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