1. Policy Statement

It is the policy of Rowcroft Hospice that all treatments offered to all patients under its care will at all times be appropriate for, and planned with, whenever possible, the individual patient.

2. Policy principles

2.1 The care and treatments offered by the hospice will always aim to treat all aspects of the whole person: physical, social, psychological and spiritual.

2.2 The hospice staff will at all times attempt to involve the individual patient in planning and delivery of care.

2.3 Patients will be provided with verbal, and where appropriate written information, to support decision making about their care and treatment.

2.4 Where a patient has drawn up an advance care plan, advance decision to refuse treatment or any such document specifying their wishes, this will be followed in accordance with the validity and applicability criteria laid out in law.

2.5 The views of relatives/carers are important and every effort will be made to establish these. It is important, however to note that the views expressed by relatives/carers must not override those of the patient and are given to staff as guidelines for best interest decisions, not instructions.

2.6 No discussion will take place between hospice staff and relatives/carers if a patient is unwilling for such a discussion to take place.

2.7 The principal aim of treatment and care delivered by the hospice is to enhance the patient’s quality of life. This may include life prolonging treatments (e.g. IV fluids, blood, antibiotics). Where a patient decides not to continue such treatments this decision is respected and their agreement sought as to what treatment modalities
they are prepared to accept.

2.8 Where a patient is assessed as lacking mental capacity to make a decision regarding a specific treatment/s, Rowcroft hospice staff will act in accordance with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

2.9 In the event of a patient experiencing a sudden, unexpected collapse, active supportive care will continue to ensure the patient is comfortable and free from pain and distress. Active resuscitation, which is treatment to try to reverse the causes of sudden, unexpected collapse (including CPR, ventilator support, the use of inotropes and renal dialysis), is seldom appropriate for patients cared for by Rowcroft hospice. There is evidence to suggest that, for terminally ill patients, the harms of cardiopulmonary resuscitation (CPR) are likely to far outweigh the possible benefits. Evidence indicates that where cardiac arrest occurs out of hospital, the survival rate to discharge is at best 5-10%\(^2,3\).

2.10 A principal focus of our care is to try to ensure dignity throughout the dying process and affirm death as a natural part of life. The decision to provide active resuscitation is a multi-disciplinary one and is decided on an individual basis. This decision should be made explicit to all health care professionals concerned with caring for that patient and the wishes of the individual lie at the heart of this decision.

2.11 Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or those close to the patient. It is good clinical practice to discuss major decisions about care with patients and / or their families and this includes decisions about DNACPR. There should always be a presumption in favour of patient (and/or family) involvement and there needs to be very convincing reasons not to involve the patient (and/or family). However, it is inappropriate to involve the patient in the process if the clinician considers that to do so is likely to cause the person to suffer physical or psychological harm\(^4,5\).

2.12 All patient and their relative/carers are encouraged to ask the Rowcroft staff any questions they may have at any time about their care.

3. Related policies, guidelines and procedures Responsibility & Accountability

- SOP for Active Resuscitation
- MCA Policy
- DoLS Policy

4. Responsibility & Accountability

- The Medical Director is responsible for the medical supervision of hospice doctors making DNACPR decisions.

- The Medical Director and Director of Patient Care are responsible for monitoring, implementing and reviewing this policy.

- Managers are responsible for ensuring that appropriate experienced clinical nurse specialists are competent in the knowledge and skills to undertake DNACPR discussions and completion of TEP forms.

Overarching policy regarding treatment decisions, do not attempt cardiopulmonary resuscitation (DNACPR) decision making and treatment escalation plans (TEPS)
- Hospice doctors and experienced and competent clinical nurse specialists are accountable for ensuring they have and maintain the relevant knowledge, skills and competencies to undertake discussion of DNACPR and completion of relevant documentation, namely TEP’s. They are also responsible for ensuring that the GP’s they work with are in agreement to them completing TEP’s for named patients. They must seek both a GP and a multidisciplinary viewpoint about decisions related to DNACPR for named patients.

