A.N.D./Do Not Attempt Resuscitation (DNAR)/TEP policies.

3. Principles

The child/young person has the right to die in peace and with dignity.

There will be some cases where attempted resuscitation following cardio-respiratory arrest is not in the child/young person’s best interests, because the potential burdens are likely to outweigh any possible benefits.
It may be against the clearly stated wishes of the child/young person and/or parents to prolong what they see as a poor quality of life by attempting Cardiopulmonary Resuscitation (CPR).

Any decision not to attempt resuscitation must not compromise the on-going needs of the child for symptom control or palliative care.

It should be noted that where a child under the age of 18 dies and when the death was not foreseen in the preceding 24 hour period, irrespective of whether a DNACPR decision has been reached, then the family/carers will be subject to a sensitive enquiry under the Southwest Peninsula Local Safeguarding Children Boards Joint Child Death Overview Protocol, which is supported by a Multidisciplinary Rapid Response Team.

4. Scope
This policy is twofold in its remit.

4.1. Firstly, for all clinical staff working within Royal Cornwall Hospitals NHS Trust :-
   4.1.1. This document outlines the Treatment Escalation Plan (TEP) and Resuscitation Decision Record (RDR).
   4.1.2. It confirms who this policy/procedure applies to, i.e. who will have to implement, or be affected by, this policy/procedure.
   4.1.3. The term DNACPR indicates that, in the event of cardiopulmonary arrest, an arrest team will not be called and neither basic nor advanced cardiopulmonary resuscitation will be started.
   4.1.4. All TEP and RDR orders must be made in accordance with this policy. Staff should report any untoward incident that occurs by not adhering to this policy by informing their line manager and reporting the incident using the Trust risk reporting system (Datix).
   4.1.5. This policy must be read in conjunction with the guidance framework found in appendix 2 and, most importantly, with National guidance published in a joint statement by the British Medical Association (2014) and the General Medical Council (2010).
   4.1.6. This policy applies to all clinical staff working within Royal Cornwall Hospitals NHS Trust.
   4.1.7. Patients in the Critical Care & Neonatal Unit are exempt from completion of a TEP form.

4.2. Secondly, by application of the TEP/RDR across all health sectors in Cornwall ensuring continuity of decision making process across the health community.

5. Legal Frameworks

A child is someone under the age of 18.

5.1 Mental Capacity Act 2005 (MCA)
The care and treatment of those under the age of 16 is generally governed by common law principles.
It is considered best practice for the provisions of the Mental Capacity Act 2005 (the MCA "Act") to be used as guiding principles when making relevant decisions for children. The MCA applies to anyone aged 16 and over.

The MCA test of capacity, details the two-stage test for capacity:

1. Whether the person has an impairment or disturbance in the functioning of their mind or brain; and
2. Whether that disturbance or impairment means that the person is unable to make the decision in question.

The MCA applies to anyone over the age of 16, with the exception that they cannot make an Advanced Decisions to Refuse Treatment (ADRT) or give a Lasting Power of Attorney (LPA) until the age of 18.

5.2 Gillick Competency Test
The test for capacity for those under the age of 16 was determined in the case of Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3. That case stated that:

"...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent."

The Judges provided further guidance on applying the Gillick competency test:

"...it is not enough that [the child] should understand the nature of the advice which is being given: [he/she] must also have a sufficient maturity to understand what is involved." and

"Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."

5.3 Parental Responsibility

5.3.1 What is parental responsibility?
Parental responsibility is a legal concept that consists of the rights, duties, powers, responsibilities and authority that most parents have in respect of their children. It includes the right to give consent to medical treatment, this right is not absolute, as well as, in certain circumstances, the freedom to delegate some decision-making responsibility to others.

Competent children can consent to diagnosis and treatment on their own behalf if they understand the implications of what is proposed. Those with parental responsibility also have a statutory right to apply for access to the health records of their child, although children who are mature enough to express views on the issue also need to be asked before parents see their record. Parental responsibility is afforded not only to parents, however, and not all parents have parental responsibility, despite arguably having equal
moral rights to make decisions for their children where they have been equally involved in their care.

5.3.2 Who possesses parental responsibility?

Throughout the United Kingdom, a mother automatically acquires parental responsibility at birth. However, the acquisition of parental responsibility by a father varies according to where and when the child's birth was registered:

For births registered in England, Wales or Northern Ireland
A father acquires parental responsibility if he is married to the mother at the time of the child's birth or subsequently. An unmarried father will acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon re-registration) from 1st December 2003 in England or Wales and from 15th April 2002 in Northern Ireland.

For births registered in Scotland
A father acquires parental responsibility if he is married to the mother at the time of the child's conception or subsequently. An unmarried father will acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon re-registration) from 4th May 2006.

Unmarried Fathers
An unmarried father, whose child's birth was registered before the dates mentioned above, or afterwards if he is not recorded on the child's birth certificate, does not have parental responsibility even if he has lived with the mother for a long time. However, the father can acquire parental responsibility by way of a court registered parental responsibility agreement with the mother or by obtaining a parental responsibility order or a residence order from the courts.

Step Parents and Civil Partners
Married step-parents and registered civil partners can acquire parental responsibility in the same ways (via a court order). Parental responsibility awarded by a court can only be removed by a court.

Divorce
Parents do not lose parental responsibility if they divorce – neither can a separated or divorced parent relinquish parental responsibility. This is true even if the parent without custody does not have contact with the child and does not make any financial contribution.

Local Authority and Other People
A local authority acquires parental responsibility (shared with anyone else with parental responsibility) while the child is subject to a care or supervision order. A guardian appointed by a court will also acquire parental responsibility. When a child is adopted, the adoptive parents are the child's legal parents and automatically acquire parental responsibility.

