PROCEDURE FOR DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) DECISION MAKING & COMMUNICATION FOR ADULTS BY NON-MEDICAL PRACTITIONERS

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1. Introduction

This clinical procedure is for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making for adults and communication by **non-medical registered healthcare practitioners**[1]**.** The frameworks supporting this procedure are provided by the NHS Scotland Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy (2016) and Decisions relating to Cardiopulmonary Resuscitation decision-making- guidance from the BMA, RC(UK) and the RCN 3rd edition first revision (2016), and GMC Treatment and care towards the end of life (GMC 2010, revised 2016).

This procedure MUST be read in conjunction with the NHS Scotland Do Not Attempt Cardiopulmonary Resuscitation Integrated Adult Policy (2016) (http://www.gov.scot/Resource/0050/00504976.pdf).

This procedure only applies to adults. For children and young people, up to the age of 18 years please use NHS Scotland Children and Young People Acute Deterioration Management (CYPADM) (Scottish Government 2012). These young people may already have a CYPADM form in their possession which details their wishes when there is an acute deterioration in their health.

2. Aims

2.1 To provide non-medical registered healthcare practitioners with guidance that supports them to lead and record DNACPR discussions and decisions, in the context of multi disciplinary team working with individuals and those who matter to them, as part of the anticipatory care planning process.

2.2 To support non-medical registered healthcare practitioners undertaking discussions and decision making in relation to DNACPR to comply with the NHS Scotland (2016) DNACPR Policy, Resuscitation Council (UK) Guidelines, Adults with Incapacity (Scotland) Act 2000, international human rights instruments such as the European Convention on Human Rights and the UN Convention on the Rights of Persons with Disabilities.

2.3 To facilitate a consistent approach by non-medical registered healthcare practitioners to person-centred CPR discussions and decisions conducted as part of the anticipatory care planning process, in line with Scottish Government (2016) policy.

3. Evidence Base

This clinical procedure is based on the following documents

NHS Scotland Do Not Attempt Cardio pulmonary Resuscitation (DNACPR) Integrated Adult Policy (2016). Scottish Government
http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/peolc/DNACPR

[1] Terms in red are defined in the glossary

Decision relating to Cardiopulmonary Resuscitation decision-making - guidance from the BMA, RC (UK) and the RCN 3rd edition first revision (2016), https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Resuscitation Council (UK) (2015) Resuscitation Guidelines. Prevention of Cardiac Arrest and Decisions About CPR (2014). https://www.resus.org.uk/resuscitation-guidelines/prevention-of-cardiac-arrest-and-decisions-about-cpr/

European Convention on Human Rights (1953) European Court of Human Rights, Council of Europe http://www.echr.coe.int/Documents/Convention_ENG.pdf

Human Rights Act (1998) UK Government http://www.legislation.gov.uk/ukpga/1998/42/contents

Equality Act (2010) UK Government http://www.legislation.gov.uk/ukpga/2010/15

Adults with Incapacity (Scotland) Act (2000) Scottish Government http://www.gov.scot/Publications/2008/03/25120154/1

General Medical Council (2016) Treatment and Care Towards the End of Life: Decision Making http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

NHS Education for Scotland and Scottish Social Services Council (2017) Palliative and End of Life Care: A Framework to Support the Learning & Development Needs of the Health & Social Care Workforce in Scotland http://elearning.scot.nhs.uk:8080/intralibrary/open_virtual_file_path/i2564n4083939t/Palliative%20framework%20interactive_p2.pdf

4. THE PROCEDURE

The Scottish Government's (2016) DNACPR policy reflects feedback and changes in national good practice guidance (Decisions Relating to Cardiopulmonary Resuscitation – guidance from the British Medical Association, Royal College of Nursing and the Resuscitation Council (UK) 2016) and recent statutory changes and legal judgments. The key ethical and legal principles that should inform all **CPR** decisions remain, but even greater emphasis has been placed on ensuring high-quality timely communication, decision-making and documentation.

The process of making CPR decisions including the appropriate involvement of and discussions with the person and those who matter / relevant others, how decisions are recorded, communicated between teams/ settings and reviewed are clearly set out in the NHS Scotland (2016) DNACPR policy to which you MUST refer to in full. Note in particular the requirement to record

- whether the person has capacity to understand a DNACPR decision
- clinical assessment that CPR would or would not be successful
- communications with the person and **those who matter / relevant others**.