5. CPR Decision Making

The overall responsibility for DNACPR decisions rests with the consultant or GP in charge of the patient’s care, in conjunction with the senior nurse involved in the care of the patient. However, they may delegate this responsibility to another registered medical practitioner or an experienced nurse who has undertaken appropriate training. Decisions should be made by the most senior member of the clinical team available and endorsed by the consultant or GP or their deputy at the earliest possible opportunity. Wherever possible, a decision should be agreed by two senior members of the health care team responsible for the patient’s care and treatment.

There are five different situations in which a DNACPR decision needs to be considered depending on the likelihood of success of CPR and the capacity of the patient:

5.1 When attempts at CPR have a reasonable chance of success and the patient has capacity for decision making.

- It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer a cardiorespiratory arrest.

- Patients should however be given as much information as they wish about their situation including information about resuscitation. It is the professional’s responsibility to find out how much the patient wishes to know or can understand.

- Written information on CPR should be available for all patients and their families.

- If a patient with capacity refuses CPR this must be respected.

- Patients should be encouraged to complete an Advanced Decision to Refuse Treatment (ADRT) or appoint a Lasting Power of Attorney for Health and Welfare (LPA) if they have specific requests regarding refusal of potential future treatments as CPR decision forms are not legally binding.

5.2 When attempts at CPR have a reasonable chance of success and the patient is assessed as not having capacity for decision-making.

The decision remains the responsibility of the consultant or GP responsible for the patient’s care taking into account the following:

- If a patient lacking capacity has a valid and applicable Advance Decision Refusing (ADRT) CPR this should be respected.

- Any properly appointed Lasting Power of Attorney for health and welfare should be consulted.

- In the absence of these, those close to the patient should be involved in discussions to
explore the patient’s wishes, feelings, beliefs and values.

- For patients who are un-befriended an Independent Mental Capacity Advocate (IMCA) must be involved.

- Relatives or friends should never be placed in a position in which they feel they are making a DNACPR decision for the patient unless they have been appointed as the patient’s personal welfare attorney under a Lasting Power of Attorney (LPA).

### 5.3 When attempts at CPR have little or no chance of success and the patient has capacity for decision-making.

- Whilst patient’s informed views are of great importance, where the expected benefit of attempted CPR may be outweighed by the burdens the GMC has stated that “there is no obligation to give treatment that is futile or burdensome.” This applies to CPR.

- If there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. When a person is in the final stages of an incurable illness and death is expected within a few hours or days, in almost all cases CPR will not be successful.

- If there is no realistic chance that CPR will be successful, Rowcroft Hospice will support a justifiable and appropriately documented decision of a healthcare professional not to attempt CPR.

- There should be a presumption in favour of patient involvement and there needs to be convincing reasons not to involve the patient in DNACPR decisions. Where a patient has made it clear they do not wish to talk about dying or discuss their end of life care, this must be respected.

- All decisions must be clearly documented in the electronic care records and any reason for not discussing it with the patient, clearly stated.

### 5.4 When attempts at CPR have little or no chance of success and the patient lacks capacity for decision making.

- The decision remains the responsibility of the consultant or GP responsible for the patient’s care.

- In order to make a fully informed decision, where it is both practicable and appropriate, they must discuss the patient’s situation and the decision with those close to the patient (subject to any confidentiality restrictions expressed if, and when, the patient had capacity).

- Where both practicable and appropriate, they should not delay contacting those close to the patient in order to do this. Of note, in the recent judgment it was stated by the judge that “a telephone call at 3.00 am may be less than convenient or desirable than a meeting in working hours, but that is not the same as whether it is practicable”.

- When it is not possible to contact those close to the patient immediately and an anticipatory decision about CPR is needed in order to deliver high-quality care that decision should be made in accordance with the relevant legislation.

- For un-befriended patients there is no need to appoint an IMCA.
5.5 When no CPR decision has been taken and the situation is clearly palliative.

- There may be occasions when due to unavoidable circumstances a Health Professional who is unable to contact a doctor immediately, makes a decision based on their knowledge of the patient, the patient’s circumstances and the patient’s wishes, not to commence CPR.

- Rowcroft Hospice will support any appropriate decisions made by the health professional in these circumstances. However, such decisions must be incontrovertible and very clearly documented.

