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Royal Cornwall Hospitals NHS Trust

Treatment Escalation Plan & Resuscitation Decision Record

(in relation to the adult patient over 18 years)

V5.0

1st January 2018

Table of Contents

1. Introduction

1.1. This policy sets out the framework to support healthcare professionals when making decisions in relation to escalation of care should the patient deteriorate and a resuscitation decision should the patient 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 (2016) and the latest General Medical Council guidance (2010). This policy **MUST** be read in conjunction with this guidance.

1.2. It is always a Health Professionals duty to act in a patient's best interest. All treatment and care that is appropriate for a patient 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.

1.3. 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 patient. 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. Moreover, all patients who are at risk of a cardiorespiratory arrest should have a clear and explicit resuscitation plan.

1.4. Much of the guidance in respect of treatment and care towards the end of life encourages early involvement and good communication with the patient. 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. If a patient lacks capacity then early engagement of the Mental Capacity Act is essential.

1.5. 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).

1.6. The term Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) indicates that in the event of cardiopulmonary arrest, neither basic nor advanced resuscitation will be instigated. This decision not to resuscitate was known in this Trust as an Allow Natural Death decision/order (A.N.D.).

1.7. 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.

1.8. 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 resuscitation.

1.9. 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 patient, over 18 years, with capacity to refuse attempts at CPR and to be involved in decisions regarding CPR.
- To ensure that healthcare professionals properly decide, involve and document a DNACPR decision in patients to whom resuscitation would not be appropriate.
- To ensure suitable provisions are made for any patients who are assessed to lack capacity.
- To provide a framework to guide staff, patients, families and carers regarding CPR decisions.
- To bring the Royal Cornwall Hospitals NHS Trust policy in line with revised guidance; court of appeal decisions and other local DNACPR/A.N.D. policies.

3. Scope

This policy is twofold in its remit.

3.1. Firstly, for all clinical staff working within Royal Cornwall Hospitals NHS Trust :-

3.1.1. This document outlines the Treatment Escalation Plan (TEP) and Resuscitation Decision Record (RDR).
3.1.2. It confirms who this policy/procedure applies to, i.e. who will have to implement, or be affected by, this policy/procedure.
3.1.3. 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.
3.1.4. 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).
3.1.5. This policy must be read in conjunction with the guidance framework found in appendix 4 and, most importantly, with National guidance published in a joint statement by the British Medical Association (2016) and the General Medical Council (2010).
3.1.6. This policy applies to all clinical staff working within Royal Cornwall Hospitals NHS Trust.
3.1.7. Patients in Critical Care are exempt from completion of a TEP form.

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

4. Definitions/Glossary

Advanced CPR	is the addition of invasive manoeuvres to restore effective ventilation and circulation. Advanced airway manoeuvres consist of interventions such as bag-valve-mask ventilation, tracheal intubation, defibrillation and the administration of intravenous drugs.
Attorney (Health and Welfare)	is a person who has been given the legal right to make decisions within the scope of their authority on behalf of the person who made the Power of Attorney. See Lasting Power of Attorney.
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
Competence	a mentally competent patient can understand and retain the information relevant to the decision in question and weigh it up before arriving at a choice.
Deputy	a clinician responsible for making TEP & resuscitation decisions who is not at consultant level; F2 or above.
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.
Independent Mental Capacity Advocate (IMCA)	a person appointed under the Mental Capacity Act 2005 to provide support and representation for a person who lacks mental capacity, where the person has no-one else to support them.
Lasting Power of Attorney	appointed under the Mental Capacity Act 2005 to have the ability to make decisions about the person's personal health and welfare and/or deal with the person's property and affairs.
Lasting Power of Attorney (Health and welfare)	The LPA gives an attorney the power to make decisions about things like the patients: • daily routine, e.g. washing, dressing, eating • medical care • moving into a care home • life-sustaining treatment It can only be used when the patient is unable to make their own decisions.
Mental Capacity	the ability to make a decision about a particular matter at the time the decision needs to be made.
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).

5. Ownership and Responsibilities

5.1. Medical Director

The Medical Director has executive responsibility for this policy.

5.2. 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 authorising actions arising from such reports.

5.3. 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.

5.4. Resuscitation Officers

The Resuscitation Officers are responsible for co-ordinating 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.