Practitioner	
Definition	This procedure applies to all non-medical registered healthcare practitioners in any care setting where their professional lead has formally agreed that this role will be supported. This would normally be a senior practitioner at AfC band 6 and above, who must achieve and maintain the required competencies to safely and effectively undertake this role within the Multi- Disciplinary team (MDT).
Application form: --- Professional Lead`s responsibilities:	Following discussion with the practitioner's professional lead, the practitioner will complete an application to develop practice, to be identified as a non-medical health care professional within the team who is able to lead, discuss and record DNACPR discussions and decisions. The application will be countersigned by the practitioner's professional lead and stored in the practitioner's personal file. See appendix 1 for the application form. The professional lead is responsible for ensuring that there is agreement with the Senior Medical and Nursing team and that documentation is completed regarding scope of practice, accountability, competency assessment and ongoing support in the area that the practitioner will undertake this role.
Practitioner's competency requirements	For essential competency requirements, See appendix 2 `Self assessment of the required competencies'. The practitioner is required to demonstrate enhanced levels of knowledge and skills in domain 2 and domain 4 of the NES (2017) Palliative & End of Life Care Education Framework, and the application of knowledge and skills about relevant legislation. For example, Adults with Incapacity.

Theory and Work based learning required	The Theory and work based learning required includes successful completion of EC4H or equivalent skills based communication training. Appendix 3 provides a flow chart of the process.
Responsibility& Accountability for DNACPR decision making	DNACPR decision-making is the responsibility of the most senior clinician who has clinical responsibility for the person during that episode of care. This will normally be the Consultant in hospital or General Practitioner for those in the community setting or care homes. The DNACPR decision making process involves the person, those who matter to them (relevant others), the medical and non-medical registered healthcare practitioners. At a local level, multidisciplinary teams (which must include the lead medical clinician responsible for the individual's care) must be clear about which members of the team will undertake discussions and decision making in relation to DNACPR. In complex or contentious situations this would usually be the Registered Medical Practitioner. An advance decision about CPR should be made in consultation with other members of the care team who have knowledge about the person and always within the context of realistic and person-centred anticipatory care planning.
The person/situation	
Assessment/planning	CPR discussions and decisions must be on an individual basis. This should be discussed with the patient who has the ability to engage in decision-making, in the context of their individual goals of care, realistic emergency treatment and care options and their priorities in relation to end-of-life care, ***unless*** it is judged that the conversation would cause distress resulting in physical or psychological harm. If the patient has an Implantable Cardioverter Defibrillator (ICD) insitu then consideration should be given at this stage as to whether it should be deactivated or not (ICD policy/procedure)**.** Where the person is unable, or does not wish to engage in discussion, this should be respected and reviewed, as appropriate . All discussions and outcomes must be clearly documented in the person's record. Practitioners should check for any previous relevant discussions or decisions that have been recorded, for example if a DNACPR form has already been completed or an **advance directive**, **living will, advance statement** or **KIS** (Key Information Summary)**.**

	Written information, NHS Scotland *'Decisions About Cardiopulmonary Resuscitation- Information for individuals, their relatives and carers* leaflet (version 2 produced August 2016) and a factsheet should be provided to support discussions, where appropriate, to the individual. Direction to other sources of information including the 'NHS Inform Palliative Care' zone may be appropriate and NES Support Around Death website.
What is the outcome of applying the NHS Scotland (2016) DNACPR Policy Decision-making framework in the following situations?	See below and refer to the Decision-making framework - Appendix 4
Situation 1 – CPR will not work for this person and the person has capacity	A clinical DNACPR decision can be made when a person's condition indicates that effective CPR would not be successful in achieving sustainable spontaneous breathing and circulation. Where it is clear in advance that CPR would not be successful it is essential that the information that CPR will not work is clearly and sensitively shared with individuals and those who matter/relevant others ***as part of a wider conversation about realistic emergency care and treatment options***, unless it is judged that the conversation would cause physical or psychological harm. This conversation should be clearly documented in the person's record.
Situation 2 – CPR will not work and the individual does not have capacity	Discuss with those who matter / relevant others unless there is a strong contraindication (for example, contacting and informing them at a particular time will cause them to suffer harm). Where it is clear in advance that CPR would not be medically successful it is essential that the information that CPR will not work is clearly and sensitively shared with individuals ***as part of a wider conversation about realistic emergency care and treatment options***, unless that conversation is judged to be not practicable or not appropriate. This should be clearly documented in the individual's medical and nursing record. If the person does not have capacity for the CPR decision, then any advance decisions about that person's care must adhere to the principles of the Adults with Incapacity (Scotland) Act 2000. If an individual has a **s47 certificate** (AWI (Scotland) Act 2000)**,** because they lack capacity around a specific treatment, then the treatment plan from that s47 should include all interventions that are required for that treatment and any intervention reasonably