Other people can also acquire parental responsibility for a child. A testamentary guardian will acquire parental responsibility if no one with parental responsibility survives the testator.

Foster parents rarely have parental responsibility. For a child born under a surrogacy arrangement, parental responsibility will lie with the surrogate mother (and husband if
married) until the intended parents either (a) obtain a parental order from a court under the Human Fertilisation and Embryology Act 1990 or (b) adopt the child.

5.3.3 Consent from people with parental responsibility
People with parental responsibilities are entitled to give consent for medical treatment on behalf of their children. Usually parents desire to make the right decision about their young child’s best interests, and most decision making is, rightly, left to children and parents with appropriate input from the clinical team. In cases of serious or chronic illness, parents may need time, respite facilities, possibly counselling, and certainly support from health professionals, but in most cases they are best placed to judge their young child’s interests and decide about serious treatment. There are limits on what parents are entitled to decide, however, and they are not entitled to demand inappropriate treatment for their children or to refuse treatment which is in the child’s best interests.

5.3.4 What are the limits to parental responsibility?
The moral authority behind parental responsibility depends in large part on the entirely reasonable supposition that parents will act in the best interests of their children. If it appears, however, that parents are following a course of action which is contrary to their child’s interests, their decisions can be challenged.

Where doctors believe that parental decisions are not in the best interests of the child, it may be necessary to seek a view from the courts, whilst meanwhile providing only emergency treatment that is essential to preserve life or prevent serious deterioration.

When asked to decide about treatment, the courts recognise their duty to protect children and have almost invariably said that serious treatment should be given against the wishes of parents where there is a good chance of it succeeding or providing significant benefit to the child. The courts are required, in their decision making, to have regard to the rights given force by the Human Rights Act, and to have the child’s welfare as the paramount consideration.

What happens when people with parental responsibility disagree?
Generally, the law only requires doctors to have consent from one person in order to lawfully provide treatment.

In practice, however, parents sometimes disagree and doctors are reluctant to override a parent’s strongly held views, particularly where the benefits and burdens of the treatment are finely balanced and it is not clear what is best for the child. Disputes between parents can be difficult for everybody involved in the child’s care. Discussion aimed at reaching consensus should be attempted.

If this fails, a decision must be made by the clinician in charge whether to go ahead despite the disagreement. The onus is then on the dissenting parent to take steps to reverse the doctor’s decision.

Competent children and the limits to parental responsibility
As children grow and mature, so their ability to make decisions on their own behalf increases until, on reaching adulthood, they are presumed to be competent to take full responsibility for personal decision-making. During this period of maturation it is possible that children will disagree with their parents as to what constitutes their best interests, and
doctors may find themselves confronted with disagreements over a proposed course of action.

In England and Wales, no statute governs the rights of people under 16 to give consent to medical treatment. In the landmark *Gillick* case for example, the judges held that "parental rights were recognised by the law only as long as they were needed for the protection of the child and such rights yielded to the child’s right to make his own decisions when he reached a sufficient understanding and intelligence to be capable of making up his own mind".

Where doctors are confronted with a situation where a competent young person refuses consent for the plan authorised by a person with parental responsibility, they should seek legal advice.

**5.4 Disagreement and Dissent**

However a refusal for treatment by a competent child can be overridden by those with parental responsibility, or by the Courts, acting, if necessary in the child’s best interests. Generally, the clinician and the parents agree what is in the best interest of the child. However, occasionally where agreement cannot be reached between the parents and the medical team, often where the clinician feels resuscitation to be inappropriate, but the parents disagree.

A dissenting child at any age is likely to have his or her views overridden.

This is despite the 1989 Children’s Act and the UN Convention, which both take a broad view of involving even ‘non-competent’ children (who may nevertheless hold important and informed views) into decision making. Such views can help adults to make more informed decisions.

Young people with capacity are entitled to give consent to medical treatment, and where they lack this capacity, it is generally those with parental responsibility who make decisions on their behalf. Refusal of treatment by competent young people up to the age of 18 is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment.

Parents cannot require doctors to provide treatment contrary to their professional judgment, but where differences are irreconcilable, it is imperative that legal advice is sought before any decision is made.

If there is disagreement between the patient, those with parental responsibility and the healthcare team despite attempts to reach agreement, legal advice should be sought. In these circumstances contact the Legal Services Department (via Switchboard), extensive documentation, including medical summary, records of actions and conversations held to date will be required at the outset.

In cases of disagreement, a court can be asked to consider whether continuing treatment would be in the best interests of the child and can override the objections of both parents and competent children.
5.5 The Children Act (England and Wales, 1989)
Provides an overall statutory framework for the provision of children's welfare and services but makes no specific provision concerning withholding or withdrawing treatment. It does however, provide inter alia that:

- The child’s welfare is paramount.
- Particular regard is paid to the ascertainable wishes and feelings of the child.
- Children of sufficient maturity and understanding may be allowed to refuse medical or psychiatric examination or other assessment (but only for the purposes of a child assessment order [section 43(8)] or an emergency protection order [section 44(7)].)

However, the Act also introduces the concept of parental responsibility (section 2.5). Those with parental responsibility may make decisions on behalf of children provided that they act in their child’s best interests.

Parental responsibility can be acquired under the Act by people who are not the child’s natural parents. This increases the number of people who could be involved in making decisions about children. Judgements under the common law would appear to allow a child who is able to understand fully the nature and purpose of medical treatment to consent. By inference, it would seem that the child could refuse lifesaving or life sustaining treatment, but decisions of the Court of Appeal have established that those with parental responsibility can over-ride a child's refusal even if the child concerned is capable of fully understanding the consequences of the decision.