5.5. Consultants

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

5.6. 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.

5.7. 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.

6. Standards and Practice

It is strongly recommended that you read the guidance framework found in appendix 4.

6.1. A TEP form including RDR needs to be considered as a minimum on any patient 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 patient died within the next 6-12 months?" is NO then a TEP form and a RDR should be completed.

6.2. The responsibility for making treatment decisions including resuscitation rests with the consultant in charge of the patient's care. This may in some circumstances be a nurse consultant with medico-legal responsibility for the patient's care.

6.3. In the absence of a consultant other doctors with full GMC registration may make these decisions in urgent circumstances; F2 and above. If there are any doubts about the right course of action, a consultant should always be contacted to discuss what to do.

6.4. Patients with Capacity

6.5. An **adult, over 18 years, with capacity** can refuse treatment. A consultant (or suitable deputy – 6.3) is responsible for determining whether a patient lacks capacity to refuse resuscitation which would otherwise be offered.

6.6. If there is a realistic chance that CPR would be successful (burden vs benefit) and the patient has capacity then the patient must be involved in deciding whether or not CPR will be attempted. A consultant or deputy should use their clinical judgement about initiating discussions around resuscitation and other treatment decisions.

6.7. A patient cannot demand resuscitation which is not clinically indicated. If a DNACPR decision is made on clear clinical grounds that CPR would not be successful (futility) the patient needs to be informed (*R (on behalf of Tracey) v Cambridge* [2014]) with an explanation for the reason for it. Only if the clinician considers this disclosure to be harmful at that time, they may withhold the conversation but MUST document the reasons on the TEP form; future review should include consideration of whether to inform the patient.

6.8. Details of any discussions with the patient regarding resuscitation must be documented on the TEP form (and if more room needed further reference made in the medical notes).

6.9. Discussion with **family and carers** should be undertaken and their views documented, unless the patient who has capacity has stated that they do not want anyone else informed. Discussions with family and carers are most relevant when a patient is unable to express his/her wishes and they might have information indicating that the patient would not have wanted attempts at resuscitation (Advance Decision to Refuse Treatment (ADRT)).

6.10. If the decision has NOT been discussed with either the adult with capacity, their family or IMCA then the reason for withholding this information **MUST** be documented. Protecting individuals from distress is not sufficient reason for not holding the discussion.

6.11. **Patient information leaflet (RCHT802)** The patient leaflet relating to TEP (RCHT802) MUST be given to the patient and/or relatives to support the communication process.

6.12. Patients who lack Capacity

6.13. If the patient **lacks capacity** under the Mental Capacity Act (2005), all treatment decisions should be in the patients best interests. If you suspect a patient lacks the capacity to make the decision in question then you are required to complete the mental capacity assessment on the back of the TEP form. Each acute treatment decision requires a documented capacity assessment; these should be completed in the medical notes or via Desuto and placed in the medical notes.

6.14. In reaching a best interests decision clinicians must try to seek the views of anyone named by the patient as being someone to be consulted, and anyone engaged in caring for the person or interested in the patient's welfare. In these circumstances it should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient but to help the healthcare team to make an appropriate decision in the patient's best interests. They should be assured that their views on what the patient would want will be taken into account but they cannot insist on treatment or on withholding or withdrawal of a treatment.

6.15. If the patient has appointed a valid **Lasting Power of Attorney (personal welfare)**. This attorney has the same legal right to refuse an attempt at resuscitation as a competent adult. They do not have the right to demand treatment.

6.16. Under the same Act, a patient who lacks capacity and who does not have any family or friends can have an Independent Mental Capacity Advocate (IMCA) appointed to them. Involvement of an IMCA especially in cases where an attempt as resuscitation is likely to be successful is really important.

6.17. If the patient does not have capacity then this discussion should take place with their family or IMCA. Any discussions with relatives and others close to the patient must reflect the patient's right to confidentiality and must be documented on the TEP form with further reference made if needed in the medical notes.

6.18. It is recognised that in urgent situations sometimes a decision NOT to attempt resuscitation will need to be made before the family can be contacted.

6.19. Disagreement

6.20.When there is **disagreement** or clearly opposing views with the patient and/or family/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. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion (*R (Tracey) v Cambridge* [2014]: 65).