	foreseeable as a consequence of that treatment. This should include consideration of anticipatory care planning including end of life care. Where there is a concern over an individual's capacity around specific treatment decisions and they do not have a s47 certificate, then capacity has to be assessed and recorded on the section 47 certificate by the **appropriate practitioner** in consultation with those who matter / relevant others, Welfare attorney or welfare guardian.
Situation 3 – CPR could work and the person does not have capacity but there is an advance statement / advance directive / living will or welfare PoA or guardian	If a welfare PoA or attorney has been appointed they must be consulted. The healthcare practitioner must see the evidence of any powers of the guardian or attorney. If the advance statement or directive refusing CPR appears to be valid and applicable to the current situation, this should be respected. An advance decision or directive cannot be used to demand a treatment that would not work.
Situation 4 – CPR could work, the person does not have capacity and there is no guardian / PoA	Sensitively discuss with those who matter / relevant others what the person would have felt to be of overall benefit for them. This discussion must happen as part of a wider anticipatory care conversation about realistic care and treatment options. It is important not to give those who matter / relevant others the impression that they are responsible for a DNACPR decision as that responsibility rests with the clinical team. If the person does not have capacity for the CPR decision, then the principles of the Adults with Incapacity (Scotland) Act 2000 apply. When the person lacks capacity, the healthcare team will discuss CPR with those who matter / relevant others to the person. If they agree that the benefits of medically successful CPR are likely to be outweighed by the burdens of that treatment, and/or that they are as certain as they can be that ***the individual would have regarded*** the quality of the sustainable life that is likely to be achieved as unacceptable, a DNACPR decision may be made. If a person has a s47 certificate because they lack capacity around a specific treatment the treatment plan from that s47, should include all interventions that are required for that treatment and any intervention reasonably foreseeable as a consequence of that treatment. This should include consideration of anticipatory care planning including end of life care.

	Where there is a concern over an individual's capacity around specific treatment decisions and they do not have a s47 certificate, then capacity has to be assessed and recorded on the section 47 certificate by the **appropriate practitioner** in consultation with those who matter / relevant others, that are important to the person.
Situation 5 – CPR could work and individual has capacity	Sensitively discuss with the person what would be of overall benefit for them. A discussion about CPR must be undertaken as part of the wider anticipatory care conversation about realistic care and treatment options. A person makes a competent advance refusal: • To CPR when the recorded and consistent wishes of the person who has capacity for that decision. • When CPR does not reflect a valid and relevant advance healthcare directive (living will). A person's informed and competently made refusal which relates to the circumstances which have arisen should be respected.
Situation 6 – individual unwilling to discuss potential for dying/ end of life care options/possibilities	The Healthcare professional must respect and document discussion. Review the need to offer further opportunities for discussion depending on assessment of the individual. Request permission to discuss this with those who matter / relevant others. Discussion with those close to the person may be used to guide a decision in the person's overall benefit, unless the person with capacity refuses and confidentiality restrictions prevent this.
Where the person wishes CPR and the healthcare professional does not agree this will be beneficial.	If the CPR decision is not accepted by the person, their representative or those close to them, a second opinion should be offered. This will normally be the responsible senior clinician. A non-medical registered healthcare practitioner should alert the senior clinician and other members of the multidisciplinary team when there is an area of concern / lack of agreement.
When no discussion has taken place and the individual has a cardio-pulmonary arrest and a DNACPR decision has not been made	It should be presumed that staff would initiate CPR for the person. However, although this should be the initial presumption, there will be some people for whom attempting CPR would clearly not be successful, for example a person in the final stages of a terminal illness where death is imminent and unavoidable. Where CPR will not work it should not be attempted. Any healthcare professional that makes and documents a carefully considered decision not to start CPR in such a situation will be supported by senior colleagues and NHS Lothian. Please note: following the **NMC** case (January 2017) the BMA and Resuscitation Council have stated "Where no explicit decision about CPR has been