Sets out fundamental principles which govern how children should be treated. The following are the most relevant for the purposes of this document:

- Article 3 states that action affecting children should have ‘their best interests’ as a primary consideration.
- Article 24 confirms the right of the child to the highest obtainable standards of health and to facilities for the treatment of illness and the rehabilitation of health.
- Article 13 confirms the child’s right of freedom of expression and to seek, receive and impart information and ideas of all kinds.
- Article 12, affirms that ‘a child who is capable of forming his/her view has the right to express those views freely on all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child’.
- The right of families to be given all necessary support in caring for their child and in the performance of their child rearing responsibilities.

5.7 The 1969 Family Law Reform Act
Respects consenting decisions of young people aged over 16 years as if they are adults, but not necessarily dissenting decisions. A dissenting child at any age is likely to have his or her views overridden.

This is despite the 1989 Children’s Act and the UN Convention, which both take a broad view of involving even ‘non-competent’ children (who may nevertheless hold important and informed views) into decision making. Such views can help adults to make more informed decisions.
### 6. Definitions / Glossary

**Advanced CPR**
Is the addition of invasive manoeuvres to restore effective ventilation and circulation. Advanced manoeuvres consist of interventions such as bag-valve-mask ventilation, tracheal intubation, defibrillation and the administration of intravenous drugs.

**Basic Care**
Includes those procedures which are essential to keep an individual comfortable. The administration of medication or the performance of any procedure which is solely or primarily designed to provide comfort to the patient or alleviate that person’s pain, symptoms or distress are facets of basic care. This includes warmth, shelter, pain relief, management of distressing symptoms (such as breathlessness or vomiting), hygiene measures (such as the management of incontinence) and the offer of oral nutrition and hydration.

**Basic CPR**
Refers to attempts which are made without the use of specialised equipment to restore effective ventilation, using expired air inflation of the lungs and to restore circulation, using external compressions of the chest wall.

**Best interests**
Any decisions made, or anything done for a person who lacks the mental capacity to make specific decisions, must be in the person’s ‘best interests’.

**Cardiac arrest**
Is the cessation of cardiac output, determined by the inability to feel a central pulse, unresponsiveness and no spontaneous breathing.

**Cardiopulmonary Resuscitation (CPR)**
Is a broad term which usually refers to attempts made to provide effective breathing and restore circulation in a patient who has cardiac arrest.

**Clinical**
Branches of medicine involving the care of individual patients.

**Deputy**
A clinician responsible for making TEP & resuscitation decisions who is not at consultant level. In respect of paediatric TEP a deputy can ONLY be a paediatric associate specialist or specialist registrar.

**Ethical**
Ethics are a set of moral rules of conduct, which pertain particularly to decisions in resuscitation.

**Healthcare Team**
Comprises the senior doctor and senior nurse together with members of their teams who are involved in the delivery of care to the individual patient.

**Neonate**
A new-born child, especially in the first few weeks of life.

**Respiratory arrest**
Describes the situation when breathing stops (apnoea).

**Resuscitation**
The medical efforts which are made to revive a person who is seriously ill/injured or who is in cardiac arrest (and appears to be dead).
7. **Ownership and Responsibilities**

7.1. **Medical Director**
The Medical Director has executive responsibility for this policy.

7.2. **Resuscitation Committee**
The Resuscitation Committee is the trust committee through which corporate decisions relating to DNACPR decisions will be exercised. This includes receiving internal or external reports relating to trust wide practices and authorizing actions arising from such reports.

7.3. **Director of Medical Education**
The Director of Medical Education is responsible for ensuring that doctors in training receive the appropriate training, it is recorded and that all non-attendees are followed up.

7.4. **Resuscitation Officers**
The Resuscitation Officers are responsible for coordinating policy updates in response to new guidance and for ensuring that monitoring procedures are in place and being followed. Resuscitation Officers will also gather this data and report trust wide practice.

7.5. **Pediatric Consultants**
A pediatric consultant has overall responsibility for children in their care. It is the responsibility of Consultants to ensure that all medical staff in their team who is involved in TEP and DNACPR decision making are familiar and comply with the procedures and documentation.

7.6. **Ward and Departmental Managers**
Ward and departmental managers are responsible for ensuring that their staff are aware of the TEP and RDR policy specifically in respect to communication and documentation. They should also ensure that their staff act as the patient’s advocate to promote decision-making following best interest principles.

7.7. **Role of Individual Staff**
It is a health professional's own responsibility, according to their own professional organisation, to work within their own sphere of competence and to comply with the policy.

8. **Standards and Practice**

8.1 **Making a decision**

Decisions must never be rushed and where appropriate additional/external professional (medical/legal/ethical) advice should be sought in consultation with the Clinical Director or equivalent senior doctor. These discussions should take place in the most appropriate setting e.g. Home, Community and Hospital.

Parents of children with known life limiting disorders (and the children if they have capacity) should be engaged in filling out a child’s wishes document early on in the course of their child’s life or soon after the diagnosis has been made.
Any decision not to attempt resuscitation should only be made once there has been full discussion with the child’s health care team. Depending on circumstances it may be beneficial to include the child’s primary, secondary and tertiary health care providers.

Where a child or young person is able to be involved in the decision, bearing in mind issues of legal capacity they should be consulted and the potential primacy of their views must be recognised. If there is conflict or disagreement, the Clinical Director (or equivalent senior doctor) should be contacted for advice.