6.21.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.

6.22. If a disagreement cannot be resolved between clinical team, patient and/or relatives then legal advice should be sought from the Trust Risk Manager Legal Services (via switchboard).

6.23. Until disagreement is resolved an attempt at resuscitation will be made.

6.24. **Patient information leaflet.** This should have been given with the initial discussion but if disagreement you MUST ensure the patient and/or relatives have received or are given an information leaflet relating to TEP and cardiopulmonary resuscitation (RCHT802) (6.11).

6.25. TEP form completion

6.26. It is the policy of the Royal Cornwall Hospitals NHS Trust to use a purple TEP form. 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. Photocopies of the original form should NOT be deemed as valid.

6.27. Any subsequent changes to treatment decisions necessitates a new TEP form being completed (see cancellation of TEP 6.43).

6.28. Decisions relating to resuscitation of an adult patient on Critical Care should be documented in the clinical notes (Appendix 5).

6.29. When a deputy makes a written order on a TEP (Appendix 3) in

accordance with paragraph 6.3, 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.

6.30. **Communication**. The purple TEP form 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.

6.31. 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. The name of that nurse should be documented on the TEP form.

6.32. That nurse is then responsible for informing the other members of the nursing team by documenting the TEP & RDR in the TEP section of the Admission nursing care record. The nurse must make it clear if the patient is FOR or NOT FOR CPR.

6.33. 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.

6.34. 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.

6.35. 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.

6.36. Care must be taken when checking the TEP documentation for current resuscitation status.

6.37. **Review** TEP and resuscitation status should be considered as part of regular patient review, BUT the decision will remain for that inpatient admission period unless the order is cancelled.

6.38. 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.

6.39. The frequency of reviews should take into account the clinical circumstances.

6.40.It would generally be expected that patients and relatives/carers/attorneys (where available) would be informed of any change in outcome. Exceptions apply when a patient has indicated a wish, and it is recorded, not to take part in such discussions or that his relatives and carers should not be involved.

6.41. **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. cardiac catheterization, 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.

6.42. Death If the patient dies, the top copy of the purple TEP should be filed in the medical notes (in the legal documentation section).

6.43. 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 legal documentation section). An entry in the patient's medical notes must be made stating that "*TEP has been cancelled and patient is FOR ACTIVE CPR*; written in black ink, dated & signed.

6.44. Amendment If a treatment decision(s) is amended, that TEP form should be cancelled as 6.42 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 changes detailed; written in black ink, dated and signed.

6.45. Discharge and Transfer from RCHT

6.46.**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 BUT the form should be crossed through with 2 diagonal lines in black ink and "DISCHARGED" written in between the lines. This is so staff can easily distinguish a TEP completed on a previous admission; any subsequent re-admission requires a new form (6.49).

6.47.If appropriate the TEP form may accompany the patient home. It is important if the TEP is to go with the patient that they and preferably their family/carers have been involved in the TEP/RDR process. In this case a photocopy of the TEP should remain in the patient's medical notes. A photocopy is only kept in the notes to raise awareness of a previous TEP and should NOT be deemed as valid. A new purple TEP form needs to be completed on future admissions. 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.

6.48.**Transfer to another healthcare organisation** If the TEP and RDR decisions are still current then the TEP form should accompany the patient. A photocopy of the TEP should remain in the patient's medical notes (see 6.47). 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.

6.49. Patients Admitted with a TEP

6.50. **Patients admitted with a TEP** When a patient 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.

6.51.**Cornwall community-wide TEP form** It is acknowledged that patients cared for by the Trust cross boundaries between primary and secondary care. The purple TEP form has been accepted for use by both the Cornwall Partnership NHS Foundation Trust & South Western Ambulance NHS Foundation Trust (although these organisations have their own specific policy relating to implementation within their organisation).

6.52.It remains our intention to continue to work with colleagues across the healthcare community to achieve a South West wide approach to advance care planning and resuscitation decisions. **To this end wherever possible and appropriate the TEP form will remain with the patient.**

7. Dissemination and Implementation

7.1. 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.

7.2. 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
- via email/letter to all Resus Link nurses
- staff daily communication bulletin (RCHT Communication)

7.3. Training

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

7.4. 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.