- This only applies in emergency situations and health professionals should do everything possible to contact either the GP or consultant or their deputy. If they are unable to do so then they must document the reasons for this in the patient’s medical records.

5.6 Discussion of CPR decisions

For any patient a decision needs to be made regarding:

- Who to include in the discussion about CPR

- What to cover in the discussion about CPR

- It is not necessary to burden a patient or relevant others with a CPR discussion where a cardiac or respiratory arrest cannot be anticipated.

- For all patients for whom CPR is felt not to be appropriate this should be discussed with the patient unless there are convincing reasons not to. Where a patient has made it clear they do not wish to talk about dying or discuss their end of life care, this must be respected. It is important to ensure that families and those close to the patient are aware of the DNACPR decision.

- If a patient’s family members are not available immediately then a timely decision should still be made and then communicated to the family at the earliest opportunity. It should be made clear to those close to the patient that their role is to help inform the decision-making process, rather than being the final decision-makers.

- All decisions must be clearly documented in the electronic care record. This will often require documentation in the electronic care record of detail beyond the content of the TEP (DNACPR) form. The content of the TEP will also need to be described on the EPaCCS system.

- In any situation, a clinician who makes a conscious decision not to inform a patient of a DNACPR decision, as they believe that informing the patient is likely to cause them harm, should document clearly their reasons for reaching this decision.

- Information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team.

- A decision not to attempt CPR applies only to CPR and inclusion of decisions relating to CPR as part of an advance care plan or a treatment escalation plan (TEP) may help to emphasise which other treatment options are and are not appropriate for each individual. The responsible health professional should initiate the process at the appropriate time. This may be delegated to other members of their team including senior nurses and other health care professionals who have been suitably trained.
5.7 Requests for CPR in situations where it will not be successful

- Patients have no legal right to treatment that is clinically inappropriate. If the healthcare team has good reason to believe that CPR will not re-start the heart and breathing this should be explained to the patient in a sensitive but unambiguous way. These decisions and discussions are not easy and should be undertaken by senior clinicians whenever possible.

5.8 If the patient doesn’t accept the decision, a second opinion should be offered. However, there is no legal obligation to offer a second opinion in cases where the patient is being treated by a multi-disciplinary team, all of whom take the view that a DNACPR decision is appropriate.

Recording and Communicating DNACPR decisions

- If a ‘DNACPR’ decision is made for a patient outside the hospice inpatient unit, the senior healthcare professional must complete the TEP (DNACPR decision) form which has a high visibility red border (Appendix 1). This is the only valid clinical decision-making document for DNACPR in Devon; it requires an ink signature.

- This is a standard form recognised by all local NHS Trusts, Out of Hours services and Hospices across Devon.

- A TEP (DNACPR) decision documented on the standard red form is therefore valid in all health care settings including during transfer from one setting to another across Devon. It should be respected by all healthcare professionals.

- The red TEP (DNACPR) form is the active form and should stay with the patient or travel with the patient on transfer to other care settings including on discharge home so that the decision is backed up by the visible presence of the form.

- The completed red form should be placed in the front of the patient care record appropriate to the care setting such as hospital, hospice or community nursing or care home care records.

- A TEP form can be scanned or copied if needed for patient care records purposes, but the original must stay with the patient (if at home) or in the patient’s medical records if they are in hospital.

- If the red form is signed under delegated authority by senior medical practitioner who is not ultimately responsible for the patient’s care (e.g. doctors on call, visiting GP, clinical nurse specialist and sisters with appropriate competencies), the form then needs the endorsement of the Consultant, GP or senior nurse responsible for the care of the patient as soon as is practically possible by counter-signing the form or documenting agreement in the patient’s medical record.

- The decision should also be reviewed if there are changes in the patient’s condition and wishes. See 5:10 re managing old versions of the TEP.

- The DNACPR decision should be communicated to other healthcare professionals involved in the patient’s care (e.g. GP, hospital teams, Out of Hours services and the ambulance service) in a timely manner. This can be achieved by documenting it in clinical letters and recording on shared electronic health records (EPaCCS).
original TEP can be copied and sent electronically to healthcare professionals. It is good practice to ensure the patient’s GP/Consultant is informed at the earliest opportunity.