Any decision not to attempt resuscitation must not compromise the on-going needs of the child for symptom control or palliative care. Discussion leading to decisions must be inclusive of the parent(s), or legal guardians, respectful of their wishes and take due regard for the rights of the child or young person.

The child or young person, parent(s) or legal guardian(s) must be given as much information as possible by the lead consultant responsible for their child’s care (or another senior clinician in his/her absence).

The child or young person, parent(s), or legal guardian(s) must be given sufficient time and support to enable them to be involved in the decision.

Where a child with capacity does not consent to a discussion, then a “do not attempt resuscitation” decision must not be taken. This process should be clearly documented.

If there is dispute between a child (whether or not they have capacity) and their parents or between the parents themselves, then the Clinical Director’s advice should be sought, in the first instance.

Any decision must be made on an individual basis. “Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, their families and the healthcare team” (UK Resuscitation Council 2014).

An individual assessment must be made in each case as to whether it is necessary or appropriate to involve the child/young person in making the decision. Whilst in some cases the child/young person might be informed there may be cases where this is inappropriate.

National guidance suggests that “where CPR may re-start the heart and breathing for a sustained period but there are doubts about whether the potential benefits outweigh the burdens, the views of the child or young person should be taken into consideration in deciding whether it should be attempted” (UK Resuscitation Council 2014).

“Where a young person with capacity refuses treatment, the potential harm caused by violating the young person’s choice must be balanced against the harm caused by failing to give treatment” UK Resuscitation Council (2014). “Usually, it is possible to reach agreement on whether or not CPR should be attempted if a child or young person suffers respiratory or cardiac arrest.
In the event of an unpredicted emergency situation where the issue of resuscitation has not been previously considered there is a presumption that full and active resuscitation will take place until the child’s lead consultant makes a decision based on the best clinical judgement at that time. However, individual clinicians or groups of clinicians must only provide treatments they believe to be in the best interests of the child. In acute presentations, clinicians should not be compelled to deliver care they consider to be futile and must retain discretion not to commence resuscitation, or to discontinue resuscitation, where there is no possibility of good outcome.

There should be a presumption in favour of attempting resuscitation unless a decision has been made.

It is strongly recommended that you read the guidance and framework found in appendix 2.

8.1. A TEP form including RDR needs to be considered as a minimum on any child that is at foreseeable risk of clinical deterioration and/or cardiac or respiratory arrest. Certainly if the answer to the question “Would you be surprised if this child died within the next 6-12 months?” is NO then a TEP form and a RDR should be completed.

8.2. The responsibility for making treatment decisions including resuscitation rests with the paediatric consultant in charge of the patient’s care.

8.3. In urgent circumstances only, a paediatric associate specialist, specialty hospital doctor or specialist registrar may make these decisions. If there are any doubts about the right course of action, a consultant should always be contacted to discuss what to do. If a new decision is made not to resuscitate a consultant should always be contacted for advice.

8.4. A competent child’s wishes should be taken into account and any life-sustaining treatment decisions should be made jointly with the family.

8.5. Details of any discussions with the child/parents regarding resuscitation must be documented on the TEP (and if more room needed further reference made in the medical notes).

8.6. When there is disagreement or clearly opposing views with the child and/or parents/carer and a deputy is making the decision the consultant should be informed. The consultant should attempt to achieve consensus and consider whether a second opinion from another consultant would benefit the discussion.

8.7. If there is disagreement within the healthcare team regarding the appropriateness of resuscitation, a second opinion must be obtained from a registered medical practitioner of consultant status.

8.8. If a disagreement cannot be resolved between clinical team, child or parents/carers then legal advice should be sought from the Legal Services (via Switchboard, an out of hours number is available via site coordinators).

8.9. Until disagreement is resolved an attempt at resuscitation will be made.
8.10. **Patient information leaflet.** It is actively encouraged that the patient information leaflet relating to TEP and cardiopulmonary resuscitation is given to the parents and/or carers to support the communication process. This MUST be done if there is a disagreement about the decisions being made.

8.11. **TEP Completion.** It is the policy of the Royal Cornwall Hospitals NHS Trust to use a purple TEP proforma to document treatment decisions including RDR (Appendix 1). Once completed, this is filed at the front of the current volume of the patient’s medical notes. Reference should be made in the current medical notes. This reference should be written “TEP completed” and “FOR OR NOT FOR CPR”. This entry should be signed and dated.

8.12. Any subsequent change necessitates a new TEP form being completed (see cancellation of TEP 8.27).

8.13. Decisions relating to resuscitation of a child in the Critical Care Unit or a baby on the neonatal unit should be documented in the clinical notes (Appendix 3).

8.14. When a deputy makes a written order on a TEP in accordance with paragraph 8.3, a consultant must countersign the decision at the earliest opportunity. The expectation is that this will be within 48 hours, but in most cases will be sooner.

8.15. **Communication.** The purple TEP proforma in the patient’s case notes is to be regarded by all staff as the authoritative statement. It is therefore important this record is reviewed and kept up to date and most importantly communicated to other staff.

8.16. The clinician making a TEP (or amending or cancelling it) is responsible for ensuring that a trained member of the nursing team on that shift is informed.

8.17. That nurse is then responsible for informing the other members of the nursing team by documenting the TEP & RDR in the 'alert section' of section one of the RCHT Nursing Documentation Framework. The nurse must make it clear if the patient is FOR or NOT FOR CPR.

8.18. If the TEP is cancelled the trained nurse informed of this decision must ensure the previous order is crossed out with 2 diagonal lines in black ink and “CANCELLED” written clearly between them. It must be signed by that nurse in the format: date, signature and name in capitals.

