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|  | | <h2 style="text-align: center;">County-wide Policy</h2> | |
| <p>Title: SOMERSET TREATMENT ESCALATION PLAN (STEP) & RESUSCITATION DECISION POLICY</p> | | | |
| <p>Keywords – Not for CPR, DNACPR, Ceiling of Care, Treatment Escalation Plan, Allow Natural Death</p> | | | |
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| <p>Ratification date: April 2018</p> | | <p>Review date: April 2021</p> | |
| <p>Applies to: Adult In-patients in Acute Trusts and appropriate adult patients in community settings</p> | | <p>Exclusions: Maternity and Day Case Patients</p> | |
| <p>Purpose: To provide clear guidance for staff with regard to the decision making process and documentation of resuscitation status including the identification of a 'ceiling of care'.</p> | | | |
| <p>VERSION CONTROL - This document can only be considered current when viewed via the Policies and Guidance database via the Trust intranet. If this document is printed or saved to another location, you are advised to check that the version you use remains current and valid, with reference to the active date.</p> | | | |

Appendices

- A - [Decision Making & Legal Representatives Algorithm](#)
- B - [Somerset Treatment Escalation Plan & Resuscitation Decision Form](#)
- C - [Documenting a Decision – Acute Trusts](#)
- D - [Documenting a Decision – Community Settings](#)
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Key Points:

- Patients do **NOT** have a right to demand treatment (including CPR) that is deemed medically inappropriate. In addition, those close to patients who lack capacity similarly have no rights to demand treatment and are **NOT** the final decision makers in this process.
- Decisions regarding CPR and treatment options recorded on another organisation's DNACPR or TEP form will be recognised until a time when the relevant information can be transferred to a STEP form.
- Decisions recorded on a Somerset Treatment Escalation Plan (STEP) form are **NOT** legally binding.
- Where no CPR status is documented, or evident, an assumption in favour of conducting CPR is made universally.
- All in-patients in Acute and Community Hospital wards **MUST** have a recorded resuscitation status using a STEP form.
- A patient with capacity **MUST** be involved in any decision to withhold a treatment unless they state they do not wish to be involved or physical or psychological harm would be expected as a direct result of these discussions. It is **NOT** sufficient to cite patient distress as a reason for not involving a patient with capacity in any decision to withhold treatment.
- It is not necessary to discuss CPR status if all emergency treatment is to be made available to a patient – simply document the rationale and the decision in favour of all interventions using a STEP form.
- There is no legal requirement to involve relatives in any decision regarding resuscitation status, it is best practice however, to involve relatives and significant others in any decisions relating to resuscitation where practicable.
- Refusal of treatment (including CPR) by patients with or without capacity with a valid Advanced Decision to Refuse Treatment **MUST** be respected and considered.

Introduction

- 1.1 Cardiac and respiratory failure are an inevitable part of dying, and it is necessary to identify, on an individual basis, those in whom cardiopulmonary resuscitation (CPR) is unlikely to be successful, when it would be against their wishes or when attempts to resuscitate would merely prolong their natural death in an invasive and distressing manner. It is therefore necessary to categorise patients with respect to these variables. Helping patients to make clear decisions is regarded as good practice and should be carried out in a sensitive, realistic and honest manner.
- 1.2 This document is a unified policy agreed between the Somerset Clinical Commissioning Group, Taunton & Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, Hospices providing for population of Somerset and South Western Ambulance Service NHS Foundation Trust. This policy takes regard of the current the guidelines published in joint statements from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2007) and the Mental Capacity Act (2005) and takes into consideration the 2014 judgement from the Royal Courts of Justice relating to Tracey v Cambridge University Hospitals NHS Trust.