	considered and recorded in advance there should be an initial presumption in favour of CPR", the statement clarified: " '…an initial presumption in favour of CPR' …does not mean indiscriminate application of CPR that is of no benefit and not in a person's best interests." "…there will be cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis. In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies." Where a person has advanced terminal illness and a cardiac arrest may be anticipated as a part of the dying process, then a CPR decision as part of timely anticipatory planning is important to preserve the dignity of the person and to allow a peaceful, natural death, also helping to prepare those who matter / relevant others. Nurses should be aware of their responsibilities under nurse verification of expected death[2]. As per Royal College of Nursing statement 2017 nurses working in an environment in which they may encounter death or cardiac arrest should ensure that they have the necessary competence to recognise when CPR may be beneficial in restoring a person to a duration and quality of life that they would value and when, realistically, CPR would be of no benefit to the person and would deprive them of a dignified death or could potentially do them harm.
Documentation	
Discussion & decisions are recorded in line with NHS Scotland (2016) policy	All discussions and decisions should be documented fully in the individual's medical and nursing records. Where a DNACPR decision is made this should be documented on the NHS Scotland (2016) Do Not Attempt Resuscitation Form. A Key Information Summary (KIS) should be created, with consent form the patient (except in certain circumstances) or updated by the GP Practice to include this information. If the person requires their ICD to be deactivated then the documentation should be completed as per ICD deactivation policy/procedure If a person is being discharged from hospital, this information should be included in the anticipatory care planning field on the immediate discharge letter. A timeframe for review of the initial decision should reflect the variability of the person's clinical

[2]This policy is being reviewed (September 2017) to reflect CNO letter of May 2017

	situation and should be recorded.
Access to DNACPR form	The form should stay with and transfer with the person to either: • A person's house • A care home where the person lives • The person's hospital medical record • The person's bedside notes When a person is at home, they and/or those who matter / relevant others must be made aware of the DNACPR form for it to be of use in an emergency situation. Where this information has not been shared, due to the likelihood of this causing physical or psychological harm to the person, the form must not be sent home with the person. The person's GP must be asked by the practitioner to record the advance decision that CPR is not a treatment option within the electronic KIS record with an explanation of the person and family's understanding The local community nursing team must also be informed by the practitioner/ When the lead clinician changes due to transfer or discharge, any DNACPR decision must be reviewed as soon as is reasonably possible, but it is assumed that the existing decision will remain valid meantime.
Reviewing and Monitoring	
Reviewing	The review of CPR decisions must be carried out on a clinically appropriate and individualised basis. A time frame for review of the initial decision should reflect the variability of the individual's clinical situation and should be recorded when the form is completed. Individuals, who are continuing to deteriorate with one or more irreversible conditions and with no prospect of recovery, to a point where CPR might work, do not need to have the DNACPR decision reviewed. This is recorded on the DNACPR form. Local clinical teams have a responsibility to ensure that CPR status is checked and clarified along with other aspects of anticipatory emergency care and treatment planning at every handover, safety huddle, ward round or multidisciplinary meeting. When the lead clinician changes due to transfer or discharge, any DNACPR decision must be reviewed as soon as is reasonably possible, but it is assumed that the existing decision will remain valid meantime.
Monitoring	Regular monitoring of local implementation of the policy will be undertaken by local teams. They have the responsibility for ensuring the policy is implemented effectively.

	Periodic audit of clinical notes where a DNACPR decision has been made but including decisions made by non-medical practitioners will be undertaken in in-patient areas.