8.19. If the resuscitation status is changed, the nurse must ensure the previous order is crossed out with 2 diagonal lines in black ink and “AMENDED” written clearly between them. The nurse should document the new decision and sign in the format: date, signature and name in capitals.

8.20. Professions allied to medicine e.g. physiotherapists are responsible for keeping themselves updated by checking the medical notes prior to treating the patient at each visit.
8.21. Care must be taken when checking the TEP documentation for current resuscitation status.

8.22. **Review.** TEP and resuscitation status should be considered as part of regular patient review, BUT the decision will remain unless the order is cancelled.

8.23. It remains the consultant’s responsibility to ensure that appropriate review of the TEP occurs and that such review(s) are documented in the medical notes. Wherever possible other members of the nursing and medical team should be involved and informed.

8.24. The frequency of reviews should take into account the clinical circumstances. It would generally be expected that children and parents/carers would be informed of any change in outcome.

8.25. **Temporary suspension.** It may be appropriate to suspend a decision not to attempt CPR temporarily during some procedures, if the procedure itself could precipitate a cardiopulmonary arrest e.g. surgical operations etc. The clinician should ensure all appropriate staff are aware of the details of the suspension to include the resuscitation status and the duration of the suspension. This should be documented in the medical notes.

8.26. **Death.** If the child dies, the top copy of the purple TEP should be filed in the medical notes (in the medical documentation section).

8.27. **Cancellation.** If a TEP is cancelled, the purple form should be crossed through with 2 diagonal lines in black ink and “CANCELLED” written clearly between them, signed and dated by the healthcare professional cancelling the order. The TEP should be filed in the medical notes (in the medical documentation section). An entry in the patient’s medical notes must be made stating that “*TEP has been cancelled and that the child is FOR ACTIVE CPR*; written in black ink, dated & signed.

8.28. **Amendment.** If a TEP and/or resuscitation decision is amended, the TEP form should cancelled as 8.27 and a new TEP form completed. An entry in the patient’s medical notes must be made stating that the TEP has been amended and the patient is now *FOR* or *NOT FOR CPR*, written in black ink, dated and signed.

8.29. **Cornwall community-wide TEP form.** It is acknowledged that children cared for by the Trust cross boundaries between primary and secondary care. The purple TEP form has been accepted for use by both the Peninsula Community Health and Cornwall Foundation Trust (although these organisations have their own specific policy relating to implementation within their organisation). It remains our intention to continue to work with colleagues across the healthcare community to achieve a county-wide approach to advance care planning and resuscitation decision. **To this end wherever possible and appropriate the TEP form will remain with the patient.**

8.30. **Discharge home.** A TEP and RDR may remain in place if the patient is discharged home from hospital. If not going with the patient then it is to be kept filed at the front of the patient’s notes. If appropriate the TEP form may
accompany the patient home. In this case a photocopy of the TEP should remain in the patient’s medical notes. Communication of the TEP and where the form is must be made to any transferring team and the family doctor with responsibility for the continuing care of the patient.

8.31. **Transfer to another healthcare organization.** If the TEP and RDR decisions are still current then the TEP form should accompany the patient if they are transferred to another Trust. A photocopy of the TEP should remain in the patient’s medical notes. Communication of the TEP must be made to any transferring team and those with responsibility for the continuing care of the patient. It will be up to the receiving organisation to review the TEP and resuscitation status of the patient upon their arrival.

8.32. **Patients admitted with a TEP.** When a child is admitted to the Royal Cornwall Hospital with a TEP, whether it is a new admission or a re-admission, the decision should be reviewed at the earliest opportunity by the clinical team. If the TEP is to remain in place, a new TEP form must be completed.

9. **Dissemination and Implementation**

9.1. This policy document will be held in the public section of the Documents Library with unrestricted access, replacing the previous version which will be archived in accordance with the Trust Information Lifecycle and Corporate Records Management Policy.

9.2. Staff will be alerted to changes from previous versions using established staff communication channels to distribute information including:

- email/letter to all consultants
- email/letter to all ward managers
- information sheet for all wards, departments and medical education
- staff newsletter item (RCHT Daily Bulletin)
- staff daily bulletin

9.3. **Training**

TEP and resuscitation decisions involve complex ethical and legal consideration and are centered around good communication with children, parents or relatives/carers and other staff members. Communication and clinical decision-making is inherent in most programmes of clinical training.

9.4. For the purposes of this policy, staff need to be aware of current legal and ethical issues and familiarise themselves with procedures and documentation laid down in the TEP and RDR policy.

9.5. Familiarisation of TEP and RDR decisions, procedures and documentation will form part of the staff annual resuscitation updates. A leaflet providing essential information regarding the ethical and legal aspects of these decisions will be provided. (Trust policies: Cardiopulmonary Resuscitation Policy and Core Training Policy Incorporating: Training Needs Analysis.) Staff members requiring additional training can contact the resuscitation officers for further advice.

9.6. The Trust also recognises that education relating to TEP, resuscitation
end-of-life care issues occurs both within the organisation and externally. This education is delivered by a variety of health providers and often forms part of a broader programme delivered by varied stakeholders.