1. Definitions

- 2.1 **Cardiopulmonary Resuscitation (CPR)** is a basic emergency procedure for life support, consisting of artificial respiration and manual external cardiac massage. It is used in cases of cardiac arrest to establish effective circulation and ventilation in order to prevent irreversible cerebral damage resulting from anoxia.
- 2.2 **Allow Natural Death (AND)** indicates that in the event of cardiopulmonary arrest, neither basic nor advanced resuscitation will be instigated.
- 2.3 **Somerset Treatment Escalation Plan & Resuscitation Decision Form (STEP)** is a document designed to facilitate communication between healthcare professionals outlining an individual treatment plan, focusing on which treatments may or may not be the most helpful for a patient should they deteriorate. A variety of treatments can be considered such as antibiotic

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therapy or mechanical ventilation and the plan must include a resuscitation decision.

3. Making the Decision

- 3.1 For the majority of patients a decision in favour of conducting CPR and all interventions is assumed. However, this may not be the case with all patients and consideration to withholding some treatments, including CPR, may be appropriate. Even if all treatment is on offer it is important to share such decisions, as a person may want to express their right to refuse them.
- 3.2 It is appropriate to consider allowing a natural death and/or implementing a 'ceiling of care' for a patient in the following instances:
 - 3.2.1 It is the decision of a patient with mental capacity.
 - 3.2.2 The clinical team considers that CPR will not restart the patient's heart and breathing.
 - 3.2.3 Where there is no benefit in restarting the patients' heart and breathing in the opinion of the medical team, in agreement with the patient or their family/carer/significant others.
 - 3.2.4 When attempting CPR is contrary to the **recorded and sustained** wishes of an adult who was mentally competent and aware of the implications at the time of making the decision and who now lacks the capacity to decide.
- 3.3 In addition, any decision not to perform CPR or any other treatment should only be made after appropriate consultation and consideration of all aspects of the patient's condition. Decisions must be taken in the best interest of the patient, following assessment that should include likely clinical outcome and the patient's known ascertainable wishes.
- 3.4 The clinician has a duty to consult a patient with capacity unless they think the patient will be distressed by being consulted and that this distress might cause the patient harm. These should be convincing reasons that would likely cause the patient to suffer physical or psychological harm (it is not sufficient to cite patient distress as a reason for not involving a patient with capacity in any decision to withhold treatment).

- 3.5 There is no legal requirement (although it is best practice) for this discussion to be held with the relatives of a patient with capacity. In practice, these discussions might best be carried out in the presence of relatives with the consent of the patient.
- 3.6 It is important to document these discussions in contemporary notes using the appropriate box on the STEP and/or in the patient's paper or electronic record. Please refer to the appendices for the documentation requirements for individual organisations.

4 Making Decisions for Those Who Lack Capacity

4.1 **Assessing lack of capacity** – The Mental Capacity Act (MCA) sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time (see below). It is a “decision-specific” and time specific test. No one can be labelled ‘incapable’ simply as a result of a particular medical condition or diagnosis.

4.2 The Capacity Test:

4.2.1 A person lacks capacity if they are unable to make decision for themselves because of impairment of, or disturbance in the functioning of, the mind or brain - “diagnostic test”

4.2.2 The Focus is on the particular matter and the particular time when decision has to be made - “functional test”

4.2.3 The test is whether a person can:

- Understand the relevant information
- Retain the information long enough to make a decision
- Use or weigh the information as part of decision-making process
- Communicate their decision

4.2.4 A person must be able to do all of these things to have capacity. An inability to do any one of these things means the person lacks the capacity to make a specific decision at a specific time.

4.2.5 Once a lack of capacity has been established, any intervention must be in the person's best interests:

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4.3 **Best Interests** – The MCA provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person making the determination must consider (do not confuse this with 'advance decisions' below). Also, people involved in caring for the person lacking capacity must be consulted concerning a person's best interests.

