Do Not Resuscitate (DNR) Guidelines
(‘Plan of Care’)

The following guideline has been reviewed locally and will continue to be used whilst awaiting the Regional Guideline which is due to be launched in 2014.

Date: July 2013
Review date: July 2016
Do Not Resuscitate (DNR) Guidelines

(‘Plan of Care’)

1. INTRODUCTION

CPR is deemed to be appropriate for all children in Wirral Hospital, and other facilities administered by WiSCH, unless there is a clear entry in the medical notes to the contrary.

The aim of these guidelines is to ensure that there is a rigorous process of shared decision – making, communication and documentation concerning decisions about cardio-pulmonary resuscitation, (CPR) for children.

The Human Rights Act 1998 (HRA) requires that “everyone’s right to life is protected by law”, but also recognises that “life should not be preserved at all costs” in that inhuman and degrading treatment is prohibited.

A decision not to resuscitate does not mean that all active treatment should cease. The decision should be accompanied by the formulation, in conjunction with the child (where appropriate) and with the child’s carers, of a plan of care for palliation, and management of respiratory compromise

The need for cardiopulmonary resuscitation is a rare occurrence in the children’s directorate. However, all staff should be familiar with procedures that relate to this situation in order to provide CPR in circumstances in which this is appropriate and not to resuscitate when it is inappropriate.

The process of decision making:

The RCPCH document, “Withholding or Withdrawing Life sustaining treatment in children”. A framework for practice “, outlines five groups of patients in whom withholding or withdrawal of life-prolonging medical treatment might be considered.

1. The “Brain Dead” Child. In the older child where criteria of brain-stem death are agreed by two practitioners, it may still be technically feasible to provide short-term cardio-respiratory support by means of ventilation and intensive care. It is universally accepted that treatment in such instances is futile and the withdrawal of current medical treatment is appropriate.

2. The “Permanent Vegetative” State. The child who develops a permanent vegetative state following severe brain insults such as trauma or hypoxia is reliant on others for all care and does not react or relate with the outside world. Thus he or she arguably has no interest in being kept alive, and life-prolonging could be considered to be ‘inhuman and degrading’
3. **The “No chance” Situation.** The child has such severe disease that life-sustaining treatment is very unlikely to reverse the pathophysiological process, and is thus futile.

4. **The “No purpose” Situation.** Although treatment may produce physiological or biochemical benefit and thus prolong life, the anticipated degree of physical impairment is likely to be so great that it is unreasonable to expect the child to bear it.

5. **The “Unbearable” Situation.** This category is similar to category 4 in that treatment may prolong life, but the anticipated degree of suffering is likely to be so great that it would not be in the child’s best interest to start or continue such treatment.

In situations that do not fit these categories, or in which there is uncertainty about the prognosis for survival or quality of life, the child should always be offered life-sustaining treatment until these issues can be resolved.

Children in the first three categories are likely to be receiving care in a specialist unit, such as paediatric intensive care, oncology or neurology. Decisions regarding resuscitation, therefore, are unlikely to be the primary responsibility of WiSCH staff, though the child's local consultant may be in close liaison with the specialist unit. The fourth and fifth categories are those most likely to be relevant to DNR decisions in WiSCH.

Any decision that a child should not have CPR should normally be taken after appropriate involvement of all members of the health care team, and in full consultation with the child’s carers and where appropriate with the child themselves and with all evidence available. Decisions must not be rushed and should be made with the parents / legal guardian, family members and the child if appropriate. The legal and professional responsibility for the final decision lies with the child’s consultant.

It may or may not be appropriate to ask the parents / carers to sign a “Plan Of Care” at this stage. A verbal agreement may have been given, if so the consultant should document details of the discussion including date and time in the patient’s case notes.

If the parents (or whoever has parental responsibility) signs the “Plan of Care” the reasons for implementing the plan should be clearly documented, using the “WiSCH AGREEMENT FOR PLAN OF CARE DOCUMENT.”

A second opinion, either within or from outside the Trust, is sought if there is not unanimity amongst the family and healthcare team concerning the decision.

**Documentation**

These guidelines only apply if there is a current, dated copy of “Plan of Care”, signed by a consultant.
The “Plan of Care”, document should be attached securely to the inside front cover of the current volume of case notes. If a “Plan of Care” is not available it will be assumed that the child is for full cardiopulmonary resuscitation.

The agreement must be reviewed and dated at each appointment with the consultant paediatrician and at least every 3 months. If, at review, circumstances dictate a change to the agreement, the Consultant should complete a new “Agreement for Plan of Care”, and detail any amendments. The review details should be dated and signed by the Consultant, and, if appropriate, the parent/legal guardian (+/- the child).

The consultant paediatrician should ensure that:

- Parents/legal guardians fully understand the implications of the agreement and in what circumstances it will be implemented.
- The agreement gives sufficient detail in relation to the circumstances in which it should or should not be activated, e.g. with reference to administering oxygen and suction, airway protection and any other treatment/management considered.
- An assessment of the child’s level of understanding and ability to give consent is undertaken (Gillick competence). Where appropriate it may be necessary to involve an independent person as the child’s advocate.
- One copy of the “Agreement for Plan of Care” is given to the parent/guardian and if appropriate to the child, and another is attached securely to the inside front cover of the current volume of the case notes. A copy should also be kept on the children’s ward.

Responsibilities of other members of the multidisciplinary team.

Nurses, therapists and other clinical staff who are involved with the child’s care should ensure that their team are aware of the “Agreement for Plan of Care”. The decision should be documented in the nursing notes and handed over at each change of shift.

If the patient attends Claire house a copy of the agreement must also be sent to them.

If a parent/legal guardian or child discusses an agreement with a member of staff other than the consultant paediatrician and wishes it to be amended, it is that person’s responsibility to contact the consultant to arrange a review appointment.
Community

An “Agreement for Plan of Care” is transferable into the community such that it is valid on home visits, in schools and in community clinics. An “Agreement for Plan of Care” must be communicated to the general practitioner in the discharge letter. It should also be communicated to ambulance staff transferring patients - they will need to be shown the necessary documentation by the healthcare professionals who transfer the care of the child to them.

Claire House Children’s Hospice

This is the children’s hospice for our area; it provides a home from home environment and does not have full resuscitation facilities.

Following a child’s death or when a child's death is anticipated, he or she may be transferred to Claire House, at the discretion of the head nurse or her deputy, providing the following conditions are met.

- Claire House is alerted to ascertain availability of a room or the Butterfly suite.
- The suggestion is discussed with the parents with sufficient time to consider this option.

There is no legal obstacle to this: as long as the death certificate has been signed and a Coroner’s post mortem is not required.
WiSCH AGREEMENT FOR PLAN OF CARE

Please refer to WiSCH DNR Guidelines before completing this document.
The document should be securely attached to the inside cover of the current
volume of the patient’s case notes.

Child’s name ____________________ Hospital number __________
Date of Birth ____________________ GP ________________
School ________________________
Name of person(s) with parental responsibility ____________________

Diagnosis ________________________________

The following details of this plan of care have been explained and discussed with
those with parental responsibility and with ______________________ (child if
appropriate)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Does the child attend Claire House?  Yes / No If yes please ensure Claire House
has a copy of this agreement form.

Name ____________________ Signature ____________________ Date (print) ____________________

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References:

Related Documents:


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