Paediatric Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
**Policy Title:** Paediatric Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

**Executive Summary:** Cardiopulmonary resuscitation (CPR) can be attempted on any individual for whom cardiac or respiratory function ceases. However, in some people this would be inappropriate, futile or against the individual’s or carers wishes. It is therefore essential to identify paediatric patients for whom cardiopulmonary arrest would represent a terminal event in their illness and for whom CPR should not be attempted.

**Supersedes:** Version 1.0

**Description of Amendment(s):** Transfer existing policy document into the corporate policy template. Update to content from revised guidance about decisions relating to CPR from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Update to content from Legal Services.

**This policy will impact on:** Clinical practices

**Financial Implications:** None

**Policy Area:** Applicable for in-patients only, i.e. paediatric patients (less than 18 years of age) within the Acute setting of East Cheshire NHS Trust

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**Version Number:** Version 2.0  
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**Issued By:** Medical Director  
**Review Date:** March 2022

**Author:** Resuscitation Officer  
**Impact Assessment Date:** June 2018

### APPROVAL RECORD

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## Appendices

- **Appendix 1:** Paediatric Do Not Attempt Cardiopulmonary Resuscitation Order (also known as Red Form)
- **Appendix 2:** Equality Impact Assessment Tool
1.0 Introduction

Cardiopulmonary resuscitation (CPR) may be attempted on any individual for whom cardiac or respiratory function ceases. Such events are inevitable as part of dying. CPR can theoretically be used on every individual prior to death. However, in some people this would be inappropriate, futile or against the individual’s or carers wishes. It is therefore essential to distinguish those patients for whom CPR should not be attempted.

This Policy is applicable for paediatric in-patients only, i.e. children less than 18 years of age.

2.0 Purpose

The factors surrounding a decision whether or not to initiate CPR involve complex clinical considerations and emotional issues. The decision for CPR of one patient may be inappropriate in a superficially similar case.

The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing issued updated guidance about decisions relating to cardiopulmonary resuscitation in June 2016. The General Medical Council also published guidelines – Treatment and care towards the end of life: good practice in decision making – in July 2010.

Most guidelines are written specifically about adult practise. The Royal College of Paediatrics and Child Health (RCPCH) have written some guidance entitled withholding or withdrawing life sustaining treatment in children 2nd edition (RCPCH May 2004).

3.0 Responsibilities

3.1 Chief Executive
Has ultimate responsibility for the implementation and monitoring of this policy.

3.2 All Directors
All Directors are responsible for the implementation of this policy.

3.3 The Resuscitation Committee
The Resuscitation Committee is responsible for the development, consultation and approval process of this policy. The Resuscitation Committee is also responsible for reviewing the policy to ensure that it follows the latest best practice.

3.4 The Resuscitation Officer
The Resuscitation Officer is a full member of the Resuscitation Committee and is responsible for monitoring compliance with this policy.

3.5 Ward/Department/Service Managers including Consultants
Managers are responsible for ensuring relevant staff have access to the policy, are trained in its implementation and are aware of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision which has been appropriately documented.
4.0 Processes and Procedures

4.1 Application

a) For most paediatric patients the likelihood of cardio-respiratory arrest is small and no clinical decision is made in advance of such an event. If cardio-respiratory arrest does occur unexpectedly, CPR should be attempted.

b) In some people there is an identifiable risk of cardiac or respiratory arrest, such as an underlying incurable condition (such as advanced cancer or neurometabolic disease), the history (such as recent cardiac surgery), or current clinical condition (such as severe sepsis). If there is a risk of cardiac or respiratory arrest a decision should be made in advance about the appropriateness of CPR whenever possible.

c) A DNACPR order (also known as Red Form) applies only to paediatric in-patients of East Cheshire NHS Trust. The DNACPR order (see appendix 1) refers solely to cardiopulmonary resuscitation; i.e. in the event of a cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation will be made. All other treatment and care, where appropriate, shall not be precluded or be influenced by a DNACPR decision.

d) The DNACPR decision is only valid during the patient’s current in-patient admission and is automatically revoked on discharge from hospital. If still applicable, another DNACPR decision may be made on subsequent admissions. A new form will need to be completed for each in-patient episode.

e) The decision not to undertake CPR on a patient is taken following appropriate consideration of the likely clinical outcome and the patient and carers known wishes. The following guidelines may support a decision not for CPR:

- **Where attempting CPR would not restart the patient’s heart and breathing.** If the health care team is as certain as it can be that attempting CPR would not restart the patient’s heart and breathing because of the patient’s clinical condition, the patient cannot gain any clinical benefit from an attempt. This should be a team decision and based on clinical assessment of the patient’s condition and up-to-date clinical guidelines and in the patient’s best interests.