4.4 **Best interests checklist:**

4.4.1 Will the person regain capacity in future? If so when?

4.4.2 The person must be involved to maximum extent possible

4.4.3 Regard must be paid to past and present wishes of the person; their relevant beliefs and values; other factors likely to be relevant to them

4.4.4 Take into account views of anyone named by the person; carer or person interested; donee of LPA; deputy; as to what would be in the person's best interests and as to their wishes etc

4.4.5 Can act be done in less restrictive way?

4.4.6 All relevant circumstances to be considered

4.4.7 If issue concerns life sustaining treatment determination re best interests must not be motivated by desire to bring about death

4.5 The MCA deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

4.5.1 **Lasting Powers of Attorney for Health & Well-being (LPAs)** – The MCA allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. A person can empower an attorney to make financial and/or health and welfare decisions on their behalf. Before it can be used an LPA must be registered with the Office of the Public Guardian. Enduring Power of Attorneys can no longer be created, but those created before April 2007 and registered subsequently remain valid (EPAs cover only financial decisions). This registered documentation must be presented to the care team in order to allow them to consider a person the appointed Attorney.

4.5.2 **Court Appointed Deputies** – The MCA provides for a system of court appointed deputies to replace the old (pre-2007) system of receivership. Deputies are able to be appointed to take decisions on welfare, healthcare and financial matters as authorised by the Court of Protection but cannot reuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues. People appointed as receivers before April 2007 will retain their powers concerning property and affairs after the implementation date and will be treated as deputies after this time.

4.5.3 See Appendix A for guidance with regard to decision making and legal representatives.

4.6 The MCA also includes three further key provisions to protect vulnerable people:

4.6.1 **Independent Mental Capacity Advocate (IMCA)** – An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for them, such as family or friends. They will only be involved where decisions are being made about serious medical treatment or a change in the person's accommodation where it is provided by the National Health Service or a local authority. The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. The Independent Mental Capacity Advocate (IMCA) service can be contacted on info@advocacyinsomerset.org.uk or telephone 0333 3447928.

4.6.2 **Advance Decisions to Refuse Treatment (ADRT)** – These allow people to make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to advance decisions. Where an advance decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. These formalities are that the decision must be in writing, signed and witnessed. In

addition, there must be an express statement that the decision stands “even if life is at risk” which must also be in writing, signed and witnessed.

4.6.3 The MCA confirms that an ADRT will be valid, and therefore legally binding on the healthcare team if the following criteria are met:

- The patient was 18 years old or over and had capacity when the decision was made.
- The decision is in writing, signed and witnessed.
- It includes the statement that the advance decision is to apply even if the patient’s life is at risk.
- The advance decision has not been withdrawn.
- The patient has not, since the advance decision has been made, appointed a welfare attorney to make decision about CPR on their behalf.
- The patient has not done anything clearly inconsistent with its terms.
- The circumstance that have arisen match those envisaged in the advance decision.
- The advance decision was not made under duress.
- The advance decision is clear and unambiguous.

4.6.4 An ADRT does not need to be completed on a specific form – it can take any form including a hand-written note – it is legally binding if it meets the criteria described above.

4.6.5 If the advance decision does not meet these criteria but appears to set out a clear indication of the patient’s wishes, it will not be legally binding but should be taken into consideration in determining the patient’s best interest.

4.7 The MCA includes a criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

4.8 In an emergency situation the decision will remain a ‘best interest’ decision, but will be highly influenced by the immediate nature of the clinical circumstances, and will also include a consideration as to whether CPR in all

the circumstances may be futile. Again the decision making rationale should be appropriately documented when clinically appropriate to do so.

5. Documenting the Decision

5.1 The general principle holds that any decision will be documented using the Somerset Treatment Escalation Plan and Resuscitation Decision form (see Appendix B for an example) with the option of adding explanatory text in the patient's record if required.

5.2 Individual organisational requirements of the documentation process can be found at Appendix C for acute trusts and Appendix D for community trusts.

5.3 The decision will be documented using the terminology:

5.3.1 **For CPR** - In the event of cardio-respiratory arrest, CPR will be undertaken

5.3.2 **To Be Allowed A Natural Death (AND)** - This definition is limited to CPR in the event of a cardio-respiratory arrest and does not alter the medical or nursing care of the patient. **All other appropriate treatment and care must continue including appropriate observations.** An AND decision does **NOT** override clinical judgement in the unlikely event of a reversible cause of a person's respiratory or cardiac arrest that does not match the circumstances envisaged when the decision was made and recorded e.g. choking, displaced tracheal tube or blocked tracheostomy.

