

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy for Infants, Children and Young people.

Effective: February 2011

Review: March 2014

1. Introduction

This policy is specific to infants, children and young people under the age of 18 years. A separate adult DNACPR policy exists for all patients of 18 years old or above. This paediatric policy is based on the 2007 BMA/RC/RCN joint statement on *Decisions Relating to Cardiopulmonary Resuscitation*.

1.1 This sets out several general principles:

- Decisions about CPR must be made on the basis of an *individual* assessment of each case.
- Advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest.
- Communication and the provision of information are essential parts of good quality care.
- It is not necessary to initiate discussion about CPR if there is no reason to believe that an individual is likely to suffer a cardiorespiratory arrest.
- Where no explicit decision has been made in advance there should be an initial presumption in favour of CPR.
- If CPR would not re-start the heart and breathing, it should not be attempted.
- Where the expected benefit of attempted CPR may be outweighed by the burdens, the individual's informed views are of paramount importance.
- A Do Not Attempt CPR decision does not override clinical judgement in the event of a reversible cause of the individual's respiratory or cardiac arrest that does not match the circumstances envisaged.
- DNACPR decisions apply only to CPR and not to any other aspects of treatment.

1.2 The joint statement then gives specific advice relating to children and young people:

- Clinical decisions relating to children and young people should be taken within a supportive partnership involving the child or young person, their families and the healthcare team.

- Young people with capacity are entitled to give consent to medical treatment, and where they lack this capacity it is generally those with parental responsibility who make decisions on their behalf.
- Refusal of treatment by competent young people up to the age of 18 is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment
- Where a young person with capacity refuses treatment, the potential harm caused by violating the young person's choice must be balanced against the harm caused by failing to give treatment.
- If there is disagreement between the child or young person, those with parental responsibility and the healthcare team despite attempts to reach agreement, legal advice should be sought.

2. The Newcastle upon Tyne Hospitals NHS Foundation Trust Principles

- 2.1 The premise of this policy is that all infants, children and young people within the Trust are for active resuscitation unless documented according to this policy. Additionally, if the cause of any child or young person's collapse is iatrogenic, (*i.e.* is a consequence of a medical intervention, *e.g.* post-anaesthesia), then any DNACPR decision is invalidated and resuscitation interventions must be implemented. However, individual clinicians or groups of clinicians must only provide treatments they believe to be in the best interests of the child. In acute presentations, clinicians should not be compelled to deliver care they consider to be futile and must retain discretion not to commence resuscitation, or to discontinue resuscitation, where there is no possibility of good outcome.
- 2.2 The decision not to attempt cardiopulmonary resuscitation (DNACPR) does not mean withdrawal of other therapies and therefore may still be compatible with vigorous medical and nursing care. The clinical team have a duty to continue palliative care after any other treatments aimed at alleviation/cure of a condition have been withdrawn. It does however mean that the resuscitation team will not be called and that ventilatory support and chest compressions will not be initiated. In addition, it would be inappropriate to admit to an intensive care area.
- 2.3 A DNACPR order should only be made after full multidisciplinary team discussion involving the child's parents or legal guardians (*i.e.* in the case of a child under the supervision of the courts the nominated responsible individual should be involved). In some instances there may be an indication to discuss the appropriateness of the DNACPR decision with other senior colleagues and with the child or young person. Any discussion with the child or young person about the withdrawal of therapies will depend not only on his or her clinical status but also on his or her capacity to understand the situation and his or her developmental

- ability to participate in such discussions (i.e. Fraser guideline children and young people).
- 2.4 All relevant discussion should be conducted by the principal consultant on the child or young person's clinical team. They must be documented in the medical notes and on the DNACPR form and should clearly state:
- The date and time of the meeting
 - The individuals present
 - Whether or not consent/consensus was reached
 - Any specific agreements made for the child or young person's clinical management.
- 2.5 If for any reason the initial discussions are undertaken by a member of the medical team other than the consultant in charge of the child or young person's care, the DNACPR order must be countersigned by the consultant within 24 hours. (In the event of this consultant's absence, another consultant must countersign it within this period).
- 2.6 Once a DNACPR order has been recorded in the medical notes and on the DNACPR form, it must be documented in the nursing notes by a senior member of the child or young person's nursing team. It is then the responsibility of that nurse to ensure the information is then effectively communicated to all staff that need to be made aware of the DNACPR decision.
- 2.7 All DNACPR orders must be reviewed daily by the ward medical and nursing staff, based on the child or young person's clinical condition. A consultant review of the continuing appropriateness of the DNACPR order must be made and documented in the medical notes and on the DNACPR form every seven days. This should be written by the consultant in charge of the child or young person's care. (In the event of the consultant's absence, another consultant must document this). Any changes in the DNACPR status must be communicated appropriately and updated in the nursing notes by a senior member of the child or young person's nursing team.
- 2.8 If the DNACPR is later withdrawn, this decision requires similar discussion and documentation as above.
- 2.9 If there is no valid written order, or there is any doubt about the DNACPR status of the child or young person, full resuscitation measures must be implemented in the event of cardio respiratory collapse.]

3. Monitoring

An annual audit will be undertaken across the Trust by the Resuscitation Training Officer and the Clinical Governance and Risk Department to determine the number of DNACPR orders in place and that the orders have been completed to a high standard.

This report will be completed by the Resuscitation Training Officer and presented to the Trust Resuscitation Training Committee. The Committee will be responsible for identifying any issues regarding compliance with the policy and will monitor action plans to correct deficiencies until all issues are resolved.

Author: Chairman of the NUTH Trust Resuscitation Committee.

4. Published Guidance

Withholding and Withdrawing Life Saving Treatment in Children. A Framework for Practice.

Royal College of Paediatrics and Child Health 1997.

Withholding and Withdrawing Life-prolonging Medical Treatment. Guidance for decision making.

British Medical Association 1999.

Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision Making.

General Medical Council 2002.

Decisions relating to cardiopulmonary resuscitation. A joint statement.

British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. London: BMA, October (2007)

The Children Act, England and Wales, 1989; Scotland 1995.

The United Nations Convention on the Rights of the Child 1989

The Human Rights Act 1998

The Mental Capacity Act 2007

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A**

Policy Title:	Do not attempt cardiopulmonary resuscitation policy for infants, children and young people	Policy Author:	Chair, Trust Resuscitation Committee
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)	No	There is no reference to any variance in policy dependent upon any of the listed criteria. Account is taken of any declared and recorded individuals wishes with regards to resuscitation. The guidance is in accordance with the Human Rights and the Mental Capacity Act 2005.
	• Race *		
	• Ethnic origins (including gypsies and travellers)		
	• Nationality		
	• Gender *		
	• Culture		
	• Religion or belief *		
	• Sexual orientation including lesbian, gay and bisexual people *		
	• Age *		
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *		
	• Gender reassignment *		
	• Marriage and civil partnership *		
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	NA	
4(a).	Is the impact of the policy/guidance likely to be negative? (If "yes", please answer sections 4(b) to 4(d)).		
4(b).	If so can the impact be avoided?	No	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d).	Can we reduce the impact by taking different action?	NO	

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Comments:	Action Plan due (or Not Applicable):
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Name and Designation of Person responsible for completion of this form: Chair of Resuscitation Committee Date: 24 February 2011

Names & Designations of those involved in the impact assessment screening process: Children's Services Directorate

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)