7.5. Familiarisation of TEP and RDR decisions, procedures and documentation in the form of a leaflet will be given to all new clinical healthcare staff on induction. (Trust policy: Induction policy)

7.6. Familiarisation of TEP and RDR decisions, procedures and documentation will also 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.) All doctors will receive face to face training as part of their mandatory update. Other staff members requiring training can contact the resuscitation officers for further advice.

7.7. The Trust also recognises that education relating to TEP, resuscitation and

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.

8. Monitoring compliance and effectiveness

Element to be monitored	(1) All RCHT incidents & complaints (via PALS) involving TEP & resuscitation decisions. (2) TEP & RDR form completion/decision-making (regular current in-patient notes review).
Lead	(1) Resuscitation Officers. (2) Governance leads for the Clinical Specialities.
Tool	(1) Datix (staff able to tick specific box for resuscitation issues). Used for reporting incidents/non-compliance. Complaints notified by PALS or ward staff. (2) Review of current in-patient case notes and TEP forms.
Frequency	(1) As and when alerts/complaints occur. (2) Monthly.
Reporting arrangements	1 The Resuscitation Officers will report their findings to the Resuscitation Committee quarterly. 2 The Governance specialty leads will forward audit result and action plan to the Resuscitation Committee. Finally, the Resuscitation Committee reports to the Trust Board via the Clinical Effectiveness Group.
Acting on recommendations and Lead(s)	The Clinical Effectiveness Group is responsible for interrogating required actions and to designate a named lead where appropriate.
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.

9. Updating and Review

9.1. This document was produced and circulated to members of the TEP Working Group and Resuscitation Committee for consultation and final approval. The TEP form was also widely circulated to senior medical staff for consultation.

9.2. This policy will be reviewed on or before 1st January 2021 by the Resuscitation Committee.

10. Equality and Diversity

10.1. 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.

10.2. Equality Impact Assessment

10.3. The Initial Equality Impact Assessment Screening form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Treatment Escalation Plan & Resuscitation Decision Record (in relation to the adult patient over 18 years) V5.0			
Date Issued/Approved:	1st January 2018			
Date Valid From:	1st January 2018			
Date Valid To:	1st January 2021			
Directorate / Department responsible (author/owner):	Ella Leuzzi/Gemma Ashton-Cleary, Resuscitation Officers, Resuscitation Committee			
Contact details:	01872 252124			
Brief summary of contents	Guidance to staff regarding Treatment Escalation Plans and cardiopulmonary resuscitation decisions.			
Suggested Keywords:	Death, TEP, Resuscitation, A.N.D., DNAR, DNACPR, 2222, CPR, Cardiopulmonary resuscitation, Resus, LCP, Liverpool care pathway.			
Target Audience	RCHT	CPFT	KCCG	
	✓			
Executive Director responsible for Policy:	Medical Director			
Date revised:	1st January 2018			
This document replaces (exact title of previous version):	Allow Natural Death (A.N.D.) Policy and Guidance Framework for Adults & Children (including neonates) V4.0.			
Approval route (names of committees)/consultation:	TEP Working Group, The Resuscitation Committee, Legal Services, Patient Focus Groups, Consultants, Snr Nurses/Matrons.			
Divisional Manager confirming approval processes	Not applicable			
Name and Post Title of additional signatories	Not Required			
Signature of Executive Director giving approval				
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical/Critical Care and Resuscitation			
Links to key external standards	CQC End of Life Care			

Related Documents:	**RCHT:** ▪ Cardiopulmonary Resuscitation Policy. ▪ Patient Information Leaflet – Treatment Escalation Plan & Cardiopulmonary Resuscitation (CPR) – RCHT 802 (2018) ▪ Policy for Consent to Examination or Treatment. **National:** ▪ The Association of Anaesthetists of Great Britain and Ireland. (2009). *Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period.* London. ▪ British Medical Association. (2016). *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. ▪ General Medical Council. (2010). *Treatment and care towards the end of life: good practice in decision making*. London: GMC. ▪ Leadership Alliance for the Care of Dying People. (2014). *One chance to get it right.* Publications gateway reference 01509. ▪ Mental Capacity Act 2005, London: The Stationary Office. ▪ NHS End of Life Care Strategy. (2008). *Promoting high quality care for all adults at the end of life.* Dept. of Health, London. ▪ R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] EWCA Civ 822. ▪ Royal College of Physicians of London. (2009). *Concise guidance to good practice. Series No. 12 Advance Care Planning.* *https://www.rcplondon.ac.uk/sites/default/files/concise-advance-care-planning-2009.pdf*
Training Need Identified?	Yes

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
01.06.20003	1.0	DNAR policy developed.	Resuscitation Team. Legal Services & Bevan Ashford
01.01.2008	2.0	Full review, original document changed.	DNAR working group/Resuscitation Committee/Legal Services.