6. Communicating the Resuscitation Decision

6.1 Patient's with capacity **must** be involved in discussions about their resuscitation status and/or treatment options and a sensitive exploration of the patient's thoughts must occur unless the clinician thinks the patient will be distressed by being consulted and that this distress might cause the patient physical or psychological harm; or they indicate that they do not wish to participate in the discussion. In these cases a decision will be made in their 'best interest'. Information concerning resuscitation and CPR is available for patients and relatives and can be found in the Trust's patient leaflet 'Decisions Relating to Resuscitation' via the Trust's leaflet database.

- 6.2 Patients who lack the capacity to make their own decisions may have appointed someone who has LPA or have a nominated IMCA and they must (where practicable) be involved in the process.
- 6.3 It is good practice to involve family members in the decision making process (with the consent of the patient with capacity) however, it should be emphasised that they are informing the process rather than making the final decision and have no legal status with this regard. It may be appropriate to involve the spiritual team to support the patient and their family through this process.
- 6.4 The original STEP form should accompany the patient on discharge home or to another care setting. For patients being transferred or discharged from acute trust settings this is only required if an AND decision has been made **or** a 'ceiling of care' is in place i.e. the patient is not for re-admission to an acute hospital. A copy of the form must remain in the patient's notes for urgent or unplanned use.
- 6.5 Where a patient with an AND decision is being discharged home, it is the medical and nursing team's responsibility to ensure that the patient's significant others are aware of the decision and know what to do in the event of the patient's death.
- 6.6 If a patient requires transportation by the ambulance service, ambulance control must be made aware of the existence of an AND decision at the time of booking.
- 6.7 The doctor making the decision must inform the senior nurse on duty of the content of the current STEP. The nurse informed of the decision should then cascade the information throughout the remainder of the team, updating nurse handover sheets (using the terminology 'for CPR' or 'AND' as appropriate) and informing allied health professionals involved in the patient's care. It is not appropriate for resuscitation status to be recorded on ward bed state boards.

6.8 It is important that the resuscitation status is communicated when the patient is transferred within the hospital including when attending other departments such as Diagnostic Imaging. It is the responsibility of the designated nurse caring for the patient to ensure that this information is communicated. The receiving department must routinely seek clarification of resuscitation status in the event that this information is not provided.

7. Reviewing Resuscitation Status and Ceiling of Care

7.1 The recorded resuscitation status will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified. There is no requirement to identify a review date.

7.2 Though indefinite, the decision should be reviewed regularly. Typically this should be whenever clinically appropriate or whenever the patient is transferred between medical teams and from one healthcare setting to another, admitted from home, in the event of significant changes in the patients' condition or in the event that the patients expressed wishes change.

8. Changing the Resuscitation Status of a Patient

8.1 The STEP form should be crossed through with a diagonal line on both sides and the lines signed and dated by the person changing the resuscitation status. Involving the patient in the revision or reversal of a decision relating to resuscitation and other treatments is required. However, if they lack capacity it may be necessary to involve a person with lasting power of attorney or an IMCA.

9. Resuscitation Status in Children and Young People

9.1 All children including neonates and young people up to their 18th birthday experiencing respiratory or cardio respiratory arrest will normally have CPR attempted, unless their condition is such that this is considered inappropriate. In this situation the consultant paediatrician in charge of the child's care will discuss this with the child where possible and their parent or legal guardian. If made, the decision to allow a natural death will be documented in the appropriate Child and Family Wishes Advance Care Plan.

10. Maternity and Day Surgery Patients

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- 10.1 Due to the fact that they are often not seen by a doctor during their admission, it is not necessary to document a 'For CPR' decision for any maternity patients as an assumption for all interventions including CPR will be made universally. In the unlikely event that a decision to Allow a Natural Death is made for a pregnant woman it should be documented in the method described above using the STEP form.
- 10.2 Similarly, a decision in favour of all treatments including CPR, is made for all day-case patients universally unless a pre-existing decision regarding treatment options including CPR is in place. In the event that a decision to Allow a Natural Death is made for a day-case patient it should be documented in the method described above using the STEP form.