10. Monitoring compliance and effectiveness

| Element to be monitored | (1) All RCHT incidents involving TEP & resuscitation decisions.  
(2) TEP & RDR form completion/decision-making (mortality review). |
|-------------------------|-----------------------------------------------------------------|
| Lead                    | (1) Resuscitation Officers.  
(2) Child Health Mortality review. |
| Tool                    | (1) Datix (staff able to tick specific box for resuscitation issues). Used for reporting incidents/non-compliance.  
(2) Review of case notes and TEP proformas (all children who die in the Trust in a specified period). |
| Frequency               | (1) As and when alerts occur.  
(2) Dictated by mortality review process. |
| Reporting arrangements  | 1 The Resuscitation Officers will report their findings to the Resuscitation Committee quarterly.  
2 The child health mortality review process has its own reporting structure. Any concerns raised during mortality review will also be reported to the Resuscitation Officers.  
Finally, the Resuscitation Committee reports to the Trust Management Committee which in turn reports via the Governance Committee to the Trust Board. |
| Acting on recommendati ons and Lead(s) | The TMC is responsible for interrogating required actions and to designate a named lead where appropriate. This is documented in meeting minutes. |
| Change in practice and lessons to be shared | Resuscitation Committee via Resuscitation Officers will forward where appropriate the lessons to be shared with all the relevant stakeholders. |

11. Updating and Review

11.1. This document was produced and circulated to members of the TEP Working Group for initial comment and then to the Resuscitation Committee for final draft approval. It was then widely circulated to senior paediatric medical and nursing staff for consultation. The Trust’s legal team was also approached for comments before final approval and ratification by the Executive lead for resuscitation.

11.2. This policy will be reviewed on or before 1st October 2018 by the Resuscitation Committee.

12. Equality and Diversity

12.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website. The Initial Equality Impact Assessment Screening form is at Appendix 5.
Appendix 1. Treatment Escalation Plan (CHA2863)
Appendix 1. Treatment Escalation Plan (Page 2 – CHA2863)

Rationale for treatment decisions and resuscitation status (be as specific as possible). Continuation box.

Has a decision or discussion occurred relating to organ donation? Y / N  If yes please document details below:

Doctor making the decision:
Name (Caps):  Signature:  Grade:
GMC No:  Date:  Time:

This form should be completed legibly in black ball point ink
• Complete patient details or affix the patient’s identification label to the top left hand corner
• The date and time of writing the form should be entered
• This form will be regarded as ‘INDEFINITE’ unless it is clearly cancelled
• The form should be reviewed whenever clinically appropriate or whenever the child is transferred from one healthcare setting to another, and admitted from home or discharged home.

If following clinical review, treatment decisions are changed:
• Clearly score through this form with two diagonal lines and write ‘CANCELLED’ in between the lines
• Sign and date just below the diagonal lines
• Complete a new form and insert in the child’s medical notes (unless cancelled completely).
Appendix 2. A.N.D./DNACPR- Decision Making Framework
CHILDREN <18 years

Is cardiac or respiratory arrest a clear possibility for the child?

No

If cardiac or respiratory arrest is a clear possibility for the child, it is not necessary to discuss CPR with the patient unless they express a wish to discuss it, but parents of and children with life limiting illnesses should be encouraged to engage in the completion of a Child and Family wishes document. This document should be regularly updated.

Yes

Is there a realistic chance that CPR could be successful?

No

If an DNACPR decision is made on clear clinical grounds that CPR would not be successful the parents or legal guardians of the child should be informed of the decision and offered an explanation as to the reason for the decision.

Yes

Where the child is Gillick competent and it is felt appropriate to do so the child should be informed of the decision not to attempt CPR and the reasons for it as part of the on going discussion about the patient’s care.

If the decision is not accepted by the parents and/or the patient a second opinion should be offered.

Complete the TEP form stating why CPR will not benefit the child
- Continue to elicit the views of the parents
- Review regularly to check if circumstances have changed
- Ensure a comfortable and natural death by effective supportive care for the child and their family with access to specialist palliative and hospice care
- In the event of the expected death allow a natural death to occur

Is the child Gillick competent?

Yes

The decision to administer CPR should be in the child’s best interest
Discuss the options with the child where appropriate
Parents or legal guardians of the child should be informed of the decision and offered an explanation as to the reason for the decision
If the person(s) with parental responsibility are not available the decision to administer CPR should be in the child’s best interest.

No

Are the potential risks/burdens of CPR greater than its likely benefits?

Yes

Discuss the options with the child where appropriate and with the person with parental responsibility to guide a decision in the patient’s best interests.
Parents or legal guardians of the child should be informed of the decision and offered an explanation as to the reason for the decision

No

CPR must be given

☐ If cardiorespiratory arrest occurs in the absence of a recorded decision there should be an initial presumption in favour of attempting CPR.
☐ Anticipatory decisions about CPR are an important part of high-quality health care for people at risk of death or cardiorespiratory arrest.
☐ Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team with appropriate competence.
☐ Decisions about CPR require sensitive and effective communication with children if appropriate and those with parental responsibility.
☐ Decisions about CPR must be documented fully and carefully.
☐ Decisions should be reviewed with appropriate frequency and when circumstances change.
☐ Advice should be sought if there is uncertainty.

This framework has been taken from, ‘Decisions relating to cardiopulmonary resuscitation’, courtesy of the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing, October 2014. It has been adapted for paediatric use.
Appendix 3. Resuscitation Decisions in the Critical Care & Neonatal Units.

Treatment in CCU and NNU can involve physiological support for one or more failing organs and biochemical systems in the body. The medical terms for this level of treatment are often grouped together under the simple lay term of ‘life support’. One system for describing limits to treatment is needed which reflects the fact that many patients and a few babies continue to receive a degree support for their cardiac, pulmonary and other physiologic systems up to the point of dying.

In CCU and NNU a patient’s or baby’s resuscitation status will be defined by any specified limits to interventional treatments normally used to support different organs or physiological systems. Treatment may be limited by being withheld or withdrawn. Current policy is that the terms ‘not for cardiopulmonary resuscitation’ or ‘allow natural death’ are not routinely used in these areas in order to avoid confusion. These terms are inadequate in themselves to describe the scope and limits to resuscitative measures routinely used.