5. Further reading

Capacity and consent http://intranet.lothian.scot.nhs.uk/nhslothian/corporate/a-z/capacityandconsent/Pages/default.aspx

EC4H http://www.ec4h.org.uk/

Health and Care Professions Council (HCPC) http://www.hcpc-uk.co.uk/

Health Improvement Scotland (HIS) (2013) DNA CPR indicator
http://www.healthcareimprovementscotland.org/our_work/person-centred_care/dnacpr/dnacpr_indicator.aspx

Nursing and Midwifery Council (NMC) (2015) The Code
https://www.nmc.org.uk/standards/code/

Realising Realistic Medicine, CMO's annual report 2015-16
http://www.gov.scot/Resource/0051/00514513.pdf

Appendix 1

Application Form for Non-Medical Practitioners to undertake Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decision Making & Communication for Adults by Non-Medical Practitioners.

Please store this completed form in the practitioner's personal file.

Name of Practitioner	
Profession	
Department	
Ward or Clinical setting	
Assessor's Name	
Assessor's Profession	
Assessor's contact details	
Relationship to practitioner e.g. Professional Lead	
Mentor identified (may be assessor above)	
Rationale for applying for this extended role (how this will benefit patient care and the strengths the practitioner bring to the role)	
Scope of practice within the MDT has been agreed locally; process for escalation of any issues and review is in place.	

Signature of Professional Lead	
Application and support agreed with the responsible medical clinician within the clinical team Signature of Professional Lead	

I undertake to complete the necessary educational preparation for this extended role and to maintain my competency in this area of practice in accordance with the NMC Code (2015) or HCPC Standards of CPD (2011) and will demonstrate my ongoing competence to a clinical work- based assessor as required by NHS Lothian.

Signature Applicant **Date**

Outcome Decision	**Support** **Decline** **Date** **Signature**

Post decision

Self Assessment completed	**Date:**
Review of self assessment and agreement of training required	**Date:**
Learning plan completed and signed off	**Date:**
Agreement date role will commence **Signature of Professional Lead**	**Date**

Appendix 2: Non-Medical Health Care Practitioner Self Assessment
This self assessment should be undertaken with your professional lead as a tool to shape discussion and to assist in identifying learning needs. These map to domain 2 and 4 of the Palliative and End of Life Care education framework that must be achieved at enhanced level.

COMMUNICATION SKILLS

	COMPETENCY	Reflection/discussion with assessor	Identified learned needs and associated action plan	Action plan completed (date)	Assessor's signature on completion of action plan	DATE
1.	Applies enhanced communication skills (see domain 2 enhanced level) to agree a shared plan with patient, relevant others/those that matter around anticipatory care in relation to DNACPR					
2.	Demonstrates the ability to effectively reflect and respond to communication challenges including uncertainty, strong emotions, denial, tension and conflict					
3.	Engages collaboratively and be able to take a lead role within the MDT in planning, co-ordinating and managing complex care plans to address individual needs, ethical choices and priorities.					

KNOWLEDGE AND SKILLED PRACTICE

	COMPETENCY	Reflection/discussion with assessor	Identified learned needs and associated action plan	Action plan completed (date)	Assessor's signature on completion of action plan	DATE
1.	Applies a comprehensive knowledge of the current legislation. ▪ NHS Scotland DNACPR policy (2016) and the processes set out in the NHS Lothian DNACPR procedure ▪ Resuscitation Guidelines 2015: Prevention of cardiac arrest and decisions about CPR (2014). Resuscitation Council (UK) ▪ NMC or HSPC Code ▪ Human Rights Act 1998 ▪ Equality Act (2010) ▪ Treatment and care towards the end of life: decision making. (2016) General Medical Council ▪ Carers (Scotland) Act 2016					
2.	Applies knowledge of Adults with Incapacity (Scotland)Act 2000, including the need for formal assessment of capacity (if required); factors which increase risk and the					