11. Mental Health In-patients

- 11.1 It is not necessary to document a 'For CPR' decision for any mental health inpatients. However, there may be inpatients for whom an AND decision is appropriate, and this should be documented in the method described above using a STEP form.

12. Performance Monitoring

- 12.1 Audit of compliance with this policy will be undertaken as part of routine audit activity in accordance with the relevant Performance Monitoring Framework. See Appendix E.

13. Review

- 13.1 This document will be maintained by the author to reflect the most up to date national guidance as applicable, and/or the current research literature. The authors are responsible for ensuring appropriate consultation by all relevant and involved organisations on the review of this document.

14. References

- *Guidelines on Decisions Relating to Cardiopulmonary Resuscitation.* (2016) Guidance from the British Medical association, the Resuscitation Council (UK) and the Royal College of Nursing.
- *Mental Capacity Act* (2005) Department of Health.
- *Tracey v Cambridge University Hospitals NHS Trust.* (2014) Neutral Citation

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Somerset Treatment Escalation Plan & Resuscitation Decision Policy - 2018

Number (2014) EWCA Civ 822, Royal Courts of Justice.

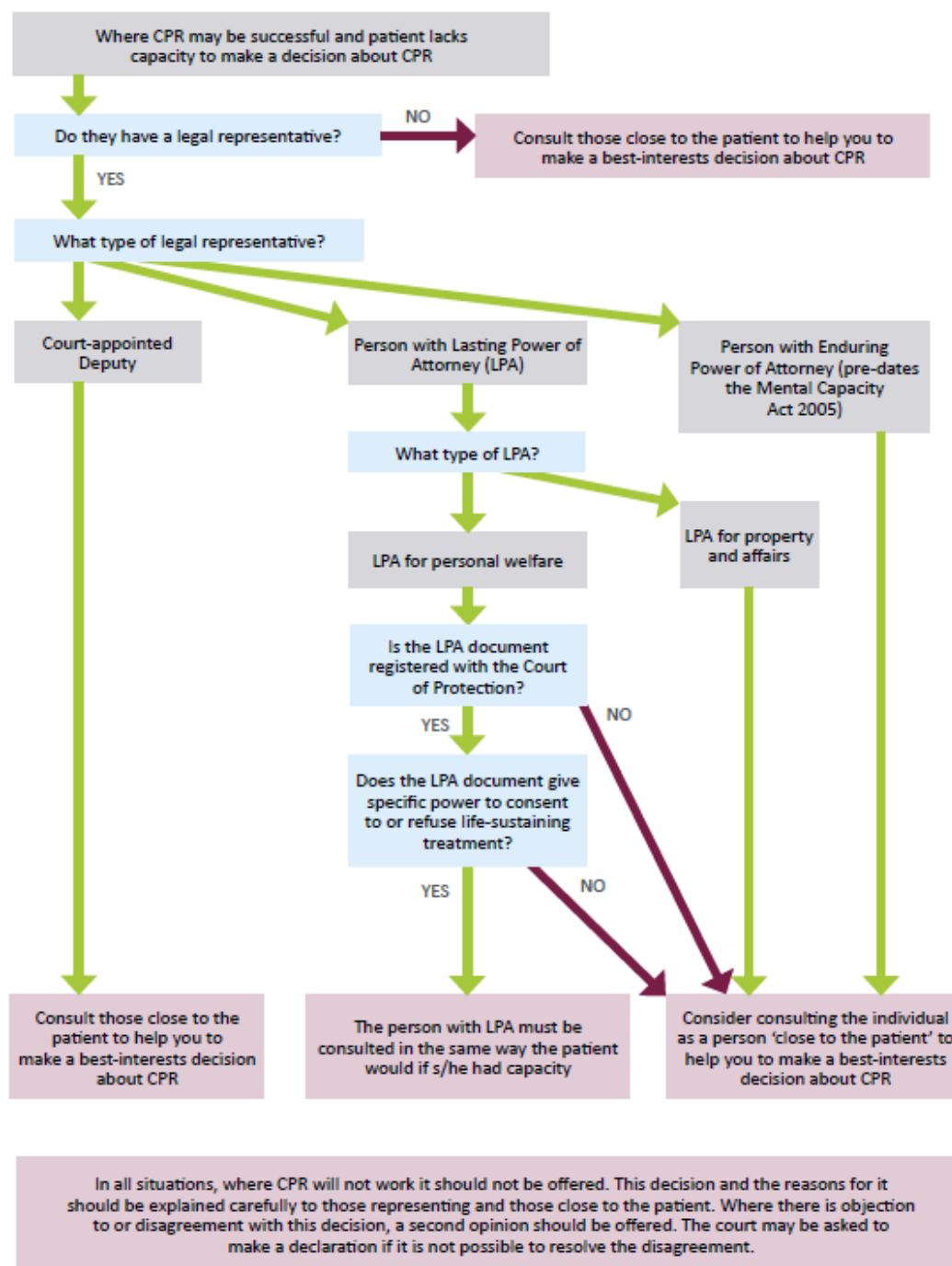
- *Recommended Standards of Recording – Do Not Attempt Resuscitation (DNAR) Decisions* (2009) Resuscitation Council (UK)