- The healthcare professional who has initiated the decision, must record the decision making process in the patient’s electronic health record and ensure their DNACPR status is complete.

In-Patient Unit (IPU)

If the patient is for CPR this is documented in the patients electronic record and ‘For Resus’ should be written in red against the patient’s name on the white board in the IPU ward office or against the electronic white board using the appropriate icon.

If the patient is not for CPR then:

- There is no need for a TEP, but DNACPR having been discussed should be indicated on the patient’s electronic record.

- The patient discharged home should normally be given a completed TEP form (with DNACPR status completed) or when transferring to another care setting (e.g. hospital transfer for admission or outpatient attendance via ambulance); however there may be some circumstances where it is not appropriate for a TEP to travel home with the patient.

In all cases

- The CPR status on the electronic care records should be completed or updated.

- The decision should be handed over from one nursing shift to the next as a matter of routine practice when a patient is for resuscitation.

- The resuscitation status of the patient should be documented in their discharge letter which should be sent to the patient’s GP on the day of discharge and copied to relevant other healthcare professionals involved in that patient’s care.

Hospice@Home

- Patients should already have a completed TEP form in the home, if not the GP must be notified to complete one.

- Other healthcare professionals involved in the patient’s care should be notified as above.

- The CPR status on electronic care record should be completed or updated.

5.9 Transferring patients

On transfer from one care setting to another the TEP form should travel with the patient. A photocopy of scanned copy of the form should remain in the originator’s notes.

Forms in the hospice should be reviewed before the patient is discharged to the community.

5.10 Cancelling DNACPR decisions

Overarching policy regarding treatment decisions, do not attempt cardiopulmonary resuscitation (DNACPR) decision making and treatment escalation plans (TEPS)
If the ‘DNACPR’ order is cancelled the form should be removed from the notes or possession, crossed through with two lines and highlighted with the instruction ‘This order is cancelled’, signed, dated and filed normally. A suitable entry must also be made in the patient’s electronic care record and all relevant agencies informed. Any copies of the order should also be crossed through, signed and dated when the agencies are informed of the cancellation.

6. Training

- Experienced nurses (greater than 2 years in post as a CNS or H@H sister) who are required to take on this extended role must undertake advanced communication skills training, and a bespoke training session on DNACPR and TEPs.

- They must also complete the competency assessment (Appendix 2)

This policy is an adaptation of a previous hospice policy on treatment decisions and The Hospice in the Weald Policy 2.8 (2016) which was adapted from South East Coast Strategic Health Authority Policy Do Not Attempt Cardiopulmonary Resuscitation Principles (DNACPR)
7. References

1. NHS South East Coast Do Not Attempt Cardio Pulmonary Resuscitation Principles (DNACPR), July 2010 (online access no longer available)


7. GMC Guidance 2010. Treatment and care towards the end of life: good practice in decision making. Accessed at Treatment and care towards the end of life - GMC (gmc-uk.org) on 23/03/2021
**APPENDIX 1**

**Treatment Escalation Plan (TEPP)**

---

<table>
<thead>
<tr>
<th>Mental Capacity</th>
<th>Do you believe the patient has capacity to be involved in making these decisions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

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

- **Is admission to an acute hospital appropriate?**
  - Yes
  - No

- **Are IV therapies appropriate?**
  - Yes
  - No

- **Are oral antibiotics appropriate?**
  - Yes
  - No

- **Is artificial feeding appropriate?**
  - Yes
  - No

- **Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?**
  - N/A
  - Yes
  - No

Are there any other Advance Care Planning documents in place? If yes, what?

In the event of a cardiorespiratory arrest this patient is:

**FOR RESUSCITATION**

**DO NOT ATTEMPT RESUSCITATION (DNACPR)**

Document rationale for best interest treatment decisions and resuscitation status and whom this was discussed with (be as specific as possible).

Has the treatment escalation plan and resuscitation decision been discussed with the patient/patient’s relatives/next of kin/carers? **Yes / No**

If no, document reason: ........................................................................................................