- **Where there is no benefit in restarting the patient’s heart and breathing.** If the patient is terminally ill and death is inevitable within a short period of time, then that person should be allowed to die naturally with full comfort and palliative measures.

- **Where the expected benefit is outweighed by the burdens of resuscitation.** Where CPR may be successful in restarting the patient’s heart and breathing, and thus prolong the patient’s life, the benefits to be gained from the prolongation of life must be weighed against the burdens to the patient of the treatment. Again, this should be a team decision and based on clinical assessment of the patient’s condition and up-to-date clinical guidelines and in the patient’s best interests.
If a patient or a person with parental responsibility for the patient is requesting CPR in the case of a cardio-respiratory arrest, but the healthcare team believes that this would not re-start the heart and breathing, this should be explained to the patient and/or person with parental responsibility in a sensitive way. These discussions may be difficult and where possible should be carried out by the consultant. If the decision is not accepted, then a second opinion should be offered by a different paediatric consultant and legal advice may be sought at that point.

If a patient is to undergo an invasive procedure (such as gastrostomy change or lumbar puncture) then it may be appropriate to suspend a DNACPR order for the duration of the procedure and monitored recovery. Under these circumstances, the risk of precipitating an arrhythmia is increased, but the arrest is much more likely to be quickly and readily reversible. Under these circumstances please adhere to the following:

- Such a decision must be reviewed before the procedure with the patient and/or the person(s) with parental responsibility as part of the consent process.
- If a patient or person with parental responsibility for the patient wishes an existing DNACPR to remain valid during such a procedure and this would significantly increase the risks, and the clinician believes that it would not be safe or successful with the DNACPR order in place, it would be reasonable not to proceed.
- The agreed DNACPR management option must be clearly documented and communicated to all the healthcare staff managing the patient during the procedure and recovery.

4.2 Who makes the DNACPR decision?

a) The overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the consultant in charge of the patient’s care. When a decision needs to be made urgently, it can be made by the consultant on-call and the named consultant should be notified.

b) DNACPR decisions should be made after discussion with the patient/person(s) with parental responsibility and their wishes must be taken into account. The patient’s wishes must be taken into account when making a decision. If they have mental capacity/Gillick competence to make the decision they must be asked to consent to the decision.

c) If the patient and/or person(s) with parental responsibility have difficulty understanding or communicating decisions, due to sensory impairment, physical disability, lack of understanding of English or other reason, then all reasonable effort should be made to assist them in all relevant discussions.

d) Patients under the age of 16 are not presumed to have capacity to make a decision by themselves and it is essential to ascertain whether they are Gillick competent. Patients over the age of 16 are presumed to have capacity to make their own decisions. If there is doubt about whether a patient over the age of 16 has capacity to make their own decision, the treating team should carry out an assessment of capacity in accordance with sections 1 – 3 of the Mental Capacity Act (2005). If the patient lacks capacity they must still be consulted about the issue but their carers/person(s) with parental responsibility must also be consulted. “As with adults, difficulties can arise where CPR may restart the heart and breathing for a sustained period but there are doubts about whether the potential benefits outweigh the potential harms and burdens. In these cases the views of the child or young person should be taken into consideration, where possible, in deciding whether or not CPR should be attempted”, British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016).
e) Young people with capacity/who are Gillick competent are entitled to give consent to medical treatment. Where a young person who is under 16 and is not Gillick competent those with parental responsibility can be asked to make decisions on their behalf. Refusal of treatment by competent young people under the age of 16 is not binding upon doctors and can be overruled by those with parental responsibility for them particularly where the treatment decision is a serious one. Where a child over 16 has capacity, their refusal may be binding but there is still the possibility that a court may make a declaration that treatment is in their best interests, particularly where the absence of treatment is likely to have serious consequences for the young person. It is essential that the clinical team seek legal advice promptly in such a situation.