- *Treatment and Care Towards End of Life: Good Practice in Decision Making* (2010) GMC

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Appendix A


Decision-making & Legal Representatives



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Appendix B

Somerset Treatment Escalation Plan & Resuscitation Decision (STEP) Form



Treatment Escalation Plan & Resuscitation Decision

This form represents clinical decisions which have been made with patient/carer involvement as far as possible.
All treatments marked as applying must be medically appropriate. Please see TEP policy for full guidance.

| | |
|---------|--|
| Name | |
| Address | |
| NHS No | |
| DOB | |

My personal priorities; what is important to me at this time in my life

| | |
|----|--|
| 1. | |
| 2. | |
| 3. | |

Boxes which are marked are treatments which are appropriate for this patient.

**For a natural and dignified death
Not for CPR**

**For cardio pulmonary
resuscitation (CPR)**

| | | |
|---|---|--|
| For hospital transfer <input type="checkbox"/> | Full escalation with referral to critical care <input type="checkbox"/> | Non-invasive ventilation Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> |
| Consider hospital transfer <i>Refer to priorities</i> <input type="checkbox"/> | Life prolonging treatment <i>Without referral to critical care</i> <input type="checkbox"/> | IV fluids Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> |
| Transfer if unmanaged symptoms <input type="checkbox"/> | May be for life prolonging treatment <i>Balance treatment priorities against harms</i> <input type="checkbox"/> | IV antibiotics Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> |
| Not for transfer to hospital <input type="checkbox"/> | Not for life prolonging treatment <input type="checkbox"/> | Oral antibiotics for treatment Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> |
| | Likely to be in the last days of life <input type="checkbox"/> | Oral antibiotics for symptom control <input type="checkbox"/> <i>For all</i> |
| | | Symptom control <input type="checkbox"/> <i>For all</i> |

This person has capacity to decide on their treatment and has been informed of these decisions

This person lacks capacity to decide on their treatment. Decisions have been made in line with the Mental Capacity Act

Escalation plan review date – indefinite unless indicated otherwise

| | | | |
|---|-------|------|--|
| Names and roles /relationships of those involved in discussions | | | |
| Clinician completing form signature | | | |
| Full name | Grade | Date | |

December 2017

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Appendix C

Documenting a Decision – ACUTE TRUSTS

Where no CPR Status is documented, or evident, an assumption in favour of conducting CPR is made universally

