

COPY - RCSLT NI response to the Advanced Care Policy Consultation

Submitted online 8 March 2022

Question 1 Ambition of Advance Care Planning (page 6)

Do you agree with the ambition of the Advance Care Planning policy? (Please Tick)

Yes **YES**

~~No~~

Please provide any further information you wish to share on your answer

Overall, this is a very informative and useful document and diagrams work well within it. The premise is excellent, and we welcome the clear link to the Mental Capacity Act (2016). The importance (as documented in the policy) of reviewing decisions and updating as appropriate should a service user's wishes change is clear and very welcome.

We welcome the explicit reference to *"Decisions must not be made on the basis of assumptions based solely on factors such as the person's age, disability, or on a professional's subjective view of a person's quality of life"*.

People with speech, language and communication needs (SLCN) often face greater difficulties in making their views known and may require specific support to participate in decisions about their life and advance care planning. Considering this, we have suggested two specific text amendments to the document in our response to ensure the active and full participation of service users with impaired communication.

Q2 What is Advance Care Planning? (Page 6)

Does the policy clearly explain what Advance Care Planning is? (Please Tick)

Yes **YES**

~~No~~

Please provide any further information you wish to share on your answer.

Suggested amendment to text

We believe this section could be strengthened and more inclusive through an explicit recognition that some adults may require additional support to access advance care planning. This is particularly the case for people with disabilities or conditions that impair their ability to have conversations. As such **we recommend an addition to this section as outlined in yellow below:**

“Advance Care Planning should be an important part of life for all adults. It needs to be encouraged by those providing care, support or treatment, to ensure that people have the opportunity to have timely, realistic and practical conversations. Some adults may require communication support to participate in advance care planning discussions.”

It is important that is acknowledged at an early point in the document, rather than being implied or assumed. This will help to ensure that people who need support to have a conversation can benefit from advance care planning.

Communication support for those with SLCN may involve providing information in a variety of formats such as easy read, using strategies to support understanding and retention of information and allowing additional time to facilitate alternative or augmented forms of communication such as gestures, signs, symbols, word boards and other communication aids.

We feel this would align well with the detail provided on page 14 about the ways in which professionals may need to adopt a ‘tailored’ approach to communication.

Q3 Values & Principles of Advance Care Planning (page 7 and page 8)

Are the Values and Principles stated in the policy clear, comprehensive and relevant? (Please Tick)

Yes **YES**

Please provide any further information you wish to share on your answer.

We welcome the inclusion of accessibility as a core value and that this should be meaningful for the person concerned.

Q4 Why is it important to have Advance Care Planning Conversations? (Page 8 and page 9)

Does the policy clearly explain the benefits of Advance Care Planning? (Please Tick)

Yes **YES**

Please provide any further information you wish to share on your answer

Q5 When should Advance Care Planning happen? (Page 10)

Do you agree that Advance Care Planning is important for any adult at any stage of life? (Please Tick)

Yes **YES**

Please provide any further information you wish to share on your answer.

Q6 How Advance Care Planning Conversation(s) are used (page 15 and page16)

Do you understand how Advance Care Planning conversations are used? (Please Tick)

Yes **YES**

Please provide any further information you wish to share on your answer

Suggested amendment to text

We note the below text on page 15 and **recommend the addition in yellow** to ensure clarity with the requirement to provide all help and support to enable a person to communicate their wishes as per the Mental Capacity Act (2016)¹. Whilst we appreciate these principles are fully explained later in the document, we believe that the additional text here is necessary.

“A person’s Advance Care Planning conversations, any recommendations and/or decisions will be used in the future should a person be unable to make a specific decision for themselves. This may be because they do not have mental capacity or are unable to communicate what their wishes are, despite all practical help and support being given.”

Q7 Components of Advance Care Planning (page 16)

**Does the components model help explain the different elements of Advance Care Planning?
(Please Tick)**

Yes **YES**

No

Please provide any further information you wish to share on your answer.

Q8 Legal Component of Advance Care Planning Mental Capacity Act (NI) 2016 (page 19 to page 22)

Is the policy clear on how mental capacity relates to Advance Care Planning? (Please Tick)

Yes **YES**

No

Please provide any further information you wish to share on your answer.

**Q9 Clinical Component of Advance Care Planning Declining Health and Unexpected Emergencies
(pages 26 to page 29)**

**Is the policy clear on: (a) How the ReSPECT recommendations form part of Advance Care Planning?
(Please Tick)**

Yes **YES**

¹ [Mental Capacity Act \(Northern Ireland\) 2016 \(legislation.gov.uk\)](https://legislation.gov.uk) Part 1 PRINCIPLES Section 5 (5) The reference in subsection (2)(c) to persons whose involvement is likely to help the person to make a decision may, in particular, include a person who provides support to help the person communicate his or her decision.

~~No~~

Please provide any further information you wish to share on your answer.

Is the policy clear on: (b) How resuscitation recommendations will be recorded on the ReSPECT form, and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms will no longer be used?

(Please Tick)

Yes YES

~~No~~

Please provide any further information you wish to share on your answer.

Q10 Further comments Further comments relating to the Advance Care Planning Policy can be noted below.

In more broad terms, members would welcome clarity about practically who will be responsible for carrying it out this policy on the ground and how will it be recorded. For example, in NHSCT specialist nurses carry out advance care planning discussions at moment as part of REACH, Anticipatory Care teams and Enhanced Care Home response teams. Will this be more widely spread out across teams going forward?

Another specific query that has arisen from our consultation with members, is whether ACP will be documented into care plans so it is deemed an essential area that will be covered (albeit at the right time for the service user).

For any additional information please contact Vivienne Fitzroy, RCSLT NI Policy Adviser:

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