Date: ........................................ Time: ........................................

Role: .................................. GMC/NMC No: ........................................

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Overarching policy regarding treatment decisions, do not attempt cardiopulmonary resuscitation (DNACPR) decision making and treatment escalation plans (TEPS)
Overarching policy regarding treatment decisions, do not attempt cardiopulmonary resuscitation (DNACPR) decision making and treatment escalation plans (TEPS)

Mental Capacity Assessment

The Mental Capacity Act (2005) requires you to assume that individuals have capacity, unless you suspect the person has an impairment or disturbance of the mind or brain. It also requires any assessment to be decision specific. If you suspect someone lacks capacity you are required to complete the 2 stage Mental Capacity Assessment.

Stage 1:

Document the reason you believe the individual has an impairment or disturbance of the functioning of the mind or brain.

Reason: ..............................................................................................................................................

Stage 2: Can the individual:

1. Understand information about the decision to be made?  Yes No
2. Retain that information in their mind?  Yes No
3. Use or weigh that information as part of the decision making process?  Yes No
4. Communicate their decision (by talking, using sign language or any other means)?  Yes No

Is the response yes to all four Stage 2 questions?

No  Yes

Is this loss of capacity likely to be temporary and can the decision wait?  If Yes Set decision review date: 

If No Is there a valid ADRT? (Advance decision to refuse treatment)?  If Yes Complete TEP form as part of discussion with patient.

If No

Is there a Personal Welfare Lasting Power of Attorney (PW-LPA) registered with the Office of the Public Guardian?  If Yes If ADRT is valid and applicable, use it to complete TEP form. For decisions to which ADRT is not applicable, apply “best interests” principles as per box below.

If No Proceed with completing TEP in line with Best Interest principles (please note if the person has no friends, relatives or unpaid carers then you must include IMCA services). Please document rationale/Best Interest principles for treatment and discussion in boxes overleaf.

This form should be completed legibly in black ball point ink

• Complete patient details or affix the patient’s identification label to the top right hand corner.
• The date and time of writing the form should be entered.
• This form will be regarded as ‘INDEFINITE’ unless it is clearly cancelled.
• The form should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another, and admitted from home or discharged home.
• Further guidance on the use of TEP Version 11 can be found on the Devon local joint formularies.

If following clinical review, treatment decisions are changed:

• Clearly score through this form, then sign and date the discontinuation box overleaf,
• File at the back of the patient’s medical notes,
• Document the change of decision in the patient’s medical notes.
• Complete a new form and insert in the patient’s medical notes.
Competency Document

The aim of undertaking this training session is to develop the practice of experienced health care professionals (HCPs), so that they can discuss decision-making for DNACPR with patients and significant others. HCPs will utilise a framework of skills and competency that reflect sound clinical knowledge and judgement.

Competency should be achieved by individuals as soon as possible after completion of the training session. It is expected that this will have occurred 3-6 months after attending.

The individual will have demonstrated competency at the level of an independent practitioner via participation in the training session which includes role play. The assessors at this session will usually be their medical supervisor or another competent member of the medical or senior nursing team.

A self-assessment against the listed competencies and a reflective discussion with their medical supervisor or line manager must take place prior to practising independently.

The medical supervisor will raise any concerns about competence in DNACPR discussion and documentation of such with the individual’s line manager.

The competency and assessment documentation is to be retained as evidence of an individual’s competency.

Acknowledgements

Competences have been adapted from the Policy developed by Hospice in the Weald and are based on The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process 2004 DOH; CHS48 Communicate significant news to individuals, Skills for Health 2007; Decisions Relating to Cardiopulmonary Resuscitation – model information leaflet BMA.
Overarching policy regarding treatment decisions, do not attempt cardiopulmonary resuscitation (DNACPR) decision making and treatment escalation plans (TEPS)

APPENDIX 2 CONTINUED

**DNACPR TRAINING**

**Competency Completion**

<table>
<thead>
<tr>
<th>Training attended/completion Dates</th>
<th>Reflection/Discussion with Line Manager</th>
<th>Signatures</th>
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</thead>
<tbody>
<tr>
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This confirms that reflective discussion has taken place to facilitate the completion of the competency record.