11.02.2010	2.1	Minor updating. Amended advance directive terminology & updated references/links.	Resuscitation Committee. Legal Services. Jay Over
01.05.2011	3.0	Full review. Name changed from Do Not Attempt Resuscitation to Allow Natural Death. Changes to wording & proforma. Paediatric proforma added. Removal of full guidance.	DNAR Working Group. Resuscitation Committee. Jay Over. Legal Services.
17.01.2012	3.1	Minor amendment to clarify the meaning of deputy in relation to disagreement.	Jay Over, Resuscitation Officer.
01.05.2015	4.0	Full review. Name changed from Allow Natural Death. Complete new form. Treatment escalation plans added. Resuscitation decision record so CPR YES or NO. Paediatric element removed to separate policy. TEP form where applicable to stay with the patient.	TEP Working Group, Resuscitation Committee, Legal Services, Consultants, Patient focus group, Patient ambassadors. Jay Over, Resuscitation Officer.
01.01.2018	5.0	Full review. Changes to the TEP form including a more robust MCA assessment, removal of "would you be surprised?" question, signature required on the back of form, review boxes added & a free text box added Minor amendment to formatting. Appendices rearranged, EIA updated, and permission sourced for framework.	TEP Working Group, Resuscitation Committee, Legal Services, Consultants Jay Over, Resuscitation Officer. Ella Leuzzi, Resuscitation Officer.

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 2. Initial Equality Impact Assessment Form

<table>
<tr><td colspan="6">Name of Name of the strategy / policy /proposal / service function to be assessed

Treatment Escalation Plan & Resuscitation Decision Record (in relation to the adult patient over 18 years) V5.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Clinical</td><td colspan="3">Is this a new or existing Policy?
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:
Jay Over</td><td colspan="3">Telephone:
01872 252124</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To ensure that healthcare professionals properly decide and document treatment including a CPR decision in patients who are at risk of deterioration and/or cardiac arrest.

To acknowledge the right of every competent adult patient to determine whether or not to accept an attempt at CPR.

To ensure suitable provisions are made for any patients who are deemed to lack capacity.

To provide a framework to staff, patients, families and carers regarding treatment including CPR decisions.</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">All DNACPR orders will be made in accordance with this policy.</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">All DNACPR orders will be made in accordance with this policy.
Inappropriate resuscitation attempts will be minimised.</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">Regular clinical audit of policy against case notes.</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">All patients
Clinical Staff
Patient carers</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>✓</td><td>✓</td><td></td><td>✓</td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups
The TEP Working Group
Resuscitation Committee
Legal Services
(Other external organisations, CPFT, SWAST & KCCG)</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">Policy ratified and agreed.</td></tr>
</table>

7. The Impact

Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		✓		
Sex (male, female, trans-gender / gender reassignment)		✓		
Race / Ethnic communities /groups		✓		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		✓		
Religion / other beliefs		✓		
Marriage and Civil partnership		✓		
Pregnancy and maternity		✓		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		✓		

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 this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	✓

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

Implementation of the TEP will only have a positive effect does not impact in any way on any of the equality strands.

Signature of policy developer / lead manager / director	Date of completion and submission
Jay Over & Ella Leuzzi	8th May 2018

Names and signatures of members carrying out the Screening Assessment	1. Ella Leuzzi 2. Jay Over	

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

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

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

Signed Ella Leuzzi

Date 8th May 2018

Appendix 3. Treatment Escalation Plan (CHA2311)

File on front of current clinical notes

NHS number: _____
Name: _____
Address: _____
_____ Affix patient label
Date of birth: _____
CR number: _____

Preferred name:

NHS

CORNWALL
Treatment Escalation Plan (TEP) and Resuscitation Decision Record

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

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

Is admission to hospital appropriate?		Yes	No
Are IV/SC fluids appropriate?		Yes	No
Are antibiotics appropriate?		Yes	No
Is artificial feeding appropriate?		Yes	No
Is deactivation of Implantable Cardioverter (ICD) therapies appropriate?	N/A	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

Please put an asterisk against any of the above and provide further information below if required.