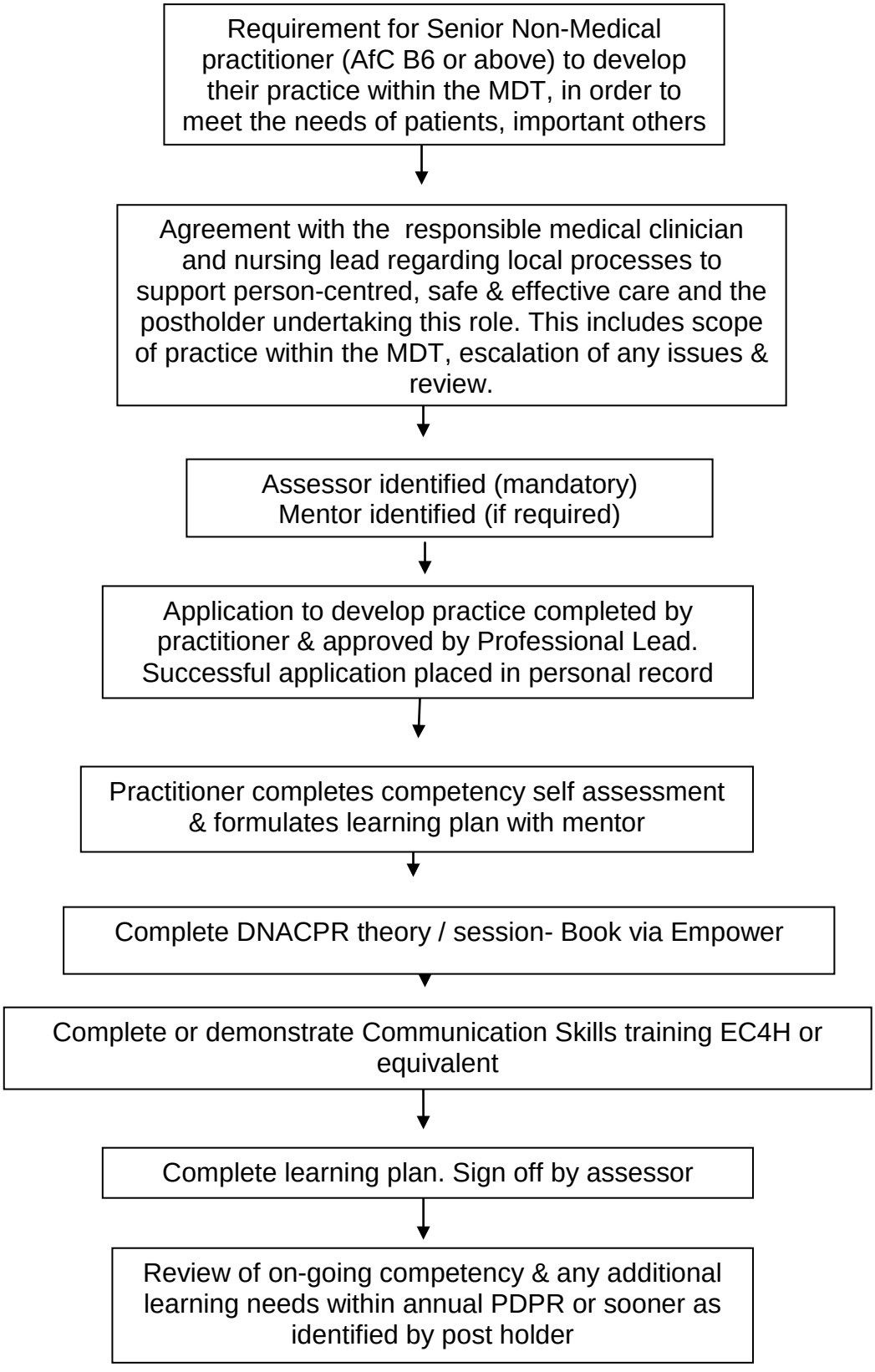
	principles of adult protection to inform decision making					
3.	Incorporates knowledge of condition and current clinical information into care planning and decision making that reflects realistic treatment options and ethical care decision					
4.	Applies a comprehensive knowledge of proactive management plans which includes potentially reversible causes of deterioration.					
5.	Recognises own limitations and consults and involve others to make appropriate and timely referrals to support complex decisions and situations and escalates as required.					
6.	Applies knowledge of the organisational processes for anticipatory care planning including documentation and information sharing. ▪ Take responsibility for documenting, appropriately sharing and regularly reviewing anticipatory care plans					