f) Usually it is possible to reach agreement on whether or not CPR should be attempted if a child or young person suffers a respiratory arrest. If there is a disagreement between the patient, those with parental responsibility and the healthcare team despite attempts to reach agreement, legal advice should be sought. Patients/those with parental responsibility for patients cannot require doctors to provide treatment contrary to their professional judgement, but doctors should try to accommodate their wishes where there is genuine uncertainty about the young person's best interests. If legal advice is required it should be sought in a timely manner.

g) DNACPR orders should also be recorded for patients expected to die imminently in whom resuscitation could not be successful. If this is not done, first responders are obliged to initiate a resuscitation attempt in accordance with the Trust Cardiopulmonary Resuscitation Policy.

4.3 Documentation and Communication

a) The DNACPR order is printed on a single sheet of Red A4 paper as shown in appendix 1. The form must be completed in full, and no abbreviations are permitted. It must be dated and signed with the doctor’s name and position.

b) The doctor recording the DNACPR decision should insert this form securely into the front of the patient’s medical records and document the decision in the case notes, stating clearly what was discussed and agreed with the person(s) with parental responsibility.

c) It is the responsibility of this doctor to ensure the DNACPR decision is communicated to the registered nurse responsible for the patient’s care. This nurse should be involved in the decision making process and must enter their name, signature, position and the date on the Red Form.

d) It is the duty of this nurse to ensure that this DNACPR decision is communicated to all other relevant members of staff and documented in the nursing notes.

4.4 Endorsement and Review of a DNACPR Order

a) A DNACPR decision should be reviewed by the treating consultant, when clinically appropriate, e.g. following any significant change in the patient’s condition. This may be the on-call consultant rather than the named consultant. A fixed review date is not recommended.

b) Whenever the DNACPR decision is reviewed and the instruction is upheld, this must be recorded in the medical record by the relevant consultant; name, position, signature and date must be entered. The person(s) with parental responsibility must be informed of the change of decision and the reason for it, where appropriate. The details of the decision and discussion should be recorded in the medical records.
c) If the DNACPR decision is cancelled, and/or when the patient is discharged from hospital, the DNACPR form should be crossed through with 2 diagonal lines in black ballpoint ink and “CANCELLED” written clearly between them. The date, name, position and signature of the healthcare professional cancelling the order must also be clearly documented. The form should then be removed from the front of the patient’s medical records and filed chronologically with the appropriate medical notes. If the patient remains in hospital it is vital that the nursing staff are informed of this decision immediately and details clearly recorded in the medical record.

4.5 Validation of a DNACPR Order

a) The decision not to resuscitate a patient is valid for the current in-patient admission only, or for the period of time documented at the last review if specified, unless the order is cancelled.

b) Any DNACPR Orders recorded in the medical or nursing notes relating to a previous admission are no longer valid.

c) If the DNACPR decision is appropriate for a subsequent admission, another DNACPR form must be completed, signed, dated and filed as above. This includes readmission to the paediatric or neonatal wards after a tertiary admission.

4.6 Other Considerations

a) If, in the event of a cardiopulmonary arrest, the first responders are unsure of the patient’s resuscitation status then a resuscitation attempt must be commenced until clarification is obtained.

4.7 Implementation and Access to this Policy

a) This policy will be approved by the Resuscitation Committee and ratified by the Risk Management Subcommittee.

b) All relevant Ward/Departmental/Service Managers including consultants will be sent a copy of this policy and must ensure that relevant staff have access to the policy and are appropriately trained in its implementation.

c) This policy will be published on the ECNHST Infonet – within the ‘Policies Section’ under the heading ‘Resuscitation’. Access to this document will be open to all ECNHST staff.

5.0 Monitoring Compliance with the Document

Compliance with the ECNHST Paediatric Do Not Attempt Cardiopulmonary Resuscitation Policy will be audited by the Resuscitation Officer on an annual basis and reported to the Resuscitation Committee.