Please provide any additional clinical guidance on specific interventions that may or may not be clinically appropriate including further details about being taken or admitted to hospital. This may also include the patient's wishes and/or a statement of their preference for priority of care; sustaining life or ensuring comfort.

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION ☐ **DO NOT ATTEMPT RESUSCITATION (DNACPR)** ☐

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

Summary of relevant information including **rationale for treatment decisions** including diagnosis and appropriate PMH:

Does the patient have the mental capacity to be involved in making these decisions?
Please tick: Yes ☐ No ☐
If you tick NO it is a statutory requirement that a Mental Capacity Assessment has been completed overleaf.

Please now complete either the HAVE or HAVE NOT box below accordingly

These decisions **HAVE** been discussed with patient/relatives/partner/IMCA (Please state whom and give brief overview):

Date: Time:

These decisions **HAVE NOT** been been discussed with the above for the following reasons:

One + all | we care
CHA2311 V4 Printed 11/2017

affix patient label

Mental Capacity Assessment relating to the CPR decision documented in this Treatment Escalation Plan (TEP)

It is confirmed that in carrying out this capacity assessment the starting point was to assume that the person had capacity and the outcome was not based on the person's age, appearance or an aspect of their behaviour alone. ☐

It is believed that the person's impairment might be affecting their ability to make this decision because of the person's behaviour, circumstances or content of communication and/or concerns raised by another regarding the person's capacity. ☐

Stage 1:

It has been established that the person does have a mental impairment or disturbance meaning they satisfy the two-stage test of capacity as defined by the Mental Capacity Act. The Impairment or disturbance is:

Reason: _____

Relevant information - All reasonable attempts were made to provide information relevant to the decision making including the nature, purpose and consequences of the decision. ☐

Support provided - The person was fully supported to ensure wherever possible they could make the decision themselves. ☐

Information was communicated:

Verbally	☐	In writing	☐
In an environment suitable for the person	☐	At a time most suitable for the person	☐

Support was provided by the person giving the information / by another (Please state:)

Stage 2: The person was able to:	**Yes**	**No**		**Yes**	**No**
Understand all the relevant information?	☐	☐	Retain all of the relevant information?	☐	☐
Weigh all of the relevant information?	☐	☐	Communicate all the relevant information?	☐	☐

Consultation - As this decision is life changing and complex and the person has been assessed as lacking the mental capacity to make the decision consultation has been undertaken with family/friends/unpaid carers, or an Independent Mental Capacity Advocate (IMCA). See overleaf.

Best interest decision	**Yes**	**No**
Does the person have a Lasting Power of Attorney for health and welfare or a Court appointed deputy?	☐	☐
Has the person made an Advance Decision to refuse this treatment?	☐	☐
Is it likely that the person will regain capacity in relation to the decision in question?	☐	☐
Can the decision wait until the person regains mental capacity?	☐	☐
Has the person been helped to participate in the decision making process as fully as possible?	☐	☐

Considering the statutory checklist (above) and taking all factors into account (Physical health and wellbeing, emotional health and wellbeing, risk of serious injury, social contacts and finances) the most appropriate decision has been made in the person's best interests.