References: NES (2017) Palliative and End of Life Care Knowledge and Skills Development Framework for the Health and Social Service Workforce in Scotland

Bibliography: NHS South of England UDNACPR competency Framework

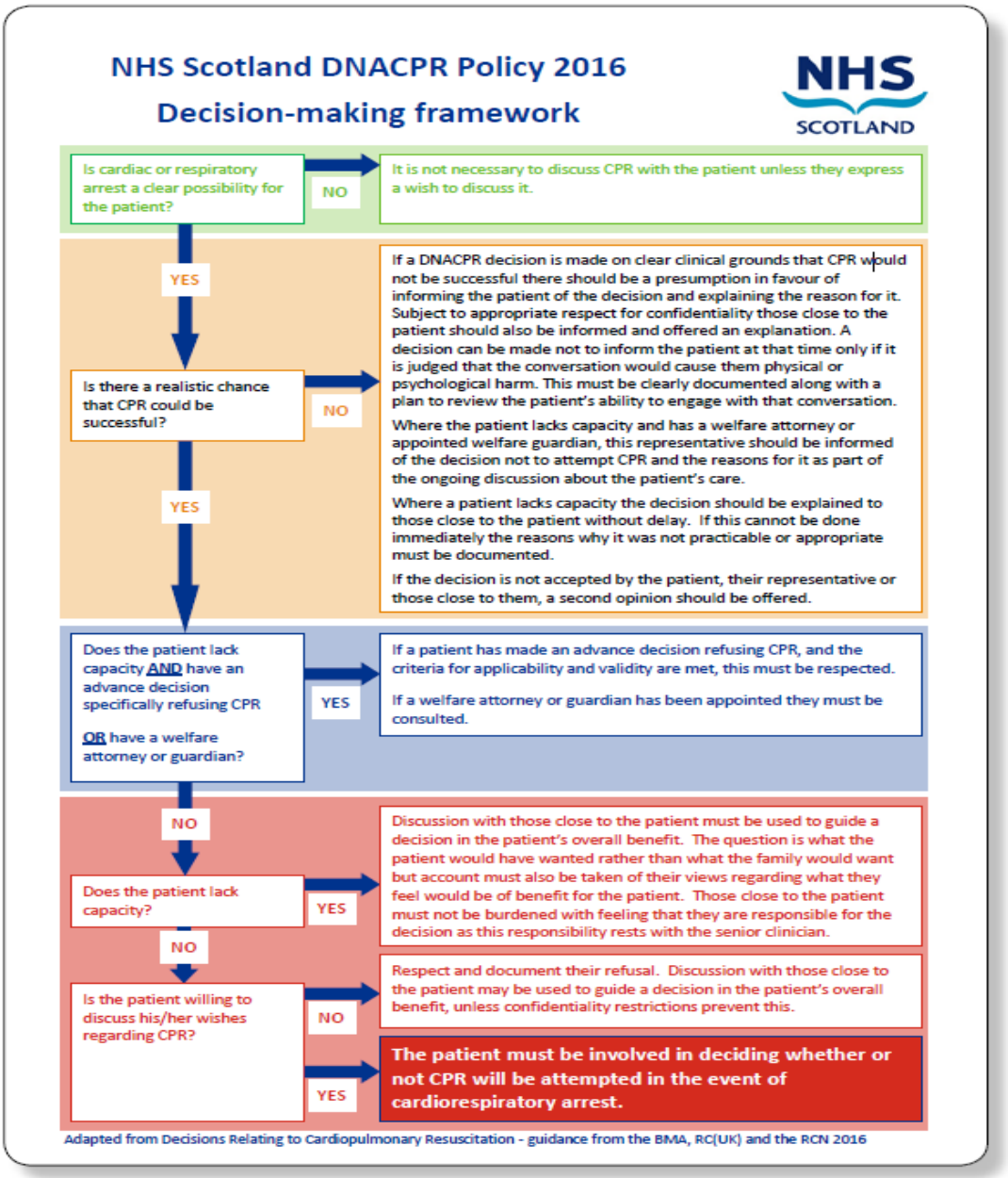
Appendix 3

Procedure for Do Not Attempt Cardiopulmonary Resuscitation Decision-making & Communication for Adults by Non-Medical Practitioners