**Documentation & Communication**

All decisions to withhold or withdraw treatment should be clearly recorded in the clinical notes, discussed with the patient, parents or family and reviewed in the same manner as the decisions discussed within this policy.

It is the collective responsibility of medical and nursing personnel to ensure that such decisions are communicated amongst the multidisciplinary team; in particular such decisions should be addressed routinely during handovers.

In the event that a patient is discharged from CCU with limitations on escalation of treatment and a resuscitation decision then a TEP form is clearly appropriate, a purple TEP form will be completed as per the Trust policy. Similarly if a baby is discharged from the NNU with a plan to limit escalation and withhold CPR then a purple TEP must be completed.

**Audit**

All patient deaths in CCU are reviewed at monthly audit meetings. A similar process occurs with all neonatal deaths. Specific consideration of resuscitation decisions and the documentation relating to the communication of these will be included in the review.

CCU and NNU will monitor complaints and correspondence and feedback to their relevant governance groups.
Who is this leaflet for?
This leaflet is for families and carers who may have to decide if their child should be resuscitated. Talking about your child’s resuscitation can be very difficult, and this leaflet aims to make it easier for you to understand what will happen and how you will be involved.

What is this leaflet about?
This leaflet is about deciding in advance with health professionals what should happen if your child’s health suddenly gets worse. It tells you:
- what resuscitation is, and
- how decisions about your child’s resuscitation are made.

What is resuscitation?
Resuscitation is an emergency treatment. It tries to revive someone who is very unwell, for example when their heart and breathing have stopped. It may include:
- repeatedly pushing down firmly on your child’s chest or using electric shocks to try to restart their heart
- using a mask or a tube to help your child breathe.

Why would I need to decide about resuscitation?
- It’s very important to talk about what is best for your child with the doctors and nurses who look after them, so they know your wishes.
- If your child’s healthcare team know your wishes, they can plan with you what is best for your child.
- Sometimes your child may not benefit from being resuscitated.
- You and your child may decide that you only want treatment that will make your child comfortable.

Children and young people under 16 who can understand what is involved have a right to decide about their health care and treatment. Even if they can’t give their consent, children and young people under 16 can be involved in discussions about their health care.
How will decisions about my child’s resuscitation be made?

- You and the health professionals who look after your child will make decisions together. Children and young people should be involved in decisions about their resuscitation, if that is what they want.
- Your child’s healthcare team should give you all the information you need to help you decide and should explain what may happen if your child is resuscitated.
- You can talk to the health professionals who look after your child at any time. But advance decisions about your child’s resuscitation are usually discussed at a special meeting – a resuscitation planning meeting.
- At the meeting you will discuss your wishes with the health professionals who look after your child, for example their consultant and named nurse. The health professionals will also say what they think is best for your child. Everybody will try to reach a decision together.
- You can bring a friend or relative with you, or someone else to speak for you, if you would like to do this.
- Usually more than one meeting will be needed to plan for your child’s care.

If you and the health professionals can’t agree on a decision, a member of NHS staff involved in your child’s care will tell you what you can do. Ask someone in your child’s healthcare team about this.

What happens if I decide that resuscitation is not right for my child?

- This decision will be written in a Children’s Treatment Escalation Plan and Resuscitation Decision Record. You will get a copy of this form.
- Copies of the form will also be held by the health professionals who care for your child, including your child’s GP, hospital and the place where they are being cared for. However, it is also important that you keep your copy of the form to show to health professionals if there is an emergency situation.
- If your child’s health suddenly gets worse, the form will tell the health professionals looking after your child what treatment has been agreed.
• If your child’s heart and breathing stop, he or she will be allowed to die naturally. The healthcare team will not try to resuscitate your child, and your child will not be moved to an intensive care unit. This decision is only about your child’s resuscitation. Your child will get any other treatment they need, and their healthcare team will continue to give them the best possible care.

What happens if I change my mind?
• If you change your mind about your child’s resuscitation, tell someone in your child’s healthcare team.
• Your child’s healthcare team will discuss with you what is best for your child.
• This discussion and any decisions will be written in your child’s medical notes.

Who else can I talk to about this?
You can talk to:
• any member of staff involved in your child’s care
• your family or friends
• the hospital chaplain
• your spiritual adviser
• organisations that provide support for children, young people and their families for example the Children’s Hospice or CLIC Sargent.

How can I find out more?
For more information about anything in this leaflet, contact:
• a member of NHS staff involved in your child’s care
• the NHS inform Helpline on 0800 22 44 88 (textphone 18001 0800 22 44 88), or
• your local citizens advice bureau (find your nearest bureau online at www.citizensadvice.org.uk or in your local phone book).
For information and support for children, young people, their families and carers, contact:

**ACT**
Brunswick Court, Brunswick Square,
Bristol BS2 8PE
Helpline 0845 108 2201
Phone 0117 916 6422
For general enquiries email info@act.org.uk
Website www.act.org.uk

**Together for Short Lives**
Helpline 08088088100
Website http://www.togetherforshortlives.org.uk

**CLIC Sargent (for children and young people with cancer)**
Child Cancer Helpline 0300 330 0803
Child Cancer Helpline email helpline@clicsargent.org.uk
Website www.clicsargent.org.uk

For information for young people about their health rights see:
‘Consent – your rights’ explains how you should be involved in decisions about your health care and treatment.
‘Confidentiality – your rights’ tells you how the health service keeps information about you private.
‘Have your say! Your right to be heard’ tells you how to give feedback or make a complaint about the NHS.