Healthcare professional / doctor making the decision:

Name (Caps): Signature: Grade:

GMC No: Date: Time: Ward:

Consultant / GP (Signature or Endorsement):

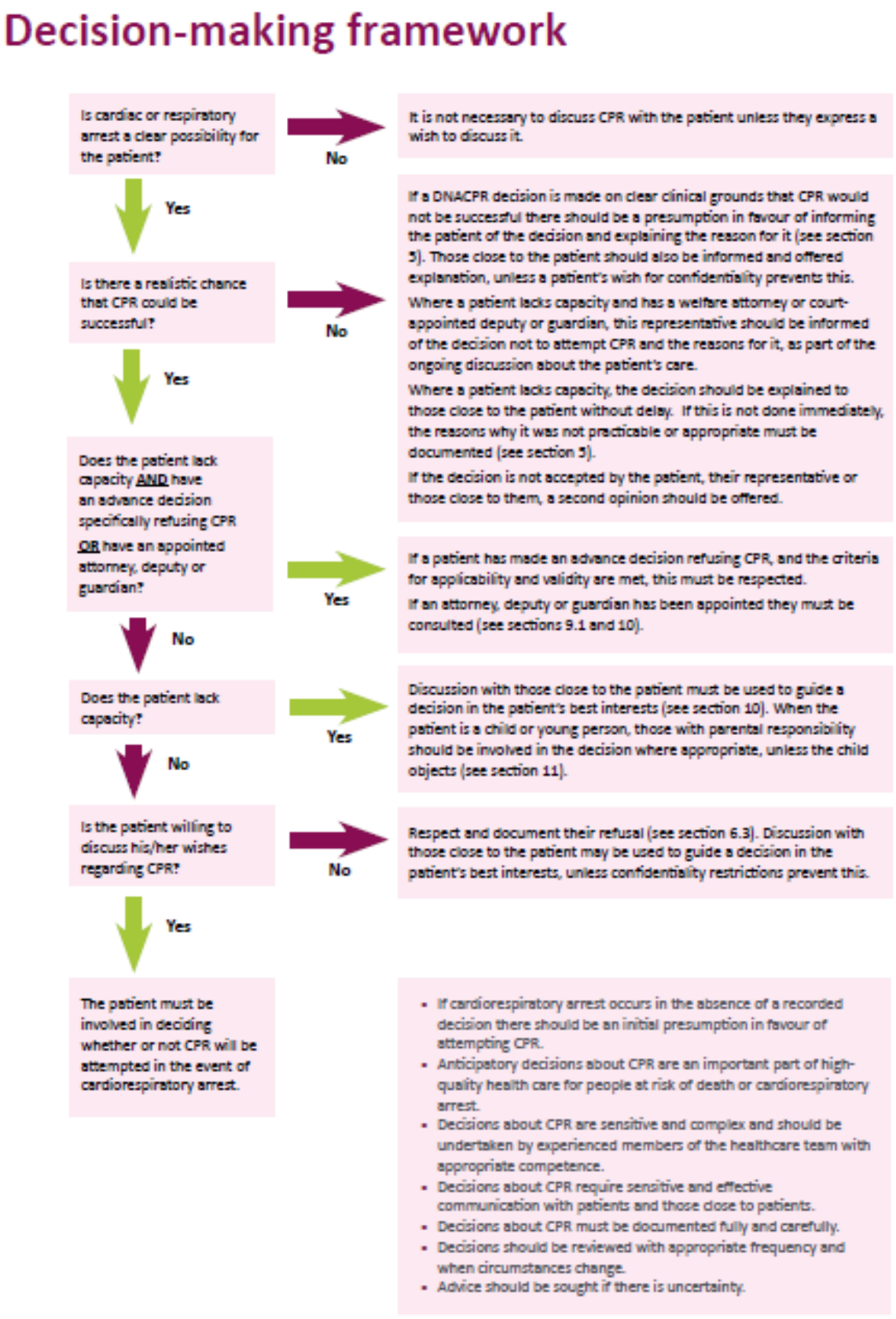
Name: Signature: Date:

Names of members of multidisciplinary team contributing to this decision including name of nurse informed (if applicable):

Review date	Grade	Clinician name	GMC / NMC	Signature

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

Appendix 4. Decision Making Framework



Resuscitation Council (UK) joint statement (2016); Page 6

Reproduced with the kind permission of the Resuscitation Council (UK).

Appendix 5. Resuscitation Decisions in Critical Care

Treatment in Critical Care (CC) 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 continue to receive a degree support for their cardiac, pulmonary and other physiologic systems up to the point of dying.

In CC a patient'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 CC 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.

Audit

All patient deaths in CC are reviewed at monthly audit meetings. Specific consideration of resuscitation decisions and the documentation relating to the communication of these will be included in the review.

CC will monitor complaints and correspondence and feedback to their relevant governance groups.