File on front of current clinical notes

NHS number: _____

Name: _____

Address: _____

_____

Affix patient label

Date of birth: _____

CR number: _____

NHS

Treatment Escalation Plan (TEP) and Resuscitation Decision Record (Children under age 18 years)

This form is for clinical guidance and it does not replace clinical judgement

Life expectancy
Would you be surprised if this child died within the next 6 - 12 months?

If No →

Has the family (+/- child) filled in a child and family wishes document?
Circle: Yes / No

If the child is currently very unwell or in the event their condition deteriorates

Is admission to an acute hospital appropriate?	Yes	No
Are IV fluids appropriate?	Yes	No
Are antibiotics appropriate?	Yes	No
Is artificial feeding appropriate?	Yes	No
Are blood tests & investigations appropriate?	Yes	No

Acute setting only		
Is non-invasive ventilation appropriate?	Yes	No
Is a referral to critical care appropriate?	Yes	No
Is a referral for dialysis appropriate?	Yes	No

In the event of a cardiorespiratory arrest this child is:

FOR RESUSCITATION ☐

DO NOT ATTEMPT RESUSCITATION (DNACPR) ☐

All treatment decisions above should be reviewed as the patient's clinical condition changes

Rationale for treatment decisions and resuscitation status:

Please tick if continued overleaf ☐

These decisions HAVE been discussed with child / parents / guardian (give brief overview):

Date: Time:

These decisions have NOT BEEN been discussed with the above for the following reasons:

Names of members of multidisciplinary team contributing to this decision:

Documentation that the TEP form has been completed in the medical notes. Circle: **Yes / No**

Doctor making the decision (Paed SpR, Associate Specialist or above):

Name (Caps): Signature: Grade:

GMC No: Date: Time: Ward:

Consultant / GP:

Name (Caps): Signature: Date:

On discharge, if appropriate and the parents and/or child have been informed of the decisions, then the original form should accompany the child and a photocopy should remain in the child's medical notes.

affix patient label

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: Ward:

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).