If the trainee is not thought competent following participation in the training session and reflective discussion with their medical supervisor or line manager, further education and support will be required.

**Supervisor/Manager** ..........................................................  **Date** .....................

**Nurse** .............................................................................  **Date** .....................

Overarching policy regarding treatment decisions, do not attempt cardiopulmonary resuscitation (DNACPR) decision making and treatment escalation plans (TEPS)
### DNAR & TEP COMPETENCIES

<table>
<thead>
<tr>
<th>SURNAME</th>
<th>FORENAME</th>
<th>CLINICAL SETTING</th>
<th>ASSESSOR’S or LINE MANAGER’S POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Community</td>
<td>Consultant</td>
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<tr>
<td></td>
<td></td>
<td>Hospice</td>
<td>Speciality Doctor</td>
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<td></td>
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<td>Community CNS Team Leader</td>
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<td>Hospice@Home Manager</td>
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<thead>
<tr>
<th>COMPETENCY</th>
<th>OUTCOME/EXPECTATION</th>
<th>DATE</th>
<th>PRACTITIONER/ ASSESSORS SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEGISLATION</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. Knowledge of national and local guidance</td>
<td>Is able to refer to national and local guidelines and policies</td>
<td></td>
<td></td>
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<tr>
<td>2. Records and documents information clearly, concisely and accurately</td>
<td>Demonstrates appropriate record keeping and completion of documentation</td>
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<td></td>
<td>Evidences awareness of keeping completed form in an appropriate place.</td>
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<tr>
<th>COMPETENCY</th>
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<th>DATE</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>PROFESSIONALISM</strong></td>
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<tr>
<td>3. Reflection on own practice</td>
<td>Recognises own learning needs and identifies how to meet these</td>
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<td></td>
<td>Takes responsibility for attending appropriate training</td>
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<tr>
<td>COMPETENCY</td>
<td>OUTCOME/EXPECTATION</td>
<td>DATE</td>
<td>PRACTITIONER/ASSESSORS</td>
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<tr>
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<tr>
<td><strong>COMMUNICATION SKILLS</strong></td>
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<tr>
<td>4. Communicates skilfully with the patient and/or proxy</td>
<td>Creates awareness of the purpose of the discussion</td>
<td></td>
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<tr>
<td>5. Communicates skilfully about patient wishes and decisions</td>
<td>Demonstrates an appropriate approach to enable ease of discussion</td>
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<tr>
<td></td>
<td>Demonstrates the use of language which is easily understood</td>
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<tr>
<td></td>
<td>Shows ability to use a wide range of communication skills, including open questions, clarification and summarising</td>
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<tr>
<td></td>
<td>Responds to questions honestly and accurately and provides opportunity for questions</td>
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<td>Allows for the expression of emotion</td>
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<td></td>
<td>Understands the additional considerations when discussions are held virtually (e.g. video consultation).</td>
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<tr>
<td>6. Communicates with the multi-professional team</td>
<td>Demonstrates appropriate consultation with team members</td>
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<td></td>
<td>Shows awareness of the need to transfer decision documentation with the patient between care settings</td>
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</table>
### Overarching policy regarding treatment decisions, do not attempt cardiopulmonary resuscitation (DNACPR) decision making and treatment escalation plans (TEPS)

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>OUTCOME/EXPECTATION</th>
<th>DATE</th>
<th>PRACTITIONER/ASSESSORS</th>
<th>SIGNATURE</th>
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<tbody>
<tr>
<td><strong>CLINICAL JUDGEMENT</strong></td>
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</table>
| 7. Reaches a decision regarding DNAR with patient and/or proxy | Demonstrates review of individuals medical history to understand current situation  
Assesses the patient’s capacity to make informed decision | | | |
| **EQUALITY AND DIVERSITY** | | | | |
| 8. Acknowledges the influence of culture, ethnicity and faith on patients and families | Demonstrates understanding of different cultures, faiths and ethnicity which may affect patients decision making | | | |