You can get these leaflets from:
- places where you get NHS care
- www.nhsinform.co.uk/rights/publications/leaflets/
- the NHS Inform Helpline on 0800 22 44 88
- your local citizens advice bureau.
# Appendix 5. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Treatment Escalation Plan &amp; Resuscitation Decision Record (in respect of adult patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; October 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>Date document becomes effective</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; October 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Jay Over, Resuscitation Officer, Resuscitation Committee</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252124</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Guidance to staff regarding Treatment Escalation Plans and cardiopulmonary resuscitation decisions in relation to children and neonates.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Death, TEP, Resuscitation, A.N.D., DNAR, DNACPR, 2222, CPR, Cardiopulmonary resuscitation, Resus, LCP, Liverpool care pathway.</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Dr Rob Parry – Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; October 2015</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>TEP Working Group, The Resuscitation Committee, Legal Services, Consultants, Snr Nurses/Matrons.</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td></td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical/Paediatrics/Critical Care and Resuscitation</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>CQC Outcomes 1 &amp; 4, NHSLA 4.7 Resuscitation</td>
</tr>
</tbody>
</table>
Related Documents:

**RCHT:**
- Cardiopulmonary Resuscitation Policy.
- Policy for Consent to Examination or Treatment.

**National:**

Royal College of Paediatrics and Child Health (RCPCH)


Children Act 1989

**BMA Card 3 Parental Responsibility**
- British Medical Association. (2014). Decisions relating to cardiopulmonary resuscitation; Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the “Joint Statement”). London: BMA.
- Leadership Alliance for the Care of Dying People. (2014). One chance to get it right. Publications gateway reference 01509.

Training Need Identified? Yes

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.06.03</td>
<td>1</td>
<td>DNAR policy developed.</td>
<td>Resuscitation Team. Legal Services &amp; Bevan Ashford</td>
</tr>
<tr>
<td>01.01.2008</td>
<td>2</td>
<td>Full review, original document changed.</td>
<td>DNAR working group/Resuscitation Committee/Legal</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Details</td>
<td>Authors and Committees</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17.01.2012</td>
<td>3.1</td>
<td>Minor amendment to clarify the meaning of deputy in relation to disagreement.</td>
<td>Jay Over, Resuscitation Officer</td>
</tr>
<tr>
<td>01.04.2015</td>
<td>4.0</td>
<td>Full review. Name changed from Allow Natural Death. Complete new form. Treatment escalation plans added. Resuscitation decision record so CPR YES or NO. Adult element removed to separate policy. TEP form where applicable to stay with the patient.</td>
<td>TEP Working Group, Resuscitation Committee, Legal Services, Consultants, Patient ambassadors. Jay Over – Resus Officer.</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 6. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): Treatment Escalation Plan &amp; Resuscitation Decision Record (Children and neonates only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong> Clinical</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong> Jay Over</td>
</tr>
<tr>
<td><strong>Telephone:</strong> 01872 252124</td>
</tr>
<tr>
<td><strong>1. Policy Aim</strong></td>
</tr>
<tr>
<td>Who is the strategy / policy / proposal / service function aimed at?</td>
</tr>
<tr>
<td>To ensure that healthcare professionals properly decide and document treatment escalation and CPR decisions in children to whom resuscitation would not be appropriate and who are at risk of deterioration.</td>
</tr>
<tr>
<td>To acknowledge the right of competent children and parents/carers to determine whether or not to accept an attempt at CPR.</td>
</tr>
<tr>
<td>To provide a framework to staff, patients, families and carers regarding resuscitation decisions.</td>
</tr>
<tr>
<td><strong>2. Policy Objectives</strong></td>
</tr>
<tr>
<td>All Treatment Escalation Plans to include resuscitation decision will be made in accordance with this policy.</td>
</tr>
<tr>
<td><strong>3. Policy – intended Outcomes</strong></td>
</tr>
<tr>
<td>All Treatment Escalation Plans to include resuscitation decision will be made in accordance with this policy. Inappropriate resuscitation attempts will be minimised.</td>
</tr>
<tr>
<td>*<em>4. <em>How will you measure the outcome?</em></em></td>
</tr>
<tr>
<td>Audit of policy against case notes.</td>
</tr>
<tr>
<td><strong>5. Who is intended to benefit from the policy?</strong></td>
</tr>
<tr>
<td>All children</td>
</tr>
<tr>
<td>Clinical Staff</td>
</tr>
<tr>
<td>Parents/carers</td>
</tr>
<tr>
<td><strong>6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Workforce</td>
</tr>
<tr>
<td>Legal Services</td>
</tr>
<tr>
<td>Patient Focus Group</td>
</tr>
<tr>
<td>*<em>b) If yes, have these <em>groups been consulted?</em></em></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>C). Please list any groups who have been consulted about this procedure.</strong></td>
</tr>
<tr>
<td>The TEP Working Group</td>
</tr>
<tr>
<td>Resuscitation Committee</td>
</tr>
<tr>
<td>Legal Services</td>
</tr>
<tr>
<td>(Other external organisations, PCH, CFT, SWAST)</td>
</tr>
</tbody>
</table>

### 7. The Impact

Please complete the following table.

<table>
<thead>
<tr>
<th>Are there concerns that the policy could have differential impact on:</th>
</tr>
</thead>
</table>
### Equality Strands:

<table>
<thead>
<tr>
<th>Strands</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  

   No

9. If you are not recommending a Full Impact assessment please explain why.

   Implementation of the TEP will only have a positive affect does not impact in any way on

   Signature of policy developer / lead manager / director

   Date of completion and submission

   Names and signatures of members carrying out the Screening Assessment

   1.

   2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed_________________________  Date_________________________