This policy will be reviewed every 3 years by the Resuscitation Committee or more often if national guidance changes.
6.0 References

Cardiopulmonary Resuscitation Policy, version 7.0, East Cheshire NHS Trust; 2016

Decisions relating to cardiopulmonary resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing; RC (UK) 2016

Mental Capacity Act, London: Crown Copyright; 2005

Treatment and care towards the end of life: good practice in decision making Guidance for doctors; General Medical Council; 2010

Withholding or Withdrawing life sustaining treatment in Children: A framework for practice, second edition; Royal College of Paediatrics and Child Health; 2004
**Paediatric Do Not Attempt Cardiopulmonary (DNACPR) Policy V2.0**

**Resuscitation Officer**

**March 2019**

**Appendix 1**

**SEE REVERSE FOR GUIDANCE NOTES TO ASSIST WITH COMPLETING THIS FORM**

**PAEDIATRIC DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)**

Children less than 18 years of age

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of DNACPR order: _______________</th>
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<tr>
<td>Address</td>
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<tr>
<td>Date of birth</td>
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Consultant ____________________________

Ward ____________________________

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. **All other appropriate treatment and care will be provided.**

1. **1a** Does the child have mental capacity to make and communicate decisions about CPR? **YES / NO**
   - If “YES” go to 1b, if “NO” go to 1c

2. **1b** Has the child been involved in the decision making process of this order? **YES / NO**

3. **1c** Have the child’s parents (or those holding legal parental responsibility) been consulted and agreed to the application of this order? **YES / NO**
   - If “YES” go to box 2, if “NO” go to 1d

4. **1d** Has a court made an order in respect of this decision? **YES / NO**
   - If “YES” go to 1e. If the answers to both 1c and 1d are “NO” legal advice must be taken before proceeding. All other decisions must be made in the child’s best interests and comply with current law

5. **1e** Date, time, location and name of Judge/Court making order:

2. **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests:**

3. **Summary of communication with patient. If this decision has not been discussed with the patient state the reason why:**

4. **Name of person(s) holding parental responsibility and summary of communication with them (also write entry in medical notes):**

5. **Other professionals contributing to this decision (write name, signature, position and date):**

6. **Consultant completing this DNACPR order:**
   - (PRINT) Name __________________________________________ Position ________________
   - Signature __________________________________________ Date ________________ Time ________________

7. **Named consultant for patient (not necessary at time of making this decision):**
   - (PRINT) Name __________________________________________ Position ________________
   - Signature __________________________________________ Date ________________ Time ________________
Guidance notes to assist with completing this form

This form should be completed legibly in black ball point ink.
All sections should be completed.

- The patient's full name, date of birth and address should be written clearly or addressograph attached.
- The date of writing the order should be entered.
- An acceptable entry in the clinical notes would be “In the event of cardiac or respiratory arrest patient is not for Cardiopulmonary Resuscitation” (do not use abbreviations).
- This order will be regarded as “INDEFINITE” for this hospital admission unless it is clearly cancelled after review.
- The order should be reviewed when clinically appropriate - e.g. a change in the patient’s condition. A fixed review date is not recommended.
- If after review, the “DNACPR” is cancelled, the form should be crossed through with 2 diagonal lines in black ball-point ink and “CANCELLED” written clearly between them, dated, signed and name/position printed by the healthcare professional responsible for cancelling the order. The cancelled form is to be retained in the patient’s notes. It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision.
- On discharge from hospital the order must be cancelled by the named nurse or doctor responsible for the patient’s care using the instructions detailed in the bullet point above.

1. Mental capacity / advance decisions:
   16 and 17-year-olds: Whilst 16 and 17-year-olds with mental capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought via the Trust Legal Department in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests:
   Be as specific as possible.

3. Summary of communication with patient:
   Whenever possible and appropriate this decision should be discussed with the patient. If this decision was not discussed with the patient, state the reason why this was inappropriate; this must also be clearly documented in the medical notes.

4. Name of person(s) holding parental responsibility and summary of communication with them:
   A full discussion should be had and the notes from that discussion filed in the medical notes. The entry recorded on this DNACPR Order is a summary only and you can use time and date of notes to direct people towards the correct section of the medical notes.