Appendix 4: decision making framework (from SG DNACPR 2016)

The Decision-Making Framework



Glossary of terms

Non-Medical Registered Healthcare Practitioners	Registered Nurse or equivalent healthcare professional qualification e.g., advanced practice Allied Health Professions
CPR	Treatment given with the aim of restoring sustainable, spontaneous circulation and breathing when both have stopped
Those who matter / relevant others	Those close to the individual such as the individual's spouse, partner, relatives, carers, named person, representative, advocate, welfare attorney or welfare guardian.
Capacity	People with capacity are able to understand their situation and the consequences of their decisions. An assessment of capacity should relate to the specific decision the person is being asked to make and to their ability to fully understand their situation and the implications of their decision. All reasonable support to aid their decision making should be offered. Individuals who are judged to lack the capacity to make decisions about their care should be managed under the principles of the Adults with Incapacity (Scotland) Act 2000.
Advance statement/Statement of wishes **Advance Directive or Advance Decision**	A written record or verbal communication on record of what the person would wish to happen in certain circumstances. It may include changes in health state or preferences for practical things to be done in future to inform future care. Only comes into force if the person loses capacity.* *Scottish law does not provide a specific framework for advance statement other than for the treatment of mental illness. There is no law in Scotland that details a document or registering body for advance decisions to refuse treatment, advance directives or living wills. However, the Adults with Incapacity Act (Scotland) states that in determining what, if any, intervention is to be made, account shall be taken of past and present wishes and feelings of the adult. This guiding principle allows previous witnessed statements about an

	intervention to be used as evidence of previous wishes.
Advance Decision to Refuse Treatment (ADRT). This applies to England and Wales.	ADRT is a specific legal document within the Mental Capacity Act in England and Wales that allows someone to refuse a treatment in advance. An ADRT does not apply in Scotland. However, it must be considered in guiding discussions and decision making. An advance decision or directive cannot be used to demand a treatment that would not work.
Living will	In Scotland the term Advance Directive is most widely used. In other parts of the UK it is called an Advance Decision and it used to be known as a Living Will.
KIS (Key Information Summary)	Key Information Summary (KIS) is an extension of the Emergency Care Summary (ECS) database. It allows selected parts of the GP electronic person's record to be shared electronically with other parts of the NHS, using a template within the GP clinical system. In addition to the information available on ECS (i.e. patient demographics, medications and allergies) the following information may be included, as appropriate to clinical need: • Past Medical History (High-priority read codes are automatically included) • Baseline functional and clinical status, including capacity • Triggers for deterioration • Current care needs and arrangements • Emergency Contacts and Next of Kin Details • How far to escalate care • Preferred place of care, and final care, other specific person/carer wishes • Palliative care information • Legal issues such as power of attorney • DNACPR status • Special alerts – for example around staff safety Often the most useful information is contained in the free text section of

	the KIS (the “special note”) as this is designed to provide a précis of the most relevant clinical and social information for a particular individual A KIS can only be written from within a GP practice and can be accessed by: • All Secondary care users • Out Of Hours service and NHS24 • Scottish Ambulance Service • Hospital Pharmacies • Hospices • Mental Health Units
s47 certificate	An adult who cannot give informed consent to medical treatment can only be treated under a Certificate of Incapacity authorised by Section 47 of the Adults with Incapacity Act. This is issued by the GP or hospital doctor and is usually renewable three yearly. The Certificate applies to treatment for physical and mental disorders that do not fall under the scope of the Mental Health (Care & Treatment) (Scotland) Act 2003
Appropriate practitioner	Solicitors, medical practitioners and others who have completed the appropriate course* can assess for capacity. Where a solicitor has doubts about an individual’s capacity, they should seek the opinion of a medical practitioner. Although the AWI act gives the medical practitioner the main responsibility to decide whether a person is capable of consenting to treatment, they are expected to use multi-disciplinary consultation as part of the overall assessment *e.g. Adults with Incapacity : The Assessment of Capacity for Health Care Professionals Module provided by Edinburgh Napier University
NMC	Nursing and Midwifery Council https://www.nmc.org.uk/
HCPC	Health and care professions council http://www.hcpc-uk.co.uk/