1. The resuscitation status of **all** in-patients (except paediatric, obstetric and day-case patients) **must** be documented using a STEP proforma (see Appendix C) at or around the time of admission.
2. In addition to this, it may be appropriate to detail which treatment interventions in the event of deterioration in a patient's clinical condition should be considered appropriate up to and including CPR and admission to critical care.
3. A decision in favour of all interventions, including CPR, can be recognised and documented by **ANY** grade of doctor or appropriately trained registered healthcare professional (i.e. specialist nurses) by completing the 'For CPR' box only. A ceiling of care need not be completed for these patients unless there are circumstances that require clarification (i.e. a decision has been made in favour of CPR in spite of medical concerns) however, the rationale for the decision **must** be documented.
4. A decision not to perform CPR and/or establishing a 'ceiling of care' should ideally be made by the consultant responsible for the care of the patient, however, when they are not available (e.g. in acute admissions) it is reasonable that the decision be made by a doctor of SPR/ST3 level at least and should be recorded by completing the 'Allow Natural Death' box of the STEP. This decision must be reviewed by the consultant responsible for the care of the patient at the earliest available opportunity i.e. post-take ward round.
5. **ANY** grade of doctor may complete a STEP **on behalf** of the Consultant or deputy but it must be documented that senior medical advice has been sought.

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6. The completed STEP form must be filed at the front of the patient's paper record.

7. Patients who are thought to be at the end of their lives should be cared for under an appropriate end of life care plan and a STEP must be completed recording the decision.

Appendix D

Documenting a Decision – COMMUNITY INPATIENT SETTINGS

Where no CPR Status is documented, or evident, an assumption in favour of conducting CPR is made universally

1. The resuscitation status of all Community Hospital and Older People's Mental Health inpatients must be reviewed and documented using a STEP form (see Appendix A) at or around the time of admission.
2. It is not necessary to document a 'For CPR' decision for mental health inpatients. However there may be inpatients for whom an AND decision is appropriate.
3. Responsibility for making an AND decision lies with the most senior doctor who has medical responsibility for the patient. Discussions about resuscitation should be undertaken by experienced medical or nursing staff. Where this discussion is undertaken by a senior nurse, any decisions must also involve the doctor holding medical responsibility for the patient. Subject to this, the STEP form can be completed by a senior nurse.
4. The completed STEP form must be scanned into RiO and kept with the patient's paper record.
5. If an AND decision is made:
 - 5.1 This must be recorded on Rio as a Rio Alert.
 - 5.2 AND status must also be recorded, with consent from the patient, on the Electronic Palliative Care Co-ordination System (EPACCS – End of Life Register).
 - 5.3 The patient's GP should be made aware of the decision at the earliest opportunity and reviewed at this time.
6. Patients in the community who are thought to be at the end of their lives should be cared for under an appropriate end of life care plan and a STEP form must be completed recording the decision.

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Appendix E

Policy performance monitoring framework – Acute Trusts

| Element of policy for monitoring | Policy section | Monitoring method - Information source (eg audit)/ Measure / performance standard | Item Lead | Monitoring frequency / reporting frequency and route | Arrangements for responding to shortcomings and tracking delivery of planned actions | Arrangement for ensuring learning / embedding improvements |
|--|----------------|---|------------------|--|--|--|
| <i>Treatment Escalation Plan (TEP)</i> | | <p>The following audit is completed quarterly on selected medical, surgical and orthopaedic wards –</p> <ol style="list-style-type: none"> 1. Is there a ceiling of care documented on the STEP? 2. Is there documented evidence of the rationale for a ceiling of care? 3. Is there documented evidence of discussion with the patient? 4. Is there documented evidence of discussion of the plan with the family/relatives? <p>Case selection ensures inclusion of both medical and surgical patients.</p> <p>On an annual basis the whole in-patient population of the acute hospital on a given day is examined in the same manner.</p> | Operational Lead | Audit undertaken quarterly and reported to the Deteriorating Patient Committee (DPC) twice annually. | <p>Where the data indicate under-performance, the Chair of the DPC will nominate a Lead to produce a corrective action plan.</p> <p>Actions are reviewed by receipt of status reports at the DPC, enabling continual monitoring to completion.</p> | Follow-up to address audit performance issues will primarily be via onward dissemination of the findings to CDs and CSLs as necessary. |

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