5. Names of members of nursing team and other professionals contributing to this decision:
   State the names and positions of professionals contributing to this decision. The registered nurse responsible for patient’s care is to sign and date the form at the time of the decision being made. It is the duty of this nurse to ensure that this decision is communicated to all other relevant members of staff and documented in the nursing notes.

6. Consultant completing this DNACPR Order:
   This may not be the patients named consultant and could be the on-call consultant.

7. Endorsement:
   The Named doctor for the patient should be notified of the decision and should endorse the order as soon as possible if agreed. If disagreed with, further discussion with all parties making the original order (medical, nursing, patient and family) should be undertaken.
Equality Analysis (Impact assessment)

1. What is being assessed?

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<tr>
<td>• Name: Jackie Cornes</td>
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<tr>
<td>• Position: Resuscitation Officer</td>
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State main purpose or aim of the policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

Cardiopulmonary resuscitation (CPR) may be attempted on any individual for whom cardiac or respiratory function ceases. Such events are inevitable as part of dying. CPR can theoretically be used on every individual prior to death. However, in some people this would be inappropriate, futile or against the individual’s or carers wishes. It is therefore essential to distinguish those patients for whom CPR would be inappropriate. The factors surrounding a decision whether or not to initiate CPR involve complex clinical considerations and emotional issues. The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing issued guidance about decisions relating to cardiopulmonary resuscitation in June 2016. The General Medical Council also published guidelines – Treatment and care towards the end of life: good practice in decision making – in July 2010.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age:** East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

**Race:**
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

**Gender:** In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

**Disability:**
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

**Sexual Orientation:**
- **CE** - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (*The Lesbian & Gay Foundation*).
- **CWAC** - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

**Religion/Belief:**
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- **Christian:** 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- **Sikh:** 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- **Buddhist:** 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- **Hindu:** 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- **Jewish:** 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- **Muslim:** 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- **Other:** 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

**Carers:** In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

**No**

**2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

**No**
3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?  Yes

Explain your response: The service may well look after patients from different race, if a patient and/or person(s) with parental responsibility’s first language is not English then interpretation may be required. All staff should be aware of the interpretation policy and interpretation/translation facilities. All staff should also know where to find information to enable them to adhere to cultural requirements of different faiths.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?  No

Explain your response: This policy applies equally regardless of gender or transgender status.

DISABILITY:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?  Yes

Explain your response: Patients and/or person(s) with parental responsibility with hearing loss may require a BSL interpreter when discussing decisions relating to cardiopulmonary resuscitation. Any extra information required for patients and/or person(s) with parental responsibility with learning disabilities should be given accordingly after assessing their individual needs.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently?  Yes

Explain your response: This policy only applies to persons under 18 years of age and and/or person(s) with parental responsibility. There is detailed information in the policy about children with capacity and taking their views into account. There is also guidance on when to seek legal advice.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  No

Explain your response: This policy applies equally regardless of sexual orientation, same sex partners, civil partners or same sex spouses will be included in any discussion with the patient and/or person(s) with parental responsibility and will be treated in the same way as heterosexual partners.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently?  Yes

Explain your response: All staff should know where to find information to enable them to adhere to cultural requirements of different faiths.
CARERS:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently? **Yes**

**Explain your response:** All staff should be aware that it is important to inform and involve carers in the care of their loved one and offer them access to support and advice as and when required. This also applies to same sex partners/civil partners/spouses.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect any other groups differently? **No**

**Explain your response:** No other impacts identified.

4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes</th>
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<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people: This Policy is only applicable to children/young people under the age of 18. Any information given to children/young people should be age appropriate. See section 4.2 where full information is given re involvement of children and young people in decisions, what to do if their wishes are contrary to parental or clinical views and when to seek legal support.</td>
<td></td>
</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children</td>
<td></td>
</tr>
</tbody>
</table>

5. Relevant consultation

*Having identified key groups, how have you consulted with them to find out their views and that they made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?*

In the first instance this policy was reviewed by East Cheshire NHS Trust paediatric consultants, followed by Legal Services. The Resuscitation Committee have reviewed and approved this policy.

6. Date completed: 22/06/18  Review Date: March 2022

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact? **No**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: 

Date: 25.6.18